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## 200.000 APPLIED BEHAVIOR ANALYSIS THERAPY GENERAL INFORMATION

## **201.000      Arkansas Medicaid Participation Requirements for Applied Behavior Analysis Therapy Providers      1-1-25**

### **201.100      Individual Service Provider Participation Requirements      1-1-25**

Individual providers of applied behavior analysis (ABA) therapy services must meet the following requirements to be eligible to participate in Arkansas Medicaid:

- A. Complete the provider participation and enrollment requirements contained within section 140.000 of this Arkansas Medicaid manual and enroll as an Arkansas Medicaid provider;
- B. Successfully pass the background checks and searches required by Ark. Code Ann. §20-48-812(c)(1-4); and
- C. Meet the credentialing, experience, training, and other qualification requirements for the ABA therapy service under section 202.000 of this Arkansas Medicaid manual.

### **201.200      Group Service Provider Participation Requirements      1-1-25**

- A. Group providers of applied behavior analysis (ABA) therapy services must meet the following requirements to be eligible to participate in Arkansas Medicaid:
  - 1. Complete the provider participation and enrollment requirements contained within section 140.000 of this Arkansas Medicaid manual; and
  - 2. Each individual performing ABA therapy services on behalf of the group must complete the individual provider participation and enrollment requirements under section 201.100 of this Arkansas Medicaid manual.
- B. A group provider of ABA therapy services must identify the certified practitioner as the performing provider on the claim when billing Arkansas Medicaid for the service.

### **201.300      Providers in Arkansas and Bordering States      1-1-25**

Providers with a principal place of business in Arkansas and within fifty (50) miles of the state line in the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may enroll as applied behavior analysis therapy providers if they meet all Arkansas Medicaid participation requirements of this Arkansas Medicaid manual.

### **201.400      Providers in States Not Bordering Arkansas      1-1-25**

Providers with a principal place of business fifty (50) or more miles from the Arkansas state line or in states not bordering Arkansas may enroll as a limited Arkansas Medicaid service provider to serve an Arkansas Medicaid eligible beneficiary by entering into a single case agreement. A provider must enter into a separate single case agreement for each Arkansas Medicaid eligible beneficiary served. A provider will retain their limited service provider status for up to one (1) year after the most recent billed date of service. [View or print the provider enrollment and contract package.](#)

## **202.000      APPLIED BEHAVIOR ANALYSIS THERAPY PROVIDER REQUIREMENTS**

### **202.100      Board-Certified Behavior Analyst (BCBA) Participation Requirements      1-1-25**

A board-certified behavior analyst (BCBA) must have board-certified behavior analyst (or more advanced) certification in good-standing from the Behavior Analyst Certification Board.

**202.200 Board-Certified Assistant Behavior Analyst (BCaBA) Participation Requirements 1-1-25**

A board-certified assistant behavior analyst (BCaBA) must have board-certified assistant behavior analyst certification in good-standing from the Behavior Analyst Certification Board.

**202.300 Registered Behavior Technician (RBT) Participation Requirements 1-1-25**

- A. A registered behavior technician (RBT) must have registered behavior technician certification in good-standing from the Behavior Analyst Certification Board.
- B. An individual in the process of completing the training and testing required to receive RBT certification may be provisionally treated as an RBT for purposes of this Arkansas Medicaid manual for up to six (6) months. If the individual has not received RBT certification within six (6) months, then they are prohibited from providing applied behavior analysis therapy services until RBT certification is obtained.

**203.000 Documentation Requirements 1-1-25****203.100 Documentation Requirements for all Medicaid Providers 1-1-25**

See section 140.000 of this Arkansas Medicaid manual for the documentation that is required for all Arkansas Medicaid providers.

**203.200 Applied Behavior Analysis Therapy Service Documentation Requirements 1-1-25**

- A. Applied behavior analysis (ABA) therapy providers must maintain in each beneficiary's service record:
  - 1. The beneficiary's:
    - a. Face sheet with the beneficiary's:
      - i. Full name, address, age, and date of birth;
      - ii. Parent/guardian name(s) and contact information;
      - iii. Assigned primary care provider;
      - iv. Medicaid number; and
      - v. Any diagnoses, allergies, and medications prescribed;
    - b. Autism spectrum disorder diagnosis;
    - c. Applicable medical records;
    - d. Evaluation Referral;
    - e. Comprehensive evaluation report(s), and any related testing results and correspondence;
    - f. Treatment prescription(s); and
    - g. Individualized treatment plan (ITP), and any required documentation in connection with each update to a beneficiary's ITP;
  - 2. Discharge notes and summary, if applicable; and
  - 3. Any other documentation and information required by the Arkansas Department of Human Services.
- B. ABA therapy providers must maintain in each beneficiary's service record the following documentation for all ABA therapy treatment services performed pursuant to section 222.200 of this Arkansas Medicaid manual:

1. Beneficiary's name;
  2. The date and beginning and ending time of the ABA therapy treatment session;
  3. The location and type of setting where the ABA therapy treatment session was provided;
  4. A description of the specific practices, procedures, and strategies within the scope of ABA peer-reviewed literature utilized and the activities performed during each ABA therapy treatment session;
  5. Name(s), credential(s), and signature(s) of the personnel who performed ABA therapy treatment services each session;
  6. Which ITP goal(s) or objective(s) each practice, procedure, and strategy utilized during the ABA therapy treatment session was intended to address;
  7. The criteria and other data collected during the ABA therapy treatment session to measure, monitor, and assess the beneficiary's progress towards their ITP goals or objectives; and
  8. Weekly (or more frequent) progress notes signed or initialed by the supervising board-certified behavior analyst describing the beneficiary's status with respect to each ITP goal or objective.
- C. ABA therapy providers must maintain in each beneficiary's service record the following documentation for all adaptive behavior treatment with protocol modification services performed pursuant to section 222.300 of this Arkansas Medicaid manual:
1. Beneficiary's name;
  2. The name and credentials of the personnel performing the ABA therapy treatment session that the supervising board-certified behavior analyst (BCBA) is observing;
  3. The date and beginning and ending time of the adaptive behavior treatment with protocol modification services;
  4. The location and type of setting where the adaptive behavior treatment with protocol modification services were provided;
  5. A description of any training or assistance provided by the BCBA while performing adaptive behavior treatment with protocol modification services;
  6. A narrative of clinical observations and data collected in connection with the beneficiary's progress towards ITP goals or objectives while performing adaptive behavior treatment with protocol modification services;
  7. Required documentation in connection with any update to a beneficiary's ITP (see section 224.000(A)(2) of this Arkansas Medicaid manual); and
  8. The name and signature of the supervising BCBA that performed the adaptive behavior treatment with protocol modification services.
- D. ABA therapy providers must maintain in each beneficiary's service record the following documentation for all family adaptive behavior treatment services performed pursuant to section 222.400 of this Arkansas Medicaid manual:
1. Beneficiary's name;
  2. Parent/guardian's name and the name of any other individuals that attended the family adaptive behavior treatment meeting;
  3. The date and beginning and ending time of the family adaptive behavior treatment meeting;
  4. The location and type of setting for the family adaptive behavior treatment meeting;

5. A summary of the topics discussed at each family adaptive behavior treatment meeting;
  6. A description of any training or assistance provided by the BCBA to the beneficiary or parent/guardian at the family adaptive behavior treatment meeting;
  7. Any parent/guardian or other individuals' concerns expressed at the family adaptive behavior treatment meeting; and
  8. The name and signature of the supervising BCBA that held the family adaptive behavior treatment meeting.
- E. Any individual ABA therapy provider must maintain:
1. Verification of their required credentials and qualifications. Refer to section 202.000 of this Arkansas Medicaid manual; and
  2. Any written contract between the individual ABA therapy provider and the group ABA therapy provider on behalf of which they provide ABA therapy services.
- F. Any group ABA therapy provider must maintain appropriate employment, certification, and licensure records for all individuals employed or contracted by the group to provide ABA therapy services. If an individual ABA therapy provider performs ABA therapy services on behalf of a group ABA therapy provider pursuant to a contract, then a copy of the contractual agreement must be maintained.

**204.000 Electronic Signatures****1-1-25**

Arkansas Medicaid will accept electronic signatures in compliance with Arkansas Code § 25-31-103 *et seq.*

**205.000 Required Referral to First Connections pursuant to Part C of Individuals with Disabilities Education Act (IDEA)****1-1-25**

The Arkansas Department of Education's First Connections program administers and monitors all Part C of IDEA activities and responsibilities for the state of Arkansas. Each ABA therapy service provider must, within two (2) working days of first contact, refer to the First Connections program any infant or toddler from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability. The referral must be made to the DDS First Connections Central Intake Unit. Each provider is responsible for documenting that a proper and timely referral to First Connections has been made.

**206.000 Required Referral to Local Education Agency pursuant to Part B of Individuals with Disabilities Education Act (IDEA)****1-1-25**

- A. Each ABA therapy service provider must, within two (2) working days of first contact, refer to the Local Education Agency (LEA) any beneficiary three (3) years of age or older that has not entered kindergarten for whom there is a diagnosis or suspicion of a developmental delay or disability.
- B. Each ABA therapy service provider must refer any beneficiary under three (3) years of age they are serving to the LEA at least ninety (90) days prior to the beneficiary's third birthday. If the beneficiary begins services less than ninety (90) days prior to their third birthday, the referral should be made in accordance with the late referral requirements of the IDEA.
- C. Referrals must be made to the LEA covering the beneficiary's place of residence.
- D. Each service provider is responsible for maintaining documentation evidencing that a proper and timely referral to has been made.

**210.000 PROGRAM ELIGIBILITY****211.000 Scope 1-1-25**

Arkansas Medicaid will reimburse enrolled applied behavior analysis (ABA) therapy providers for covered ABA therapy services when such services are provided pursuant to an individualized treatment plan to beneficiaries who meet the eligibility requirements of this Arkansas Medicaid manual. Medicaid reimbursement is conditional upon compliance with this manual, manual update transmittals, and official program correspondence.

**212.000 Beneficiary Eligibility Requirements 1-1-25****212.100 Age Requirement 1-1-25**

A beneficiary must be enrolled in the Child Health Services (EPSDT) Arkansas Medicaid program and between eighteen (18) months and twenty-one (21) years of age to receive applied behavior analysis therapy services.

**212.200 Qualifying Diagnosis 1-1-25**

A beneficiary must have an autism spectrum disorder (ASD) diagnosis established in accordance with Ark. Code Ann. § 20-77-124, to receive applied behavior analysis therapy services. The ASD diagnosis must be demonstrated by:

- A. A delineation of American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders criteria; or
- B. The results of one or more formalized ASD evaluation instruments administered by qualified professionals as defined in Ark. Code Ann. § 20-77-124.

**212.300 Referral to Evaluate 1-1-25**

- A. Applied behavior analysis (ABA) therapy services require an initial evaluation referral signed and dated by:
  - 1. The beneficiary's Arkansas Medicaid assigned primary care provider (PCP);
  - 2. A substitute physician in accordance with section 171.600 of this Arkansas Medicaid manual; or
  - 3. An affiliated physician or PCP operating under the same Arkansas Medicaid group provider as the Arkansas Medicaid assigned PCP.
- B. An initial evaluation referral is required to be completed on a form DMS-641 ER "Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Evaluation Referral." [View or print the form DMS-641 ER.](#)
- C. A DMS-641 ER evaluation referral is only required to perform the *initial* comprehensive evaluation related to ABA therapy services.
- D. No evaluation referral is required for an ABA therapy provider to perform a comprehensive reevaluation necessary to demonstrate a beneficiary's continued eligibility for ABA therapy services (see section 212.500(B) of this Arkansas Medicaid manual).
- E. When a beneficiary has an active treatment prescription for ABA therapy services pursuant to a DMS-641 TP and switches to a new ABA therapy provider, the new provider is not required to obtain or maintain in the beneficiary's service record a DMS-641 ER since any evaluation performed by the new provider would not be the beneficiary's initial comprehensive evaluation for ABA therapy services.

- F. If a beneficiary becomes ineligible for ABA therapy services at any time, then another, new DMS-641 ER evaluation referral and initial comprehensive evaluation is required prior to restarting ABA therapy services.

**212.400 Treatment Prescription****1-1-25**

- A. Applied behavior analysis (ABA) therapy services require a treatment prescription signed and dated in accordance with the following:
  - 1. A beneficiary's *initial* treatment prescription must be signed and dated by the beneficiary's Arkansas Medicaid assigned primary care provider (PCP).
  - 2. A beneficiary's renewal treatment prescription must be signed and dated by:
    - a. The beneficiary's Arkansas Medicaid assigned PCP;
    - b. A substitute physician in accordance with section 171.600 of this Arkansas Medicaid manual; or
    - c. An affiliated physician or PCP operating under the same Arkansas Medicaid group provider as the Arkansas Medicaid assigned PCP.
- B. Unless a shorter time is specified on the treatment prescription, a treatment prescription for ABA therapy services is valid for:
  - 1. Up to six (6) months for a beneficiary from eighteen (18) months to eight (8) years of age; and
  - 2. Up to twelve (12) months for a beneficiary from eight (8) to twenty-one (21) years of age.
    - a. Age is determined based on the beneficiary's age as of the date of the treatment prescription.
- C. A treatment prescription for ABA therapy services must be on a form DMS-641 TP "Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Treatment Prescription." [View or print the form DMS-641 TP.](#)
- D. Beneficiaries who are already receiving ABA therapy services pursuant to an active treatment prescription (on a DMS-693 form) as of January 1, 2025, are not required to obtain a new treatment prescription on a form DMS-641 TP until their existing treatment prescription expires.
- E. A new DMS-641 TP treatment prescription is not required when a beneficiary changes PCPs. An existing treatment scripton would remain valid through its date of expiration if it was valid at the time originally signed.

**212.500 Comprehensive Assessment****1-1-25**

- A. Applied behavior analysis (ABA) therapy services must be medically necessary as demonstrated by the results of a comprehensive evaluation completed by a board-certified behavior analyst (BCBA). An autism spectrum disorder (ASD) diagnosis alone is not sufficient documentation to demonstrate medical necessity.
  - 1. An initial comprehensive evaluation must be performed to demonstrate initial eligibility for ABA therapy services.
  - 2. Once a beneficiary is receiving ABA therapy services, a comprehensive reevaluation must be performed at least every:
    - a. Six (6) months for beneficiaries from eighteen (18) months to eight (8) years of age; and
    - b. Twelve (12) months for beneficiaries from eight (8) to twenty-one (21) years of age.

- B. The initial comprehensive evaluation and each comprehensive reevaluation report must include the following information:

While all the following information must be included in any comprehensive evaluation report, there is not a required order or format in which the comprehensive evaluation report must be prepared.

1. The beneficiary's:
  - a. Name, age, and date of birth;
  - b. Assigned primary care provider; and
  - c. Supervising board-certified behavior analyst (BCBA);
2. A summary of available background history on the beneficiary, including without limitation:
  - a. Pertinent medical, mental, and developmental history, including any medications prescribed to ameliorate behaviors;
  - b. The primary language spoken in the beneficiary's home;
  - c. Whether the beneficiary is currently enrolled in a public or private school or is home-schooled;
  - d. Any additional types of services the beneficiary is known to be currently receiving (i.e. Occupational Therapy, Physical Therapy, or Speech-Language Pathology, Early Intervention Day Treatment services, behavioral health services, etc.);
  - e. Beneficiary's response to any prior treatment(s) performed by the current ABA therapy provider, which in the case of a comprehensive reevaluation for ABA therapy services must include:
    - i. The date the beneficiary started receiving ABA therapy services from the current provider, and if there have been any gaps in ABA therapy treatment services since services started with the current provider;
    - ii. A summary of specific individualized treatment plan goals or objectives met since the beneficiary's immediately preceding comprehensive evaluation;
    - iii. A summary of communication, social, self-help, or other adaptive behavioral skill improvements or acquisitions specific to the beneficiary's targeted area(s) of functional deficit since the beneficiary's immediately preceding comprehensive evaluation;
    - iv. A summary of specific replacement behaviors, tasks, or activities successfully implemented since the beneficiary's immediately preceding comprehensive evaluation;
    - v. A list of specific interfering behaviors minimized or eliminated since the beneficiary's immediately preceding comprehensive evaluation; and
    - vi. Any available direct or indirect evidence of the beneficiary's replacement behaviors, problem behavior reduction or elimination, or skill acquisition in targeted area(s) of deficit transitioning across natural environment settings since the beneficiary's immediately preceding comprehensive evaluation;
3. A summary of one (1) or more interviews with the parent(s), caregiver(s), or other individuals involved in the life of the beneficiary, as appropriate, which should include:
  - a. The date the interview was held;
  - b. The beneficiary's current functioning, skill deficits, and problem behaviors (long-term and recent);



- c. The family's current needs and concerns;
  - d. Any recent family or home stressors and changes; and
  - e. Any other pertinent information concerning the beneficiary and their suspected area(s) of deficit as it relates to their typical daily activities;
    - i. Lack of interview summary is excused if there is documented parent/caregiver refusal or unavailability after reasonable attempts;
- 4. The results of one of the nationally recognized skills-based assessment instruments accepted by the Department of Human Services ([View or print the list of accepted assessment instruments](#)):
  - a. Assessment instrument(s) not included on the accepted list may be administered as a supplement to (but not a replacement for) the administration of one of the accepted instruments;
  - b. It is recommended that when possible and appropriate the same instrument(s) be used for each beneficiary's comprehensive evaluation to establish a benchmark and allow for direct comparison of beneficiary scoring over time.
- 5. If there is a targeted interfering behavior(s), the administration and results of a functional behavior assessment;
- 6. The location(s) and setting(s) where the BCBA conducted direct observation of and data collection on the beneficiary;
- 7. The BCBA's analysis of the beneficiary's current skill and functional strengths, deficits, delays, limitations, and barriers across at least the following domains, including the basis for how the BCBA reached those conclusions for each domain (i.e. direct observation, medical file review, parent interview, etc.):
  - a. Communication and language;
  - b. Social behavior and play;
  - c. Independent play and leisure;
  - d. Self-help and daily living skills;
  - e. Sleeping and feeding;
  - f. Classroom and academic skills; and
  - g. Interfering behavior(s) resulting in harm to self, acting as barrier to learning, or limiting access to community;
    - i. If there are no deficits or concerns in a specific domain (or no interfering behaviors), then that fact should be noted.
- 8. A detailed description of the area(s) of functional skill deficits and delays, beneficiary limitations, and interfering behavior(s) that are to be addressed by ABA therapy services;
  - a. It will not automatically be deemed medically necessary for each beneficiary area of deficit to be addressed by ABA therapy services.
- 9. The BCBA's recommendations on the frequency, duration, and intensity of ABA therapy services;
- 10. The BCBA's interpretation of the beneficiary's medical history, family history, parent or other caregiver interviews, assessment instrument results, and direct observation and data collection that justifies the BCBA's recommendations on the frequency, duration, and intensity of the ABA therapy services;
- 11. A recommended individualized treatment plan (ITP) with goals and objectives to address each targeted area of deficit, functional limitation, and problem behavior included on the ITP;
- 12. The recommended setting(s) for ABA therapy treatment service delivery and how and why the treatment service delivery setting(s) are appropriate for the beneficiary;

13. The parent, guardian, or other family member or caregiver home program, which should include a written description of:
  - a. The specific intervention practices and strategies to be implemented by the parent/caregiver; and
  - b. During what typical activities and in what setting(s) those practices and strategies are to be performed;
14. The schedule of family adaptive behavior treatment service meetings between the supervising BCBA and parent/guardian with an explanation of why the scheduled frequency and duration of family adaptive behavior treatment service meetings is appropriate for the beneficiary; and
15. The signature and credentials of the BCBA who performed and completed the comprehensive evaluation report. A BCBA is certifying to each of the following conditions when signing a comprehensive evaluation report recommending ABA therapy services for the beneficiary:
  - a. The beneficiary's ASD diagnosis is the primary contributing factor to their developmental or functional delays, deficits, or problem behaviors that are to be addressed by ABA therapy services;
  - b. The level of complexity of the beneficiary's condition is such that ABA therapy services can only be safely and effectively performed by or under the supervision of a BCBA; and
  - c. There is a reasonable expectation that ABA therapy services will result in meaningful improvement of the beneficiary's developmental or functional delays, deficits, and problem behaviors because the beneficiary exhibits:
    - i. The ability to learn and develop generalized skills to assist with their independence; and
    - ii. The ability to develop generalized skills to assist in addressing problem behaviors.

## 220.000 PROGRAM SERVICES

### 221.000 Non-covered Services

1-1-25

- A. Arkansas Medicaid will only reimburse for those services listed in sections 222.000 through 223.000, subject to all applicable limits.
- B. Covered services are only reimbursable when delivered in accordance with the beneficiary's individualized treatment plan. See section 224.000.
- C. All ABA therapy services must be delivered by a single ABA therapy provider. Transitioning, alternating, or coordinating ABA therapy services concurrently among multiple ABA therapy service providers is prohibited.
  1. For group ABA therapy providers, this means all ABA therapy services must be performed by individual providers affiliated with the same group.
  2. This provision does not eliminate or in any way restrict a beneficiary's right to select or change their choice of ABA therapy service provider.
- D. A beneficiary receiving Autism Waiver services is prohibited from receiving ABA therapy services.

### 222.000 Covered Services

1-1-25

### 222.100 Behavior Identification Assessment Services

1-1-25

- A. A provider may be reimbursed for medically necessary behavior identification assessment services, which include the following components:
  - 1. Performing the annual comprehensive evaluation, which includes:
    - a. Administering an assessment instrument(s);
    - b. Conducting the parent/guardian interview; and
    - c. Completing the accompanying annual comprehensive evaluation report; and
  - 2. Developing the initial individualized treatment plan (ITP).
    - a. Updating or revising an existing ITP is an adaptive behavior treatment with protocol modification service (see section 222.300 of this Arkansas Medicaid manual).
- B. Behavior identification assessment services medical necessity:
  - 1. Medical necessity for behavior identification assessment services is established by:
    - a. For a beneficiary's initial comprehensive evaluation, an initial evaluation referral on a form DMS-641 ER "Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Evaluation Referral" (see section 212.300 of this Arkansas Medicaid manual). [View or print the form DMS-641 ER](#); or
    - b. For a beneficiary's required comprehensive reevaluations, an active treatment prescription for applied behavior analysis therapy services on a DMS-641 TP that is expiring within sixty (60) days of the date of the comprehensive reevaluation.
  - 2. An evaluation referral on a DMS-641 ER is only required to perform a beneficiary's *initial* comprehensive evaluation.
- C. Behavior identification assessment services must be performed by a board-certified behavior analyst (BCBA) enrolled with Arkansas Medicaid.
- D. All behavior identification assessment services must be prior authorized in accordance with section 240.000 of this Arkansas Medicaid manual).
- E. Behavior identification assessment services are reimbursed on a per unit basis. The unit of service calculation should only include face-to-face time spent by the BCBA with the beneficiary and/or parent/guardian conducting a comprehensive evaluation and any non-face-to-face time spent by the BCBA preparing the accompanying comprehensive evaluation report and developing the beneficiary's *initial* ITP. Updating an existing ITP is considered an adaptive behavior treatment with protocol modification service. [View or print the billable behavior identification assessment services procedure code and description.](#)

**222.200 Applied Behavior Analysis Therapy Treatment Services****1-1-25**

- A. A provider may be reimbursed for medically necessary applied behavior analysis (ABA) therapy treatment services. ABA therapy treatment services are techniques and methods designed to minimize a beneficiary's developmental or functional delays, deficits, or maladaptive behaviors so that the beneficiary's ability to function independently across their natural environments is maximized.

ABA therapy treatment services include the following components (not all of which may be billable):

- 1. Performing ABA therapy treatment services in accordance with the beneficiary's individualized treatment plan (ITP);
- 2. Collecting data and recording session notes in accordance with the ITP; and

3. Reporting progress and concerns to the supervising board certified behavioral analyst (BCBA), as needed.
- B. ABA therapy treatment services medical necessity:
1. Medical necessity for ABA therapy treatment services is initially established by:
    - a. The results of an initial comprehensive evaluation; and
    - b. A treatment prescription on a DMS-641 TP “Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Treatment Prescription” (see section 212.400 of this Arkansas Medicaid manual). [View or print the form DMS-641 TP](#).
  2. The continued medical necessity of ABA therapy treatment services must be demonstrated by:
    - a. The results of a comprehensive reevaluation;
    - b. A treatment prescription on a DMS-641 TP “Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Treatment Prescription” (see section 212.400 of this Arkansas Medicaid manual); and
    - c. One of the following:
      - i. The beneficiary’s demonstrated progress toward one or more of the following:
        - A. Acquiring new communication, social, self-help, or other adaptive behavioral skills in the targeted area(s) of deficit;
        - B. Minimizing or eliminating targeted problem behavior(s); or
        - C. Reducing targeted area(s) of functional deficit or delay (as demonstrated by assessment instrument scores over time); or
      - ii. A list of variables that impacted the beneficiary’s response to their ABA therapy treatment services and a detailed description of how those variables prevented the beneficiary’s anticipated progress towards their ITP goals and objectives since the beneficiary’s immediately preceding comprehensive evaluation.
  3. Notwithstanding anything to the contrary contained in this section 222.200, ABA therapy treatment services cease to be medically necessary if:
    - a. A beneficiary is not demonstrating progress toward ITP goals or objectives over time; or
    - b. Targeted skill acquisition, replacement behaviors, and problem behavior elimination are unable to be transitioned across a beneficiary’s natural environment settings over time.
      - i. The transitioning of targeted skill acquisition, replacement behavior(s), and problem behavior(s) elimination across the beneficiary’s natural environment settings (outside of treatment sessions) can be demonstrated through documented beneficiary, parent, teacher, or other caregiver feedback (verbally, in writing, or through assessment/survey responses, i.e. Vineland Adaptive Behavior Scales), pictures, videos, and other sources, when properly supported by beneficiary progress observed during treatment sessions in a clinic or other non-natural environment settings.
      - ii. The transitioning of targeted skill acquisition, replacement behavior(s), and problem behavior(s) elimination across the beneficiary’s natural environment settings is not required to be demonstrated through in-person observation by the supervising BCBA in a beneficiary’s natural environment.

- C. ABA therapy treatment service delivery requirements:
  - 1. ABA therapy treatment services must be performed by a:
    - a. BCBA;
    - b. Board-certified assistant behavior analyst (BCaBA) who is supervised by a BCBA in accordance with section 222.300(C) of this Arkansas Medicaid manual; or
    - c. Registered behavior technician (RBT) who is supervised by a BCBA in accordance with section 222.300(C) of this Arkansas Medicaid manual.
  - 2. ABA therapy treatment service delivery must be performed on a one-on-one basis with a qualified BCBA, BCaBA, or RBT working with a single beneficiary throughout the entire ABA therapy treatment service session.
  - 3. Group ABA therapy treatment service delivery is prohibited.
- D. All ABA therapy treatment services must be prior authorized in accordance with section 240.000 of this Arkansas Medicaid manual.
  - 1. The amount of ABA therapy treatment services performed during a week cannot exceed the prescribed or authorized number of units per week.
  - 2. Prescribed or authorized units of ABA therapy treatment services not performed during a week due to beneficiary illness, beneficiary unavailability, or any other reason do not carryforward and cannot be made up in earlier or later weeks.
  - 3. A week for these purposes is Monday through Sunday.
- E. A single clinician cannot perform more than fifty (50) billable hours of ABA therapy treatment services per week.
- F. ABA therapy treatment services are reimbursed on a per unit basis. The unit of service calculation should only include time spent delivering face-to-face ABA therapy treatment services directly to the beneficiary. [View or print the billable applied behavior analysis therapy treatment procedure code and description.](#)

**222.300 Adaptive Behavior Treatment with Protocol Modification Services****1-1-25**

- A. A provider may be reimbursed for medically necessary adaptive behavior treatment with protocol modification services. Adaptive behavior treatment with protocol modification services involve the in-person observation of applied behavior analysis (ABA) therapy treatment service delivery by a supervising board-certified behavior analyst (BCBA), which may include the following components:
  - 1. Actively training or assisting a board-certified assistant behavior analyst (BCaBA) or registered behavior technician (RBT) under the BCBA's supervision with the delivery of services to a beneficiary during an ABA therapy treatment session;
  - 2. Educating and training a BCaBA or RBT under the BCBA's supervision on how to:
    - a. Collect the required data; and
    - b. Record the service session notes necessary to assess the beneficiary's progress towards individualized treatment plan (ITP) goals and objectives;
  - 3. Conducting clinical observation of and data collection on the beneficiary's progress towards ITP goals and objectives during an ABA therapy treatment session delivered by a BCaBA or RBT under the BCBA's supervision; and
  - 4. Adjusting and updating the ITP as required.
    - a. A BCBA delivering direct one-on-one ABA therapy treatment services to a beneficiary (i.e. not supervising a BCaBA or RBT perform an ABA therapy treatment session) is not considered an adaptive behavior treatment with

protocol modification service under this section 222.300, and must be billed as an ABA therapy treatment service pursuant to section 222.200 of this Arkansas Medicaid manual.

- B. Medical necessity for adaptive behavior treatment with protocol modification services is established by a treatment prescription for ABA therapy treatment services on a DMS-641 TP "Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Treatment Prescription" (see section 212.400 of this Arkansas Medicaid manual).
- C. Each BCaBA or RBT performing ABA therapy treatment services must be supervised by a BCBA who is responsible for the quality of the services rendered:
  - 1. A supervising BCBA must be an enrolled Arkansas Medicaid provider.
  - 2. A supervising BCBA must meet the following minimum in-person observation thresholds for each BCaBA or RBT under their supervision:
    - a. Five percent (5%) of the total ABA therapy treatment hours performed by the BCaBA or RBT; and
    - b. One (1) hour of ABA therapy treatment delivery performed by BCaBA or RBT every thirty (30) days.
  - 3. When not directly observing an ABA therapy treatment session, a supervising BCBA must be on-call and immediately available to advise and assist throughout the entirety of any ABA therapy treatment session performed by a BCaBA or RBT under their supervision. Availability by telecommunication is sufficient to meet this requirement.
  - 4. A supervising BCBA must review and approve the data collection and progress notes completed by a BCaBA or RBT under their supervision prior to submitting a claim for any ABA therapy treatment services delivered.
  - 5. A supervising BCBA is limited to the lesser of the following supervision caseload limits:
    - a. A maximum combined total of twelve (12) BCaBAs and RBTs at any given time; or
    - b. A caseload of BCaBAs or RBTs requiring no more than twenty-five (25) hours of billable adaptive behavior treatment with protocol modification services per week.
- D. Adaptive behavior treatment with protocol modification services must be performed by a BCBA enrolled with Arkansas Medicaid.
- E. All adaptive behavior treatment with protocol modification services must be prior authorized in accordance with section 240.000 of this Arkansas Medicaid manual.
- F. Adaptive behavior treatment with protocol modification services are reimbursed on a per unit basis. The unit of service calculation should only include time spent supervising, observing and interacting in-person with the beneficiary and BCaBA or RBT under the BCBA's supervision during an ABA therapy treatment session. [View or print the billable adaptive behavior treatment with protocol modification services procedure code and description.](#)

- A. A provider may be reimbursed for medically necessary family adaptive behavior treatment services. Family adaptive behavior treatment services are quarterly or more frequent meetings between the beneficiary's parent(s)/guardian(s) or other appropriate caregiver and the supervising board-certified behavior analyst (BCBA), where the supervising BCBA:



1. Discusses the beneficiary's progress;
  2. Provides any necessary technical or instructional assistance to the parent/guardian in connection with applied behavior analysis therapy service delivery;
  3. Answers any parent/guardian or beneficiary questions and concerns; and
  4. Discusses any necessary changes to the beneficiary's individualized treatment plan.
- B. Medical necessity for family adaptive behavior treatment services is established by a treatment prescription for ABA therapy treatment services on a DMS-641 TP "Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Treatment Prescription" (see section 212.400 of this Arkansas Medicaid manual).
- C. Family adaptive behavior treatment services must include the participation of the parent/guardian or other appropriate beneficiary caregiver.
- D. Family adaptive behavior treatment services must be performed by a BCBA enrolled with Arkansas Medicaid.
- E. All family adaptive behavior treatment services must be prior authorized in accordance with section 240.000 of this Arkansas Medicaid manual.
- F. Family adaptive behavior treatment services are reimbursed on a per unit basis. The unit of service calculation should only include time spent collaborating face-to-face with the parent/guardian. [View or print the billable family adaptive behavior treatment services procedure code and description.](#)

**223.000 Telemedicine Services****1-1-25**

- A. The following services may be delivered through telemedicine:
1. Adaptive behavior treatment with protocol modification services.
  2. Family adaptive behavior treatment services.
- B. All other covered applied behavior analysis (ABA) therapy services must be conducted in-person.
- C. Parental/guardian consent is required prior to telemedicine service delivery.
- D. All telemedicine services must be delivered in accordance with the Arkansas Telemedicine Act, Ark. Code Ann. § 17-80-401 to -407, or any successor statutes, and section 105.190 of this Arkansas Medicaid manual.
- E. All covered services delivered through telemedicine must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and beneficiary, parent/guardian, or other practitioner via a telecommunication link.
- F. ABA therapy services delivered through telemedicine in compliance with this section 223.000 are reimbursed in the same manner and subject to the same limits as in-person, face-to-face service delivery.

**224.000 Individualized Treatment Plan****1-1-25**

- A. The supervising board-certified behavior analyst (BCBA) must develop an individualized treatment plan (ITP) for each beneficiary.
1. A beneficiary's ITP should be updated by the supervising BCBA as necessary based on beneficiary progress or lack thereof, but at a minimum must be updated the sooner to occur of:

- a. Every twelve (12) months; or
    - b. When the beneficiary has shown no progress towards ITP goals or objectives in six (6) months.
  2. The supervising BCBA must document each time a beneficiary's ITP is updated, which at a minimum must include a listing of each specific change and why the change was necessary.
- B. Each ITP must include the following:
1. A written description of each goal or objective (see subsection C. below for specific ITP goal or objective requirements);
  2. A description of the specific practices, procedures, and strategies within the scope of ABA peer-reviewed literature anticipated to be utilized and the activities anticipated to be performed as part of applied behavior analysis therapy treatment services;
  3. The specific criteria and other data that will be collected on each ITP goal or objective during treatment service delivery to monitor and measure the beneficiary's progress, which must at a minimum include the following for each goal and objective included on an ITP:
    - a. The beneficiary's baseline measurement for the goal or objective's criteria when the goal or objective was first included on the ITP;
    - b. The beneficiary's measurement for the goal or objective's criteria on the beneficiary's immediately preceding comprehensive evaluation report;
    - c. The beneficiary's current measurement for the goal or objective criteria;
    - d. The beneficiary's anticipated progress toward each goal or objective between now and the next comprehensive evaluation;
    - e. The level of measurement that will be considered mastery of the goal or objective criteria (i.e. the condition(s) under and proficiency with which a behavior or skill must be demonstrated for the goal and objective to be considered completed);
      - i. The mastery of any goal or objective criteria must include the transferring of the goal or objective outcome across the beneficiary's natural environments;
    - f. The estimated goal or objective mastery date or timeframe at the time the goal or objective was first included on the ITP;
    - g. The estimated goal or objective mastery date or timeframe at the time of the immediately preceding comprehensive evaluation;
    - h. Current estimated goal or objective mastery date or timeframe; and
    - i. If the estimated goal or objective mastery date or timeframe is extended, a narrative must be included that:
      - i. Identifies the date that the mastery date or timeframe was extended;
      - ii. Identifies the barriers to mastery that required the extension; and
      - iii. Describes the modifications to practices, procedures, and strategies that were made to address the lack of progress;
  4. The discharge criteria for the beneficiary transitioning out of prescribed ABA therapy services, which must also include the following information:
    - a. The beneficiary's original anticipated discharge date from ABA therapy services when ABA therapy services were initiated with the current provider (for a beneficiary already receiving ABA services as of January 1, 2025, as of the beneficiary's next ITP update after January 1, 2025);
    - b. The beneficiary's anticipated discharge date from ABA therapy services as of the beneficiary's immediately preceding comprehensive evaluation report;



- c. The beneficiary's current anticipated discharge date from ABA therapy services;
    - d. Always include each of the following as standalone, additional objective discharge criteria:
      - i. When a beneficiary is failing to progress toward ITP goals and objectives over time; and
      - ii. If targeted skill acquisition, replacement behaviors, and problem behavior elimination are unable to be transitioned into the beneficiary's natural environments over time; and
  - 5. When appropriate, include a positive behavior support plan for interfering behavior(s).
    - a. The use of punishment procedures in positive behavior support plans is expressly prohibited.
- C. ITP goals and objectives must comply with the following:
- 1. All ITP goals and objectives must:
    - a. Be specific to the beneficiary;
    - b. Be observable;
    - c. Be measurable, with a clear definition of what level of measurement the beneficiary must reach for the goal or objective to be considered mastered or completed;
    - d. Written in the form of a:
      - i. Specific new communication, social, self-help, or other adaptive behavioral skill the beneficiary is working toward successfully performing (skill acquisition goal);
      - ii. A replacement behavior the beneficiary is working toward successfully implementing (replacement behavior goal);
      - iii. Interfering behavior the beneficiary is working toward reducing (behavior reduction goal); or
      - iv. Caregiver skill, task, or activity towards which the beneficiary's parent or other caregiver is working toward successfully performing (parent goal); and
    - e. Include a target duration or date for each ITP goal or objective to transfer to the beneficiary's natural environment.
  - 2. Each behavioral reduction ITP goal or objective must have one (1) or more skill acquisition or behavior replacement ITP goal(s) or objective(s) tied directly to it;
  - 3. Each behavior replacement ITP goal or objective must be tied directly to a behavior reduction ITP goal or objective;
  - 4. Each skill acquisition ITP goal or objective should be tied directly to a behavioral reduction ITP goal or objective unless:
    - a. It is the rare situation where an ITP contains only skill acquisition goals and objectives; and
    - b. The supervising BCBA includes detailed clinical rationale in the ITP for why ABA therapy services are appropriate for a beneficiary that has no targeted behavioral reduction goals or objectives;
  - 5. The total number of goals and objectives included on a beneficiary's ITP must:
    - a. Correlate with and support the frequency, intensity, and duration of the prescribed ABA therapy services;
    - b. Be supported by the comprehensive evaluation; and

- c. Be clinically appropriate for the beneficiary.
- 6. Maintenance of an existing functional skill or eliminated interfering behavior is not an appropriate ITP goal or objective unless functional skill or behavioral regression is a medically recognized symptom of the beneficiary's underlying diagnosis.
  - a. If maintenance of an existing functional skill or eliminated interfering behavior is included as an ITP goal or objective, then there must be a detailed narrative included in the ITP explaining why maintenance is an appropriate ITP goal or objective for the beneficiary.
- 7. ITP goals and objectives must be designed and implemented so that skill acquisition, behavior replacement, or interfering behavior elimination the beneficiary is working toward is progressively transitioned into natural environments over time.
  - a. It may be appropriate (particularly in cases involving extreme interfering behaviors) for initial goals and objectives to involve demonstrating skill acquisition or behavior modification in a clinic or other controlled setting; however, ITP goals and objectives must be designed so that the desired skill gains and behavior modification are progressively transferred into the beneficiary's natural environments.
  - b. For example, a beneficiary's ITP goals and objectives could be incrementally updated over time from demonstrating skill acquisition, behavior replacement, or interfering behavior elimination in a specially modified clinic room, to a standard clinic room, to a simulated natural environment, and then into their natural environment as the beneficiary accomplishes the ITP goal or objective across each of the progressively less controlled environments.

## 230.000 PRIOR AUTHORIZATION

### 231.000 Prior Authorization for Applied Behavior Analysis Therapy Services 1-1-25

- A. Prior authorization is required for an applied behavior analysis (ABA) therapy provider to be reimbursed for ABA therapy services.
- B. [View or print instructions for submitting a prior authorization request for ABA therapy services.](#)

### 232.000 Administrative Reconsideration and Appeal 1-1-25

An applied behavioral analysis (ABA) therapy provider may submit a request for administrative reconsideration and appeal of a prior authorization denial in accordance with sections 160.000, 190.000, and 191.000 of this Arkansas Medicaid manual and the Arkansas Administrative Procedures Act, Ark. Code Ann. §§ 25-15-20, et seq.

## 250.000 REIMBURSEMENT 1-1-25

### 251.000 Method of Reimbursement 1-1-25

- A. Covered services use fee schedule reimbursement methodology. Under fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service under Arkansas Medicaid. The maximum allowable reimbursement for a service is the same for all applied behavior analysis (ABA) therapy providers.
- B. The following standard reimbursement rules apply to all ABA therapy services:
  - 1. A full unit of service must be rendered to bill a unit of service.

2. Partial units of service may not be rounded up and are not reimbursable.
3. Non-consecutive periods of service delivery over the course of a single day may be aggregated when computing a unit of service.
4. Time spent preparing a beneficiary for services or cleaning or prepping an area before or after services is not billable.
5. Unless otherwise specifically provided for in this Arkansas Medicaid manual, concurrent billing is not allowed. It is considered concurrent billing when multiple practitioners bill Medicaid for services provided to the same beneficiary during the same time increment.
6. Rest, toileting, or other break times between service activities is not billable.
7. Time spent on documentation alone is not billable as a service unless otherwise specifically permitted in this Arkansas Medicaid manual.

**251.100 Fee Schedules****1-1-25**

- A. Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. [View or print the applied behavior analysis therapy fee schedule.](#)
- B. Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.
- C. Fee schedules and procedure codes do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time.

## SECTION II - AUTISM WAIVER CONTENTS

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### 200.000 AUTISM WAIVER GENERAL INFORMATION

<b>201.000</b>	<b>Arkansas Medicaid Participation Requirements for Autism Waiver Providers</b>	<b>1-1-25</b>
<b>201.100</b>	<b>Individual Service Provider Participation Requirements</b>	<b>1-1-25</b>

Individual providers of Autism Waiver services must meet the following requirements to be eligible to participate in Arkansas Medicaid:

- A. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual;

- B. Meet the credentialing, experience, training, and other qualification requirements of the applicable Autism Waiver service under section 202.000 of this Medicaid manual; and
- C. Obtain certification as an Autism Waiver provider from Arkansas Department of Human Services, Division of Developmental Disabilities Services or its contracted vendor.

### **201.200      Group Service Provider Participation Requirements**

1-1-25

Group providers of Autism Waiver services must meet the following requirements to be eligible to participate in Arkansas Medicaid:

- A. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual;
- B. Each individual performing Autism Waiver services on behalf of the group must complete the individual provider participation and enrollment requirements under section 201.100 of this Medicaid manual; and
- C. Obtain certification as an Autism Waiver provider from the Arkansas Department of Human Services, Division of Developmental Disabilities Services or its contracted vendor.

### **201.300      Providers in Arkansas and Bordering States**

1-1-25

Providers with a principal place of business in Arkansas and within fifty (50) miles of the state line in the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may enroll as Autism Waiver providers if they meet all Arkansas Medicaid participation requirements of this Arkansas Medicaid manual.

## **202.000      AUTISM WAIVER PROVIDER REQUIREMENTS**

### **202.100      Intensive Intervention Providers**

1-1-25

- A. Intensive Intervention providers are those Autism Waiver service providers that are certified to provide one or more of the following Autism Waiver services:
  - 1. Individual Assessment, Treatment Development, and Monitoring services;
  - 2. Lead Therapy Intervention services;
  - 3. Line Therapy Intervention services; and
  - 4. Therapeutic Aides and Behavioral Reinforcers.
- B. Each individual rendering Autism Waiver services on behalf of a group intensive intervention provider must meet the credentialing, experience, training, and other qualification requirements for the applicable service.

### **202.200      Consultative Clinical and Therapeutic Provider Participation Requirements**

1-1-25

- A. Consultative Clinical and Therapeutic providers must:
  - 1. Be an Institution of Higher Education with the capacity to conduct research specific to autism spectrum disorders;
  - 2. Have a central/home office located within the State of Arkansas; and
  - 3. Have the capacity to provide services in all areas within the State of Arkansas.
- B. A Consultative Clinical and Therapeutic provider and each Clinical Services Specialist employed or contracted to provide Consultative Clinical and Therapeutic services must be independent of the intensive intervention provider selected by the parent/guardian.

### **202.300      Interventionist Participation Requirements**

1-1-25

An Interventionist performing Individual Assessment, Treatment Development, and Monitoring Services must:

- A. Have a minimum of two (2) years' experience performing one (1) or more of the following for children with autism spectrum disorder:
  - 1. Developing individualized treatment;
  - 2. Providing intensive intervention services; or
  - 3. Overseeing an intensive intervention program; and
- B. Hold either:
  - 1. A Master's (or more advanced) degree in psychology, speech-language pathology, occupational therapy, special education, or related field; or
  - 2. A certificate as a board certified behavior analyst (BCBA) from the Behavior Analyst Certification Board.

#### **202.400 Lead Therapist Participation Requirements**

**1-1-25**

- A. A Lead Therapist performing Lead Therapy Intervention services must:
  - 1. Hold a Bachelor's (or more advanced) degree in education, special education, psychology, speech-language pathology, occupational therapy, or related field;
  - 2. One of the following:
    - a. Have completed one hundred twenty (120) hours of autism spectrum disorder training; or
    - b. Have both:
      - i. Received an Autism Certificate offered by the University of Arkansas; and
      - ii. A minimum of two (2) years of experience in intensive intervention services to children with autism spectrum disorder.
- B. In a hardship situation, DDS or its contracted vendor may allow an individual to act as a Lead Therapist and perform Lead Therapist Intervention services prior to meeting all the requirements in section 202.400(A).
  - 1. A hardship situation exists when a beneficiary needs Lead Therapy Intervention services and staff is not available who meet all training/experience requirements.
  - 2. In a hardship situation, the individual or group performing Lead Therapy Intervention services must meet all training/experience requirements in section 202.400(A) within one (1) year.

#### **202.500 Line Therapist Participation Requirements**

**1-1-25**

- A. A Line Therapist performing Line Therapy Intervention services must:
  - 1. Be at least eighteen (18) years of age;
  - 2. Hold at least a high school diploma or GED;
  - 3. Have completed eighty (80) hours of autism spectrum disorder training; and
  - 4. Have a minimum of two (2) years' experience working with children.
- B. In a hardship situation, DDS or its contracted vendor may allow an individual to act as a Line Therapist and perform Line Therapist Intervention services prior to meeting all the requirements in section 202.500(A).
  - 1. A hardship situation exists when a beneficiary needs Line Therapy Intervention services and staff is not available who meet all training/experience requirements.
  - 2. In a hardship situation, the individual or group performing Line Therapy Intervention services must meet all training/experience requirements in section 202.500(A) within one (1) year.

**202.600 Clinical Services Specialist (CSS) Participation Requirements 1-1-25**

Each Clinical Services Specialist employed or contracted by a Consultative Clinical and Therapeutic provider to perform Consultative Clinical and Therapeutic services must hold a certificate in good-standing as a board-certified behavioral analyst (BCBA) from the Behavior Analyst Certification Board.

**203.000 Supervision 1-1-25**

- A. The Clinical Services Specialist providing consultative clinical and therapeutic services to a beneficiary must perform quality reviews to ensure appropriate implementation of the intensive intervention services included in the plan of care:
  - 1. Quality reviews are initially conducted monthly.
  - 2. If the beneficiary is progressing as expected through the first quarter of Autism Waiver services, quarterly quality reviews are permitted as long as the beneficiary continues to progress as expected.
- B. The Interventionist must perform monthly on-site monitoring of intensive intervention service(s) delivery by the parent/guardian, Lead Therapist, and Line Therapist.
- C. The Lead Therapist must perform weekly or more frequent in-person monitoring of intensive intervention service(s) delivery by the Line Therapist.

**204.000 Documentation Requirements 1-1-25****204.100 Documentation Requirements for all Medicaid Providers 1-1-25**

See section 140.000 of this Arkansas Medicaid manual for the documentation that is required for all Arkansas Medicaid providers.

**204.200 Autism Waiver Service Documentation Requirements 1-1-25**

Autism Waiver providers must maintain in each beneficiary's service record in the Autism Waiver Database maintained by Arkansas Department of Human Services, Division of Developmental Disabilities Services (DDS) or its contracted vendor:

- A. The beneficiary's autism spectrum disorder diagnosis;
- B. The beneficiary's applicable medical records;
- C. The beneficiary's plan of care;
- D. The beneficiary's individualized treatment plan (ITP);
- E. The evaluations conducted as part of any level of care determination or in the development of the beneficiary's comprehensive clinical profile;
- F. The beneficiary's form DHS-3330;
- G. All clinical progress assessments of the beneficiary;
- H. The parent/guardian's signed election to receive Autism Waiver services;
- I. The parent/guardian's signed choice of provider form;
- J. The quarterly reviews conducted by the clinical services specialist;
- K. Each session of intensive intervention service delivery must include the following documentation:
  - 1. Beneficiary name;
  - 2. The date and beginning and ending time of intensive intervention service delivery;

3. A description of specific intensive intervention techniques or activities that were utilized during the session;
4. The location and type of setting where the intensive intervention services were provided;
5. Name(s), credential(s), and signature(s) of the personnel who performed the intensive intervention services;
6. Which of the beneficiary's ITP goals and objectives the session's intensive intervention services were intended to address;
7. Weekly or more frequent progress notes signed or initialed by the Lead Therapist describing the beneficiary's status with respect to their ITP goals and objectives; and
8. Any other documentation and information required by the Arkansas Department of Human Services, Division of Developmental Disabilities Services (DDS) or its contracted vendor.

### 204.300 Electronic Signatures

1-1-25

Arkansas Medicaid will accept electronic signatures, in compliance with Arkansas Code § 25-31-103, *et seq.*

## 210.000 PROGRAM ELIGIBILITY

### 211.000 Scope

1-1-25

The purpose of the Autism Waiver is to provide one-on-one, intensive early intervention treatment in a natural environment setting to beneficiaries between eighteen (18) months and eight (8) years of age with a diagnosis of autism spectrum disorder.

### 212.000 Beneficiary Eligibility Requirements

1-1-25

#### 212.100 Age Requirement

1-1-25

- A. A beneficiary must be between eighteen (18) months and eight (8) years of age to receive Autism Waiver services.
- B. A beneficiary must enroll in the Autism Waiver on or before their fifth (5th) birthday to allow for the maximum three (3) consecutive years of Autism Waiver services prior to turning eight (8) years old. See section 221.000(C) of this Arkansas Medicaid manual.

#### 212.200 Qualifying Diagnosis

1-1-25

- A. A beneficiary must have an autism spectrum disorder (ASD) diagnosis as defined in Ark. Code Ann. § 20-77-124.
- B. The beneficiary's ASD diagnosis must be the primary contributing factor to their developmental or functional delays, deficits, or maladaptive behaviors to receive Autism Waiver services.

#### 212.300 Institutional Level of Care

1-1-25

- A. A beneficiary must require an institutional level of care (LOC) to enroll in the Autism Waiver and receive Autism Waiver services. A beneficiary is deemed to require an institutional LOC for Autism Waiver eligibility purposes if they meet one of the following:
  1. A beneficiary scores seventy (70) or less in any two (2) of the Vineland Adaptive Behavior Scales (Vineland) domains.
  2. A beneficiary three (3) years of age or older:
    - a. Scores eighty-five (85) or less in any two (2) Vineland domains; and



- b. Has a Vineland Maladaptive Behavior Index Score between twenty-one (21) and twenty-four (24).
  - 3. A beneficiary under the age of three (3):
    - a. Scores eighty-five (85) or less in any two (2) Vineland domains; and
    - b. Has a Temperament Atypical Behavior Scale score of at least eight (8).
      - i. Vineland scores falling within a domain's confidence interval for the beneficiary's developmental age will not preclude a beneficiary from Autism Waiver eligibility. For example, a beneficiary with a Vineland Communication domain score of seventy-four (74) where the beneficiary's developmental age confidence interval for the domain is four (4) points would be treated as a score of seventy (70) for purposes of this section 212.300.
- B. A beneficiary must receive an annual LOC evaluation to demonstrate continued eligibility for the Autism Waiver.

## 220.000 PROGRAM SERVICES

### 221.000 Non-covered Services

1-1-25

- A. Arkansas Medicaid will only reimburse for those services listed in sections 220.000 through 222.600, subject to all applicable limits.
- B. Autism Waiver services are reimbursable if, and only to the extent, authorized in the beneficiary's plan of care. See section 223.000.
- C. A beneficiary can receive a maximum of three (3) years of Autism Waiver services. Autism Waiver services are not covered beyond the three (3) year maximum limit.

### 222.000 Covered Services

1-1-25

#### 222.100 Individual Assessment, Treatment Development, and Monitoring Services

1-1-25

- A. Individual Assessment, Treatment Development, and Monitoring services include the following components:
  - 1. Administering the evaluation instrument(s) and conducting the clinical observations necessary to create a comprehensive clinical profile of the beneficiary's skill deficits across multiple domains, including without limitation language/communication, cognition, socialization, self-care, and behavior.
    - a. The administration of the Assessment of Basic Language and Learning Skills-Revised instrument (ABLLS-R) is a required part of the comprehensive clinical profile.
    - b. Other evaluation instruments and clinical judgment may also be utilized so long as it supports the development of the beneficiary's comprehensive clinical profile.
  - 2. Developing the individualized treatment plan (ITP) that guides the day-to-day delivery of intensive intervention services and includes without limitation the:
    - a. Intensive intervention service(s) delivery schedule;
    - b. Short and long-term goals and objectives; and
    - c. Data collection that will be implemented to assess progress towards those short and long-term goals and objectives.
  - 3. Training and educating the parent/guardian, Lead Therapist, and Line Therapist on how to:
    - a. Implement and perform the intensive intervention service(s) included on the ITP;

- b. Collect the required data; and
  - c. Record the service session notes necessary to assess the beneficiary's progress towards ITP goals and objectives.
- 4. Performing monthly monitoring of intensive intervention service delivery by the parent/guardian, Lead Therapist, and Line Therapist.
- 5. Completing beneficiary clinical progress assessments and adjusting the comprehensive clinical profile and ITP as required. Clinical progress assessments must be completed for each beneficiary at least every four (4) months and must always include:
  - a. The administration of an ABLLS-R; and
  - b. A written assessment of the beneficiary's progress based on an in-depth review of the data and session notes entered by the Lead Therapist and Line Therapist.
- B. Individual Assessment, Treatment Development, and Monitoring services must be performed by a qualified Interventionist.
- C. Individual Assessment, Treatment Development, and Monitoring services may be completed through telemedicine if in compliance with section 222.600 of this Medicaid manual, except for a beneficiary's initial evaluation, which must be conducted in-person in the beneficiary's natural environment setting.
- D. Individual Assessment, Treatment Development, and Monitoring services are reimbursed on a per unit basis. The unit of service calculation should only include time spent administering beneficiary evaluations, conducting clinical observation, monitoring Lead and Line Therapist service delivery, or providing face-to-face training to the parent/guardian and Lead and Line Therapists. The unit of service calculation does not include time spent in transit to and from a service setting. [View or print the billable Individual Assessment, Treatment Development, and Monitoring procedure codes and descriptions.](#)

**222.200****Consultative Clinical and Therapeutic Services****1-1-25**

- A. Consultative Clinical and Therapeutic services provide high level, independent clinical oversight of the implementation of the beneficiary's plan of care and individualized treatment plan, and include the following components:
  - 1. Conducting quality reviews to ensure appropriate implementation of the intensive intervention services included in the plan of care.
    - a. Quality reviews are initially conducted monthly.
    - b. If the beneficiary is progressing as expected through the first quarter of Autism Waiver services, quarterly quality reviews are permitted as long as the beneficiary continues to progress as expected.
  - 2. Providing technical assistance to the parent/guardian, Lead Therapist, and Line Therapist when the beneficiary is not progressing as expected.
  - 3. Notifying DDS or its contracted vendor if any issues related to Autism Waiver compliance are discovered.
- B. Consultative Clinical and Therapeutic services must be performed by a qualified Clinical Services Specialist.
- C. Consultative Clinical and Therapeutic services may be conducted through telemedicine in accordance with section 222.600 of this Medicaid manual, unless:
  - 1. The beneficiary, parent/guardian, Lead Therapist, or Line Therapist needs dictate that Consultative Clinical and Therapeutic services should be performed by the Clinical Services Specialist in-person; or
  - 2. The beneficiary is not progressing as expected.

- D. Consultative Clinical and Therapeutic services are reimbursed on a per unit basis. The unit of service calculation does not include time spent in transit to and from a service setting. View or print the billable Consultative Clinical and Therapeutic procedure codes and descriptions.

**222.300 Lead Therapy Intervention Services****1-1-25**

- A. Lead Therapy Intervention services include the following components:
  - 1. Providing intensive intervention service(s) in accordance with the individualized treatment plan (ITP);
  - 2. Weekly or more frequent in-person monitoring of the intensive intervention service(s) delivery by the Line Therapist;
  - 3. Reviewing all data collected and service session notes recorded by the Line Therapist and parent/guardian;
  - 4. Training, assisting, and supporting the parent/guardian and Line Therapist;
  - 5. Receiving parent/guardian feedback and responding to parent/guardian concerns or forwarding them to the appropriate person; and
  - 6. Notifying the Interventionist when issues arise.
- B. Lead Therapy Intervention services must be performed by a qualified Lead Therapist.
- C. Lead Therapy Intervention services involving the beneficiary must:
  - 1. Be conducted in a typical home or community setting for a similarly aged child without a disability or delay that the beneficiary and their family frequent, such as the beneficiary's home, neighborhood playground or park, church, or restaurant; and
  - 2. Include the participation of a parent/guardian.
- D. Lead Therapy Intervention services are reimbursed on a per unit basis. The unit of service calculation should only include time spent delivering face-to-face services to the beneficiary and parent/guardian, monitoring Line Therapist service delivery, or providing face-to-face training to a Line Therapist. The unit of service calculation does not include time spent in transit to and from a service setting. [View or print the billable Lead Therapy Intervention procedure codes and descriptions.](#)

**222.400 Line Therapy Intervention Services****1-1-25**

- A. Line Therapy Intervention services include the following components:
  - 1. Providing intensive intervention service(s) in accordance with the individualized treatment plan (ITP);
  - 2. Collecting data and recording session notes in accordance with the ITP; and
  - 3. Reporting progress and concerns to the Lead Therapist or Interventionist, as needed.
- B. Line Therapy Intervention services must be performed by a qualified Line Therapist.
- C. Line Therapy Intervention services involving the beneficiary must:
  - 1. Be conducted face-to-face in a typical home or community setting for a similarly aged child without a disability or delay that the beneficiary and their family frequent, such as the beneficiary's home, neighborhood playground or park, church, or restaurant; and
  - 2. Include the participation of a parent/guardian.
- D. Line Therapy Intervention services are reimbursed on a per unit basis. The unit of service calculation should only include time spent delivering face-to-face services to the beneficiary and parent/guardian, and does not include time spent in transit to and from a service setting. [View or print the billable Line Therapy Intervention procedure codes and descriptions.](#)

**222.500 Therapeutic Aides and Behavioral Reinforcers 1-1-25**

- A. Therapeutic aides and behavioral reinforcers are tools, aides, or other items a beneficiary uses in their home when necessary to implement and carry out the beneficiary's individualized treatment plan (ITP) and substitute materials or devices are otherwise unavailable.
- B. The Interventionist determines when therapeutic aides and behavioral reinforcers should be included in the ITP.
- C. A beneficiary may keep any therapeutic aides and behavioral reinforcers after exiting the Autism Waiver as long as the requirements of the Parent/Guardian Participation Agreement are met.
- D. Therapeutic aides and behavioral reinforcers are limited to a maximum reimbursement of one thousand dollars (\$1,000.00) per beneficiary, per lifetime. View or print the billable Therapeutic Aides and Behavioral Reinforcers codes and descriptions.

**222.600 Telemedicine Services 1-1-25**

- A. Consultative Clinical and Therapeutic services and Individual Assessment, Treatment Development, and Monitoring services may be delivered through telemedicine in accordance with this section 222.600.
  - 1. A beneficiary's initial evaluation by the Interventionist may not be conducted through telemedicine and must be performed through traditional in-person methods.
  - 2. Parental or guardian consent is required prior to telemedicine service delivery.
  - 3. All telemedicine services must be delivered in accordance with the Arkansas Telemedicine Act, Ark. Code Ann. § 17-80-401 to -407, or any successor statutes, and section 105.190 of this Medicaid manual.
- B. The Autism Waiver service provider is responsible for ensuring service delivery through telemedicine is equivalent to in-person, face-to-face service delivery.
  - 1. The Autism Waiver service provider is responsible for ensuring the calibration of all clinical instruments and proper functioning of all telecommunications equipment.
  - 2. All Autism Waiver services delivered through telemedicine must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and beneficiary, parent/guardian, or practitioner via a telecommunication link.
  - 3. A store and forward telecommunication method of service delivery where either the beneficiary, parent/guardian, or practitioner records and stores data in advance for the other party to review at a later time is prohibited, although correspondence, faxes, emails, and other non-real time interactions may supplement synchronous telemedicine service delivery.
- C. Autism Waiver services delivered through telemedicine delivered in compliance with this section 222.600 are reimbursed in the same manner and subject to the same benefit limits as in-person, face-to-face service delivery.

**223.000 Plan of Care 1-1-25**

- A. The Division of Developmental Disabilities Services or its contracted vendor must develop an individualized plan of care for each beneficiary.
  - 1. The plan of care must be developed by an individual who has either:
    - a. A Registered Nurse license; or
    - b. A Bachelor's (or more advanced) degree in psychology, nursing, speech-language pathology, education, or related field.
  - 2. The plan of care must be developed in collaboration with:

- a. The parent/guardian; and
  - b. Any other individuals requested by the parent/guardian.
- B. Each beneficiary's plan of care must include the following:
  - 1. The beneficiary's identification information, which includes without limitation the beneficiary's:
    - a. Full name;
    - b. Address;
    - c. Date of birth;
    - d. Medicaid number; and
  - 2. The name and credentials of the individual responsible for plan of care development;
  - 3. The beneficiary's needs and potential risks;
  - 4. The intensive intervention service(s) that will be implemented to meet those needs;
  - 5. The amount, frequency, and duration of each intensive intervention service; and
  - 6. The parent/guardian's choice of intensive intervention service provider(s).
- C. A beneficiary's plan of care must be updated at least annually and any time the beneficiary is not progressing as expected.

**224.000****Individualized Treatment Plan****1-1-25**

- A. The Individual Assessment, Treatment Development, and Monitoring service provider selected by the beneficiary's parent/guardian must develop an individualized treatment plan (ITP) for the beneficiary.
  - 1. The individual responsible for developing and updating the ITP must be a qualified Interventionist.
  - 2. The Interventionist must develop and update the ITP in in collaboration with the:
    - a. Lead Therapist;
    - b. Line Therapist;
    - c. Parent/guardian; and
    - d. Any other individuals requested by the parent/guardian.
- B. Each ITP must include the following:
  - 1. The beneficiary's identification information, which includes without limitation the beneficiary's:
    - a. Full name;
    - b. Address;
    - c. Date of birth; and
    - d. Medicaid number; and
  - 2. The name and credentials of the Interventionist responsible for ITP development;
  - 3. A written description of a minimum of three (3) goals and objectives, which must each be:
    - a. Written in the form of a regular function, task, or activity the beneficiary is working toward successfully performing;
    - b. Measurable; and
    - c. Specific to the individual beneficiary;
  - 4. The intensive intervention service(s) delivery schedule;
  - 5. Detailed instructions for implementation of intensive intervention services including the job title(s) or credential(s) of the personnel that will furnish the intensive intervention service(s);
  - 6. The data collection that will be required to monitor and assess progress towards the beneficiary's goals and objectives; and

7. When appropriate, a positive behavior supports plan for maladaptive behavior.
- C. A beneficiary's ITP must be updated every four (4) months after the administration of the Assessment of Basic Language and Learning Skills-Revised instrument, and anytime a beneficiary is not progressing as expected.

## 250.000 REIMBURSEMENT

### 251.000 Method of Reimbursement

1-1-25

Except as otherwise provided in this manual, covered Autism Waiver services use fee schedule reimbursement methodology. Under fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service under Arkansas Medicaid. The maximum allowable reimbursement for a service is the same for all Autism Waiver providers.

- A. A full unit of service must be rendered to bill a unit of service.
- B. Partial units of service may not be rounded up and are not reimbursable.
- C. Non-consecutive periods of service delivery over the course of a single day may be aggregated when computing a unit of service.

### 251.100 Fee Schedules

1-1-25

- A. Arkansas Medicaid provides fee schedules on the DHS website. [View or print the Autism Waiver fee schedule](#).
- B. Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.
- C. Fee schedules and procedure codes do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time.

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

January 1, 2025

CATEGORICALLY NEEDY

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

**25. Applied Behavioral Analysis (ABA) Therapy**

- (1) Applied Behavior Analysis (ABA) therapy is only one component of services to treat Autism Spectrum Disorder (ASD). ABA therapy services are provided in accordance with 42 CFR 440.130(c).
- (2) ABA therapy services must be prescribed by the beneficiary's Arkansas Medicaid assigned primary care provider (PCP);
- (3) ABA therapy services must be performed by a:
  - a. Board-certified behavior analyst (BCBA) who must have board-certified behavior analyst (or more advanced) certification in good-standing from the Behavior Analyst Certification Board;
  - b. Board-certified assistant behavior analyst (BCaBA) who must have board-certified assistant behavior analyst certification in good-standing from the Behavior Analyst Certification Board; or
  - c. Registered behavior technician (RBT) who must have registered behavior technician certification in good-standing from the Behavior Analyst Certification Board.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
Page 1zz.13

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

January 1, 2025

CATEGORICALLY NEEDY

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**4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)**

**25. Applied Behavioral Analysis (ABA) Therapy (Continued)**

4. ABA therapy services include the following components:
  - a. Behavior identification assessment services, which include the following components:
    - i. Performing required comprehensive evaluations; and
    - ii. Developing the initial individualized treatment plan (ITP);
  - b. ABA therapy treatment services, which includes delivering ABA therapy treatment services directly to the beneficiary in accordance with the beneficiary's ITP;
  - c. Adaptive behavior treatment with protocol modification services, which includes the following components:
    - i. Actively training or assisting a BCaBA or RBT with the delivery of services to a beneficiary during an ABA therapy treatment session;
    - ii. Conducting clinical observation of and data collection on the beneficiary's progress towards ITP goals and objectives during an ABA therapy treatment session; and
    - iii. Adjusting and updating the ITP as required;
  - d. Family adaptive behavior treatment services, which are meetings between the beneficiary's parent(s)/guardian(s) or other appropriate caregiver and the supervising BCBA, where the supervising BCBA:
    - i. Discusses the beneficiary's progress;
    - ii. Provides any necessary technical or instructional assistance to the parent/guardian in connection with service delivery;
    - iii. Answers any parent/guardian or beneficiary questions and concerns; and
    - iv. Discusses any necessary changes to the beneficiary's individualized treatment plan.

TN: 24-0015

Approval: 11/07/25

Effective Date: 01-01-25

Supersedes TN: NEW



AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

January 1, 2025

MEDICALLY NEEDY

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

25. Applied Behavioral Analysis (ABA) Therapy

- (1) Applied Behavior Analysis (ABA) therapy is only one component of services to treat Autism Spectrum Disorder (ASD). ABA therapy services are provided in accordance with 42 CFR 440.130(c).
- (2) ABA therapy services must be prescribed by the beneficiary's Arkansas Medicaid assigned primary care provider (PCP);
- (3) ABA therapy services must be performed by a:
  - a. Board-certified behavior analyst (BCBA) who must have board-certified behavior analyst (or more advanced) certification in good-standing from the Behavior Analyst Certification Board;
  - b. Board-certified assistant behavior analyst (BCaBA) who must have board-certified assistant behavior analyst certification in good-standing from the Behavior Analyst Certification Board; or
  - c. Registered behavior technician (RBT) who must have registered behavior technician certification in good-standing from the Behavior Analyst Certification Board.

TN: 24-0015

Approval: 11/07/2024

Effective Date: 01-01-25

Supersedes TN: NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 2xx.5

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

January 1, 2025

MEDICALLY NEEDY

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

25. Applied Behavioral Analysis (ABA) Therapy (Continued)

4. ABA therapy services include the following components:
  - a. Behavior identification assessment services, which include the following components:
    - i. Performing required comprehensive evaluations; and
    - ii. Developing the initial individualized treatment plan (ITP);
  - b. ABA therapy treatment services, which includes delivering ABA therapy treatment services directly to the beneficiary in accordance with the beneficiary's ITP;
  - c. Adaptive behavior treatment with protocol modification services, which includes the following components:
    - i. Actively training or assisting a BCaBA or RBT with the delivery of services to a beneficiary during an ABA therapy treatment session;
    - ii. Conducting clinical observation of and data collection on the beneficiary's progress towards ITP goals and objectives during an ABA therapy treatment session; and
    - iii. Adjusting and updating the ITP as required;
  - d. Family adaptive behavior treatment services, which are meetings between the beneficiary's parent(s)/guardian(s) or other appropriate caregiver and the supervising BCBA, where the supervising BCBA:
    - i. Discusses the beneficiary's progress;
    - ii. Provides any necessary technical or instructional assistance to the parent/guardian in connection with service delivery;
    - iii. Answers any parent/guardian or beneficiary questions and concerns; and
    - iv. Discusses any necessary changes to the beneficiary's individualized treatment plan.

TN: 24-0015

Approval: 11/07/2024

Effective Date: 01-01-25

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page lrr

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-  
OTHER TYPES OF CARE

Revised: January 1, 2025

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and  
Treatment of Conditions Found (Continued)

(19) Physical Therapy and Related Services (Continued)

3. Speech-Language Therapy (Continued)

At the beginning of each calendar year, Medicaid officials and the Arkansas Speech-Language Therapy Association or its successor will arrive at mutually agreeable increase or decrease in reimbursement rates based on the market forces as they impact on access. Any agreed upon increase or decrease will be implemented at the beginning of the following state fiscal year, July 1 with any appropriate State Plan changes.

(19a) Applied Behavior Analysis (ABA) Therapy

Applied Behavior Analysis (ABA) therapy services are reimbursed on a per unit basis using fee schedule reimbursement methodology, where reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service under Arkansas Medicaid. DHS engaged an independent actuary to conduct a rate study on ABA therapy services during the summer of 2023 to determine appropriate service rates. The rate study considered direct wages (using Arkansas-specific May 2021 Bureau of Labor Statistics data), indirect and transportation costs, employee related expenses, and supervisor time, and used an independent rate model approach that captured the average expected costs a reasonably efficient Arkansas provider would incur while delivering ABA therapy services. The applicable fee schedule of ABA therapy service rates is published on the agency's website.

(20) Rehabilitative Services for Persons with Physical Disabilities (RSPD)

1. Residential Rehabilitation Centers

The per diem reimbursement for RSPD services provided by a Residential Rehabilitation center will be based on the provider's fiscal year end 1994 audited cost report as submitted by an independent auditor plus a percentage increase equal to the HCFA Market Basket Index published for the quarter ending in March. A cap has been established at \$395.00. This is a prospective rate with no cost settlement. Room and board is not an allowable program cost. The criteria utilized to exclude room and board is as follows: The total Medicaid ancillary cost was divided by total Medicaid inpatient days which equals the RSPD prospective per diem. The ancillary cost was determined based upon Medicare Principles of Reimbursement. There is no routine cost included.

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

1. Changes the autism spectrum disorder requirement from all (3) of the following to at least two (2) of the following three (3) licensed professionals, either each individually or as a team: physician, psychologist and speech language pathologist.
- 2.Changes the term for individual performing Individual Assessment, Treatment Development, and Monitoring services from a "Consultant" to an Interventionist" to avoid confusion with Clinical Services that performs Consultative and Therapeutic service.
3. Cover changes to the Memorandum of Understanding between Division of Medical Services and Division of Developmental Disabilities Services.
4. Add clarifying information on the strategies employed by the State to discover /identify problems /issues with autism waiver functions.
- 5.Updated and rebased Autism Waiver services based on results of independent, third-party rate study.
  - Lead Therapy Intervention - \$7.50 per unit to \$15.60 per unit
  - Line Therapy Intervention - \$4.50 per unit to \$12.75 per unit
- 6.Arkansas has an approved American Rescue Plan Act (ARP)Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021, to March 31,2025. Due to the expiration of the Appendix, the state is seeking to amend the base waiver to include the Program terms.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A. The State of Arkansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (optional - this title will be used to locate this waiver in the finder):

Autism Waiver

**C. Type of Request:** renewal

**Requested Approval Period:** (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

☐ 3 years ☒ 5 years

**Waiver Number:** AR.0936.R02.00

**Draft ID:** AR.026.02.00

**D. Type of Waiver** (select only one):

Regular Waiver

**E. Proposed Effective Date:** (mm/dd/yy)

07/01/24

**Approved Effective Date:** 07/01/24

### PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 1. Request Information (2 of 3)

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

☐ **Hospital**

Select applicable level of care

☐ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

☐ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

☐ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

☐ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

**1. Request Information (3 of 3)**

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**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

☒ **Not applicable**☐ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates (check each that applies):**☐ **§1915(b)(1) (mandated enrollment to managed care)**☐ **§1915(b)(2) (central broker)**☐ **§1915(b)(3) (employ cost savings to furnish additional services)**☐ **§1915(b)(4) (selective contracting/limit number of providers)**☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**☐ **A program authorized under §1915(j) of the Act.**☐ **A program authorized under §1115 of the Act.**

Specify the program:

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.****2. Brief Waiver Description**

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Autism Waiver provides intensive one-on-one intervention services in a natural environment to children from (18) months to (7) years of age with a diagnosis of autism spectrum disorder (ASD). The ASD diagnosis must be the primary contributing factor to the child's delays, deficits, or maladaptive behaviors to qualify for the Autism Waiver. Autism Waiver services allow eligible children to live in the community and preclude or postpone institutionalization. Specifically, these services are available to beneficiaries who: 1.) Have an ASD diagnosis; 2.) Meet ICF/IDD institutional level of care criteria; 3.) Are between eighteen (18) months and (8) years of age.

4.) Have a parent /guardian actively participating in the implementation of the service plan.

The Autism Waiver offers the following Services 1.) Individual Assessment/Treatment Development/and Monitoring; 2.) Therapeutic Aides and Behavioral Reinforcers; 3.) Lead Therapy Intervention; 4) Line Therapy Intervention; and 5.) Consultative Clinical and Therapeutic Services. The first four services are performed by Intensive Intervention providers. Consultative Clinical and Therapeutic Services are provided by Clinical Services Specialists working with a four-year university program.

The Autism Waiver program is operated by The Department of Human Services, Division of Developmental Disabilities Services("DDS"). DDS contracts with a third- party vendor to assist in the day-to-day operation and the administration of the Autism Waiver, including without limitations administering the evaluation instruments and collecting the data used to determine whether an applicant meets eligibility requirement, the plan of care ("POC") and certifying Autism Waiver providers.

Vendor assigns each beneficiary an Autism Waiver Coordinator who develops the POC outlining the intensive intervention services to be provided, to the beneficiary by the selected certified community service provider. An intensive intervention is a type of individualized evidence -based intervention as described in the National Autism Center's National Standards Project 2nd edition. Intensive intervention services include behavioral interventions, cognitive behavioral intervention packages, comprehensive behavioral treatments, language training, modeling, naturalist teaching, strategies, parent training packages, peer training packages, pivotal response treatments, schedules, scripting, self -management, social skills packages, and story-based interventions. New interventions that are found to be effective may also be used.

**3. Components of the Waiver Request**

**The waiver application consists of the following components. Note: Item 3-E must be completed.**

**A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ☐ Yes. This waiver provides participant direction opportunities. *Appendix E is required.*
- ☒ No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*

**F. Participant Rights.** **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards.** **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability.** **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration.** **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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**A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

- ☒ Not Applicable
- ☐ No
- ☐ Yes

**C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

- ☒ No
- ☐ Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- ☐ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.  
*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.  
*Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*



## 5. Assurances

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In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals

with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

**Notice of Rule Making:**

The Director of the Division of Medical Services of the Department of Human Services announces for the 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, & 25-10-129. Public Notice will run from October 6,2023 through November 6,2023, will be available in the Arkansas statewide Democrat Gazette newspaper. Public comments must be submitted in writing at ar.gov/dhs-proposed-rules or the following email address ORP@dhs.arkansas.gov

No comments submitted.

A public hearing by remote access only through a Zoom webinar will be held on October18,2023, at 1:00 p.m. and public comment may be submitted at the hearing.

No comments submitted.

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

Pitman

**First Name:**

Elizabeth

**Title:**

Division of Medical Services

**Agency:**

Office of Legislative and Intergovernmental Affairs, Department of Human Services

**Address:**

P. O. Box 1437, Slot S-401

**Address 2:**

**City:**

Little Rock

**State:**

Arkansas

**Zip:**

72203-1437

**Phone:**

(501) 508-8875 Ext:  ☐ TTY

Fax:

(501) 404-4619

E-mail:

elizabeth.pitman@dhs.arkansas.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Stone

First Name:

Melissa

Title:

Director

Agency:

Division of Developmental Disabilities Services, Department of Human Services

Address:

PO Box 1437

Address 2:

Slot N501

City:

Little Rock

State:

Arkansas

Zip:

72201

Phone:

(501) 682-8665 Ext:  ☐ TTY

Fax:

(501) 682-8380

E-mail:

melissa.weatherton@dhs.arkansas.gov

## 8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

Portland Gilbert

State Medicaid Director or Designee

Submission Date: Apr 17, 2024

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

Last Name: Gilbert

First Name: Portland

Title: Assistant Director

Agency: Division of Developmental Disabilities, Department of Human Services

Address: PO Box 1437, N502

Address 2:

City: Little Rock

State: Arkansas

Zip: 72201

Phone: (501) 682-8702 Ext:  ☒ TTY

Fax: (501) 682-8687

E-mail: Attachments portland.gilbert@dhs.arkansas.gov

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ Replacing an approved waiver with this waiver.
- ☐ Combining waivers.
- ☐ Splitting one waiver into two waivers.
- ☐ Eliminating a service.
- ☐ Adding or decreasing an individual cost limit pertaining to eligibility.
- ☐ Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
- ☐ Reducing the unduplicated count of participants (Factor C).
- ☐ Adding new, or decreasing, a limitation on the number of participants served at any point in time.
- ☐ Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
- ☐ Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

**Additional Needed Information (Optional)**

Provide additional needed information for the waiver (optional):

**Appendix A: Waiver Administration and Operation**

**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- ☐ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- ☐ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- ☐ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- ⦿ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Division of Developmental Disabilities Services

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Department of Human Services, Division of Medical Services ("DMS") is the state's Medicaid agency. The Arkansas Department of Human Services, Division of Developmental Services ("DDS") acts as the operating agency for the Autism Waiver under the administrative authority of DMS. DMS and DDS have entered into an Interagency Memorandum of Understanding ("MOU") to establish the respective obligations and responsibilities of each agency in connection with the operations and administration of the Autism Waiver.

DMS specifically delegates the following operational and administrative functions to DDS as the operating agency pursuant to the MOU:

1. Participant enrollment
2. Waiver enrollment managed against approved limits
3. Waiver expenditures managed against approved levels
4. Level of care evaluations
5. Review of participant service plans
6. Prior authorization of waiver services
7. Utilization management
8. Qualified provider enrollment
9. Rules, policies, procedures, and information developing governing waiver program
10. Quality assurance and quality improvement

The term MOU is (1) year it automatically renews for additional one (1) year period unless terminated by one of the parties. The entirety of the MOU is reviewed and discussed by DMS and DDS at each regularly scheduled quarterly meeting to ensure no amendments to the MOU are necessary; however, the MOU may be amended at any time upon the mutual agreement of the parties.

The MOU permits DDS to hire a third- party vendor ("Vendor") to assist with the day-to-day operations and administration of the Autism Waiver as long as any MOU obligations performed pursuant to a written, legally binding contract containing adequate performance measures. The MOU requires DDS to conduct regular reviews of the vendors performance and allows DMS to observe, review and direct Vendor activities at any time.

DMS ensures DDS performs its assigned operational and administrative functions in accordance with the MOU and the waiver requirements by meeting with DDS on at least a quarterly basis to discuss Vendor performance, the DDS Review report, any complaints and critical incidents reported, and to address any other waiver operational or administrative issues. If it is determined that an amendment to the MOU is necessary, then DMS and DDS would execute and amendment as soon as possible.

DMS the Medicaid Management Information System and the Arkansas Department of Human Services, Division of County Operations eligibility system, to monitor DDS and ensure it performs the assigned operational administrative waiver functions in accordance with the MOU and waiver requirements.

## Appendix A: Waiver Administration and Operation

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*



DDS currently contracts with a third -party vendor (" Vendor") to assist with certain aspects of the day- to- day administrative and operational functions of the Autism Waiver. Vendor assist DDS with the following operational and administrative waiver functions:

- 1.Participant enrollment
- 2.Waiver enrollment against approved limits
- 3.Level of care evaluation
- 4.Prior authorization of waiver services
- 5.Utilization management
- 6.Qualified provider enrollment
- 7.Quality assurance and quality improvement activities

Vendor has established and actively maintains a secure electronic database ("Autism Waiver Database") for data management and communication with certified Autism Waiver providers. The Autism Waiver Database acts as the repository for Autism Waiver beneficiary service records, Autism Waiver service provider certification and personnel files, and complaint/grievance and critical incident reports and investigations.

- ☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ☒ **Not applicable**
- ☐ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

- ☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

- ☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in

conducting waiver operational and administrative functions:

DDS has primary oversight responsibility over the third-party vendor contracted to assist with the day-to-day administrative and operational Autism Waiver functions.

DMS maintains ultimate administrative authority over the Autism Waiver and provides a second line of oversight for any contracted third-party vendor.

## Appendix A: Waiver Administration and Operation

**6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The contract between DDS and the third-party vendor ("Vendor") establishes specific minimum performance standards that ensure Vendor performs Autism Waiver operational and administrative functions in accordance with waiver requirements. These Vendor contract performance measures are designed to track the performance measures attached to each Appendix within the Autism Waiver application ("Performance Measures") and ensure Vendor's operational and administrative activities comply with the Autism Waiver requirements.

Vendor has established and actively maintains a secure electronic database ("Autism Waiver Database") for data management and communication with DMS, DDS, and certified Autism Waiver providers. The Autism Waiver Database acts as the repository for Autism Waiver beneficiary service records, Autism Waiver provider certification and personnel files, and complaint/grievance and critical incident reports and investigations. Vendor has developed a data report for each Performance Measure for which the Autism Waiver Database is the data source. Vendor runs each data report monthly to discover and identify potential issues with the operation and administration of the waiver. The results of these monthly data reports are aggregated into a quarterly Autism Waiver Report, which is submitted to DDS and reviewed to ensure Vendor's operational and administrative activities comply with the Autism Waiver requirements.

DDS staff also have access to the Autism Waiver Database for the purpose of conducting quality reviews to monitor Vendor performance. DDS conducts a quarterly retrospective random sample reviews ("DDS Reviews") of at least twenty percent (20%) of active beneficiary service, provider certification, and provider personnel records in the Autism Waiver Database to verify the data submitted by Vendor in the Autism Waiver Report and monitor Vendor to ensure its operational and administrative activities comply with the Autism Waiver requirements.

Additionally, DDS and Vendor meet on at least a quarterly basis to discuss the results of the Autism Waiver Report and DDS Reviews, review any complaints and critical incidents reported in the prior quarter, and address any adjustments to Autism Waiver operations or administration that need to be made. Any necessary Vendor corrective action steps or plans are developed at the quarterly meeting. Any active corrective action plan would be reviewed and discussed at each quarterly meeting.

Finally, DMS uses the Medicaid Management Information System and the Department of Human Services, Division of County Operations' eligibility system on an on-going basis to monitor Vendor compliance with its contractually required performance obligations with respect to Autism Waiver requirements.

## Appendix A: Waiver Administration and Operation

**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

#### a. Methods for Discovery: Administrative Authority

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

#### i. Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

Number and percent of policies and procedures developed by DDS that are reviewed and approved by the Medicaid Agency ("DMS) prior to implementation. Numerator: Number of policies and procedures developed by DDS that were reviewed by DMS prior;

**Denominator: Number of policies and procedures developed by DDS.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**JIRA**

Responsible Party for data collection/generation( <i>check each that applies</i> ):	Frequency of data collection/generation( <i>check each that applies</i> ):	Sampling Approach( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

#### Vendor Problem Discovery and Identification Strategies

DDS's contracted vendor ("Vendor") has established and actively maintains a secure electronic database ("Autism Waiver Database") for data management and interaction with DMS, DDS, and certified Autism Waiver providers. Specifically, the Autism Waiver Database acts as a repository for:

1. Beneficiary service records
2. Provider certification records
3. Provider personnel files
4. Complaints/grievances
5. Critical incidents
6. All documentation related to investigations involving Autism Waiver complaints and critical incidents.

All information related to a beneficiary's participation in the Autism Waiver is maintained in the beneficiary's service record in the Autism Waiver Database, including the beneficiary's application, diagnostic information, level of care evaluation results, service delivery notes, and all communications relating to the beneficiary. The Autism Waiver Database provides a secure, individualized log-in for each Autism Waiver provider's Interventionists, Lead Therapists, and Line Therapists, which allows these professionals to access a beneficiary's service record, upload evaluation and reevaluation results, upload and update individual treatment plans, and enter service delivery and progress notes. The individualized log-ins only allow providers and their professionals access to the beneficiary service records of those beneficiary's they are actively serving.

The Autism Waiver Database is also used to maintain documentation related to provider certification and personnel files. This documentation would include an Autism Waiver provider's certification application and certificate, and all successfully passed background checks, registry searches, and drug screens for personnel that provide Autism Waiver services on behalf the certified provider. A provider must also upload to the Autism Waiver Database documentation demonstrating that each of its professionals delivering Autism Waiver services on its behalf has met any applicable education, experience, licensing, and training requirements.

Vendor has developed a data report for each performance measure ("Performance Measure") in this waiver for which the Autism Waiver Database is the data source. Vendor runs each data report monthly to discover and identify potential issues with the operation and administration of the waiver. The results of these the monthly data reports are aggregated into a single Autism Waiver Report, which is submitted to DDS each quarter.

#### Operating Agency Problem Discovery and Identification Strategies

DDS staff are provided read only access to the Autism Waiver Database for the purpose of conducting retrospective reviews on a quarterly basis. The specifics of these retrospective reviews are described in detail in each of the Appendices of this waiver, but generally are conducted to verify the results of the Autism Waiver Report and confirm Vendor's compliance with contract performance standards. DDS uses the Raosoft Calculation System to determine a sample size for retrospective reviews that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error. The results of DDS's retrospective reviews are aggregated into a single DDS Review report, which is submitted to DMS each quarter.

DDS also meets with Vendor on at least a quarterly basis to discuss the results of the Autism Waiver Report and DDS Review report, review any complaints and critical incidents reported in the prior quarter, and address any adjustments to Autism Waiver operations or administration that need to be implemented.

#### Medicaid Agency Problem Discovery and Identification Strategies

DMS staff are provided read only access to the Autism Waiver Database for the purpose of conducting retrospective reviews. The specifics of these retrospective reviews are described in detail in each of the Appendices of this waiver, but generally are conducted to verify the results of the Autism Waiver Report, confirm Vendor's compliance with contract performance standards, and ensure DDS is complying with all obligations within both the waiver and the Interagency Memorandum of Understanding.

DMS holds a quarterly meeting with DDS to discuss the Vendor's performance, DDS Review report, the most recent Autism Waiver Report, and address any other operational or administrative issues discovered during retrospective review.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DDS and DDS's contracted vendor ("Vendor") meet on at least a quarterly basis to discuss the results of the Autism Waiver Report and DDS Review report, review any complaints and critical incidents reported in the prior quarter, and discuss Autism Waiver operations generally. If issues with the operation of the Autism Waiver are discovered, then DMS, DDS, and Vendor will discuss appropriate adjustments and remediation on a case-by-case basis. Discussion will typically take place during regularly scheduled quarterly meetings, unless a more immediate meeting is required.

The type of remediation implemented depends on the issue and surrounding circumstances and may include without limitation one or more of the following: corrective action plan, training, revising a service plan, revoking provider certification, recoupment, system design changes, the parent/guardian selecting a new community service provider, and the involuntary removal of a beneficiary from the Autism Waiver.

How each remediation effort is implemented and monitored and the party directly responsible is determined prior to implementation. The party directly responsible for implementing and monitoring the progress of a remediation effort depends on the type of remediation effort implemented. Vendor will typically be responsible for implementing and monitoring corrective action plans, trainings, certification revocations, and the removal of a beneficiary from the Autism Waiver. DMS or DDS will typically be responsible for implementing and monitoring remediation efforts involving recoupments, system design changes, and issues involving Vendor's responsibilities under its contract with DDS.

In cases where a new or updated policy or procedure was not approved by DMS prior to implementation, remediation includes DMS reviewing the policy or procedure and approving or removing, as appropriate. The status of each active remediation effort will be discussed at each quarterly meeting until the remediation effort is completed or resolved.

Investigations, findings, and other documentation related to the Vendor's monitoring of remediation efforts will be maintained in the Autism Waiver Database. Recoupments will be monitored and tracked by DMS through the Medicaid Management Information system. System design changes will be documented through updates to existing or implementation of new Autism Waiver policies and procedures and amendments to the Autism Waiver. Finally, documentation related to remediations in connection with Vendor's performance under its contract will be maintained in the contract file.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: 150px; margin-top: 5px;">DDS's contracted vendor</div>	<input type="checkbox"/> Annually

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ **No**

☐ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility****B-1: Specification of the Waiver Target Group(s)**

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> <b>Aged or Disabled, or Both - General</b>					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> <b>Intellectual Disability or Developmental Disability, or Both</b>					
	<input checked="" type="checkbox"/>	Autism	1	7	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> <b>Mental Illness</b>					



Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			

**b. Additional Criteria.** The state further specifies its target group(s) as follows:

1. A beneficiary must be diagnosed with Autism Spectrum Disorder (“ASD”), as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) put out by the American Psychiatric Association, the presence of ASD is demonstrated by a formalized ASD evaluation instrument, such as the Childhood Autism Rating Scale or Autism Diagnostic Observation Scale, administered by an appropriately licensed professional, or a delineation of DSM criteria.
2. A beneficiary's ASD diagnosis must be from by at least two (2) of the following three (3) licensed professionals either individually or as a team: physician, psychologist, and speech-language pathologist. The ASD diagnosis must be the primary contributing factor to the beneficiary’s delays, deficits, or maladaptive behaviors to qualify for the Autism Waiver.
3. A beneficiary’s level of care evaluation must demonstrate the beneficiary requires an ICF/IID institutional level of care.
4. A beneficiary must be between eighteen (18) months and eight (8) years of age.
5. A beneficiary may receive a maximum of three (3) years of Autism Waiver services as codified in Arkansas Act 1008 of 2015. The clock on the three (3) year service limitation starts on the first billable Autism Waiver service date.
6. A beneficiary must be determined eligible for the Autism Waiver on or before their fifth birthday to allow for a maximum three (3) years of service prior to reaching the Autism Waiver maximum age limitation on their eighth (8th) birthday.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- ☐ Not applicable. There is no maximum age limit
- ☒ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

*Specify:*

The Autism Waiver Coordinator assigned to the beneficiary by DDS’s contracted vendor initiates transition planning when a beneficiary no longer meets Autism Waiver eligibility criteria or three (3) months prior to the date the client would reach their three (3) year service limitation, whichever is earlier. Transition planning starts with the Autism Waiver Coordinator scheduling a transition conference at the beneficiary’s home with the parent/guardian. During the transition conference the Autism Waiver Coordinator provides the parent/guardian with information about other services, supports, and appropriate referrals available (i.e., Medicaid state plan services, other waiver alternatives, and programs available through the Local Education Agency), and answers any of the parent/guardian’s questions about the beneficiary’s exit from the Autism Waiver. The Autism Waiver Coordinator also assists the beneficiary and parent/guardian with transitioning to other service providers. A transition conference with any new service provider is scheduled when requested by the parent/guardian.

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☒ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

**The limit specified by the state is (*select one*)**

- ☐ **A level higher than 100% of the institutional average.**

Specify the percentage:

- ☐ **Other**

*Specify:*

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the state is (*select one*):**

- ☐ **The following dollar amount:**

Specify dollar amount:

**The dollar amount (*select one*)**

- ☐ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- ☐ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**
- ☐ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

☐ Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☐ Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	270
Year 2	270
Year 3	270
Year 4	270
Year 5	270

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

- ☐ The state does not limit the number of participants that it serves at any point in time during a waiver year.
- ☒ The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	180
Year 2	180
Year 3	180
Year 4	180
Year 5	180

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- ☒ Not applicable. The state does not reserve capacity.
- ☐ The state reserves capacity for the following purpose(s).

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in

the waiver.

**e. Allocation of Waiver Capacity.**

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

DDS's contracted vendor ("Vendor") accepts applications, administers evaluation instruments, and collects data that is used to determine whether an applicant meets the Autism Waiver eligibility requirements. If it is determined an applicant meets the eligibility requirements, then the applicant is enrolled in an available Autism Waiver slot. If an applicant meets the eligibility requirements and there is not an available Autism Waiver slot, a waiting list is established. When a waiting list exists, Vendor continues to accept and process applications and any applicants determined to be eligible for the Autism Waiver are added to the waiting list on a first come, first served basis. As Autism Waiver slots become available, eligible applicants are enrolled into available slots in the order they were added to the waiting list.

An applicant must be enrolled in an Autism Waiver slot on or before their fifth (5th) birthday to allow for the maximum three (3) years of services before reach the Autism Waiver maximum age limitation at their eighth (8th) birthday. An entry age requirement prevents an applicant from enrolling in an Autism Waiver slot immediately prior to their eighth (8th) birthday, leaving insufficient time to recruit staff and provide Autism Waiver services prior to the applicant reaching the maximum age limitation.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

**a. 1. State Classification.** The state is a (*select one*):

- ☒ §1634 State
- ☐ SSI Criteria State
- ☐ 209(b) State

**2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

- ☐ No
- ☒ Yes

**b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation

limits under the plan. *Check all that apply:*

---

**Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

---

- ☐ Low income families with children as provided in §1931 of the Act
- ☒ SSI recipients
- ☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- ☐ Optional state supplement recipients
- ☐ Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- ☐ 100% of the Federal poverty level (FPL)
- ☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR §435.330)
- ☐ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- ☐ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

*Specify:*

---

**Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed**

---

- ☐ No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- ☒ Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

*Select one and complete Appendix B-5.*

- ☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217
- ☒ Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

*Check each that applies:*

- ☒ A special income level equal to:

Select one:

- ☒ **300% of the SSI Federal Benefit Rate (FBR)**  
☐ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ☐ **A dollar amount which is lower than 300%.**

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**  
☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**  
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**  
☐ **Aged and disabled individuals who have income at:**

Select one:

- ☐ **100% of FPL**  
☐ **% of FPL, which is lower than 100%.**

Specify percentage amount:

- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.*

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- ☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

- ☐ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

- ☐ Use spousal post-eligibility rules under §1924 of the Act.  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)
- ☒ Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

#### b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

##### i. Allowance for the needs of the waiver participant (*select one*):

- ☐ The following standard included under the state plan

*Select one:*

- ☐ SSI standard
- ☐ Optional state supplement standard
- ☐ Medically needy income standard
- ☐ The special income level for institutionalized persons

(*select one*):

- ☐ 300% of the SSI Federal Benefit Rate (FBR)
- ☐ A percentage of the FBR, which is less than 300%

Specify the percentage:

- ☐ A dollar amount which is less than 300%.

Specify dollar amount:

- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ Other standard included under the state Plan

*Specify:*

- ☐ The following dollar amount

Specify dollar amount:  If this amount changes, this item will be revised.



- ☒ The following formula is used to determine the needs allowance:

*Specify:*

The maintenance needs allowance is equal to the beneficiary's total income as determined under the post-eligibility process which includes income that is placed in a Miller trust.

- ☐ Other

*Specify:*

---

ii. Allowance for the spouse only (*select one*):

---

- ☒ Not Applicable (see instructions)
- ☐ SSI standard
- ☐ Optional state supplement standard
- ☐ Medically needy income standard
- ☐ The following dollar amount:

Specify dollar amount:  If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

*Specify:*

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iii. Allowance for the family (*select one*):

---

- ☒ Not Applicable (see instructions)
- ☐ AFDC need standard
- ☐ Medically needy income standard
- ☐ The following dollar amount:

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ☐ The amount is determined using the following formula:

*Specify:*

- ☐ Other

*Specify:*

---

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

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- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ☒ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☐ **The state does not establish reasonable limits.**
- ☐ **The state establishes the following reasonable limits**

*Specify:*

---

## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (3 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

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**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (4 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

---

**Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.**

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## Appendix B: Participant Access and Eligibility

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### B-5: Post-Eligibility Treatment of Income (5 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (6 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

#### f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (7 of 7)

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

#### g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

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

#### i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

#### ii. Frequency of services. The state requires (select one):

- ☒ The provision of waiver services at least monthly
- ☐ Monthly monitoring of the individual when services are furnished on a less than monthly basis

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- ☐ Directly by the Medicaid agency
- ☒ By the operating agency specified in Appendix A
- ☐ By a government agency under contract with the Medicaid agency.

*Specify the entity:*

- ☐ Other

*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

DDS's contracted vendor assigns one of its Autism Waiver Coordinators to an applicant when it has confirmed the applicant has an autism spectrum disorder diagnosis and meets the age eligibility requirements. When there is an available Autism Waiver slot for the applicant, the assigned Autism Waiver Coordinator schedules an on-site meeting with the applicant and parent/guardian to conduct the initial level of care ("LOC") evaluation. During the on-site visit, the Autism Waiver Coordinator will administer the adaptive functioning and behavior evaluations necessary to determine if the applicant requires an institutional level of care. Each initial LOC evaluation will at a minimum include the administration of the Vineland Adaptive Behavior Scales ("Vineland") and Temperament Atypical Behavior Scale ("TABS") evaluation instruments.

Any individual serving as an Autism Waiver Coordinator must:

1. Have a minimum of two (2) years' experience working with children diagnosed with autism spectrum disorder; and
2. Have either:
  - a. A Registered Nurse license; or
  - b. A Bachelor's or more advanced degree in psychology, speech-language pathology, occupational therapy, education, or a related field.

The Autism Waiver Coordinator uses the Vineland and TABS results to complete the Form DHS-703. The Autism Waiver Coordinator then submits the completed DHS-703 and any supporting documentation to the Arkansas Department of Human Services, Division of Provider Support and Quality Assurance, Office of Long-Term Care ("OLTC").

OLTC reviews the Form DHS-703 and supporting documentation to determine if the applicant meets institutional level of care criteria. If OLTC determines the applicant meets institutional level of care criteria, then OLTC issues a Form "DHS-704 Decision for Nursing Home/Waiver Placement" that officially establishes the applicant meets the institutional level of care criteria necessary for Autism Waiver eligibility. Each individual issuing a level of care determination on behalf of OLTC must be a licensed Registered Nurse.

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency

(if applicable), including the instrument/tool utilized.

An applicant must require an ICF/IID institutional level of care to qualify for the Autism Waiver. An applicant is deemed to require an institutional level of care if appropriate intelligence and adaptive functioning and behavior evaluation instruments demonstrate significant deficits in adaptive functioning and/or the presence of significant behavioral challenges. This is the same level of care criteria used to establish a beneficiary's eligibility for admission into one of the state's ICF/IID facilities. The annual level of care ("LOC") reevaluation process is conducted in the exact same manner as the initial LOC evaluation process.

Each LOC evaluation must include the administration of Vineland Adaptive Behavior Scales ("Vineland") and Temperament Atypical Behavior Scale ("TABS") evaluation instruments by the Autism Waiver Coordinator.

An applicant/beneficiary scoring of seventy (70) or less in any two (2) of the Vineland domains is deemed to require an institutional level of care for Autism Waiver eligibility purposes. Vineland Scores above seventy (70) falling within domain's confidence interval for the applicant/beneficiary's developmental age are also deemed to meet the institutional level of care threshold for that domain. For example, Vineland domain score of seventy-four (74) where the confidence interval is five (5) points would be deemed to meet the institutional level of care threshold for that domain.

An applicant/beneficiary aged three (3) or older scoring eighty-five (85) or less on two (2) of the three (3) Vineland adaptive behavior domains (Communication, Daily Living Skills, Socialization) and between twenty-one (21) and twenty-four (24) on the Vineland Maladaptive Behavior Index is also deemed to require an institutional level of care for Autism Waiver eligibility purposes. Vineland adaptive behavior scores falling within the domain's confidence interval for the applicant's/beneficiary's developmental age are also deemed to meet the institutional level of care threshold for that domain.

Finally, an applicant/beneficiary under the age of three (3) scoring eighty-five (85) or less on two (2) of the three (3) Vineland adaptive behavior domains of eight (8) and above on the TABS is also deemed to require an institutional level of care for Autism Waiver eligibility purposes.

For purposes of an applicant's initial LOC evaluation, the results of an already administered Vineland or TABS may be used if administered within the immediately preceding six (6) months. Any already administered evaluation instrument must have been administered by appropriately licensed professionals as required by the particular instrument.

The Autism Waiver Coordinator uses the LOC evaluation results to complete the Form DHS-703. The Autism Waiver Coordinator submits the completed DHS-703 and any supporting documentation to the Arkansas Department of Human Services, Division of Provider Support and Quality Assurance, Office of Long-Term Care ("OLTC"). OLTC then reviews the Form DHS-703 and supporting documentation to determine if an applicant/beneficiary meets ICF/IID institutional level of care criteria for Autism Waiver eligibility purposes.

**e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- ☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Autism Waiver eligibility determination process starts with the parent/guardian submitting a completed Autism Waiver application packet to DDS's contracted vendor ("Vendor"). Vendor then conducts an initial review of the application to determine if the applicant has the required qualifying autism spectrum disorder ("ASD") diagnosis and is within the eligible age range. If an application requires additional information, Vendor will request in writing the additional information from the parent/guardian.

Once Vendor has confirmed the applicant has the required ASD diagnosis and meets the age eligibility requirements, Vendor will assign the applicant an Autism Waiver Coordinator. When there is an available Autism Waiver slot for the applicant, the assigned Autism Waiver Coordinator schedules an on-site meeting with the applicant and parent/guardian to conduct the initial level of care ("LOC") evaluation. If there is not an available Autism Waiver slot for the applicant, then the applicant would be placed on the waiting list and the Autism Waiver Coordinator would not schedule an on-site meeting until a slot becomes available. "On-site" refers to a home and community setting, which will usually be the applicant's home; however, other community locations identified by the parent/guardian (such as the park, grocery store, church, etc.) may be selected based on the skills and behaviors of the applicant. The on-site meeting must be held no more than thirty (30) days after the later of the date: (i) Vendor confirms the applicant has the required ASD diagnosis and meets the age eligibility requirements; or (ii) an Autism Waiver slot becomes available.

During the on-site visit, the Autism Waiver Coordinator will administer the adaptive functioning and behavior evaluations necessary to determine if the applicant/beneficiary requires an institutional level of care. Each LOC evaluation will at a minimum include the administration of Vineland Adaptive Behavior Scales ("Vineland") and Temperament Atypical Behavior Scale ("TABS") evaluation instruments. For purposes of an applicant's initial LOC determination, Vendor may use the results of an already administered evaluation instrument if it was completed within the prior six (6) months. Any already administered evaluations must have been administered by appropriately licensed professionals as required by the evaluation instruments utilized.

The on-site visit may also include data collection, parent/guardian selection of an Autism Waiver community service provider, execution of the (Parent/Guardian Participation Agreement), and preliminary development of the plan of care ("POC").

The Autism Waiver Coordinator uses the LOC evaluation results to complete the Form DHS-703. The completed DHS-703 and any supporting documentation is submitted to the Arkansas Department of Human Services, Division of Provider Support and Quality Assurance, Office of Long-Term Care ("OLTC"). OLTC reviews the DHS-703 and supporting documentation to determine if the applicant/beneficiary meets ICF/IID institutional level of care criteria for Autism Waiver eligibility purposes.

If OLTC determines the applicant/beneficiary meets ICF/IID institutional level of care criteria, then OLTC issues a Form "DHS-704 Decision for Nursing Home/Waiver Placement" that officially establishes the applicant/beneficiary meets the institutional level of care criteria necessary for Autism Waiver eligibility. The DHS-704 must be issued within ten (10) days of the date of the beneficiary's on-site visit.

Once Vendor has received the DHS-704, the Autism Waiver Coordinator submits the DHS-704 and all other applicable financial information the Arkansas Department of Human Services, Division of County Operations ("DCO"). DCO then determines whether the applicant/beneficiary meets the Autism Waiver financial eligibility requirement. If DCO determines the applicant/beneficiary is financially eligible for the Autism Waiver, then a Form DHS-3330 is delivered to Vendor. Once the Vendor receives the DHS-3330 from DCO, the applicant/beneficiary has successfully met all Autism Waiver eligibility criteria.

The DHS-704 that establishes the applicant/beneficiary meets ICF/IID institutional level of care criteria is effective for twelve (12) months. The DHS-3330 that establishes the applicant/beneficiary meets financial eligibility criteria is also effective for twelve (12) months. As a result, an applicant/beneficiary must go through the entire LOC evaluation and financial eligibility process every twelve (12) months to demonstrate continued eligibility for enrollment in the Autism Waiver. The annual LOC reevaluation process is conducted in the exact same manner as the initial LOC evaluation process.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- ☐ Every three months
- ☐ Every six months

☒ Every twelve months

☐ Other schedule

*Specify the other schedule:*

**h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

☒ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

☐ The qualifications are different.

*Specify the qualifications:*

**i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

The Form DHS-704 that establishes an applicant meets ICF/IID institutional level of care criteria is effective for twelve (12) months. The first day of each month, DDS's contracted vendor ("Vendor") runs an Autism Waiver Database report that pulls every beneficiary who has a DHS-704 expiring within the next ninety (90) days. The Autism Waiver Coordinator for each beneficiary on the report schedules an on-site visit to conduct the beneficiary's level of care ("LOC") reevaluation. Once the Autism Waiver Coordinator has conducted the LOC reevaluation, the Autism Waiver Coordinator will use the reevaluation results to complete the DHS-703 Form. The Autism Waiver Coordinator submits the completed DHS-703 and any supporting documentation to the Arkansas Department of Human Services, Division of Provider Support and Quality Assurance, Office of Long-Term Care ("OLTC").

OLTC reviews the DHS-703 and any supporting documentation to determine if the beneficiary continues to meet ICF/IID institutional level of care criteria for Autism Waiver eligibility purposes. If OLTC determines the beneficiary continues to meet ICF/IID institutional level of care criteria, then OLTC issues the Form "DHS-704 Decision for Nursing Home/Waiver Placement" that officially establishes the beneficiary continues to meet the institutional level of care criteria necessary for Autism Waiver eligibility for another twelve (12) months from the date of the new DHS-704. The new DHS-704 must be issued within ten (10) days of the date of the beneficiary's on-site visit.

**j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

An Autism Waiver beneficiary's service record, which includes the initial level of care evaluation and all level of care reevaluation documentation, will be maintained by DDS's contracted vendor ("Vendor") for at least five (5)- years after the date the beneficiary exits the Autism Waiver. Vendor also maintains paper files of each applicant's initial level of care evaluation and each beneficiary's level of care reevaluations.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

**i. Sub-Assurances:**

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of applicants for whom there was a reasonable indication that services may be needed in the future who received an initial level of care (LOC) evaluation**  
**Numerator:** number of applicants for whom there was a reasonable indication that services may be needed in the future who received an initial LOC evaluation.  
**Denominator:** Number of applicants files reviewed.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>



	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> A sample of applicants assigned a slot at least 30 days but less than 1 year that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

**b. Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as*

*specified in the approved waiver.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percent of level of care (LOC) evaluations completed using the instrument required within the waiver. Numerator: Number of LOCs evaluations completed using the instruments required with the waiver. Denominator: Number of beneficiary service records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>

<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div>DDS's contracted vendor</div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:  <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div>A sample of clients who had level of care evaluations completed during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</div>
	<input type="checkbox"/> <b>Other</b> Specify:  <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div>DDS's contracted vendor</div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Specify: <div></div>

**Performance Measure:**

**Number and percent of level of care (LOC) evaluations administered by a qualified evaluator. Numerator:** Number of LOC evaluations administered by a qualified evaluator; **Denominator:** Number of beneficiary service records reviewed

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:

		A sample of beneficiaries who had level of care evaluation completed during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number and percent of initial level of care ("LOC") evaluations completed in**

accordance with the processes described in the approved waiver; Numerator: Number of initial LOC evaluations completed in accordance with the processes described in the approved waiver; Denominator: Number of initial LOC evaluations reviewed.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:

		A sample of applicants receiving site visits ten 10 days but less than 1 year before the end period under review that provides a valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

#### Vendor Problem Discovery and Identification Strategies

DDS's contracted vendor ("Vendor") has established and actively maintains a secure electronic database ("Autism Waiver Database") for data management and communication with DMS, DDS, and certified Autism Waiver providers. The Autism Waiver Database acts as a repository for Autism Waiver beneficiary service records, and Vendor is responsible for uploading the results of an applicant/beneficiary's initial level of care ("LOC") evaluation and each annual reevaluation into the beneficiary's service record in the Autism Waiver Database.

Vendor has developed a data report for each performance measure in this Appendix B ("Performance Measure") for which the Autism Waiver Database is the data source. Vendor runs each data report monthly on all active beneficiary service records to discover and identify potential issues with the timeliness, accuracy, appropriateness, and quality of LOC initial evaluations and reevaluations, and provide a monthly one hundred percent (100%) review of Vendor's compliance with Autism Waiver LOC evaluation requirements. The results of each monthly Performance Measure data report are aggregated into the Vendor's Autism Waiver Report, which is submitted to DDS each quarter.

#### Operating Agency Problem Discovery and Identification Strategies

DDS staff are provided read only access to the Autism Waiver Database for the purpose of conducting random sample retrospective reviews of active Autism Waiver beneficiary service records on a quarterly basis ("DDS Reviews"). DDS Reviews ensure operational compliance with waiver requirements related to LOC initial evaluations and reevaluations, verify the results of the Autism Waiver Report submitted by Vendor, and measure Vendor's compliance with its contract performance standards and the assurances within the waiver application. DDS uses the Raosoft Calculation System to determine a sample size for retrospective reviews that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error. The results of DDS Reviews are compiled into the DDS Review Report that is shared with Vendor and DMS during quarterly meetings.

DDS meets with Vendor on at least a quarterly basis to discuss the results of the Autism Waiver Report, DDS Review report, and to address any issues involving the timeliness, accuracy, appropriateness, and quality of LOC initial evaluations and reevaluations.

#### Medicaid Agency Problem Discovery and Identification Strategies

DMS staff are provided read only access to the Autism Waiver Database for the purpose of conducting retrospective reviews to verify the results of the Autism Waiver Report, confirm Vendor's compliance with contract performance standards, and ensure DDS is complying with all obligations within both the waiver and the Interagency Memorandum of Understanding.

DMS holds a quarterly meeting with DDS to discuss the results of its retrospective review, the DDS Review Report, the most recent Autism Waiver Report, and address any operational or administrative issues related to the timeliness, accuracy, appropriateness, and quality of all LOC initial evaluations and reevaluations. Any necessary corrective action plans and adjustments to Autism Waiver systems operations that need to be implemented based off the results of those reports would also be discussed.

### **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.



If issues in connection with the timeliness, accuracy, appropriateness, or quality of level of care (“LOC”) initial evaluations and reevaluations are discovered during review of DDS’s contracted vendor’s (“Vendor”) performance, the DDS Review Report, or the Autism Waiver Report, then DMS, DDS, and Vendor will discuss the appropriate remediation on a case-by-case basis. Discussion will typically take place during regularly scheduled quarterly meetings, unless a more immediate meeting is required.

The type of remediation implemented depends on the issue and surrounding circumstances and may include without limitation one or more of the following: corrective action plan, training, recoupment, system design changes, the parent/guardian selecting a new Autism Waiver community service provider, and the involuntary removal of a beneficiary from the Autism Waiver.

How each remediation effort is implemented and monitored and the party directly responsible is determined prior to implementation. The party directly responsible for implementing and monitoring the progress of a remediation effort depends on the type of remediation effort implemented. Vendor will typically be responsible for implementing and monitoring corrective action plans, trainings, and removals involving beneficiaries and their parent/guardian. DMS or DDS will typically be responsible for implementing and monitoring remediation efforts involving recoupments and system design changes, or if the issue involves Vendor’s responsibilities related to the timeliness, accuracy, appropriateness, or quality of LOC initial evaluations and reevaluations.

Investigations, findings, and other documentation related to Vendor’s monitoring of remediation efforts will be maintained in the Autism Waiver Database. Recoupments will be monitored by DMS through the Medicaid Management Information system. System design changes will be documented through updates to existing or implementation of new Autism Waiver policies and procedures and amendments to the Autism Waiver. Finally, documentation related to remediations in connection with Vendor’s performance under its contract will be maintained in the contract file.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div>DDS's contracted vendor</div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

**a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Autism Waiver Coordinator will offer each beneficiary’s parent/guardian with the choice between institutional care and Autism Waiver services during the on-site visit to conduct the initial level of care evaluation (or annual reevaluation). The Choice of Care form will document the decision of the parent/guardian. The choice will remain in effect until such time as the parent/guardian changes their mind and notifies the Autism Waiver Coordinator.

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

A copy of the completed Choice of Care form is kept in the beneficiary’s service record in the Autism Waiver Database maintained by DDS's contracted vendor.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

All Department of Human Services (DHS) forms are available in English and Spanish. The forms are translated into other languages when necessary. DHS maintains an ongoing contract for translation services.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Other Service	Consultative Clinical and Therapeutic Services		
Other Service	Individual Assessment/ ,Treatment Development/, and Monitoring		
Other Service	Lead Therapy Intervention		
Other Service	Line Therapy Intervention		
Other Service	Therapeutic Aides and Behavioral Reinforcers		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:  

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:  

Consultative Clinical and Therapeutic Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
<div></div>	<div></div>
Category 2:	Sub-Category 2:
<div></div>	<div></div>
Category 3:	Sub-Category 3:
<div></div>	<div></div>
Category 4:	Sub-Category 4:
<div></div>	<div></div>

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Consultative Clinical and Therapeutic services provide high level, independent clinical oversight of the Autism Waiver by conducting quality reviews assessing each beneficiary's progress toward service plan goals and objectives and the efficacy of the intensive intervention services under the current service plan, and providing as needed technical assistance to the parents/guardians, Interventionist, and the Lead and Line Therapists of the selected community service provider involved in the delivery of intensive intervention services.

Consultative Clinical and Therapeutic services must be performed by Clinical Services Specialists ("CSS"). An individual must hold a Board-Certified Behavioral Analyst certificate to qualify as a CSS.

When a quality review of a beneficiary's service record does not show the expected progress the Clinical Service Specialist with either provide technical assistance to the parent /guardian, Interventionist, and Lead and Line Therapist implementing the intensive intervention services or schedule a conference to determine if the service plan needs to be modified.

Consultative Clinical and Therapeutic services may be conducted through the use of telemedicine technology, unless the needs of the beneficiary, parent/guardian, Interventionist, Lead Therapist, or Line Therapist dictate that the services should be performed in-person, or when the beneficiary is not progressing as expected. Telemedicine services must be the equivalent of face-to-face service delivery and delivered through real-time interaction via a telecommunication link. Consultative Clinical and Therapeutic Services involve the CSS observing the delivery of a Lead or Line Therapy service session with the beneficiary and parent/guardian. While CSS may observe the Lead or Line Therapy services session through telemedicine, the actual Lead or Line Therapy service session would always occur in the natural environment (typically in the beneficiary's home) with a parent /guardian and lead or line therapist present. The onsite lead or line therapist can provide any necessary technical assistance to the beneficiary or parent / guardian when Consultative Clinical and Therapeutic Services are performed by telemedicine. A parent/guardian would always be present during Consultative Clinical and Therapeutic Services and would have to consent to any services delivered.

Consultative Clinical and Therapeutic services (both telehealth and in-person) involving the beneficiary must be conducted with the beneficiary in their natural environment to ensure community integration.

The beneficiary's parent/guardian must be present throughout a remote session to ensure the privacy of the beneficiary is respected.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Consultative Clinical and Therapeutic Services are limited to thirty-six (36) hours (144 units) per year.

**Service Delivery Method** (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

**Specify whether the service may be provided by** (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Institution of Higher Education

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

Service Type: Other Service

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**Service Name: Consultative Clinical and Therapeutic Services**

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**Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

A Consultative Clinical and Therapeutic service provider must be an institution of Higher Education with the capacity to conduct research specific to autism spectrum disorders ("ASD").

The Institution of Higher Education must be:

- 1) Be staffed by Clinical Services Specialists ("CSS");
- 2) Have a central/home office located within the State of Arkansas; and
- 3) Have the capacity to provide Consultative Clinical and Therapeutic services to all areas within the State of Arkansas;

Each CSS employed or contracted by a Consultative Clinical and Therapeutic service provider to perform Consultative Clinical and Therapeutic services must hold a Board-Certified Behavioral Analyst (or more advanced) certificate.

A Consultative Clinical and Therapeutic service provider and each CSS performing such services must be independent of the community service provider selected by the parent/guardian to perform the intensive intervention service. Additionally, each Consultative Clinical and Therapeutic service provider must be an enrolled Medicaid to provider.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS's contracted vendor certifies all Consultative Clinical and Therapeutic service providers and monitors each through the Autism Waiver Database to ensure that all Clinical Services Specialists performing Consultative Clinical and Therapeutic services on behalf of a provider hold a Board-Certified Behavioral Analyst (or more advanced) certificate.

**Frequency of Verification:**

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

**Service Definition (Scope):**

Individual Assessment, Treatment Development, and Monitoring services includes the following components:

(1) Administering the evaluation instruments and conducting the clinical observations necessary to create a comprehensive clinical profile of the beneficiary's skills deficits across multiple domains, including without limitation language/communication, cognition, socialization, self-care and behavior. The evaluation instruments used are individualized to the beneficiary's presenting symptoms, must include administration of the Assessment of Basic Language and Learning Skills-Revised ("ABLLS-R"). The initial evaluation must be administered in person; however, required reevaluations may be conducted by telemedicine with parent/guardian consent. Any reevaluation conducted through telemedicine would occur in the beneficiary natural environment with a parent /guardian present.

(2) Developing the individualized treatment plan ("ITP") that guides the day- to-day delivery of intensive interventions services. The ITP must at a minimum include:

- The intensive intervention service(s) delivery schedule :
- The short- and long-term goals and objectives: and
- The data collection that will be implemented to assess beneficiary progress towards those short- and long- term goals and objectives.

(3) (3) Trainings and educating the parent/guardian, Lead Therapist, and Line Therapists on how to

- Implement and perform the intensive intervention service(s) included in the beneficiary's service plan;
- collect detailed the required data, and regarding the child's progress.
- Record the service session notes necessary to assess the beneficiary's progress towards goals and objectives.

(4) Performing monthly monitoring of intensive intervention service implementation and delivery by the parent/guardian, Lead Therapist, and Line Therapist.

(5) Completing beneficiary clinical progress assessments and adjusting the comprehensive clinical profile and ITP as required. Clinical progress assessments must be completed for each beneficiary at least every four (4) months and must always include the administration of an ABLLS-R and an in-depth review of the data and session notes entered by the Lead Therapist and Line Therapist.

All Individual Assessment, Treatment Development, and Monitoring services must be performed by a qualified Interventionist.

When appropriate, Individual Assessment, Treatment Development, and Monitoring services may be conducted via telehealth; however, the first contact and initial evaluation between an Interventionist and a beneficiary and parent/guardian must be in-person in a natural environment setting. The Autism Waiver Coordinator during the required in-person initial on-site visit will ensure that the beneficiary and the parent/guardian have the necessary technology (and the ability to use it) if telehealth service delivery will be utilized for future services. Additional on-site assistance can be scheduled if necessary.

Individual Assessment, Treatment Development, and Monitoring services (both telehealth and in-person) involving the beneficiary must be conducted with the beneficiary in their natural environment to ensure community integration.

The beneficiary's parent/guardian must be present throughout a remote session to ensure the privacy of the beneficiary is respected. The parent/guardian's presence at each Individual Assessment, Treatment Development, and Monitoring service session involving the beneficiary (both remote and in-person) will ensure the health and safety of the beneficiary and the successful delivery of services for beneficiaries who need hands on/physical assistance."

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Individual Assessment, Treatment Development, and Monitoring services are Limited to ninety (90) hours (360 units) per year.

**Service Delivery Method** (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies)*:

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intensive Intervention Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Individual Assessment/ ,Treatment Development/, and Monitoring

Provider Category:

Agency

Provider Type:

Intensive Intervention Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:



Each Interventionist employed or contracted by an Individual Assessment, Treatment Development, and Monitoring service providers to perform Individual Assessment, Treatment Development, and Monitoring service provider to perform Individual Assessment, Treatment Development, and Monitoring services:

1. Have a minimum of two (2) years’ experience performing one or more of the following for children with autism spectrum disorder:
- i. Developing individual treatment plans;

ii. Providing intensive intervention services; or

iii. overseeing an intensive intervention program; and

Hold either:

- i. A certificate as a Board-Certified Behavior Analyst from the Behavior Analyst Certification Board; or

ii Master’s (or more advanced) degree in psychology, speech-language pathology, occupational therapy, special education or related field

Verification of Provider Qualifications  
Entity Responsible for Verification:

DDS’s contracted vendor will certify all Individual Assessment, Treatment Development, and Monitoring service providers, and monitors each through the Autism Waiver Database to ensure that all Interventionists performing services for a provider meet applicable experience, degree, and certification requirements.

Frequency of Verification:

Annually

Appendix C: Participant Services

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C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:  
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:  
Lead Therapy Intervention

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

#### Service Definition (Scope):

Lead Therapy Intervention services includes the following components:

- (1) Providing intensive intervention services in accordance with the beneficiary's individualized treatment plan
- (2) Weekly or more frequent in-person monitoring of intensive intervention service(s) delivery by the Line Therapist
- (3) Reviewing all data collected and service session notes recorded by the Line Therapists and the parents/guardian;
- (4) Training, assisting, and supporting the parent/guardian and Line Therapist
- (5) Receiving parents/guardian feedback and responding to parent /guardian concerns or forwarding those concerns to the appropriate person; and
- (6) Notifying the assigned Interventionist and Autism Waiver Coordinator when issues arise .

Any problems noted by the Lead Therapist will be reported to the Interventionist and the Autism Waiver Coordinator who will amend the service plan as necessary.

Lead Therapy Intervention services involving the beneficiary must:

1. Be conducted in a typical home or community setting for a similarly aged child without a disability or delay that the beneficiary and their family frequent, such as the beneficiary's home, neighborhood playground or park, church, or restaurant; and
2. Include the participation of a parent/guardian.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Lead Therapy Intervention services are limited to six (6) hours (24 units) per week.

#### Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by *(check each that applies)*:

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intensive Intervention Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Lead Therapy Intervention

Provider Category:

Agency

Provider Type:

Intensive Intervention Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Each Lead Therapist performing Lead Therapy Intervention services must.

1. Hold a bachelor's (or more advanced) degree in education, special education, psychology, speech-language pathology, occupational therapy, or related field;
2. Have either:
  - i. Completed one hundred twenty (120) hours of autism training; or
  - ii. Received an Autism Certificate from the University of Arkansas; and
3. Have a minimum of two (2) years' experience providing intensive intervention services to children with autism spectrum disorder.

A Lead Therapy Intervention service provider may be issued provisional certification in a hardship situation. A hardship situation exists when a beneficiary needs Lead Therapy Intervention services and there is no

individual available with the credentials and experience required to qualify as a Lead Therapist. Provisional certification of an individual or organization requires that the all credential and experience requirements be completed within the first year of service.

#### Verification of Provider Qualifications

##### Entity Responsible for Verification:

DDS's contracted vendor certifies all Lead Therapist Intervention service providers and monitors each through the Autism Waiver Database to ensure that all Lead Therapists meet the applicable education, certification, training, and experience requirements.

##### Frequency of Verification:

Annually

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

#### Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

#### Service Title:

Line Therapy Intervention

#### HCBS Taxonomy:

##### Category 1:

##### Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

#### Service Definition (Scope):

Line Therapy Intervention services include the following component:

- (1) Providing the intensive intervention service(s) in accordance with the Individual Treatment Plan (ITP).
- (2) Collecting data and recording data according session notes in accordance with the ITP; and
- (3) Reporting progress/-and concerns to the Lead Therapist or Interventionist as needed.

Line Therapy Intervention services are overseen at multiple levels. The Lead Therapist has primary oversight responsibility and is in the beneficiary's home on a weekly or more frequent basis to observe the Line Therapist, during an intensive intervention service session. The Interventionist Clinical Services Specialist also provide oversight for the Line Therapist, who is in the home each week to observe the performance of the Line Therapist and review the data.

Line Therapy Intervention services involving the beneficiary must:

1. Be conducted in a typical home or community setting for a similarly aged child without a disability or delay that the beneficiary and their family frequent, such as the beneficiary's home, neighborhood playground or park, church, or restaurant; and
2. Include the participation of a parent/guardian.

#### Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Line Therapy Intervention services are limited to twenty-five (25) hours (100 units) per week.

#### Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

#### Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Intensive Intervention

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Line Therapy Intervention****Provider Category:**

Agency

**Provider Type:**

Intensive Intervention

**Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):

Each Line Therapists performing Line Therapy Intervention services must:

- 1.Be at least eighteen (18) years of age;
- 2.Hold at least a high school diploma or GED,;
- 3.Have completed eighty (80) hours of autism spectrum disorder training, and
4. Have a minimum of two (2) years' experience working with children.

A Line Therapist Intervention service provider may be issued provisional certification in a hardship situation. A hardship situation exists when a beneficiary is in needs of Line Therapy Intervention services and there is no individual available with the credentials and experience to qualify as a Line Therapist. Provisional certification of an individual or organization requires all credential and experience requirements to be completed within the first year of service.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

DDS'S contracted vendor certifies all Line Therapist Intervention service providers and monitors each through the Autism Waiver Database to ensure that all Line Therapists meet the applicable education, certification, training, and experience requirements.

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

**Service Definition (Scope):**

Therapeutic aides and behavioral reinforcers are tools, aides, and or other behavioral reinforcers items provided to a beneficiary for use in their home when necessary to implement and carry out the beneficiary's service plan and substitute materials or devices are otherwise unavailable.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The total cost of therapeutic aides and behavioral reinforcers is limited to a maximum of one thousand dollars (\$1,000.00) per beneficiary, per lifetime, and may only be provided in situations where substitute materials or aides are unavailable.

**Service Delivery Method (check each that applies):**

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-based organizations

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service  
Service Name: Therapeutic Aides and Behavioral Reinforcers

Provider Category:

Agency

Provider Type:

Community-based organizations

Provider Qualifications

License (specify):

Certificate (specify):

Therapeutic Aide and Behavioral Reinforcers certification.

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS's contracted vendor certify all Therapeutic Aide and Behavioral Reinforcer providers and monitors each through the Autism Waiver Database to ensure that the required certification is maintained.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):

- ☒ Not applicable - Case management is not furnished as a distinct activity to waiver participants.



- ☐ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All Autism Waiver providers employees, contractors, subcontractors' interns, volunteers, trainees, or other persons who have a routine contact with or provide services directly to Autism Waiver beneficiaries must successfully pass a criminal background check pursuant to Ark. Code Ann. § 20-38-103, prior to performing services on behalf of the provider. A new criminal background check must be conducted at least once every five (5) years.

If the Autism Waiver provider can verify that an applicant who would have routine contact with or provide services directly to Autism Waiver beneficiaries has lived continuously in the State of Arkansas for the past five (5) years, then the provider must conduct only a state criminal background check through the Arkansas State Police. If the Autism Waiver provider cannot verify the applicant has lived continuously in the State of Arkansas for the past five (5) years, then the provider must conduct both a national criminal background check through the Federal Bureau of Investigation and a state criminal background check through the Arkansas State Police.

If the results of a criminal background check establish that the applicant was found guilty of or pled nolo contendere (no contest) to a disqualifying offense under §Ark. Code. Ann. 20-38-105, then the Autism Waiver provider may not employ or otherwise allow the applicant to perform Autism Waiver services on behalf of the provider.

Each Autism Waiver service provider must maintain in the Autism Waiver Database a personnel file for each person who has routine contact with or provides services directly to Autism Waiver beneficiaries. Each personnel file must include the person's most recent criminal background check(s). Each Autism Waiver service provider must also maintain a signed Provider Assurance stating that criminal background checks are performed on all persons who have routine contact with or provide services directly to Autism Waiver beneficiaries.

DDS's contracted vendor reviews each Autism Waiver service provider's personnel files at initial certification and annual recertification to ensure all persons who have routine contact with or provide services directly to Autism Waiver beneficiaries have a successfully passed, up-to-date criminal background check(s). Program DMS also requires criminal background checks pursuant to Ark. Code Ann. § 20-38-103, prior to enrollment as an Arkansas Medicaid provider.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ☐ **No. The state does not conduct abuse registry screening.**
- ☒ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All Autism Waiver service provider employees, contractors, subcontractors, interns, volunteers, trainees, or other persons who have routine contact with or provide services directly to Autism Waiver clients must successfully pass adult maltreatment registry and child maltreatment registry checks prior to performing services on behalf of the provider. New adult and child maltreatment registry checks must be conducted at least once every two (2) years.

An Arkansas Adult and Long-Term Care Facility Resident Maltreatment Central Registry and an Arkansas Child Maltreatment Central Registry are maintained by the Arkansas Department of Human Services. If the results of an adult maltreatment or child maltreatment registry check establish that an applicant or person that has routine contact with or provides services directly to Autism Waiver clients is included on one of the registries, then the Autism Waiver provider may not employ or otherwise allow the person to perform Autism Waiver services on behalf of the provider.

Each Autism Waiver service provider must maintain in the Autism Waiver Database a personnel file for each person who has routine contact with or provides services directly to Autism Waiver clients. Each personnel file must include the person's most recent adult maltreatment and child maltreatment registry checks. Each Autism Waiver service provider must also maintain a signed Provider Assurance stating that adult maltreatment and child maltreatment registry checks are performed on all persons who have routine contact with or provide services directly to Autism Waiver clients.

DDS's contracted vendor reviews each Autism Waiver service provider's personnel files at initial certification and annual recertification to ensure all persons who have routine contact with or provide services directly to Autism Waiver clients have successfully passed, up-to-date adult maltreatment and child maltreatment registry checks.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**Note:** Required information from this page (Appendix C-2-c) is contained in response to C-5.

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ Self-directed

☐ Agency-operated

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☒ The state does not make payment to relatives/legal guardians for furnishing waiver services.
- ☐ The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ☐ Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☐ Other policy.

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Autism Waiver services provider enrollment is open, continuous, and available to any interested party. Any individual or organization interested in becoming an Autism Waiver provider can contact DDS's contracted vendor ("Vendor") for information and to obtain an application packet certification. There are no restrictions applicable to requesting this information.

All Autism Waiver providers must meet the state's certification requirements for the particular Autism Waiver service and the Arkansas Medicaid enrollment criteria. The certification requirements are detailed in the applications. Medicaid enrollment requirements are detailed in the Medicaid provider contract, which is included with each application packet.

Applicants are allotted as much time as needed to complete an application. Once the application packet is complete and correct, Vendor processes the application and issues an Autism Waiver Provider certificate to the applicant. The applicant is responsible for sending the Autism Waiver Provider certificate and other required documentation to the Medicaid Provider Enrollment Unit in order to become an enrolled Medicaid provider. Autism Waiver service providers are required to be recertified by Vendor each year.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of providers that receive annual re-certification. Numerator:**

**Number of providers that received annual recertification; Denominator: Total number of providers files reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px;"> A sample of providers that have been certified over 1 year as of the end of the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

**Performance Measure:**

**Number and percent of providers that adhered to licensure standards and other standards prior to furnishing Autism Waiver. Numerator: Number of providers that adhered to licensure standards and other standards prior to furnishing Autism Waiver services Denominator: Total number of new providers.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:

		A sample of providers that served beneficiaries during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number and percent of providers, that received certification in accordance with the waiver prior to delivering services. Numerator: Number of providers that received certification in accordance with the waiver prior to delivery of services;**



**Denominator: Total number of provider files reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px;">             A sample of providers that served beneficiaries during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.           </div>
	<input type="checkbox"/> <b>Other</b> Specify:	

--	--	--

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of providers meeting waiver training requirements as evidenced by a signature on the provider assurances letter. Numerator: Number of providers meeting waiver training requirements as evidenced by a signature on the provider assurance letter; Denominator: Total number of provider files reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:

		A sample of providers that served beneficiaries during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

#### Vendor Oversight of Service Providers

A provider must be certified by DDS's contracted vendor ("Vendor") to provide Autism Waiver services. Non-licensed/non-certified providers are prohibited. A certified Autism Waiver service provider directory is continuously maintained and updated by Vendor to offer parents/guardians their choice of community provider for the intensive intervention services included in a beneficiary's service plan. Vendor recertifies all Autism Waiver service providers annually.

Each Autism Waiver provider maintains a certification file in the Autism Waiver Database with documentation evidencing its compliance with all Autism Waiver certification requirements, including without limitation all entity governing documents, a completed application, certificate of good standing, and all Autism Waiver service provider certificates. Additionally, each Autism Waiver provider maintains in the Autism Waiver Database a personnel file for each employee, contractor, subcontractor, intern, volunteer, trainee, or other person who has routine contact with or provide services to Autism Waiver beneficiaries. Each personnel file must contain the results of the person's most recent criminal background check, adult maltreatment registry check, and child maltreatment registry check. Each Autism Waiver provider is also required to include documentation demonstrating that each person providing Autism Waiver services to a client meets the applicable license, certificate, training, and experience requirements to perform a specific service. The personnel files in the Autism Waiver Database must be actively maintained and updated. Vendor will review all Autism Waiver service provider personnel files as part of the annual recertification of each service provider.

Vendor contacts new Autism Waiver service providers within thirty (30) days of certification to provide training and information on the day-to-day operation of the Autism Waiver, including without limitation eligibility criteria, how to make proper referrals, documentation requirements, available forms, reporting, Section II of the Autism Waiver Medicaid Manual, and claims processing. Vendor also meets face-to-face with each new Autism Waiver service provider within three (3) months of certification to discuss all of the above and any issues that have arisen within the first three (3) months of Autism Waiver participation.

Vendor contacts each existing Autism Waiver provider at least twice per year to discuss any problems, new Autism Waiver policies, and any other pertinent topics. Finally, Vendor is required to schedule at least two (2) in-service trainings per year that are available to all Autism Waiver providers. Each in-service training must be scheduled in advance and have an agenda, sign-in sheet, evaluation, etc.

Each employee, contractor, subcontractor, intern, volunteer, trainee, or other person who has routine contact with or provides Autism Waiver services directly to beneficiaries must attend an orientation prior to performing any Autism Waiver services. This orientation must include training on the purpose and philosophy of the Autism Waiver program, the provider's written code of ethics, record keeping requirements, procedures for reporting changes in a beneficiary's condition, and the beneficiary's right to confidentiality. All Autism Waiver providers must sign an annual Provider Assurance letter verifying each employee or contractor attends orientation prior to performing any Autism Waiver services.

Finally, Vendor has developed a data report for each performance measure in this Appendix C ("Performance Measure") for which the Autism Waiver Database is the data source. Every month Vendor runs each Performance Measure's data report on all active provider certification and personnel files to discover and identify potential issues and provide a monthly one hundred percent (100%) review of Vendor's compliance with provider certification and personnel requirements. The results of each monthly Performance Measure data report are aggregated into Vendor's Autism Waiver Report, which is submitted to DDS each quarter.

#### DDS Oversight of Service Providers

DDS staff are provided read only access to the Autism Waiver Database for the purpose of conducting random sample retrospective reviews of active Autism Waiver provider certification and personnel files on a quarterly basis ("DDS Reviews"). DDS Reviews ensure operational compliance with the Autism Waiver requirements related to service provider certification and personnel, verify the results of the Autism Waiver Report submitted by Vendor, and measure Vendor's compliance with its contract performance standards and the assurances within the waiver application. DDS uses the Raosoft Calculation System to determine a sample size for retrospective

reviews that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error. The results of DDS Reviews are compiled into the DDS Review Report that is shared with Vendor and DMS during quarterly meetings.

#### DMS Oversight of Service Providers

DMS staff are provided read only access to the Autism Waiver Database for the purpose of conducting retrospective reviews to verify the results of the Autism Waiver Report, confirm Vendor's compliance with contract performance standards, and ensure DDS is complying with all obligations within both the waiver and the Interagency Memorandum of Understanding.

DMS also holds a quarterly meeting with DDS to discuss the results of its retrospective review, the DDS Review Report, the most recent Autism Waiver Report, and address any operational or administrative issues related to provider certification and personnel requirements. Any necessary corrective action plans and adjustments to Autism Waiver systems operations that need to be implemented based off the results of those reports would also be discussed.

### **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If issues in connection with Autism Waiver provider certifications or the use of qualified personnel are discovered during review of Vendor's performance, the DDS Review Report, or the Autism Waiver Report, then DMS, DDS, and DDS's contracted vendor ("Vendor") will discuss the appropriate remediation on a case-by-case basis. Discussion will typically take place during regularly scheduled quarterly meetings, unless a more immediate meeting is required.

The type of remediation implemented depends on the issue and surrounding circumstances and may include without limitation one or more of the following: corrective action plan, training, recoupment, system design changes, revoking provider certification, and the parent/guardian selecting a new Autism Waiver community service provider.

How each remediation effort is implemented and monitored and the party directly responsible is determined prior to implementation. The party directly responsible for implementing and monitoring the progress of a remediation effort depends on the type of remediation effort implemented. Vendor will typically be responsible for implementing and monitoring corrective action plans, trainings, and revoking provider certifications. DMS or DDS will typically be responsible for implementing and monitoring remediation efforts involving recoupments and system design changes, or if the issue involves Vendor's responsibilities related to provider certification and personnel requirements.

Investigations, findings, and other documentation related to Vendor's monitoring of remediation efforts will be maintained in the Autism Waiver Database. Recoupments will be monitored by DMS through the Medicaid Management Information system. System design changes will be documented through updates to existing or implementation of new Autism Waiver policies and procedures and amendments to the Autism Waiver. Finally, documentation related to remediations in connection with Vendor's performance under its contract will be maintained in the contract file.

### **ii. Remediation Data Aggregation**

#### **Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div>DDS's contracted vendor</div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

☐ **Other Type of Limit.** The state employs another type of limit.  
*Describe the limit and furnish the information specified above.*

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1.

Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2.

Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

The primary service delivery setting for the Autism Waiver service is a natural environment home and community-based settings that provides inclusive opportunities, such as the child’s home, church, places where the family shops, restaurants, ball parks, etc., As a result, all Autism Waiver service settings meet and will continue to meet the home and community-based settings requirements. There are no segregated settings utilized in the Autism Waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Autism Waiver Plan of Care



**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

- ☐ **Social Worker**

*Specify qualifications:*

- ☒ **Other**

*Specify the individuals and their qualifications:*

DDS's contracted vendor ("Vendor") hires or contracts with staff ("Autism Waiver Coordinators") who are responsible for developing each beneficiary's the plans of care ("POC"). The POC documents a beneficiary's needs and potential risks, the intensive intervention service(s) that will be implemented to meet those needs, the amount, frequency, and duration of each intensive intervention service, the parent/guardian's choice of Autism Waiver community service provider and establishes any necessary emergency backup plan.

Each Autism Waiver Coordinators employed or contracted by Vendor must:

1. Have a minimum of two (2) years' experience working with young children with autism spectrum disorder; and
2. Have either:
  - i. A Registered Nurse license; or
  - ii. A Bachelor's (or more advanced) degree in psychology, nursing, speech-language pathology, education, or related field.

Once the Autism Waiver Coordinator has completed the POC, the Interventionist employed or contracted by the Autism Waiver community provider selected by the parent/guardian uses the POC to develop the individualized treatment plan ("ITP"). The ITP operationalizes the POC by identifying the beneficiary's individualized diagnosis, needs, strengths, problem behaviors, short- and long-term goals and objectives, the intensive intervention service(s) delivery schedule, and the data collection required to assess the beneficiary's progress towards short- and long-term goals and objectives.

Each Interventionist employed or contracted by the selected Autism Waiver community service provider must:

1. Have a minimum of two (2) years' experience developing service plans for, providing intensive intervention services to, or overseeing an intensive intervention services program for children with autism spectrum disorder; and
2. Hold either:
  - i. A certificate as a Board-Certified Behavior Analyst (BCBA) from the Behavior Analyst Certification Board; or
  - ii. A Master's (or more advanced) degree in psychology, speech-language pathology, occupational therapy, special education, or related field.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

#### b. Service Plan Development Safeguards. *Select one:*

- ☒ Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- ☐ Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Once DDS's contracted vendor ("Vendor") confirms an applicant has the required autism spectrum disorder diagnosis and meets the age eligibility requirements, Vendor assigns the applicant an Autism Waiver Coordinator. Once there is an available Autism Waiver slot for the applicant, the assigned Autism Waiver Coordinator schedules an on-site meeting with the parent/guardian to conduct the level of care evaluation of the applicant, inform the parent/guardian of the services offered through the Autism Waiver, offer the parent/guardian choice of Autism Waiver services and service provider, and collect initial data for service plan development.

The Autism Waiver service plan is a client's plan of care ("POC"), which is developed by the Autism Waiver Coordinator in collaboration with the parent/guardian, knowledgeable professionals, and any other individuals the parent/guardian wishes to participate. The development of the POC is driven by the results of adaptive functioning and behavior evaluations, the beneficiary's risks and needs, and the parent/guardian's preferences. Since the parent/guardian is the primary informant during the POC development process, it ensures that the parent/guardian's perspective and concerns will be central to POC development and to determine who is included in the development process.

The Interventionist employed or contracted by the selected Autism Waiver community service provider uses the POC to develop the beneficiary's individualized treatment plan ("ITP") in collaboration with the ITP team, which consists of the Interventionist, Lead Therapist, Line Therapist, parent/guardian, and any other individuals requested by the parent/guardian ("ITP Team"). The Interventionist initiates ITP development by conducting the evaluations and clinical observations necessary to complete the beneficiary's comprehensive clinical profile that identifies the beneficiary's individualized needs, strengths, disabilities, and problem behaviors.

The Interventionist then uses the comprehensive clinical profile in collaboration with the ITP team to complete the ITP, which must include: (i) the specific treatment goals and objectives in domains such as communication/language, socialization, self-care/self-regulation, and cognition, (ii) detailed instructions for implementation of intensive intervention services, and (iii) the data collection required to monitor and assess beneficiary progress towards the goals and objectives. Any specific parent/guardian goal(s) are also included in the ITP. The parent/guardian is the primary source of information throughout the ITP development process, which ensures that the parent/guardian's perspective, concerns, and developmental goals and objectives will also be central to and prioritized throughout service plan development.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Once DDS's contracted vendor ("Vendor") confirms an applicant has an autism spectrum disorder diagnosis and meets the age eligibility requirements, Vendor assigns the applicant an Autism Waiver Coordinator. Once there is an available Autism Waiver slot for the applicant, the assigned Autism Waiver Coordinator schedules an on-site meeting with the parent/guardian to conduct the level of care evaluation of the applicant, inform the parent/guardian of the services offered through the Autism Waiver, offer the parent/guardian choice of Autism Waiver services and community service provider, and collect initial data for service plan development. The assigned Autism Waiver Coordinator provides the parents/guardians the names of provider agencies, the contact persons for the program, and telephone numbers/email addresses for all certified Autism Waiver community service providers. From this list, parents/guardians may select the certified Autism Waiver community service provider of their choice.

The Autism Waiver service plan is a client's plan of care ("POC"), which is developed by the Autism Waiver Coordinator. Once an applicant is determined to be eligible for the Autism Waiver, the Autism Waiver Coordinator develops the POC in collaboration with the parent/guardian, knowledgeable professionals, and any other individuals the parent/guardian wishes to participate. The POC is developed prior to the delivery of any Autism Waiver services and must be updated at least annually. If there are amendments to the Autism Waiver that impact the services available to a beneficiary, the Autism Waiver Coordinator will provide the updated information to all parents/guardians once the amendments are approved and ready for implementation.

POC development is driven by the results of adaptive functioning and behavior evaluations, the beneficiary's strengths and needs, and the parent/guardian's preferences. The strengths and needs of the are assessed through the use of administration of evaluation instruments, which at a minimum must include the Vineland Adaptive Behavior Scales, ("Vineland") and the Temperament and Atypical Behavior Scale ("TABS"). Vineland provides detailed information the beneficiary's strengths and weakness in areas such as communications daily living skills, socialization, motor skills and maladaptive behavior. The TABS provides additional behavioral information by assessing four (4) categories of behavior: detached, hypersensitive-active, under reactive, and dysregulated. The Vineland and TABS are required to be administered as part of the beneficiary's level of care evaluation for Autism Waiver eligibility purposes.

The POC must include a statement of the beneficiary's needs, the intensive intervention service(s) that will be implemented to meet those needs, the amount, frequency, and duration of each intensive intervention service(s), and the type of Autism Waiver service provider who will furnish the intensive intervention service(s).

The POC must also include the roles and responsibilities of the Autism Waiver Coordinator, Interventionist, the Clinical Services Specialist ("CSS"), and the parent/guardian in connection with the implementation and monitoring of for the services included in the beneficiary's POC and individualized treatment plan ("ITP").

Additionally, during the service plan development process the parent/guardian must sign a Parent/Guardian Participation Agreement ("Participation Agreement"). The Participation Agreement outlines specific participation requirements that must be fulfilled by the parent/guardian including a minimum of fourteen (14) hours of parent/guardian participation per week. The fourteen (14) hours of required parent/guardian participation may include whatever times and beneficiary routines that are agreed upon by the parent/guardian and Interventionist. Training will be provided to the parent/guardian by the Interventionist to equip and enable the parent/guardian to fulfill this requirement.

A beneficiary's assigned Autism Waiver Coordinator is responsible for coordinating Autism Waiver services and ensuring services are delivered in accordance with the POC and ITP. As part of this coordination responsibility, the Autism Waiver Coordinator must have at least monthly contact with a member of the beneficiary's ITP Team either face-to-face, by email, through a virtual platform such as Zoom, or by phone/text.

The Autism Waiver Coordinator is responsible for scheduling and coordinating the annual meeting to review and update the POC and amending POC when the results of the monitoring or information obtained from the parent/guardian, or a member of the ITP Team indicates the need for a change. The Autism Waiver Coordinator will always provide a copy of the updated or revised POC to the parent/guardian, the Interventionist, and CSS working with the client.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs

and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Once an applicant is determined eligible for the Autism Waiver, the assigned Autism Waiver Coordinator develops the beneficiary's plan of care ("POC") in collaboration with the parent/guardian, knowledgeable professionals, and any other individual the parent/guardian wishes to participate. The beneficiary's potential risk are assessed and identified as part of the POC development process.

A Vineland Adaptive Behavior Scale evaluation instrument and a Temperament and Atypical Behavior evaluation instrument and a (Temperament and Atypical Behavior Scale) evaluation instrument are administered during each of the on-site home visits by the Autism Waiver Coordinator to establish a beneficiary's initial and continued eligibility. There are instruments identify issue present risks factors for the beneficiary such as self -injurious behavior, aggressive/destructive behavior, elopement behaviors, inability to communicate needs/wants and food aversion /pica behaviors. The parent/guardian is the primary informant when administering these evaluation instruments, which ensures that the parent/guardian's perspective and concerns will be central to identifying potential beneficiary risk factors.

As these individualized risk factors are identified, they are listed on the POC to enable the Interventionist to develop specific intensive interventions, goals, and objectives to address these issues. These intensive interventions, as well as preventative strategies to avoid emergencies and deescalate behaviors related to these risk factors, are included on the beneficiary's individualized treatment plan ("ITP") by the Interventionist. Intervention strategies must focus on positive approaches that reinforce appropriate behavior and avoid the use of restraint, seclusion, and other punitive practices. Additionally, a behavior intervention plan is developed when necessary to remediate behavioral issues related to a beneficiary's risk factors.

The Clinical Support Specialist ("CSS") and Autism Waiver Coordinator review the beneficiary's service record to determine the beneficiary's progress toward treatment goals and objectives and the removal of risk factors.

Additionally, during the service plan development process the parent/guardian must sign a Parent/Guardian Participation Agreement ("Participation Agreement"). The Participation Agreement outlines specific participation requirements that must be fulfilled by the parent/guardian including a minimum of fourteen (14) hours of parent/guardian participation per week. The twenty (20) hours of required parent/guardian participation may include whatever times and client routines that are agreed upon by the parent/guardian and Interventionist. Training will be provided to the parent/guardian by the Interventionist to equip and enable the parent/guardian to fulfill this requirement.

A meeting will be scheduled with the parent/guardian when there is a violation of the terms of the Participation Agreement. The meeting will review the terms of the Participation Agreement, explain the consequences of failing to

comply with the terms of the Participation Agreement and establish a deadline for the parent/guardian to comply with the terms of the Participation Agreement. The meeting will be documented as an attachment to the Participation Agreement. If the parent/guardian fails to meet the deadline for compliance or chooses not to participate according to the terms of the Participation Agreement, then the beneficiary may be removed from the Autism Waiver following ten (10) days' notice. The decision to disenroll a beneficiary will be made as a joint decision by the Autism Waiver Coordinator and the CSS only after the parent/guardian has been counseled and offered an opportunity for corrective action. If the ITP or service schedule can be modified to better facilitate the parent/guardian's participation, the Autism Waiver Coordinator will assist in implementing such adjustments. Each situation will be evaluated on a case-by-case basis. Since the Participation Agreement requires the parent/guardian to be present and actively involved in the delivery of intensive intervention services throughout a beneficiary's participation in the Autism Waiver, their relationship and intimate knowledge of the beneficiary will be utilized to avoid emergency situations.

In situations where behaviors cab result in emergency situation, the parent/guardian m Lead Therapist and Line Therapist are trained on emergency response. If an emergency does occur it is documented in the beneficiary 's service record and reviewed by the Interventionist, the CSS, and /Autism Waiver Coordinator to determine if changes in the POC to ITP are needed to avoid recurrence of the emergency.

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Each applicant is assigned an Autism Waiver Coordinator by DDS's contracted vendor ("Vendor") once it is confirmed the applicant has an autism spectrum disorder diagnosis and meets the age eligibility requirements. The assigned Autism Waiver Coordinator provides the parents/guardians the names contact person, and telephone numbers/email address for all certified Autism Waiver community service providers. From the list, parent/ guardian may select the certified Autism Waiver community service provider of their choice.

If the parents/guardian requests assistance in researching the list of certified Autism Waiver community service providers, the Autism Waiver Coordinator will provide the parent/guardian with a list of questions they may ask when interviewing and deciding to choose among potential providers. This list includes questions such as:

- How many years' experiences do you have serving children with autism spectrum disorder?
- How many Autism Waiver clients have you served in the Autism Waiver program to date?
- What staff credentials do you require?
- If selected, how long will it take to hire and begin delivering services?
- How much involvement will I have in the selection process of staff who will work with my child?

The assigned Autism Waiver Coordinator is always available to discuss any questions/concerns the parents/guardian has regarding the certified Autism Waiver community service provider selection process. Ultimately, the parent/guardian's choice of certified Autism Waiver community service provider will be documented by the Autism Waiver Coordinator on the beneficiary's plan of care.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Department of Human Services determines eligibility and transmits the eligibility file to DDS's contracted vendor (Vendor), who is responsible for the development of the plans of care (POC) and plan approval. Access to the beneficiary service records are controlled and maintained by the Vendor in its Autism Database. The Medicaid Agency receives an automation file daily via the MMIS system.

These files are used by the Medicaid agency and DDS to perform retrospective reviews, quarterly. A sample size of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a ninety-five percent (95%) confidence.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- ☐ Medicaid agency  
☒ Operating agency  
☐ Case manager  
☒ Other  
Specify:

DDS's contracted vendor.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Autism Waiver Coordinator assigned to the beneficiary by DDS's contracted vendor ("Vendor") develops the beneficiary's plan of care ("POC") and is responsible for monitoring both the implementation of the service plan and the health and welfare of the beneficiary. The POC documents the beneficiary's needs and potential risks, the intensive intervention service(s) that will be implemented to meet those needs, the amount, frequency, and duration of each intensive intervention service, the parent/guardian's choice of Autism Waiver services and community service provider, and any necessary emergency.

The Interventionist assigned to the beneficiary by the selected Autism Waiver community service provider develops the beneficiary's individualized treatment plan ("ITP") in collaboration with the Lead Therapist, Line Therapist, parent/guardian, and any other individual requested by the parent/guardian ("ITP Team"). The ITP Team is also responsible for monitoring both the implementation of the service plan and the health and welfare of the beneficiary. The ITP operationalizes the POC and includes at a minimum (i) the specific treatment goals and objectives, (ii) detailed instructions for implementation of intensive intervention services, and (iii) the data collection required to monitor and assess beneficiary progress towards the goals and objectives. Any specific parent/guardian goal(s) are also included in the ITP. When necessary, the ITP includes the results of a functional analysis of behavior, a positive behavior supports plan for maladaptive behavior, and a behavioral reinforcer survey.

Once the ITP has been developed, the Interventionist is responsible for training the Lead Therapist, Line Therapist, and parent/guardian on how to implement and perform the intensive intervention service(s) included on the ITP and how to collect data required to assess the client's progress towards ITP goals and objectives. The Interventionist conducts monthly monitoring of intensive intervention service implementation and delivery by the parent/guardian, Lead Therapist, and Line Therapist, and reviews data and session notes to assess the clinical progress of the beneficiary and adjust the beneficiary's comprehensive clinical profile and ITP as required. Clinical progress assessments of the beneficiary are completed by the Interventionist at least every four (4) months and must include the administration and review of an Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) evaluation instrument. The Autism Waiver Coordinator has monthly contact with at least one member of the ITP Team either face-to-face or by phone. The Autism Waiver Coordinator attempts to contact different ITP Team members each month to ensure multiple perspectives on the beneficiary's progress are received. If problems are identified by any member of the ITP Team, contact will be made with the Interventionist and Autism Waiver Coordinator to address the issue(s). All such contacts will be documented in the beneficiary's service record maintained in the Autism Waiver Database.

The Clinical Services Specialist ("CSS") employed or contracted by the Consultative Clinical and Therapeutic service provider is also responsible for providing oversight and monitoring of the service plan, and is required to be independent of both the Arkansas Department of Human Services, Division of Medical Services and the selected Autism Waiver community service provider that develops the ITP and delivers the intensive intervention services.

The CSS monitors proper implementation of the ITP, proper data collection, and the beneficiary's progress toward ITP goals and objectives. For the first quarter of Autism Waiver services the CSS performs a monthly review. After the first three (3) months of Autism Waiver services, the CSS performs quarterly reviews so long as the beneficiary is progressing as expected. If a beneficiary is not progressing as expected, problem behaviors develop, or an ITP Team member expresses concern, the CSS will conduct reviews more frequently. If over a six (6) month period the CSS determines the beneficiary is not showing the expected progress, the CSS will either provide technical assistance to the parent/guardian, Lead Therapist, and Line Therapist, or schedule a conference to determine if the POC or ITP needs to be modified. If the identified issues are related to Autism Waiver compliance (i.e. a failure to deliver services identified in the POC, failure to comply with terms of Parent Participation Agreement, etc.), the CSS will contact the Autism Waiver Coordinator to solicit assistance resolving the issue.

The parent/guardian is required to participate in the delivery of intensive intervention services, so there is no risk that the beneficiary will be unattended if the Line Therapist is unable to attend a scheduled intensive intervention service session. Additionally, the Lead Therapist could be scheduled to cover for the Line Therapist when the Line Therapist is unable to maintain a scheduled service session for any reason. Finally, the Line Therapist, Lead Therapist and parent/guardian are all trained in implementation of the ITP, which allows for the substitution of personnel.

**b. Monitoring Safeguards. Select one:**

- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**



- ☐ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.
- The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:  
Number and percent of participants plan of care that addressed beneficiary needs.  
Numerator: number of POCs that addressed beneficiary needs; Denominator:  
number of POCs reviewed.

Data Source (Select one):  
Other  
If 'Other' is selected, specify:  
Autism Waiver Database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100%

		<b>Review</b>
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px;"> A sample of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:****Number and percent of POCs that addressed health and safety risk factors.****Numerator:** number of POCs that addressed health and safety risk factors;**Denominator:** number of POCs reviewed.**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> A sample of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 10px;"></div>

**Performance Measure:**

**Number and percent of plans of care ("POC") that addressed parent/guardian personal goals and objectives. Numerator:** number of POCs that addressed parent/guardian personal goals and objectives; **Denominator:** number of POCS reviewed.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:

		A sample of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**b. Sub-assurance:** *The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of plans of care ("POC") that were reviewed and updated at least annually or when warranted by changes in the beneficiary's needs. Numerator: number of POC's that were reviewed and updated at least annually or when warranted by changes in the beneficiary's needs; Denominator: number of POC's reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>

<input type="checkbox"/> <b>Other</b> Specify:  	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:  
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px;"> A sample of applicants assigned a slot 30 days but less than 1 year before the end of the period under review that provides a valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
	<input type="checkbox"/> <b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>



<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percent of beneficiaries who received services in type, scope, amount, frequency and duration specified the plan of care ("POC"). Numerator: Number of beneficiaries who received services in type, scope, amount, frequency and duration specified in the plan of care ("POC"); Denominator: number of POC's reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
<input type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <div></div>		Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div>A sample of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

**e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of beneficiary service records that documented the parent/guardian was offered choice of Autism Waiver Services. Numerator: number beneficiary service records that documented the parent/guardian was offered choice of Autism Waiver Services. Denominator: number of beneficiary service records reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<div></div>		<div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:  <div>: A sample of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.</div>
	<input type="checkbox"/> <b>Other</b> Specify:  <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  <div></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>

**Performance Measure:**

**Number and percent of beneficiary service records with signed freedom of choice documenting the parent/guardian was offered choice of provider. Numerator:** number of beneficiary service records with signed freedom of choice forms that documenting the parent/guardian was offered choice of provider; **Denominator:** number of service records reviewed.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:

		A sample of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The state currently implements a system of monitoring that ensures the timelines, appropriateness, and quality of all service plans and require each parent/guardian to be offered choice of Autism Waiver services or institutional care, choice of Autism Waiver Services and choice of Autism Waiver community service provider. The Autism Waiver Coordinator assigned to each beneficiary by DDS's contracted vendor ("Vendor") uploads or enters into the beneficiary's service record in the Autism Waiver Database all evaluation results, clinical observations, case notes from meetings, and other information pertinent to the plan of care ("POC") development process. Additionally, the selected Autism Waiver community service provider is required to enter into the beneficiary's service record all service delivery and progress notes related to each intensive intervention service session.

Vendor has developed a data report for each performance measure in this Appendix D ("Performance Measure"). Every month Vendor runs each Performance Measure's data report on all active provider certification and personnel files to discover and identify potential issues and provide a monthly one hundred percent (100%) review of Vendor's compliance with Autism Waiver service plan timeliness, appropriateness, and quality requirements and all parent/guardian choice requirements. The results of each monthly Performance Measure data pull are aggregated into the Vendor's Autism Waiver Report, which is submitted to DDS each quarter.

DDS conducts reviews of active Autism Waiver client service records on a quarterly basis ("DDS Reviews"). DDS Reviews ensure operational compliance with those Autism Waiver requirements related to parent/guardian choice of Autism Waiver services and community provider and requirements related to the timeliness, appropriateness, and quality of service plans. DDS Reviews also verify the results of the Autism Waiver Report and measure Vendor's compliance with contract performance standards and the assurances within the Autism Waiver application. DDS Reviews are compiled into a DDS Review Report that is shared with Vendor and DMS during quarterly meetings.

DDS and Vendor meet on at least a quarterly basis to discuss the results of the Autism Waiver Report, DDS Review Report, and to address any issues discovered related to the timeliness, appropriateness, and quality of service plans. Any necessary corrective action plans and adjustments to Autism Waiver systems operations that need to be implemented based off the results of those reports would also be discussed.

Finally, DMS and DDS hold a quarterly meeting to discuss Vendor's performance, DDS Reviews, the most recent Autism Waiver Report, and address any operational or administrative issues related to the timeliness, accuracy, appropriateness, and quality of service plans.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If issues in connection with the completeness of plans of care (“POC”), timeliness of the POC development, appropriateness of intensive intervention services, offering of parent/guardian choice of Autism Waiver services and community provider, or compliance with any program policy involving service plan development, amendments, and updates are discovered during review of Vendor’s performance, DDS Reviews, or the Autism Waiver Report, then DMS, DDS, and DDS’s contracted vendor (“Vendor”) will discuss the appropriate remediation on a case-by-case basis. Discussion will typically take place during regularly scheduled quarterly meetings, unless a more immediate meeting is required.

Remediation efforts will depend on the issue and surrounding circumstances and may include without limitation corrective action plans, training, recoupments, system design changes, revocation of provider certification, the parent/guardian selecting a new community Autism Waiver service provider, and removal of a beneficiary from the Autism Waiver. The manner and method of how each remediation effort will be monitored and tracked and the party directly responsible will be determined prior to implementation.

The party directly responsible will usually depend on the remediation effort implemented. Vendor will typically be responsible for implementing and monitoring corrective action plans, trainings, revoking Autism Waiver service provider certification, or disenrolling beneficiaries. DMS or DDS will typically be lead in remediation efforts involving recoupments and system design changes, or if the issue involves Vendor’s responsibilities related to monitoring or certifying Autism Waiver services providers or personnel. The status of each currently active remediation effort will be discussed at the quarterly meetings until completed or resolved.

Investigations, findings, and other aspects of remediation efforts conducted by Vendor in connection with Autism Waiver beneficiaries or service providers will be maintained in the Autism Waiver Database. Recoupments will be tracked by DMS and the Medicaid Management Information system. System design changes will be documented through amendment to the Autism Waiver. Finally, documentation related to remediations in connection with Vendor’s performance under its contract will be maintained in the contract file.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">DDS contracted vendor</div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ No

☐ Yes



Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- ☐ Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- ☒ No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- ☐ Yes. The state requests that this waiver be considered for Independence Plus designation.
- ☐ No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant Direction (1 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (2 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (3 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Autism Waiver Coordinator assigned to the beneficiary by DDS's contracted vendor ("Vendor") provides the parent/guardian with information on appeal rights during the on-site visit to conduct the beneficiary's initial level of care evaluation and each annual level of care reevaluation. The parent/guardian is also informed of their right to appeal and request a fair hearing via a Notice of Action whenever there is any adverse action taken in connection with an Autism Waiver beneficiary. An "adverse action" would include without limitation any ineligibility determination or decision to deny, suspend, reduce, or terminate Autism Waiver services.

A Notice of Action explains the sanction that was taken, the effective date of the action, the type of coverage effected, and the reasons for the action. It also provides the parent/guardian with contact information should they have any questions about the Notice of Action and informs them of the beneficiary's right to request an appeal hearing. The Notice of Action includes a document called the "Client Appeal Hearing Rights" that, includes information on what an appeal hearing is, how to file for an appeal, the date by which an appeal must be filed, and lists out all the beneficiary and parent/guardian rights as it pertains to the appeal hearing.

Parent/guardian appeals are submitted to and handled by the DHS Office of Appeals and Hearings. Autism Waiver community service provider appeals are submitted to and handled by the Arkansas Department of Health, Office of Medicaid Provider Appeals. Appeals are administered in accordance with section 160.000 of the Autism Waiver Medicaid provider manual. All appeals shall conform to the Arkansas Administrative Procedure Act, Ark. Code Ann. §§ 25-15-201 – 25-15-218.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☒ **No. This Appendix does not apply**
- ☐ **Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

DDS's contracted vendor is responsible for receiving, addressing, investigating, and tracking complaints/grievances related to the Autism Waiver.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Any interested party may submit to DDS's contracted vendor ("Vendor") a complaint/grievance relating to the operation of the Autism Waiver, including without limitation parents/guardians, Autism Waiver service provider staff, and relatives, teachers, or friends of a beneficiary. Autism Waiver service providers can submit a complaint/grievance, and all required supplemental information through the Autism Waiver Database portal using the "complaint" tab. Parents/guardians and any other interested parties may submit a complaint/grievance to Vendor by fax, mail, or calling a toll-free number.

The type of grievance/complaint submitted determines how it is handled. Complaints/grievances alleging abuse and neglect of a child are immediately routed to the Division of Children and Family Services Arkansas Child Maltreatment Hotline for appropriate action. Complaints/grievances concerning an Autism Waiver service provider's delivery of Autism Waiver services or lack thereof, non-compliance with Autism Waiver requirements, any adverse action, level of care evaluation, or other issue that does not involve an allegation of abuse or neglect are handled by Vendor.

Vendor must attempt to contact the individual who registered the complaint/grievance to substantiate the complaint/grievance and determine if an investigation is necessary no later than the next business day. If Vendor determines that an investigation is necessary, Vendor is responsible for investigating the complaint/grievance and entering its findings into the Autism Waiver Database. Vendor's investigation findings are also communicated by telephone call or mailed correspondence to the individual who submitted the complaint/grievance when appropriate and permissible under applicable confidentiality laws. If parent/guardian files a complaint/grievance, then they are informed of their right to appeal Vendor's findings and that the filing of a complaint/grievance is not a prerequisite or substitute for a fair hearing.

The following information, if available, is maintained in the Autism Waiver Database for each complaint/grievance:

- The name and contact information of the individual that submitted the complaint/grievance
- The beneficiary/ies involved in the complaint/grievance
- The individual against whom the complaint/grievance is made, and, if applicable, the Autism Waiver service provider for whom they provide services
- Vendor staff who initially received the complaint/grievance
- Vendor staff assigned to investigate
- A summary of the complaint/grievance
- The investigation findings
- All actions taken relative to investigation findings

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

☒ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Arkansas Child Maltreatment Act, Ark. Code Ann. § 12-18-101, et seq., defines those acts that are considered child abuse, neglect, and exploitation. The Arkansas Child Maltreatment Act also defines who is a mandatory reporter of child abuse, neglect, and exploitation. Mandatory reporters under the Arkansas Child Maltreatment Act include without limitation. DDS staff, staff of DDS's contracted vendor ("Vendor") staff, Autism Waiver providers staff, and all enrolled Medicaid provider. The Division of Children and Family Services ("DCFS"), Child Protective Services unit operates the Arkansas Child Maltreatment Hotline, which is used by mandatory reporters and the general public to report alleged child abuse, neglect, and exploitation. Mandatory reporters are required by law to report incidents of child abuse, neglect, and exploitation to the Arkansas Child Maltreatment Hotline immediately upon discovery.

The Division of Developmental Disabilities Service's ("DDS") contracted vendor ("Vendor") reviews and evaluates all incident reports involving the delivery of Autism Waiver services to ensure correct procedures and timeframes are followed. In the event Autism Waiver service provider staff has failed to notify proper authorities such as the Child Abuse Hotline, or the police department, Vendor ensures the notifications are made immediately. If an incident warrants investigation, Vendor investigates and submits findings of the review to DDS. Vendor also notifies the Autism Waiver service provider involved.

The Autism Waiver service provider is required to submit a plan of correction to DDS through Vendor, who performs necessary follow-up to monitor progress toward compliance.

Additionally, DHS Incident Reporting Policy #1090 identifies those specific critical incidents that Autism Waiver service providers are required to report to Vendor. Critical incidents are reported to Vendor by Autism Waiver service providers through the Autism Waiver Database portal. The list of critical incidents must be reported if they occur as part of the delivery of Autism Waiver services:

- A significant injury to, or death of, a beneficiary.
- Serious injury to a beneficiary;
- Threatened or attempted suicide of a beneficiary;
- The arrest or conviction of a beneficiary;
- Any situation where the location of beneficiary is unknown and cannot be determined within two (2) hours;
- Maltreatment or abuse as defined in Arkansas Child Maltreatment Act or Arkansas Adult Maltreatment Act; and
- Any other violation of a beneficiary's rights which jeopardizes the beneficiary's health or quality of life (which includes restraints, restrictive interventions, and seclusion).

DHS Policy #1090 requires Autism Waiver providers to report to the DHS Communications Director via telephone within one (1) hour, regardless of the hour, any critical incidents that receive or are expected to receive media attention. Critical incidents involving suicide, death from abuse, maltreatment, exploitation, or serious injury are to be reported to the DHS Chief Counsel via telephone within one (1) hour, regardless of the hour. All other critical incidents are required to be reported to Vendor no later than the end of the second business day following the critical incident.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including

how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A Division of Children and Family Services, Child Protective Services unit (“CPS”) brochure containing information on what constitutes abuse, the signs and symptoms of abuse, the persons required to report abuse, and how reports of abuse should be made is provided to the parent/guardian of each Autism Waiver applicant when initial contact is made by DDS’s contracted vendor. Duplicate copies of the brochure are available if additional copies are needed for other family members or friends.

The Autism Waiver Coordinator also reviews with the parent/guardian during on-site visits to conduct the level of care evaluation and each annual level of care reevaluation the information contained in the CPS brochure.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Division of Children and Family Services (“DCFS”), Child Protective Services unit operates the Arkansas Child Maltreatment Hotline which is used by mandatory reporters and the general public to report alleged child maltreatment. DCFS has a legislative mandate to accept reports, investigate, substantiate, and resolve incidents of child abuse, neglect, and exploitation in Arkansas. DCFS has jurisdiction to investigate all cases of child maltreatment in conjunction with the Arkansas State Police Crimes Against Children Division (“CACD”). Generally, CACD investigates Priority I child maltreatment allegations and DCFS investigates Priority II child maltreatment allegations. DCFS is responsible for ensuring the health and safety of the children regardless of which agency is conducting the investigation.

A child maltreatment investigation will begin no later than twenty-four (24) hours after receipt of the report if severe maltreatment (Priority I) is indicated. All other child maltreatment investigations must begin within seventy-two (72) hours of receipt of the report. An investigative determination must be made within thirty (30) days. If the circumstances of the child present an immediate danger of severe maltreatment, DCFS will take the child into protective custody for up to seventy-two (72) hours.

Autism Waiver service providers are also required to report the occurrence of those critical incidents listed in DHS Policy # 1090. Autism Waiver providers report the occurrence of these critical incidents to DDS’s contracted vendor (“Vendor”) through the Autism Waiver Database portal which has a tab used for critical incident reporting.

As soon as the critical incident report is entered into the Autism Waiver Database or otherwise received by Vendor, the critical incident report must be evaluated by Vendor to determine if the incident is a mandatory reportable event and if the Autism Waiver service provider staff has notified the proper authorities (such as the Arkansas Child Maltreatment Hotline, or the police department). If Vendor determines required notifications have not been made, then Vendor prioritizes the incident and ensures those notifications are immediately made. Each reported critical incident (whether requiring mandatory reporting or not) is investigated, and the following timeframes apply to all Vendor investigations:

- Attempted telephone contact with the reporter is required by the next business day.
- Investigations must be completed within thirty (30) days, unless inability to contact necessary parties delays completion.
- Vendor must enter the investigation findings into the Autism Waiver Database upon completion.
- If determined necessary by DDS or Vendor, Vendor will request a plan of correction with a timeline of completion from the Autism Waiver service provider or parent/guardian involved and monitor the progress.
- Investigation findings are mailed to the beneficiary's parent/guardian within ten (10) days of completion.

The parent/guardian and other relevant parties are informed of investigation results by telephone or in writing. Information from all critical incidents reported to Vendor are maintained in the Autism Waiver Database, including information on resolution of the critical incidents investigated by Vendor.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.



DDS's contracted vendor is responsible for compiling into a single report all complaint/grievance and critical incident reports involving Autism Waiver from all sources. DDS and Vendor review the complaint/grievance and critical incident report, including all investigations and supporting documents at each quarterly meeting to identify patterns and make systematic corrections when necessary. Critical incidents are reviewed on a case-by-case basis.

DDS has access to the Autism Waiver Database that acts as the incident management system and ensures proper functioning of the incident management system by conducting a 100% review of all reported critical incidents through the Autism Waiver Database on quarterly basis.

DDS and Vendor review and discuss each reported complaint/grievance and critical incident from the prior quarter at each quarterly meeting, and address problems discovered, corrective actions plan, and any other remediation efforts that are deemed necessary to reduce or prevent similar occurrence from happening in the future. A special meeting between DDS and Vendor may be held immediately to discuss and act upon a complaint/grievance or critical incident if necessary due to the seriousness of the situation. The discussions and resulting plans are then reviewed, discussed, and finalized at the quarterly meeting between DMS and DDS.

DDS's Vendor performs any necessary follow-up if after DDS review and discussion of an incident the investigation is not deemed completed and closed. Any incident investigation not finalized and closed at the quarterly meeting will remain open and will be discussed at the next quarterly meeting until all recommended remediation steps have been completed and the incident investigation is closed. Final investigation findings are mailed by Vendor to the beneficiary's parent/guardian within ten (10) days of closure.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

**a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☒ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Autism Waiver Coordinator employed or contracted by DDS's contracted vendor ("Vendor"), the Clinical Services Specialist("CSS") employed or contracted by the Consultative Clinical and Therapeutic service provider, and the Interventionist employed or contracted by the selected Autism Waiver community service provider are all responsible for monitoring unauthorized use of restrictive interventions. The Autism Waiver Coordinator and Interventionist will have at least monthly contact with beneficiaries and the CSS will have at least quarterly contact with beneficiaries. Information about the prohibition on the use of restrictive interventions is included in the training of all Autism Waiver service providers staff and in the program description information provided to parents/guardians as part of Autism Waiver enrollment and level of care evaluation process. If there is any report of the use of interventions, an immediate investigation will be conducted by the Autism Waiver Coordinator and appropriate action taken to ensure that their use of restrictive interventions is immediately discontinued.

The only use of physical restraint allowable under the Autism Waiver is as an emergency intervention to protect the safety of the beneficiary or another person. An "" emergency"" is defined as a situation which poses imminent risk of injury to the beneficiary or another person. Physical restraint is allowable only during the context of the emergency and only for the duration of that emergency. It cannot be used as a contingent punitive consequence for non-cooperative or non-compliant behavior.

The use of physical restraint in an emergency and any other use of restraints is considered a reportable critical incident, and must be reported by Autism Waiver service providers through the Autism Waiver Database. Reports of the use of restraints are always investigated by Vendor to discuss the situation, address the requirements of the Autism Waiver, and develop a strategy to prevent future occurrences.

- ☐ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

**i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** (*Select one*):

- ☒ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Autism Waiver Coordinator employed or contracted by DDS's contracted vendor ("Vendor"), the Clinical Services Specialist("CSS") employed or contracted by the Consultative Clinical and Therapeutic service provider, and the Interventionist employed or contracted by the selected Autism Waiver community service provider are all responsible for monitoring the unauthorized use of restrictive interventions. The Autism Waiver Coordinator and Interventionist will have at least monthly contact with beneficiaries and the CSS will have at least quarterly contact with beneficiaries. Information about the prohibition on the use of restrictive interventions is included in the training of all Autism Waiver service provider staff and in the information provided to parents/guardians as part of Autism Waiver enrollment and level of care evaluation process. If there is any report of the use of restrictive interventions, an immediate investigation will be conducted by the Autism Waiver Coordinator and appropriate action taken to ensure that the use of restrictive interventions is immediately discontinued.

The use of restrictive interventions is considered a reportable critical incident and must be reported by Autism Waiver service providers through the Autism Waiver Database. Reports of the use of restrictive interventions are always investigated by Vendor to discuss the situation, address the requirements of the Autism Waiver, and develop a strategy to prevent future occurrences.

- ☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

☒ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Autism Waiver Coordinator employed by DDS's contracted vendor ("Vendor"), the Clinical Services Specialist ("CSS") employed or contracted by the Consultative Clinical and Therapeutic service provider, and the Interventionist employed or contracted by the selected Autism Waiver community service provider are all responsible for monitoring the unauthorized use of seclusion. The Autism Waiver Coordinator and Interventionist will have at least monthly contact with beneficiaries and the CSS will have at least quarterly contact with beneficiaries. Information about the prohibition of the use of seclusion is included in the training of all Autism Waiver community service provider staff and in the information provided to parents/guardians as part of Autism Waiver enrollment and level of care evaluation process. If there is any report of the use of seclusion an immediate investigation will be conducted by the Autism Waiver Coordinator and appropriate action taken to ensure that the use of seclusion is immediately discontinued.

The use of seclusion is considered a reportable critical incident and must be reported by Autism Waiver service providers through the Autism Waiver Database. Reports of the use of seclusion are always investigated by Vendor to discuss the situation, address the requirements of the Autism Waiver, and develop a strategy to prevent future occurrences.

- ☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- ☒ **No. This Appendix is not applicable** (do not complete the remaining items)
- ☐ **Yes. This Appendix applies** (complete the remaining items)

**b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

**i. Provider Administration of Medications.** Select one:

- ☐ **Not applicable.** (do not complete the remaining items)
- ☐ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** (complete the remaining items)

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**iii. Medication Error Reporting.** *Select one of the following:*

- ☐ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

- (c) Specify the types of medication errors that providers must *report* to the state:

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Health and Welfare**

***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")***

**i. Sub-Assurances:**

- a. **Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

### Performance Measure:

**Number and percent of critical incident involving abuse, neglect, exploitation and unexplained death that were reported within required time frames. Numerator:** number of critical incidents involving abuse, neglect, exploitation and unexplained death reported within required time frames; **Denominator:** Number of critical incidents involving abuse, neglect, exploitation and unexplained death.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> Specify: 	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: 	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: 

**Performance Measure:**

Number and percent of records that documented the parent/guardian received information about how to identify and report abuse, neglect, exploitation and critical incidents. Numerator: Number of records that documented the parent/guardian received information about how to identify and report abuse, neglect exploitation and critical incidents; Denominator: Number of records reviewed.

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 5px;"> A sample of beneficiaries who had active plans of care during the period under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error. </div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly



<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percent of critical incidents and complaints requiring investigation that were initiated and completed in accordance with waiver procedures and state law.**

**Numerator:** number of critical incidents and complaints requiring investigation initiated and completed in accordance with waiver procedures and state law;

**Denominator:** number of critical incidents/complaints requiring investigation.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>

<b>Agency</b>		
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	Specify: <div></div>

**Performance Measure:**

**Number and percent of critical incidents and complaints requiring investigation where there was appropriate follow-up. Numerator:** number of critical incidents and complaints requiring investigation where there was appropriate follow-up;  
**Denominator:** number of critical incidents and complaints requiring investigation.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <div></div>
	<input type="checkbox"/> <b>Other</b> Specify:	

--	--	--

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>

**Performance Measure:**

**Number of critical incidents where root cause was identified. Numerator: number and percent of critical incidents where root cause was identified Denominator: number of critical incidents.**

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Autism Waiver database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval =  <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify:  <input type="text"/>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:  <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:  <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  <input type="text"/>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:  <input type="text"/>

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

### Performance Measure:

**# and percent of provider files with policies, procedures, and training in place to demonstrate the prohibition on the use of restrictive interventions including restraints and seclusion. N: # of provider files with policies, procedures, and training in place to demonstrate the prohibition on the use of restrictive interventions including restraints and seclusion; D: # of provider files reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:

		A sample of providers that served clients during the quarter under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver providers who meet and adhered to state health care standards established in licensure requirements. Numerator: Number of waiver providers who meet and adhered to state health care standards established in licensure requirements; Denominator: Number of waiver provider files reviewed.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Autism Waiver Database**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input type="checkbox"/> Other Specify: <div></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify:



		A sample of providers that served beneficiaries during the quarter under review that provides a statistically valid sample with a 95% confidence level and a +/- 5% margin of error.
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

DDS's contracted vendor ("Vendor") maintains in the Autism Waiver Database all Autism Waiver complaints/grievances and critical incidents reported from any source along with any applicable findings and supporting documentation provided upon submission or collected during an investigation. DDS and Vendor review and discuss each reported complaint/grievance and critical incident from the prior quarter at each quarterly meeting, and address problems discovered, corrective actions plans, and any other remediation efforts that are deemed necessary after review. A special meeting between DDS and Vendor may be held immediately to discuss and act upon a complaint/grievance or critical incident if necessary due to the seriousness of the situation. The discussions and resulting plans are then reviewed, discussed, and finalized at the quarterly meeting between DMS and DDS.

DMS has final approval of any remediation efforts or systematic changes that are the result of complaint/grievance and critical incident reviews.

#### b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If issues within the Autism Waiver are discovered upon review of a reported complaint/grievance or critical incident, then DMS, DDS, and DDS's contracted vendor ("Vendor") will discuss the appropriate remediation on a case-by-case basis. Discussion will typically take place during regularly scheduled quarterly meetings, unless a more immediate meeting is required.

Remediation efforts will depend on the issue and surrounding circumstances and may include without limitation corrective action plans, training, recoupments, system design changes, revocation of provider certification, the parent/guardian selecting a new community Autism Waiver service provider, and the disenrollment of a beneficiary from the Autism Waiver. The manner and method of how each remediation effort will be monitored and tracked and the party directly responsible will be determined prior to implementation.

The party directly responsible will usually depend on the remediation effort implemented. Vendor will typically be responsible for implementing and monitoring corrective action plans, trainings, revocation of provider certifications, and the disenrollment of beneficiaries from the Autism Waiver. DMS or DDS will typically be lead in remediation efforts involving recoupment and system design changes, or if the issue involves Vendor's responsibilities for accepting, monitoring, investigating, and tracking complaints/grievances and critical incidents. The status of each active remediation effort will be discussed at the quarterly meeting until completed or resolved.

Investigations, findings, and other aspects of remediation efforts conducted by Vendor in connection with Autism Waiver clients or service providers will be maintained in the Autism Waiver Database. Recoupments will be tracked by DMS and the Medicaid Management Information system. System design changes will be documented through amendment to the Autism Waiver. Finally, documentation related to remediations in connection with Vendor's performance under its contract will be maintained in the contract file.

#### ii. Remediation Data Aggregation

##### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<div></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- ☒ No
- ☐ Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DDS holds separate meetings with its contracted vendor (“Vendor”) and DMS on at least a quarterly basis to discuss the DDS Review Report, Autism Waiver Report, any operational problems discovered, all complaints/grievances and critical incidents reported, necessary corrective actions plans, and other appropriate remediation efforts and system improvement or program changes.

If it is determined by DMS that one or more system design changes or improvements is required. DMS will meet with DMS and vendor to discuss what system improvement or program design change are necessary, the relative priority of each system improvement or design change based on the nature of the problems, the complexity of the solutions and the financial impact. Special meetings will be held, if necessary, to develop an action plan for implementation, which would include without limitation determining and submitting customer service request required to implement the system improvement or design changes, developing any new elements and components, seeking CMS approval and stakeholder public comments, if applicable, determining the appropriate testing period before implementation, and establishing the data collection necessary to monitor and track the effectiveness of the system design changes. These meetings may involve participation from the assigned DHS information technology consulting firm and other parties deemed appropriate.

ii. System Improvement Activities

Responsible Party( <i>check each that applies</i> ):	Frequency of Monitoring and Analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually

Responsible Party( <i>check each that applies</i> ):	Frequency of Monitoring and Analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>Other</b> Specify: <div>DDS's contracted vendor</div>	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div>as needed</div>

### b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DMS, DDS, and DDS's contracted vendor ("Vendor") are all responsible for monitoring, tracking, and analyzing the effectiveness of any system design changes to the Autism Waiver. DMS, in collaboration with DDS and Vendor, establishes the mechanism, methods, and party with primary responsibility for monitoring and tracking Autism Waiver system design changes on a case-by-case basis during the design phase and prior to implementation. DMS, DDS, and Vendor review and discuss the data collected on the system design change at each quarterly meeting to ensure effective implementation. Meetings to review system design change data may initially be held monthly or more frequently if deemed necessary to ensure minimal disruption.

If it is determined that additional system design changes are required, or, if the implementation of the system design change needs to be altered, then meetings are held to determine appropriate action. Appropriate third parties will be included to assist on an as-needed basis.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDS and its contracted vendor monitor the Quality Improvement Strategy (QIS) on an ongoing basis and review the QIS annually. A review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort is set in motion to complete a revision to the QIS which may include submission of a Waiver amendment. DDS utilizes the QIS during the quarterly meeting.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- ☒ No  
☐ Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

- ☐ HCBS CAHPS Survey :  
☐ NCI Survey :  
☐ NCI AD Survey :  
☐ Other (*Please provide a description of the survey tool used*):

## *Appendix I: Financial Accountability*

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### *I-1: Financial Integrity and Accountability*

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Pre-Payment Integrity*

Three (3) different, independent service providers are involved in the development of an Autism Waiver service plan. The involvement of multiple independent providers acts as a pre-payment financial integrity safeguard to ensure only those Autism Waiver services of the type, scope, amount, frequency, and duration medically necessary are included in the beneficiary's service plan.

1. The Division of Developmental Disabilities Services ("DDS") contracted vendor ("Vendor") employs or contracts with an Autism Waiver Coordinator to develop a beneficiary's plan of care ("POC"). The POC documents the beneficiary's needs and potential risks, the intensive intervention service(s) that will be implemented to meet those needs, the amount, frequency, and duration of each intensive intervention service, and the parent/guardian's choice of Autism Waiver services and Autism Waiver community service provider.
2. The selected community service provider employs or contracts with an Interventionist who uses the POC to complete the beneficiary's comprehensive clinical profile and develop the beneficiary's individual treatment plan ("ITP"). The ITP operationalizes the POC by identifying the beneficiary's individualized needs, strengths, disabilities, and problem behaviors, the specific intensive intervention service(s) delivery schedule, the short and long-term goals and objectives, and the data collection required to assess the beneficiary's progress towards short- and long-term goals and objectives.
3. The Institution of Higher Education serving as the Consultative Clinical and Therapeutic service provider employs or contracts with a Clinical Services Specialist ("CSS") who performs oversight of the service plan. The CSS reviews the beneficiary's progress toward ITP goals and objectives on at least a quarterly basis to determine the efficacy of the Autism Waiver services in the current ITP. If a review of a beneficiary's service record does not show the expected progress, the CSS will either provide technical assistance to the parent/guardian, Lead Therapist, and Line Therapist implementing the intensive intervention services or schedule a conference to discuss modification of the type, scope, amount, frequency, or duration of intensive intervention services included in the service plan. This oversight ensures that the Autism Waiver services performed are medically appropriate for the beneficiary and that the Autism Waiver services are implemented with fidelity.

Autism Waiver service providers submit Autism Wavier service claims through the Medicaid Management Information System ("MMIS"). MMIS acts as a pre-payment financial integrity check for the state on all Autism Waiver service claims. MMIS verifies a beneficiary's Autism Waiver eligibility and an Autism Waiver service provider's active Medicaid enrollment for the date of service prior to paying an Autism Waiver service claim. MMIS has the applicable per unit rate for each Autism Waiver service pre-loaded and also has edits in place that will prevent the payment of claims exceeding any applicable daily, weekly, or annual benefit/service limits for an Autism Waiver service. MMIS only pays claims that clear all eligibility and financial edits.

*Post-Payment Integrity*

All Post-Payment Integrity reviews described below are conducted the same for all Autism Waiver services and providers. Every quarter DDS conducts a lottery method random sample retrospective desk review of active beneficiary service records from the immediately preceding quarter. The active beneficiary service records are reviewed to determine if beneficiaries received, and Autism Waiver service providers were paid for, only those Autism Waiver services in the type, scope, amount, frequency, and duration specified in the service plan, and if such services were paid at the correct rate. This is done by reviewing the POC in the beneficiary service record in the Autism Waiver Database maintained by Vendor and comparing it to the Autism Waiver services billed and paid through MMIS. Any overpayment(s), non-compliance, or irregularities discovered are reported to DMS for recoupment or other appropriate action. DDS uses the Raosoft Calculation System to determine a sample size that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.

Additionally, DMS conducts its own annual retrospective desk review of active beneficiary service records in the immediately preceding quarter to determine if beneficiaries received, and Autism Waiver service providers were paid for, only those Autism Waiver services in the type, scope, amount, frequency, and duration specified in his or her service plan. DMS also uses the Raosoft Calculation System to determine a sample size that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- five percent (5%) margin of error.

Autism Waiver providers who are paid a total of \$100,000 or more during a year by the State of Arkansas are required to submit an independent financial statement audit for that year in accordance with the Government Auditing Standards. Autism Waiver providers who are paid more than \$750,000 in federal funds during a year must have an independent single

audit conducted for that year in accordance with OMB Circular A-133. All required Autism Waiver service provider audits are submitted to and reviewed by the DHS Office of Payment Integrity and Audit ("OPIA") for compliance with audit requirements. If issues are discovered during review of an audit, then OPIA is responsible for notifying DMS for recoupment or other appropriate action.

The Centers for Medicare and Medicaid Services ("CMS") conducts audits of Medicaid claims (including Autism Waiver service claims) in accordance with the Payment Error Rate Measurement ("PERM") regulations every three (3) years. CMS reviews the claims to ensure the services were medically appropriate, provided to an eligible beneficiary, and paid at the correct amount. PERM reviews are intended to:

- identify those Medicaid programs that may be susceptible to significant improper payments;
- estimate the amount of improper payments;
- submit those estimates to Congress; and
- submit a report on actions the agency is taking to reduce improper payments.

The entity responsible for the periodic independent audit of the Autism Waiver program is Arkansas Legislative Audit ("ALA"). ALA audits are conducted in compliance with state law pursuant to the Single Audit Act. The Office of Medicaid Inspector General also conducts independent annual random reviews of all Medicaid programs, including the Autism Waiver. If a review finds errors in billing and fraud is not suspected, DMS recoups the payment(s) from the Autism Waiver provider. If fraud is suspected, then the provider is referred to the Medicaid Fraud Control Unit and Arkansas Attorney General's office for appropriate action.

Any non-compliance or irregularities resulting in an overpayment that are discovered during any post-payment review or audit are reported to DMS for recoupment and other appropriate action to ensure non-compliance and overpayment will no longer occur in the future. When an issue with payment integrity is discovered, a referral to OMIG is made and OMIG issue a recoupment letter to the provider. Provider can dispute or agree with the recoupment action. Corrective action plans are typically not involved in recoupment actions by the state. If recoupment determination is ultimately agreed to or upheld, then recoupment is conducted through MMIS. The DMS financial team reports any recouped payments for Autism Waiver services as a prior period adjustment on the CMS-64 to remove the payments from claims for federal financial participation.

None of the services provided under the Autism Waiver are subject to EVV requirements.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

#### a. Methods for Discovery: Financial Accountability Assurance:

**The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

##### i. Sub-Assurances:

##### a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

##### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to



analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of service claims which paid only those services rendered.**

**Numerator: number of service claims which paid only for those services rendered;**

**Denominator: Number of paid service claims reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify:

		<p><i>A sample size of paid service claims during the period under review that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.</i></p>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of service claims that were paid using the correct rate. Numerator:** Number of service claims paid using the correct rate specified in waiver; **Denominator:** number of paid service claims reviewed.

*Data Source (Select one):***Other***If 'Other' is selected, specify:***MMIS**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div>A sample size of service claims paid during the period under review that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.</div>
	<input type="checkbox"/> <b>Other</b> Specify:	

--	--	--

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number and percent of paid service claims coded and paid in accordance with the reimbursement methodology specified in the waiver. Numerator: number of paid service claims coded and paid in accordance with the reimbursement methodology specified in the waiver. Denominator: number of paid service claims reviewed.**

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample Confidence</b>

		Interval = <div></div>
<input type="checkbox"/> <b>Other</b> Specify: <div></div>	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <div></div>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: <div>Specify: A sample size of claims paid during the period under review that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.</div>
	<input type="checkbox"/> <b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input type="checkbox"/> <b>Annually</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="text"/>	
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> Specify: <input type="text"/>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of rates which remain consistent with the approved rate methodology throughout the five-year waiver cycle. Numerator: number of rates which remain consistent with the approved rate methodology throughout the five-year waiver cycle. Denominator: number of rates.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
<input checked="" type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Representative Sample</i> <i>Confidence Interval =</i>

<input type="checkbox"/> <b>Other</b> Specify:  	<input type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:  
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:  
	<input type="checkbox"/> <b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:  	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:  

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If financial accountability or integrity issues are discovered during DDS or DMS reviews of beneficiary service records or Autism Waiver service claims submitted through the Medicaid Management Information System ("MMIS"), then DMS, DDS, and DDS's contracted vendor ("Vendor") will discuss the appropriate remediation on a case-by-case basis. Discussion will typically take place during regularly scheduled quarterly meetings, unless a more immediate meeting is required.

Remediation efforts will depend on the issue and surrounding circumstances and may include without limitation corrective action plans, training, recoupments, system design changes, revoking provider certification, the parent/guardian selecting a new Autism Waiver community service provider, and disenrolling a beneficiary from the Autism Waiver. The manner and method of how each remediation effort will be monitored and tracked and the party directly responsible will be determined prior to implementation.

The party directly responsible will usually depend on the remediation effort implemented. Vendor will typically be responsible for implementing and monitoring corrective action plans, trainings, revoking provider certification, and disenrolling beneficiaries. DMS or DDS will typically be lead in remediation efforts involving recoupments, changes to MMIS, and system design changes, or if the issue involves Vendor's responsibilities for accepting, monitoring, investigating, and tracking complaints/grievances and critical incidents. The status of each currently active remediation effort will be discussed at the quarterly meeting until the effort is completed or resolved.

Investigations, findings, and other aspects of remediation efforts conducted by Vendor in connection with Autism Waiver financial accountability will be maintained in the Autism Waiver Database. Recoupments will be tracked by DMS and MMIS. System design changes will be documented through amendment to the Autism Waiver. Finally, documentation related to remediations in connection with Vendor's performance under its contract will be maintained in the contract file.

**ii. Remediation Data Aggregation****Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input checked="" type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input checked="" type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:



Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):

c. **Timelines**  
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

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I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Division of Developmental Disabilities Service (“DDS”) is responsible for rate determination with oversight from the Division of Medical Services (“DMS”). There is an established procedure followed by DDS that ensures DMS reviews and approves all reimbursement rates and methodologies prior to implementation. Reviews include examination of provider enrollment data and beneficiary access to services. Autism rates are published for comment and are made available to the general public and all providers. The public is afforded an opportunity to comment on proposed rates and the rate determination process through the DMS website. Autism services rates are made available to parents/guardians or anyone else upon request. A review of Autism Waiver rates and rate setting methodology is conducted at least every five (5) years.

The Division of Medical Services holds a public comment period of thirty (30) calendar days in connection with any rate determination. Public Notice runs for thirty (30) days in the Arkansas statewide Democrat Gazette newspaper. Public comments must be submitted in writing at [ar.gov/dhs-proposed-rules](http://ar.gov/dhs-proposed-rules) or the following email address [ORP@dhs.arkansas.gov](mailto:ORP@dhs.arkansas.gov). A public hearing by remote access only through a Zoom webinar is held and public comment may be submitted at the hearing. See Main Section 6-I for specifics regarding public comments for this renewal.

DMS and DDS conducted a review to rebase Autism Waiver rates during the summer of 2023. DMS and DDS engaged an independent actuary to assist in the development of appropriate Autism Waiver service rates. Autism Waiver service rates have not been changed since the inception of the Autism Waiver. Autism services rates do not vary geographically or by provider.

Autism Waiver rates were assessed taking into account direct wages, indirect and transportation costs, employee related expenses, and supervisor time, using an independent rate model approach that serves to capture the average expected costs a reasonably efficient Arkansas provider would incur while delivering each Autism Waiver service. Hourly wages for each service were assessed using Arkansas-specific May 2021 wage data from the Bureau of Labor Statistics based on position responsibilities.

All Autism Waiver services use fee schedule reimbursement methodology. Under fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service under Arkansas Medicaid. The maximum allowable reimbursement for a service is the same for all Autism Waiver providers. The fee schedule for the Autism Waiver program can be found on the DHS website at: <https://humanservices.arkansas.gov/wp-content/uploads/AUTISM-fees.pdf>

The \$1,000 flat rate for behavioral reinforcers and therapeutic aides was determined through discussions with professionals credentialed at the level. This amount was considered sufficient to allow delivery of the intensive intervention service families who may not already have sufficient materials on hand in the home.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Autism Waiver service providers submit Autism Waiver claims and are reimbursed directly through the Medicaid Management Information System.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (select one):

- ☒ No. state or local government agencies do not certify expenditures for waiver services.
- ☐ Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Medicaid Management Information System ("MMIS") verifies Autism Waiver eligibility and Autism Waiver service provider's active Medicaid enrollment for the date of service prior to paying an Autism Waiver claim. All Autism Waiver claims are processed through MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and in compliance with the Medicaid maximum allowable cost provisions.

Additionally, every quarter DDS conducts a lottery method random sample retrospective desk review of active beneficiary service records from the immediately preceding quarter. The active beneficiary service records are reviewed to determine if beneficiaries received, and Autism Waiver service providers were paid for, only those Autism Waiver services in the type, scope, amount, frequency, and duration specified in the service plan, and if such services were paid at the correct rate. This is done by reviewing the plan of care in the beneficiary service record in the Autism Waiver Database maintained by DDS's contracted vendor and comparing it to the Autism Waiver services billed and paid through MMIS. DDS uses the Raosoft Calculation System to determine a sample size that provides a statistically valid sample with a ninety-five percent (95%) confidence level and a +/- 5% margin of error.

Any non-compliance or irregularities resulting in an overpayment that are discovered during any payment review or audit are reported to DMS for recoupment and other appropriate action to ensure non-compliance and overpayment will no longer occur in the future. When an issue with payment integrity is discovered, a referral to OMIG is made and OMIG issue a recoupment letter to the provider. Provider can dispute or agree with the recoupment action. Corrective action plans are typically not involved in recoupment actions by the state. If recoupment determination is ultimately agreed to or upheld, then recoupment is conducted through MMIS. The DMS financial team reports any recouped payments for Autism Waiver services as a prior period adjustment on the CMS-64 to remove the payments from claims for federal financial participation.

None of the services included in the Autism Waiver are subject to EVV requirements.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims

(including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

**a. Method of payments -- MMIS (select one):**

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

## **Appendix I: Financial Accountability**

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### **I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- ☐ **No. The state does not make supplemental or enhanced payments for waiver services.**
- ☒ **Yes. The state makes supplemental or enhanced payments for waiver services.**

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

Arkansas has an approved American Rescue Plan Act (ARP) Spending Plan under section 9817 that outlines the Workforce Stabilization Incentive Program. The effective dates of the Workforce Stabilization Incentive Program are from October 1, 2021 to March 31, 2025. Due to the expiration of the Appendix K, the State is seeking to amend the base waiver to include the Program. Arkansas has designed a HCBS Workforce Stabilization Incentive Program to allow providers to customize resources that best fit their organization's size, operational needs, and business priorities. The State allotted funding to providers using the following incentive categories:

**Hiring bonus:** new direct service providers (DSPs) hired during the ARP effective period (i.e., October 1, 2021, through March 31, 2025) may receive a hiring/recruitment payment after completing a minimum of thirty (30) calendar days of employment. The payment may be made in installments based on the provider's business model but cannot exceed \$1,000 per employee or contractor. **Longevity bonus:** longevity payments for DSPs who continuously provide service with the same employer for a minimum of three (3) months. The bonus cannot be paid in a one-time lump sum and must recur on a regular cadence determined by the employer. The recurring bonus can be paid through March 31, 2025, or until the provider allocation is depleted. Individual DSPs can earn bonuses up to the Longevity Bonus cap but cannot exceed \$15,000 total per employee or contractor. **Complex Care Longevity bonus:** complex care longevity payments for DSPs who provide care to at least one (1) individual with complex care needs. Bonus payments are provided on regular and recurring basis determined by the employer and is based upon the DSPs experience, commitment and need for the employee to continue to work with the complex care recipient. DSPs can earn bonuses up to the Complex Care Longevity Bonus cap but cannot exceed \$3,500 total per employee or contractor. Complex Care means a history of legal involvement, elopement risk, combative or aggressive behavior, multiple inpatient placements, DCFS or DYS involvement, or wheelchair or bed bound.

The supplemental or enhanced payments were made available to providers of Line Therapy Intervention services under the Autism Waiver to provide hiring bonuses, longevity bonuses and complex care longevity bonuses to direct care workers who provide all Autism Waiver direct care services. Providers were required to apply for the program through an online application process. A Remittance Advice notice went to all Autism Waiver providers on January 14, 2022; a dedicated webpage was developed to explain the program; the ARP Workforce Stabilization Incentive Program Operational Plan is available on that link as well as several recorded Zoom seminars, and Facebook videos that were advertised during January of 2022. Specifically, the Program was made available to providers of Line Therapy Intervention services under the Autism Waiver. These providers were also mailed a letter explaining the application process and deadline to the address they had on file with Medicaid enrollment. All providers also received a reminder email prior to the application deadline.

Eligible providers proactively applied under their individual Tax Identification Number (TIN) and received one lump sum check based upon the unduplicated recipient count and paid claim amounts for state fiscal year 2021. The allocation formula was 70% of the provider's recipient count and 30% based upon paid claims.

The source of the non federal share for the Program utilizes State General Revenue and eligible providers are able to retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

- ☐ No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- ☒ Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

*An Institution of Higher Education in the, a State of Arkansas is one of the qualifications to be certified as the Consultative Clinical and Therapeutic Services provider under the Autism Waiver. Many of the Institutions of Higher Education in the State of Arkansas are state agencies and could therefore become state government providers of Consultative Clinical and Therapeutic services and receive payment under the Autism Waiver.*

## **Appendix I: Financial Accountability**

### **I-3: Payment (5 of 7)**

#### **e. Amount of Payment to State or Local Government Providers.**

*Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:*

- ☒ *The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.*
- ☐ *The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*
- ☐ *The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

*Describe the recoupment process:*

## **Appendix I: Financial Accountability**

### **I-3: Payment (6 of 7)**

**f. Provider Retention of Payments.** *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ☒ *Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*
- ☐ *Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

*Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.*

## **Appendix I: Financial Accountability**

### **I-3: Payment (7 of 7)**

#### **g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ☒ **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

*Specify the governmental agency (or agencies) to which reassignment may be made.*

**ii. Organized Health Care Delivery System. Select one:**

- ☒ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

*Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:*

**iii. Contracts with MCOs, PIHPs or PAHPs.**

- ☒ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

- ☐ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ☐ **This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these**



*plans are made.*

- ☐ *If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

*In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☐ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☒ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

(a) Department of Human Services, Division of Developmental Disabilities; and  
(b) Intergovernmental Transfer (IGT).

- ☐ **Other State Level Source(s) of Funds.**

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- ☒ **Not Applicable.** *There are no local government level sources of funds utilized as the non-federal share.*
- ☐ **Applicable**

*Check each that applies:*

- ☐ **Appropriation of Local Government Revenues.**

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

☐ **Other Local Government Level Source(s) of Funds.**

*Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**  
☐ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**  
☐ **Provider-related donations**  
☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a. Services Furnished in Residential Settings.** Select one:

- ☒ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**  
☐ **As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

**Do not complete this item.**

**Appendix I: Financial Accountability****I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

*Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:*

- ☒ *No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*
- ☐ *Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ☒ *No. The state does not impose a co-payment or similar charge upon participants for waiver services.*
- ☐ *Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

**i. Co-Pay Arrangement.**

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ *Nominal deductible*
- ☐ *Coinsurance*
- ☐ *Co-Payment*
- ☐ *Other charge*

*Specify:*

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
- ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
- iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
- iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☒ No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- ☐ Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: ICF/IID**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	45025.43	14207.00	59232.43	131175.00	21098.00	152273.00	93040.57
2	45025.43	14619.00	59644.43	134979.00	21710.00	156689.00	97044.57
3	45025.43	14991.00	60016.43	138488.00	22264.00	160752.00	100735.57
4	45025.43	15362.00	60387.43	141950.00	22815.00	164765.00	104377.57
5	45025.43	15716.00	60741.43	145215.00	23340.00	168555.00	107813.57

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (1 of 9)**

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	270		270
Year 2	270		270
Year 3	270		270
Year 4	270		270
Year 5	270		270

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (2 of 9)**

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay on the Autism Waiver by a beneficiary for waiver years one (1) through five (5) has been estimated based on actual utilization data pulled from MMIS on July 28, 2023, using service dates for the waiver year December 7, 2021, through December 6, 2022.

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (3 of 9)**

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Waiver years one (1) through five (5) number of users and average units per user have been estimated to remain flat from the Waiver Year five (5) levels of the previously approved Waiver as there are no additional individuals being added to be served. The average cost per unit for Lead Therapy Intervention and Line Therapy Intervention services for Waiver years one (1) through five (5) were increased in accordance with the results of the rate study during the summer of 2023 referenced in appendix I-2.a.

**ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Waiver year one (1) has been estimated based on Waiver Year 2022 historical data pulled from MMIS on July 28, 2023, for clients while enrolled on the Autism Waiver and adding a four and one tenth percent (4.1%) average market growth basket. Market basket data is published at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>. The four and one tenth percent (4.1%) average market growth basket was the rate published on that site on July 28, 2023. The market basket rate of (4.1%) was applied to the Waiver Year 2022 historical data pulled from MMIS on July 28, 2023, to arrive at WY 1 estimate of Factor D'.

The growth factor for waiver years two (2) through five (5) equals the CMS market basket average for the corresponding waiver year:

- WY 1 to 2 = 2.9%
- WY 2 to 3 = 2.6%
- WY 3 to 4 = 2.5%
- WY 4 to 5 = 2.3%

The State will review utilization and trends. Based on this continued review and analysis, factor D' may be adjusted and amendments submitted as needed.

The Autism Waiver has a D' that significantly lower than its G'. The data used to arrive at G' was a pull of halo services received by children from birth to eighteen (18) years of age while they resided in an intermediate care facility during Waiver Year 2022. This data pull was from MMIS on July 28, 2023, for services dates December 7, 2021, to December 6, 2022. There were only sixty-eight (68) children that met these criteria, and the group had high pharmacy needs and some hospital stays that skewed the data given the small applicable pool, resulting in a D' that is significantly lower than the G'.

**iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Waiver year one (1) has been estimated based on the July 2023 daily rate pulled from MMIS for a child residing at the State of Arkansas public intermediate care facility in Conway, Arkansas, which is the only state public intermediate care facility that serves children requiring an institutional level of care, multiplied by the average length of stay of an Autism Waiver beneficiary during waiver year 2022 as pulled from MMIS on July 28, 2023.

The growth factor for waiver years two (2) through five (5) equals the CMS market basket average for the corresponding waiver year:

- WY 1 to 2 = 2.9%
- WY 2 to 3 = 2.6%
- WY 3 to 4 = 2.5%
- WY 4 to 5 = 2.3%

The State is and will continue to review utilization and trends. Based on this continued review and analysis, factor G may be adjusted, and amendments submitted for review as needed.

**iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Waiver year one (1) has been estimated based on state plan utilization costs for children residing at the State of Arkansas public intermediate care facility in Conway, Arkansas, as pulled from MMIS for Waiver year 2022 on July 28,2023, and adding a four and one tenth percent (4.1%) average market growth basket. Market basket data is published at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData>.The four and one tenth percent (4.1%) average market growth basket was the rate published on that site on July 28,2023. The market basket rate of (4.1%) was applied to the Waiver Year 2022 historical data pulled from MMIS on July 28,2023, to arrive at WY 1 estimate of Factor G'.

The growth factor for waiver years two (2) through five (5) equals the CMS market basket average for the corresponding waiver year:

- WY 1 to 2 = 2.9%
- WY 2 to 3 = 2.6%
- WY 3 to 4 = 2.5%
- WY 4 to 5 = 2.3%

The State is and will continue to review utilization and trends. Based on this continued review and analysis, factor G' may be adjusted, and amendments submitted for review as needed.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Consultative Clinical and Therapeutic Services	
Individual Assessment/ ,Treatment Development/, and Monitoring	
Lead Therapy Intervention	
Line Therapy Intervention	
Therapeutic Aides and Behavioral Reinforcers	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:						225504.00
GRAND TOTAL:						12156866.60
Total Estimated Unduplicated Participants:						270
Factor D (Divide total by number of participants):						45025.43
Average Length of Stay on the Waiver:						265

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	225504.00	
Individual Assessment/ ,Treatment Development/, and Monitoring Total:						1599669.00
Individual Assessment/Treatment Development	15 minutes	270	227.00	26.10	1599669.00	
Lead Therapy Intervention Total:						2800353.60
Lead Therapy Intervention	15 minutes	270	664.00	15.62	2800353.60	
Line Therapy Intervention Total:						7463340.00
Line Therapy Intervention	15 minutes	270	2168.00	12.75	7463340.00	
Therapeutic Aides and Behavioral Reinforcers Total:						68000.00
Therapeutic Aides and Behavioral Reinforcers	1 package	68	1.00	1000.00	68000.00	
GRAND TOTAL:					12156866.60	
Total Estimated Unduplicated Participants:					270	
Factor D (Divide total by number of participants):					45025.43	
Average Length of Stay on the Waiver:						265

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:						225504.00
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	225504.00	
Individual Assessment/ ,Treatment Development/, and Monitoring Total:						1599669.00
Individual					1599669.00	
GRAND TOTAL:					12156866.60	
Total Estimated Unduplicated Participants:					270	
Factor D (Divide total by number of participants):					45025.43	
Average Length of Stay on the Waiver:						265



Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assessment/Treatment Development	15 minutes	270	227.00	26.10		
<b>Lead Therapy Intervention Total:</b>						2800353.60
Lead Therapy Intervention	15 minutes	270	664.00	15.62	2800353.60	
<b>Line Therapy Intervention Total:</b>						7463340.00
Line Therapy Intervention	15 minutes	270	2168.00	12.75	7463340.00	
<b>Therapeutic Aides and Behavioral Reinforcers Total:</b>						68000.00
Therapeutic Aides and Behavioral Reinforcers	1 package	68	1.00	1000.00	68000.00	
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						12156866.60 270 45025.43 265

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consultative Clinical and Therapeutic Services Total:</b>						225504.00
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	225504.00	
<b>Individual Assessment/ ,Treatment Development/, and Monitoring Total:</b>						1599669.00
Individual Assessment/Treatment Development	15 minutes	270	227.00	26.10	1599669.00	
<b>Lead Therapy Intervention Total:</b>						2800353.60
Lead Therapy Intervention	15 minutes	270	664.00	15.62	2800353.60	
<b>Line Therapy</b>						7463340.00
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						12156866.60 270 45025.43 265

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Intervention Total:</b>						
Line Therapy Intervention	15 minutes	270	2168.00	12.75	7463340.00	
<b>Therapeutic Aides and Behavioral Reinforcers Total:</b>						68000.00
Therapeutic Aides and Behavioral Reinforcers	1 package	68	1.00	1000.00	68000.00	
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						12156866.60 270 45025.43 265

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consultative Clinical and Therapeutic Services Total:</b>						225504.00
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	225504.00	
<b>Individual Assessment/ Treatment Development/, and Monitoring Total:</b>						1599669.00
Individual Assessment/Treatment Development	15 minutes	270	227.00	26.10	1599669.00	
<b>Lead Therapy Intervention Total:</b>						2800353.60
Lead Therapy Intervention	15 minutes	270	664.00	15.62	2800353.60	
<b>Line Therapy Intervention Total:</b>						7463340.00
Line Therapy Intervention	15 minutes	270	2168.00	12.75	7463340.00	
<b>Therapeutic Aides and Behavioral Reinforcers Total:</b>						68000.00
Therapeutic Aides					68000.00	
<b>GRAND TOTAL:</b> Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						12156866.60 270 45025.43 265

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Behavioral Reinforcers	1 package	68	1.00	1000.00		
GRAND TOTAL:						12156866.60
Total Estimated Unduplicated Participants:						270
Factor D (Divide total by number of participants):						45025.43
Average Length of Stay on the Waiver:						265

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consultative Clinical and Therapeutic Services Total:</b>						225504.00
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	225504.00	
<b>Individual Assessment/ ,Treatment Development/, and Monitoring Total:</b>						1599669.00
Individual Assessment/Treatment Development	15 minutes	270	227.00	26.10	1599669.00	
<b>Lead Therapy Intervention Total:</b>						2800353.60
Lead Therapy Intervention	15 minutes	270	664.00	15.62	2800353.60	
<b>Line Therapy Intervention Total:</b>						7463340.00
Line Therapy Intervention	15 minutes	270	2168.00	12.75	7463340.00	
<b>Therapeutic Aides and Behavioral Reinforcers Total:</b>						68000.00
Therapeutic Aides and Behavioral Reinforcers	1 package	68	1.00	1000.00	68000.00	
GRAND TOTAL:						12156866.60
Total Estimated Unduplicated Participants:						270
Factor D (Divide total by number of participants):						45025.43
Average Length of Stay on the Waiver:						265

## **RULES SUBMITTED FOR REPEAL**

**Rule #1: FBI Background Check Form**

**Rule #2: First Connections Program Under Part C of  
the Individuals With Disabilities Act**



# ~~Application Record Notification~~

## ~~Notification~~

~~Fingerprints submitted will be used to check the criminal history records of the FBI.~~

## ~~\*Obtaining Copy~~

~~Procedures for obtaining a copy of FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.30 through 16.33 or go to the FBI website at <http://www.fbi.gov/about-us/cjis/background-checks>.~~

## ~~\*Change, Correction, or Updating~~

~~Procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.~~

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**REPEAL-EO 23-02**

~~Rules for the Division of Developmental Disabilities~~

~~First Connections Program~~

~~Under Part C of the Individual with Disabilities Education Act~~

REPEAL-EO 23-02



~~LAST UPDATED: July 1, 2022~~

## **Subchapter 1. General.**

### **101. Authority.**

- (a) ~~These standards are promulgated under the authority of Ark. Code Ann. § 20-14-503.~~
- (b) ~~The Division of Developmental Disabilities Services (DDS) is the designated lead agency for the State of Arkansas, responsible for performing all certification, general supervision, monitoring, and other regulatory functions involved in the implementation and administration of Part C of the IDEA.~~

### **102. Purpose.**

~~The purpose of these standards is to:~~

- (1) ~~Serve as the minimum standards for Service Providers; and~~
- (2) ~~Ensure that all aspects of the First Connections program are carried out in compliance with the requirements of Part C of the IDEA.~~

### **103. Definitions.**

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- (a)
  - (1) ~~“Assistive Technology and Adaptive Equipment” means an item or product used to increase, maintain, or improve the functional capabilities of the child.~~
  - (2) ~~“Assistive Technology and Adaptive Equipment” does not mean a device that must be surgically implanted, or any therapy equipment typically found in clinics.~~
- (b) ~~“Business Day” means Monday through Friday, except for any day that is recognized as a holiday by the State of Arkansas.~~
- (c) ~~“Calendar Day” means the period from midnight to the following midnight, Monday through Sunday including without limitation holidays and days schools are closed.~~
- (d) ~~“CDS” means the comprehensive database system used by First Connections into which Service Providers enter the information and upload the documentation required by these standards.~~
- (e) ~~“Change in Ownership” means one (1) or more transactions within a twelve-month period that, in the aggregate, result in a change in greater than fifty percent (50%) of the ownership, financial, or voting interests of a Service Provider.~~



- (f) ~~“CMDE” means the comprehensive multi-disciplinary developmental evaluation of a child that is used to determine the child’s First Connections eligibility and identify the child’s and family’s strengths, priorities, resources, and concerns.~~
- (g) ~~“DDS” means the Arkansas Department of Human Services, Division of Developmental Disabilities Services.~~
- (h) ~~“Evaluation Report” means a written report about a child’s evaluation results that is used to guide the IFSP team in developing a child’s IFSP.~~
- (i) ~~“Early Intervention Services” means any of the following developmental services:~~
- ~~(1) Service Coordination Services;~~
  - ~~(2) Assistive Technology and Adaptive Equipment and Services;~~
  - ~~(3) Audiology Services;~~
  - ~~(4) Family Training, Counseling, and Home Visit Services;~~
  - ~~(5) Health Services;~~
  - ~~(6) Medical Services;~~
  - ~~(7) Nursing Services;~~
  - ~~(8) Nutrition Services;~~
  - ~~(9) Occupational Therapy Evaluations and Services;~~
  - ~~(10) Physical Therapy Evaluations and Services;~~
  - ~~(11) Psychological Services;~~
  - ~~(12) Sign Language and Cued Language Services;~~
  - ~~(13) Social Work Services;~~
  - ~~(14) Specialized Evaluation Services;~~
  - ~~(15) Speech-Language Pathology Evaluations and Services;~~
  - ~~(16) Transportation Services;~~
  - ~~(17) Developmental Therapy Services;~~

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- ~~(18) Vision Services;~~
- ~~(19) Parent Education Services; and~~
- ~~(20) Any other developmental, corrective, or supportive services that meet the needs of a child as determined by the IFSP team and incorporated into the IFSP.~~
- ~~(j) “Employee” means an Employee or other agent of a Service Provider who has direct contact with a child participating in First Connections including without limitation any Employee, contractor, sub-contractor, intern, volunteer, trainee, or agent.~~
- ~~(k) “Family Assessment” means the family-directed assessment performed by a Service Coordinator using an assessment tool and conducting a personal interview that identifies the family resources, priorities, and concerns; the child’s Natural Environment; and the typical child and family community activities that will assist the IFSP team in developing the IFSP.~~
- ~~(l) “Family Delay” means the child or Parent is unavailable for any reason.~~
- ~~(m) “First Connections” means the DDS program that administers, monitors, and carries out all activities and responsibilities for the State of Arkansas under Part C of IDEA to ensure appropriate Early Intervention Services are available to all infants and toddlers from birth to thirty-six (36) months of age (and their families) that are suspected of having a developmental delay.~~
- ~~(n) “First Connections Central Intake Unit” means the unit that serves as the single referral point of entry for First Connections.~~
- ~~(o) “IDEA” means the Individuals with Disabilities Education Act.~~
- ~~(p) “IFSP” means an individual family service plan which is a written and individualized plan that includes Early Intervention Services and other services necessary to meet the identified unique needs of the child and their family and to enhance the child’s development.~~
- ~~(q) “LEA” or “Local Education Agency” means the school district, education cooperative, or other State of Arkansas accredited education agency for the area where a child resides.~~
- ~~(r)~~
- ~~(1) “Market or Marketing” means the accurate and honest advertisement of a Service Provider that does not also constitute solicitation.~~
- ~~(2) “Marketing” includes without limitation:~~
- ~~(i) Advertising using traditional media;~~

- ~~(ii) Distributing brochures or other informational materials regarding the services offered by the Service Provider;~~
  - ~~(iii) Conducting tours of the Service Provider's place of practice to interested children and Parents;~~
  - ~~(iv) Mentioning services offered by the Service Provider in which the child or Parent might have an interest; and~~
  - ~~(v) Hosting informational gatherings during which the services offered by the Service Provider are described.~~
- ~~(s) "Native Language" means the language and primary mode of communication used by an individual.~~
- ~~(t)~~
  - ~~(1) "Natural Environment" means activities in which a same-aged child without a disability would participate in at appropriate home and community-based locations, such as the family home, parks, libraries, churches, and grocery stores.~~
  - ~~(2) "Natural Environment" does not mean:~~
    - ~~(i) A clinic, hospital, Service Provider's office, early intervention day treatment center, or other facility in which the majority of individuals are not typically developing; or~~
    - ~~(ii) Removing a child from an integrated setting or room to provide Early Intervention Services in an isolated setting or room.~~
- ~~(u) "Parent" means one (1) of the following individuals who is responsible for protecting and representing the child's rights and interests during their participation in First Connections:~~
  - ~~(1) A natural, adoptive, or foster parent;~~
  - ~~(2) A legal guardian;~~
  - ~~(3) A relative or other family member with whom the child lives acting in the place of a Parent;~~
  - ~~(4) An individual legally responsible for the child's welfare; or~~
  - ~~(5) A Surrogate Parent.~~
- ~~(v) "Parental Consent" means the Parent demonstrating formal, written approval of a proposed activity.~~

- (w) ~~“Part C Funds” means the federal grant funds available to First Connections which may be used to administer, monitor, and carry out all activities and responsibilities under Part C of IDEA, including without limitation payments to Service Providers for the delivery of those Early Intervention Services included on a child’s IFSP.~~
- (x) ~~“Personally Identifiable Information” means any information, written or otherwise, that would make a child or family member’s identity easily traceable including without limitation:~~
- ~~(1) The name of a child, Parent, or other family member;~~
  - ~~(2) The address of a child, Parent, or other family member;~~
  - ~~(3) A personal identifier number such as a Social Security or Medicaid identification number;~~
  - ~~(4) Photographic images of a child, Parent, or family member; and~~
  - ~~(5) A list of personal characteristics or other information that would make it possible to identify the child with reasonable certainty.~~
- (y) ~~“Service Coordinator” means a First Connections staff member or a Service Provider certified to perform service coordination services.~~
- (z) ~~“Service Provider” means an individual or organization that has been certified by First Connections to provide one (1) or more Early Intervention Services to children participating in First Connections.~~
- (aa)
- ~~(1) “Solicit or Solicitation” means the initiation of contact with a child or their family by a Service Provider, when the child is currently receiving services from another Service Provider, with the purpose of persuading the child or Parent to switch to or otherwise use the services of the Service Provider that initiated the contact.~~
  - ~~(2) “Soliciting or Solicitation” includes without limitation inducing a child or their family by:~~
    - ~~(i) Contacting the family of a child who is currently receiving services from another Service Provider;~~
    - ~~(ii) Offering cash or gift incentives to a child or their family;~~
    - ~~(iii) Offering free goods or services not available to other similarly situated children or their families;~~

- ~~(iv) Making negative comments to a child or their family regarding the quality of services performed by another Service Provider;~~
  - ~~(v) Promising to provide services in excess of those necessary;~~
  - ~~(vi) Giving a child or their family the false impression, directly or indirectly, that the Service Provider is the only Service Provider that can perform the services desired by the child or their family; or~~
  - ~~(vii) Engaging in any activity that DDS reasonably determines to be “Solicitation.”~~
- ~~(bb) “Surrogate Parent” means an individual appointed by a judge or First Connections to serve as a child’s Parent for purposes of protecting and representing the child’s rights and interests during the child’s participation in First Connections when there is no other qualifying individual able or willing to serve in that role.~~
- ~~(cc) “Written Notice” means delivery of written notice to the Parent or a Service Provider in their Native Language and in language that is understandable to the general public, of an action, proposed action, or refusal to act, which must include without limitation:~~
  - ~~(1) The action taken, not taken, or proposed to be taken or not taken;~~
  - ~~(2) The reason for taking or not taking the action;~~
  - ~~(3) All applicable due process and appeal rights, or instructions on where to find all applicable due process and appeal rights; and~~
  - ~~(4) Any applicable procedures and timelines for exercising due process or appeal rights, or where to find any applicable procedures and timelines for exercising due process or appeal rights.~~

## **Subchapter 2. Certification.**

### **201. Certification Required.**

- ~~(a) An individual or organization must be certified by DDS to provide any Early Intervention Service.~~
- ~~(b) A separate DDS certification is required for each type of Early Intervention Service.~~
- ~~(c) A Service Provider must comply with all applicable requirements of these standards to maintain certification for a particular Early Intervention Service.~~
- ~~(d) An individual or organization that is on the Medicaid excluded provider list is prohibited from being a Service Provider.~~

### **202. Application for Certification.**

- ~~(a)~~
  - ~~(1) To apply for Early Intervention Service certification, an Service Provider must submit a complete application to First Connections.~~
  - ~~(2) A complete application includes without limitation:~~
    - ~~(i.) Documentation demonstrating the Service Provider's entire ownership, including without limitation all information on the applicant's governing body as well as financial and business interests.~~
    - ~~(ii.) Documentation of the Service Provider's management, including without limitation the management structure and members of the management team;~~
    - ~~(iii.) Documentation of the Service Provider's contractors and the contractors that the Service Provider intends to use as part of providing First Connections Early Intervention Services;~~
    - ~~(iv.) All documentation demonstrating compliance with the standards for the Early Intervention Services for which certification is sought; and~~
    - ~~(v.) All other documentation or other information requested by DDS.~~
- ~~(b) A request for a Change in Ownership is initiated by a potential new owner submitting a complete application described in Section 202(a)(2), which must include a detailed description of how the existing Service Provider's business and children will be transferred to the new owner if the Change of Ownership application is approved.~~

## **Subchapter 3. Administration.**

### **301. Organization and Ownership.**

- (a) ~~A Service Provider must be authorized and in good standing to do business under the laws of the State of Arkansas.~~
- (b)
  - (1) ~~If the Service Provider is an entity or organization, it must appoint a single manager as the point of contact for First Connections matters and provide First Connections with updated contact information for that manager.~~
  - (2) ~~This manager must have decision-making authority for the Service Provider and all its Employees as well as the ability to ensure that First Connections requests, concerns, inquiries, and enforcement actions are addressed and resolved to the satisfaction of First Connections.~~
- (c)
  - (1) ~~A Service Provider cannot transfer any Early Intervention Service certification to any other person or entity.~~
  - (2) ~~A Service Provider cannot complete a Change in Ownership unless DDS approves the application of the new ownership pursuant to Sections 202.~~
  - (3) ~~A Service Provider cannot change its name or otherwise operate under a different name than the one listed on the certification without prior Written Notice to First Connections.~~

### **302. Personnel and Staffing.**

- (a)
  - (1) ~~A Service Provider must comply with all requirements applicable to Employees under these standards, including without limitation drug screens, criminal background checks, adult and child maltreatment registry checks, and sex offender registry searches.~~
  - (2.) ~~A Service Provider must verify that an Employee continues to meet all requirements upon the request of First Connections or whenever the Service Provider receives information after hiring that would create a reasonable belief that an Employee no longer meets all requirements, including without limitation~~

~~requirements related to drug screens, criminal background checks, adult and child maltreatment registry checks, and sex offender registry searches.~~

~~(b)~~

- ~~(1) A Service Provider must conduct criminal background checks for all Employees as required pursuant to Ark. Code Ann. § 20-38-101, et seq.~~
- ~~(2) A Service Provider must conduct an Arkansas Child Maltreatment Central Registry check on each Employee prior to hiring and at least every two (2) years thereafter.~~
- ~~(3) A Service Provider must conduct an Arkansas Adult Maltreatment Central Registry check on each Employee prior to hiring and at least every two (2) years thereafter.~~
- ~~(4) A Service Provider must conduct a drug screen that tests for the use of illegal drugs on each Employee prior to hiring.~~
- ~~(5) A Service Provider must conduct an Arkansas Sex Offender Central Registry search on each Employee prior to hiring and at least every two (2) years thereafter.~~

~~(c) Each Employee must successfully pass all required checks, screens, and searches required in Section 302 (b).~~

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### **303. Employee Records.**

- ~~(a) A Service Provider must maintain a personnel file for each Employee in CDS including without limitation:~~
- ~~(1) Evidence of all required criminal background checks;~~
  - ~~(2) All required Child Maltreatment Registry checks;~~
  - ~~(3) All required Adult Maltreatment Registry checks;~~
  - ~~(4) Documentation demonstrating that the Employee maintains in good standing all professional licensures, certifications, or credentials that are required for the Employee or the Early Intervention Service the Employee is performing; and~~
  - ~~(5) Documentation demonstrating that the Employee meets all continuing education, in-service, or other training requirements applicable to that Employee under these standards as well as any professional licensures, certifications, or credentials held by that Employee.~~



- ~~(b) A Service Provider must maintain its own separate and complete electronic or paper personnel file for each Employee in addition to the personnel file maintained for each Employee in CDS.~~
- ~~(c) A Service Provider must make all Employee personnel files available to First Connections upon request.~~

### **304. Client Service Records and Personally Identifiable Information.**

- ~~(a) A Service Provider must maintain a complete service record for each child in CDS that includes (at a minimum) all documentation related to a child's eligibility determination, their IESP, service delivery, Written Notices, Parental Consents, and any other documentation related to the child that is required under these standards.~~
- ~~(b) If a Service Provider elects to maintain its own set of service records in addition to the service record maintained for each child in CDS, then the Service Provider must maintain service records and Personally Identifiable Information in compliance with the requirements of Part C of IDEA and all applicable state and federal laws and rules governing the protection of medical, social, personal, financial, and electronically stored records, including without limitation the Health Insurance Portability and Accountability Act (HIPAA), the Privacy Act of 1974, and the Family Educational Rights and Privacy Act (FERPA).~~

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~~(c)~~

- ~~(1) A Service Provider must provide access to, and at least one (1) no cost copy of, a child's service record to each of the following individuals within ten (10) Calendar Days upon request:~~
  - ~~(i) First Connections staff;~~
  - ~~(ii) A Parent; and~~
  - ~~(iii) The authorized representative of a Parent.~~
- ~~(2) A Service Provider must explain and interpret the contents of a child's service record when requested by a Parent.~~
- ~~(3)~~
  - ~~(i) A Parent has the right to request an amendment to the child's service record when the Parent believes that the service record is inaccurate, misleading, or violating the child's privacy or other rights.~~

- (ii) ~~A Service Provider must respond to a Parent's child service record amendment request within ten (10) Calendar Days of receipt of the request.~~
- (iii) ~~If a Parent's child service record amendment request is denied, the Service Provider must:~~
  - (A) ~~Inform the Parent of their right to include the Parent's statement of facts concerning the amendment request in the child service record; and~~
  - (B) ~~Provide Parental Notice of the Parent's due process rights to challenge the denial through First Connections dispute resolution procedures.~~

**305. First Connections Referrals.**

- (a) ~~A Service Provider must refer to the DDS First Connections Central Intake Unit within two (2) Business Days of first contact with all infants and toddlers from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability.~~
- (b) ~~A CMDE and determination of program eligibility cannot be conducted when a referral to First Connections occurs less than forty-five (45) days before the child's third birthday. See Section 306 regarding LEA referral.~~

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**306. LEA Referrals and Notifications.**

- (a)
  - (1) ~~If a child is referred to First Connections forty-five (45) days or less before the child's third birthday, then the Service Coordinator must make a referral to the child's LEA unless there is documented refusal of Parental Consent or failure to obtain Parental Consent despite documented, repeated attempts.~~
  - (2) ~~If a child is referred to First Connections between ninety (90) and forty-six (46) days before their third birthday, then the Service Coordinator must make a referral to the child's LEA as soon as possible after the child is determined eligible for First Connections.~~
- (b) ~~For every child with an IFSP, the Service Coordinator must send a quarterly LEA notification to the appropriate LEA no later than ninety (90) days prior to a child's third birthday.~~
- (c) ~~A Service Provider is required to enter documentation in CDS evidencing that any required referral or notification was completed in a proper and timely manner.~~

**307. Transition Plan.**

~~(a)~~

- ~~(1) Each child must have a transition plan developed and included in their IFSP between nine (9) months and ninety (90) days prior to their third birthday.~~
- ~~(2) Each transition plan must include without limitation:~~
  - ~~(i) The transition services and activities necessary to support the child's and family's transition out of First Connections;~~
  - ~~(ii) A minimum of three (3) specific steps that will be taken to prepare the child for the changes in service delivery and learning environment;~~
  - ~~(iii) A specific action step that will be taken by the Parent or other caregiver to prepare the child for the changes in service delivery and learning environment;~~
  - ~~(iv) Documentation that the Service Coordinator provided the Parent with a copy of the Transition Guide;~~
  - ~~(v) Documentation that the Service Coordinator provided the Parent with LEA contact information concerning Part B services; and~~
  - ~~(vi) Documentation that the Service Coordinator referred the child to the DDS Children with Chronic Health Conditions program or that the Parent declined the referral.~~

~~(b) The transition plan development process must include:~~

- ~~(1) A Parent;~~
- ~~(2) A Service Coordinator; and~~
- ~~(3) Other individuals requested by the Parent.~~

**308. Transition Conference.**

~~(a) A transition conference must be held no later than ninety (90) days before the child's third birthday.~~

~~(b)~~

- ~~(1) The only justifications for failing to hold the transition conference at least ninety (90) days before the child's third birthday are:~~
  - ~~(i) Family Delay;~~
  - ~~(ii) Lack of Parental Consent; or~~
  - ~~(iii) The child's referral to First Connections was received less than ninety (90) days from the child's third birthday.~~
- ~~(2) The reason for Family Delay or lack of Parental Consent must be documented in the child's service record.~~
- ~~(3) The transition conference must be held as soon as practicable after Parental Consent is obtained or the circumstances causing Family Delay no longer exist.~~

~~(c) The transition conference must include the following individuals:~~

- ~~(1) A Parent;~~
- ~~(2) A Service Coordinator;~~
- ~~(3) A Service Provider;~~
- ~~(4) An LEA or representative of any other program to which the child is transitioning; and~~
- ~~(5) Other individuals requested by the Parent.~~

~~(d) The transition conference may be held in-person or by any other means that are acceptable to the Parent and other participants.~~

~~(e)~~

- ~~(1) The transition conference must be held in a setting and at a time convenient to the Parent.~~
- ~~(2) Written Notice of the transition conference must be provided to all participants at least fourteen (14) days in advance.~~
- ~~(3) It must be documented if the Parent requests that a transition conference be held prior to receiving Written Notice.~~

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**309. Document Destruction.**

- (a) ~~A Service Provider must retain all child service records for at least five (5) years from the date the child exits First Connections, or until the conclusion of all reviews, appeals, investigations, administrative or judicial actions related to an exited child's service record (if longer than five (5) years).~~
- (b) ~~A Service Provider must comply with all applicable state and federal laws and rules governing the destruction of child service records and Personally Identifiable Information, including without limitation Part C of IDEA and the General Education Provision Act.~~

**310. Written Notice.**

- (a) ~~If Written Notice involves a proposed action, meeting, or refusal to act, then unless otherwise stated in these Rules, the Written Notice must be delivered at least seven (7) Calendar Days prior to the proposed action, meeting, or refusal to act described in the Written Notice.~~
- (b) ~~A Service Provider must upload documentation into CDS demonstrating the delivery and receipt of all Written Notices in the manner required by these standards.~~

**311. Parental Consent.**

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- (a)
  - (1) ~~A Service Provider must fully inform a Parent in advance of all relevant information pertaining to the activity for which Parental Consent is sought, including without limitation:~~
    - (i) ~~A complete description of the activity for which Parental Consent is sought;~~
    - (ii) ~~An explanation that Parental Consent is voluntary and may be withdrawn at any time, but that any revocation will not be retroactive;~~
    - (iii)
      - (A) ~~A description of any information that will be released (if any) and to whom;~~
      - (B) ~~The purpose of releasing the information; and~~
      - (C) ~~The duration of time that the information will be released.~~

- (2) ~~A Service Provider must fully answer all Parent questions for Parental Consent to be valid.~~
  - (3) ~~A Service Provider must communicate in the Parent's Native Language to fully inform the Parent and answer the Parent's questions when seeking Parental Consent.~~
  - (4) ~~A Service Provider cannot use lack of Parental Consent as justification for failing to meet a requirement under these standards unless there is a documented refusal signed by the Parent or documented repeated attempts to obtain Parental Consent.~~
- (b) ~~A Service Provider must upload documentation into CDS demonstrating the delivery and receipt of all Parental Consents in the manner required by these standards.~~

**312. Marketing and Solicitation.**

- (a) ~~A Service Provider can Market its services.~~
- (b) ~~A Service Provider cannot Solicit a child or their family.~~

**313. Third-party Service Agreements.**

- (a) ~~A Service Provider may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards.~~
- (b) ~~A Service Provider must ensure that all third-party vendors and contractors comply with these standards and all other applicable laws, rules, and regulations.~~

**314. System of Payments.**

- (a) ~~A Service Provider must provide any service on the IFSP at no cost to the Parent.~~
- (b) ~~Part C Funds may only be used when there are no other federal, state, local, or private resources available to pay for the Early Intervention Service.~~
- (c)
- (1) ~~A Parent cannot be required to obtain private insurance or enroll in Medicaid (including TEFRA) to receive the services necessary to reach IFSP goals.~~

~~(2)~~

- ~~(i) A Service Provider must have Parental Consent to submit a claim for payment for Early Intervention Services through a child or Parent's Medicaid.~~
- ~~(ii) Prior to obtaining Parental Consent, a Service Provider must provide the Parent the approved written notification regarding the use of the child or Parent's Medicaid and a statement of the no cost protection provisions.~~

~~(3)~~

- ~~(i) A Service Provider must have Parental Consent to submit a claim for payment for Early Intervention Services through a Parent's private insurance.~~
- ~~(ii) Prior to obtaining Parental Consent, a Service Provider must provide the Parent the approved systems of payments information and a statement of the no cost protection provisions.~~

~~(4)~~

- ~~(i) When a Parent's private insurance or Medicaid is used, the Parent is responsible for any applicable private insurance or Medicaid premiums.~~

~~(ii)~~

- ~~(A) Any co-payments and deductibles in connection with Early Intervention Services that are not covered by private insurance, Medicaid, or other funding may be paid with Part C Funds.~~
- ~~(B) A Parent may be reimbursed using Part C Funds for any co-payments and deductibles in connection with Early Intervention Services they paid that are not covered by private insurance, Medicaid, or other funding.~~

~~(5) Part C Funds may be used to prevent a delay in providing Early Intervention Services pending reimbursement from the insurer or other available funding source that has ultimate responsibility for payment.~~

~~(c) A Service Provider must accept the Medicaid payment for an Early Intervention Service as payment in full regardless of amount.~~

~~(d) If a Parent has granted Parental Consent to bill their Medicaid and private insurance, then the Service Provider must first bill and receive a denial from the private insurance before billing Medicaid for an Early Intervention Service.~~

**315. Exiting Children.**

- (a) ~~Upon the exiting of a child from First Connections, the Service Provider must ensure the following are entered or uploaded into CDS:~~
- ~~(1) Finalized required service delivery notes; and~~
  - ~~(2) Final goals and objectives status rating.~~
- (b) ~~Upon the exiting of a child from First Connections, the Service Coordinator must ensure the following are entered or uploaded into CDS:~~
- ~~(1) The reason for exit;~~
  - ~~(2) Final Child Outcomes Summary Rating; and~~
  - ~~(3) A complete Parent family rating unless there is a documented refusal signed by the Parent or documented repeated attempts to obtain.~~
- (c)
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- ~~(1) If a child exits First Connections and does not have a transition conference, then the Service Coordinator must hold an exit conference.~~
  - ~~(2) An exit conference must include the:~~
    - ~~(i) Parent;~~
    - ~~(ii) Service Coordinator;~~
    - ~~(iii) Service Provider; and~~
    - ~~(iv) Any other individual the Parent requests to attend.~~
  - ~~(3) The only justification for failure to hold a transition conference or an exit conference is Family Delay.~~
  - ~~(4) The exit conference may be held in-person or by any other means that are acceptable to the Parent and other participants.~~



**316. Refusal to Serve.**

- ~~(a) If a selected Service Provider is unable or unwilling to serve a child, then the Service Provider must inform the Service Coordinator within two (2) Business Days of being notified in CDS of its selection as a Service Provider by a Parent.~~
- ~~(b) The Service Provider is responsible for documenting that it has made a timely refusal to serve election.~~
- ~~(c)~~
  - ~~(1) A Service Provider is prohibited from selecting the children they do or do not serve based on location of the child (if a teleservices option is available) or the perceived complexity of the child's needs.~~
  - ~~(2) If First Connections reasonably suspects a Service Provider is electing the children they do or do not serve based on a prohibited reason, it is the Service Provider's responsibility to demonstrate that its refusals to serve have been for permitted reasons.~~

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**Subchapter 4. Physical/Service Setting Requirements.**

**401. Natural Environment.**

(a)

- (1) ~~All Early Intervention Services listed on an initial IFSP must be performed in the child's Natural Environment.~~
- (2) ~~All Early Intervention Services listed on any other IFSP must be performed in the child's Natural Environment unless the requirements of Section 401(b) below are documented.~~

(b)

- (1) ~~An Early Intervention Service listed on an IFSP (other than the initial IFSP) can be performed in a setting that is not Natural Environment only when:~~
  - (i) ~~A functional goal of a child has not been achieved in the Natural Environment;~~
  - (ii) ~~There has been a meeting of the full IFSP team to update the IFSP by modifying goals, adjusting intervention strategies, and improving Parent implementation of intervention strategies in an attempt to achieve the functional goals in the Natural Environment setting;~~
  - (iii) ~~There is a summary describing why the functional goals were not achieved after updating the IFSP with modified goals, adjusted intervention strategies, and improved Parent implementation of intervention strategies and implementing Natural Environment practices for at least a ninety (90) Calendar Day period; and~~
  - (iv) 
    - (A) ~~There is a conversion plan for transitioning the Early Intervention Service setting back to Natural Environment once the specific functional goals linked to that Early Intervention Service have been met.~~
    - (B) ~~The conversion plan must list:~~
      - (I) ~~Specific steps;~~
      - (II) ~~Timelines; and~~

~~(III) Individuals involved.~~

~~(C) A conversion plan cannot exceed six (6) months.~~

~~(2) A meeting of the full IFSP team must be held to update the IFSP and implement new strategies if unable to transition any Early Intervention Service setting back to Natural Environment within six (6) months.~~

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**Subchapter 5. Eligibility and the Individual Family Service Plan (IFSP).**

**501. Eligibility Generally.**

(a) Each of the following criteria must be met for a child to participate in First Connections:

- (1) ~~The child is under three (3) years of age.~~
- (2) ~~The child meets at least one of the following:~~
  - (i) ~~A score on both an age-appropriate standardized norm and criterion referenced developmental evaluation that indicates a developmental delay of twenty-five percent (25%) of the child's chronological age or greater in one (1) or more of the five (5) development domains, in accordance with Section 502;~~
  - (ii) ~~A documented developmental diagnosis of a condition that has a high probability of developmental delay, in accordance with Section 503; or~~
  - (iii) ~~It is the informed clinical opinion of the IFSP team that the child qualifies for First Connections, in accordance with Section 504.~~
- (3) ~~The child must be receiving at least one (1) Early Intervention Service.~~
- (4) ~~The child is not enrolled with and receiving Tier II or Tier III services through a Provider-Led Arkansas Shared Savings Entity ("PASSE").~~

(b) Every child referred to First Connections must have an individual acting as Parent.

(c)

- (1)
  - (i) ~~Each child referred to First Connections at least forty-six (46) days prior to their third birthday must have a meeting to determine eligibility.~~
  - (ii) ~~A CMDE must be completed prior to the meeting to determine eligibility.~~
- (2) ~~The meeting to determine eligibility must include, at a minimum:~~
  - (i) ~~The Service Coordinator;~~
  - (ii) ~~The evaluator that conducted the age-appropriate standardized developmental evaluations, or a knowledgeable representative who can also serve as member of the IFSP team at the initial IFSP meeting;~~

- ~~(iii) The Parent; and~~
- ~~(iv) Any other individual the Parent would like to attend.~~

**502. Developmental Delay.**

- ~~(a) A qualifying developmental delay as described in Section 501(a)(2)(i) is demonstrated by a score on both an age appropriate standardized norm and criterion referenced developmental evaluation performed within the past six (6) months that indicates a developmental delay of twenty-five percent (25%) of the child's chronological age or greater in one (1) or more of the five (5) development domains:~~

- ~~(1) Physical;~~
- ~~(2) Cognitive;~~
- ~~(3) Communication;~~
- ~~(4) Social or emotional; and~~
- ~~(5) Adaptive or self-help.~~

~~(b)~~

- ~~(1) The evaluator must follow the instrument's protocol for scoring.~~
- ~~(2) If the developmental evaluation scoring results do not yield a whole number, then the evaluator should round up to the next whole number for any score ending in five tenths (.5) or higher, and round down to the next whole number for any score ending in four tenths (.4) or lower.~~
- ~~(3) The evaluator must convert scoring results to a percentage of chronological age delay.~~
- ~~(4)~~
  - ~~(i) The evaluator must adjust scoring for prematurity on any developmental evaluation administered to a child under eighteen (18) months of age who was born premature.~~
  - ~~(ii) When an adjustment for prematurity is required, the evaluator must use age-appropriate standardized developmental evaluation instruments that are still valid when adjusted for prematurity.~~

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**503. Developmental Diagnosis.**

- (a) ~~A qualifying developmental diagnosis as described in Section 501(a)(2)(ii) is demonstrated by a medical diagnosis of a condition that has a high probability of resulting in a developmental delay, including without limitation:~~
- ~~(1) Down syndrome and other chromosomal abnormalities associated with intellectual disability;~~
  - ~~(2) Congenital syndromes and conditions associated with delays in development such as fetal alcohol syndrome, intra-uterine drug exposure, prenatal rubella, and severe macro and microcephaly;~~
  - ~~(3) Metabolic disorders;~~
  - ~~(4) Intra-cranial hemorrhage;~~
  - ~~(5) Malignancy or congenital anomaly of brain or spinal cord;~~
  - ~~(6) Spina bifida;~~
  - ~~(7) Seizure disorder, asphyxia, respiratory distress syndrome, neurological disorder, and sensory impairments; and~~
  - ~~(8) Maternal Acquired Immune Deficiency Syndrome.~~
- (b) ~~The qualifying developmental diagnosis must be from a licensed physician.~~

**504. Informed Clinical Opinion.**

- (a) ~~The informed clinical opinion of the IFSP team may be used to qualify a child for participation in First Connections.~~
- ~~(1) Informed clinical opinion cannot be used to negate the results of any developmental evaluation used to establish First Connections eligibility.~~
  - ~~(2) Informed clinical opinion may be issued only at the meeting to determine eligibility.~~
- (b) ~~When informed clinical opinion qualifies a child for First Connections, the IFSP must either:~~
- ~~(1) Detail the specific developmental concern that forms the basis of the informed clinical opinion and describe the rationale, contributing factors, and specific results of the CMDE that indicate the child qualifies for First Connections, including~~

~~without limitation why the CMDE evaluations do not clearly reflect the child's functional ability; or~~

- ~~(2) Detail the specific condition and contributing factors that form the basis of the informed clinical opinion and describe how the specific condition affects the child's functional ability such that the child qualifies for First Connections.~~

**505. Evaluations Generally.**

~~(a)~~

- ~~(1) Parental Consent is required prior to scheduling and conducting an evaluation.~~
- ~~(2) Written Notice is required prior to conducting an evaluation.~~
- ~~(3) A Parent or other caregiver must be present for the evaluation.~~

~~(b)~~

- ~~(1) Any instrument and procedures used as part of an evaluation must be performed by an individual qualified to administer the evaluation instrument.~~
- ~~(2) An evaluation must be administered in the child's Natural Environment with the Parent or other caregivers.~~
- ~~(3) All aspects of an evaluation must be communicated in the child's and the family's Native Language.~~

~~(c)~~

~~(1)~~

- ~~(i) Each evaluation performed must have its own Evaluation Report.~~
- ~~(ii) The Evaluation Report must be prepared by the individual who conducted the evaluation.~~
- ~~(iii) The Evaluation Report must be written in a format and using language that is free of jargon and understandable to the general public.~~
- ~~(2) The completed Evaluation Report must be uploaded into CDS and the evaluation results keyed into the child's service record within twenty-one (21) Calendar Days of the date the Service Provider was notified to perform the evaluation, unless there is documentation demonstrating Family Delay.~~

- ~~(3) The Evaluation Report must include, at a minimum:~~
- ~~(i) Child's name, birthdate and Native Language;~~
  - ~~(ii) Name of the participating Parent or other caregiver and their Native Language;~~
  - ~~(iii) Name of the evaluation instrument and date administered;~~
  - ~~(iv) Name and credentials of individual who conducted the evaluation;~~
  - ~~(v) Date and location where the evaluation was administered;~~
  - ~~(vi) Referral source and why the child was referred;~~
  - ~~(vii) Complete child and family social history, which should include:~~
    - ~~(A) All individuals living in same household as child;~~
    - ~~(B) Observation of the child in their Natural Environment engaged in typical child and family routines and activities;~~
    - ~~(C) Information about the child, including without limitation birth and development;~~
    - ~~(D) The family's concerns about the child;~~
    - ~~(E) The child's educational history; and~~
    - ~~(F) The child's medical history, including without limitation a health, vision, and hearing summary.~~
  - ~~(viii) Complete child developmental history, including without limitation the child's interests, abilities, strengths, and developmental needs;~~
  - ~~(ix) Recommendations that support the family in assisting in the child's learning and development, which should include:~~
    - ~~(A) Solutions to family issues, such as activities and routines in which the family would like the child to participate more fully;~~
    - ~~(B) The skills needed for the child to successfully participate in the family identified activity or routine;~~

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- ~~(C) Skills that the family could benefit from learning that would assist the child's development and participation in everyday routines and activities;~~
  - ~~(D) Assistive Technology devices, adaptations of existing equipment, or acquisition of other materials that will support the child's participation in everyday family routines and activities;~~
  - ~~(E) Information that would enhance the family's capacity to assist the child's development and participation in everyday routines and activities; and~~
  - ~~(F) Referrals to people and community resources outside of First Connections that would assist the child and family in expanding opportunities for involvement in community activities.~~
- ~~(x) The signature, date, and credentials of individual who conducted the evaluation.~~

**506. Comprehensive Multi-Disciplinary Developmental Evaluation (CMDE)**

~~(a)~~

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- ~~(1) Every child referred to the First Connections Central Intake Unit at least forty-six (46) Calendar Days prior to their third birthday must receive a complete CMDE.~~
  - ~~(2) A new CMDE must be conducted annually prior to the annual IFSP review to determine the child's continued eligibility for First Connections.~~
- ~~(b) In addition to those requirements contained in Section 505, each CMDE must also:~~
- ~~(1) Be conducted by a multidisciplinary team that consists of one (1) or more individuals qualified or certified in two (2) or more separate disciplines or professions; and~~
  - ~~(2) Involve the administration of:~~
    - ~~(i)~~
      - ~~(A) If it is an initial CMDE, both an age-appropriate standardized norm referenced developmental evaluation instrument AND an age-appropriate criterion referenced developmental evaluation instrument that measure the child's functioning in each of the five (5) developmental areas; or~~

- (B) ~~If it is an annual CMDE to demonstrate the child's continued eligibility, either an age-appropriate standardized norm referenced developmental evaluation instrument OR an age-appropriate criterion referenced developmental evaluation instrument that measure the child's functioning in each of the five (5) developmental areas; and~~

- (ii) ~~A Family Assessment.~~

**507. Initial IFSP Meeting.**

- (a)

- (1)

- (i) ~~The initial IFSP meeting to develop the initial IFSP must be held within forty-five (45) Calendar Days of the referral to the First Connections Central Intake Unit.~~
- (ii) ~~An initial IFSP meeting is not required if the referral was received by the First Connections Central Intake Unit less than forty-six (46) Calendar Days from the child's third birthday.~~

- (2)

- (i) ~~Family Delay is the only justification for failure to hold the initial IFSP meeting within forty-five (45) Calendar Days of receipt of the referral by the First Connections Central Intake Unit.~~
- (ii) ~~The reason for Family Delay must be documented in the child's record.~~
- (iii) ~~The initial IFSP meeting must be held as soon as practicable after the circumstances causing Family Delay no longer exist.~~

- (3) ~~A child must have a completed CMDE prior to the initial IFSP meeting.~~

- (b) ~~The initial IFSP meeting must include, at a minimum:~~

- (1) ~~The initial Service Coordinator;~~
- (2) ~~The evaluator who conducted the age-appropriate standardized developmental evaluation instrument, or a knowledgeable representative;~~
- (3) ~~The Parent; and~~

- ~~(4) Any other individuals that the Parent would like to attend.~~
- ~~(c) An initial IFSP meeting may be held in-person or by any other means acceptable to the Parent and other participants.~~
- ~~(d) (1) Written Notice of the initial IFSP meeting must be provided to the Parent and any other participants.~~
  - ~~(2) It must be documented if the Parent requests the initial IFSP meeting be held prior to receiving Written Notice.~~

**508. Individual Family Service Plan (IFSP).**

- ~~(a) An IFSP must include, at a minimum:~~
  - ~~(1) The child's present level of development stated in months with the percentage of child's chronological age delay in each of the five (5) developmental domains, based on professionally acceptable objective criteria;~~
  - ~~(2) The family's resources, priorities, and concerns related to the development of the child;~~
  - ~~(3) One or more family outcomes stating what the Parent will accomplish;~~
  - ~~(4) A list of at least five (5) specific child functional outcomes, which must be specific, functional, family-driven, linked to child and family activities and routines, and measurable in a range of months not to exceed six (6);~~
  - ~~(5) The specific action step(s) that will be taken by the Parent or other caregivers, within typical child and family activities, to reach each functional outcome;~~
  - ~~(6) The list of Early Intervention Services and accompanying service delivery information, which must include:~~
    - ~~(i) The location for each Early Intervention Service session, which must be in the child's Natural Environment unless there is justification meeting the requirements of Section 401(b);~~
    - ~~(ii) A schedule of service delivery that includes the frequency and intensity of each Early Intervention Service session and whether sessions are on an individual or group basis;~~
    - ~~(iii) The Service Provider;~~

- (iv) ~~The specific date by which the child will be expected to achieve the outcome tied to the Early Intervention Service; and~~
- (v) ~~Identification of the funding source for the Early Intervention Service.~~
- (7) ~~A list of other services that the child or family will need or receive through sources outside of First Connections in order to achieve the child's outcomes;~~
- (8) ~~The CMDE results;~~
- (9) ~~If a child is within ninety (90) Calendar Days of their third birthday, a transition plan is required to be included in the IFSP, unless the child was referred to First Connections Central Intake Unit between ninety (90) and forty-six (46) Calendar Days prior to their third birthday; and~~
- (10) ~~The original date of meeting and signatures of all parties participating in an IFSP meeting.~~
- (b) ~~An IFSP expires at the earlier of either the child's third birthday or after twelve (12) months. The IFSP can only be renewed at an annual IFSP review.~~
- (1) ~~Early Intervention Services must stop when an IFSP expires.~~

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- (i) ~~Parental choice or Family Delay are the only justifications for allowing an IFSP to expire before the child's third birthday.~~
- (ii) ~~The parental choice or Family Delay must be documented in the child's service record.~~
- (iii) ~~If Family Delay is the cause, then the annual IFSP review must be held to renew the IFSP as soon as practicable after the circumstances causing Family Delay no longer exist.~~

### **509. IFSP Reviews.**

- (a) ~~An annual IFSP review must be held at least every twelve (12) months after the initial IFSP meeting.~~
- (b) ~~A bi-annual IFSP review must be held within six (6) months after the initial IFSP meeting and any annual IFSP review.~~

~~(c)~~

- ~~(1) An IFSP review may be requested sooner or more frequently by the Parent.~~
- ~~(2) All annual and bi-annual IFSP reviews must include, at a minimum:~~
  - ~~(i) The Service Coordinator;~~
  - ~~(ii) A Service Provider performing at least one (1) Early Intervention Service for the child;~~
  - ~~(iii) The Parent; and~~
  - ~~(iv) Any other individuals that the Parent would like to attend.~~

~~(d) An IFSP review may be held in-person or by any other means acceptable to the Parent and other participants.~~

~~(e)~~

- ~~(1) Written Notice of an IFSP review must be provided to the Parent and any other participants.~~
- ~~(2) It must be documented if the Parent requests a IFSP review be held prior to receiving Written Notice.~~

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**510. Interim IFSP.**

- ~~(a) A child can begin receiving Early Intervention Services under an interim IFSP prior to completion of the CMDE when:~~
  - ~~(1) There is a documented need for immediate services at the time of referral that cannot wait for the completion of the CMDE; and~~
  - ~~(2) The available documentation demonstrates the child is eligible for First Connections pursuant to Section 501; however, informed clinical opinion cannot be used to demonstrate a child's eligibility for purposes of an interim IFSP.~~
- ~~(b) An interim IFSP meeting should be scheduled as soon as possible after the determination of immediate need and must include the following individuals:~~
  - ~~(1) Parent; and~~
  - ~~(2) Service Coordinator.~~

- ~~(c) The interim IFSP must include the following, at a minimum:~~
- ~~(1) Name of the Service Coordinator;~~
  - ~~(2) One (1) or more functional child outcomes and the action steps that will be taken to reach each functional outcome;~~
  - ~~(3) The date by which the child will be expected to achieve the outcomes tied to the Early Intervention Service~~
  - ~~(4) The Early Intervention Service(s) determined to be needed immediately to meet the outcomes;~~
  - ~~(5) The name of the Service Provider selected by the Parent to provide the Early Intervention Service(s);~~
  - ~~(6) A statement that the Early Intervention Service(s) will be performed in the child's Natural Environment;~~
  - ~~(7) The location for each Early Intervention Service session;~~
  - ~~(8) A schedule of service delivery that includes the frequency and intensity of each Early Intervention Service session and whether sessions are on an individual or group basis; and~~
  - ~~(9) Funding source for the Early Intervention Service(s).~~
- ~~(d) The use of an interim IFSP does not excuse, delay, extend, or toll the forty-five (45) Calendar Day requirement in Section 501(a)(1).~~

**Subchapter 6. Early Intervention Services.**

**601. Services Generally.**

- (a) ~~Early Intervention Services included on the IFSP must begin no later than thirty (30) Calendar Days from the date of Parental Consent.~~
- (b)
  - (1)
    - (i) ~~Parental Consent is required prior to the delivery of any Early Intervention Service.~~
    - (ii) ~~A parent may revoke Parental Consent at any time for any reason.~~
    - (iii) ~~A Parent may decline any Early Intervention Service or any other service or activity at any time without jeopardizing any other Early Intervention Service.~~
    - (iv) ~~A Parent has the right to change the Service Provider for any Early Intervention Service at any time and for any reason with the exception that a Parent cannot switch initial Service Coordinators without the prior consent of First Connections.~~
  - (2) ~~A Parent or other caregiver is required to attend and participate in each session of Early Intervention Services.~~
  - (3) ~~The Service Provider must actively consult with and train the participating Parent or other caregiver on the early intervention strategies described in the child's IFSP when delivering an Early Intervention Service.~~
- (c) ~~No requirement in these standards will be considered completed until the required information is entered or the required documentation uploaded into CDS.~~
- (d)
  - (1) ~~A Service Provider must perform all Early Intervention Services at the scheduled time unless:~~
    - (i) ~~There is justifiable reason, as determined in the reasonable discretion of First Connections staff;~~
    - (ii) ~~There is Family Delay; or~~

- ~~(iii) Alternative arrangements have been made with the Parent in advance.~~
- ~~(2) The Service Provider must document one (1) of the justifications described in Section 601(d)(1) applies.~~
- ~~(e) Any Early Intervention Service documentation required to be entered or uploaded into a child's service record must be completed no later than thirty (30) days after the Early Intervention Service was completed.~~

**602. Service Coordination.**

- ~~(a) Service coordination services must be performed by a Service Provider who is a certified Service Coordinator.~~
- ~~(b)~~
  - ~~(1) A Service Coordinator must have:~~
    - ~~(i)~~
      - ~~(A) A bachelor's (or more advanced) degree in education, social work, or a related field; or~~
      - ~~(B) A high school diploma, GED, or the equivalent, and have completed the First Connections targeted case management training with at least seventy percent (70%) proficiency on the exit exam.~~
    - ~~(ii) Two (2) years' experience working with individuals with developmental disabilities.~~
    - ~~(iii) Completed all First Connections training and professional development requirements.~~
  - ~~(2) A Service Coordinator may only provide service coordination services for one (1) Service Provider organization.~~
  - ~~(3) A Service Coordinator is limited to a maximum service coordination caseload of fifty (50) children without prior approval from First Connections.~~
- ~~(c)~~
  - ~~(1) An initial Service Coordinator is assigned at the time of a child's referral to the First Connections Central Intake Unit.~~
  - ~~(2) An initial Service Coordinator is responsible for:~~



- ~~(i) Making initial contact with the Parent and initiating the child's file in CDS;~~
- ~~(ii) Discussing with the Parent the parental rights and procedural safeguards;~~
- ~~(iii) Obtaining Parental Consent;~~
- ~~(iv) Offering the Parent the choice of evaluators to perform the CMDE; and~~
- ~~(v) Ensuring any required initial IFSP meeting is held within forty-five (45) Calendar Days of the referral to the First Connections Central Intake Unit.~~

~~(d)~~

- ~~(1) The Parent will be offered their choice of an ongoing Service Coordinator at the initial IFSP meeting.~~
- ~~(2) The ongoing Service Coordinator's responsibilities include without limitation:~~
  - ~~(i) Updating the child's service record in CDS as required, including without limitation completing and uploading the Family Assessment;~~
  - ~~(ii) Assisting the Parent in obtaining access to Early Intervention Services and other services identified in the IFSP, including making referrals to providers and scheduling appointments;~~
  - ~~(iii) Coordinating the provision of Early Intervention Services and other services that the child needs or is being provided;~~
  - ~~(iv) Coordinating evaluations and assessments;~~
  - ~~(v) Ensuring that the Early Intervention Services and other services identified in the IFSP are provided in the child's Natural Environment;~~
  - ~~(vi) Facilitating and participating in the development, review, and evaluation of IFSPs;~~
  - ~~(vii) Coordinating, facilitating, and monitoring the delivery of services on the IFSP to ensure that the services are provided in a timely manner;~~
  - ~~(viii) Conducting follow-up activities to determine that appropriate services are being provided;~~
  - ~~(ix) Informing families of their rights and procedural safeguards and explaining the Parent Participation Agreement;~~

- ~~(x) Coordinating the funding sources for services on the IFSP; and~~
- ~~(xi) Facilitating the development of a transition plan to preschool, or, if appropriate, to other services.~~
- ~~(3) If through adoption or otherwise there is a change in the Parent, then the Service Coordinator must close out the child's service record in CDS under the former Parent and open a new service record under the new Parent.~~
- ~~(e) A Service Coordinator must maintain the following documentation in the child's service record for each service coordination service provided:~~
  - ~~(1) The specific activities performed; and~~
  - ~~(2) Recommendations based on the results of the service coordination service, if any.~~

**603. Assistive Technology and Adaptive Equipment and Services.**

- ~~(a) An Assistive Technology or Adaptive Equipment service is any service that directly assists a child or their family in the selection, acquisition, or use of an Assistive Technology or Adaptive Equipment device.~~
- ~~(b) An Assistive Technology or Adaptive Equipment device Service Provider must be enrolled as a Durable Medical Equipment provider with the Arkansas Medicaid Program.~~
- ~~(c) An Assistive Technology or Adaptive Equipment Service Provider is required to:~~
  - ~~(1) Provide instruction and training on how to use Assistive Technology or Adaptive Equipment to the child and Parent or other caregiver, as required;~~
  - ~~(2) Provide ongoing assistance to adjust any Assistive Technology or Adaptive Equipment as needed by child or Parent;~~
  - ~~(3) Assume liability for Assistive Technology or Adaptive Equipment devices and warranties;~~
  - ~~(4) Install, maintain, and replace any defective parts or devices;~~
  - ~~(5) Research and recoup payment from any third-party sources available to the child and their Parent prior to billing First Connections; and~~
  - ~~(6) Submit the purchase or rental price for Assistive Technology or Adaptive Equipment within five (5) Business Days from the date a request is received from the Service Coordinator.~~

- (d) ~~A Service Provider must maintain the following documentation in the child's service record for each Assistive Technology or Adaptive Equipment device order:~~
- ~~(1) The date the order was received;~~
  - ~~(2) The name of the Service Coordinator who placed the order;~~
  - ~~(3) The price quoted for the order;~~
  - ~~(4) The date the quote was submitted to the Service Coordinator;~~
  - ~~(5) A copy of the Medicaid or private insurance denial, if applicable;~~
  - ~~(6) The date of delivery and installation of the Assistive Technology or Adaptive Equipment device;~~
  - ~~(7) A narrative of the instruction and training provided to the child and Parent or other caregiver when installed; and~~
  - ~~(8) The Parent or other caregiver's signature verifying that the delivery, installation, and required instruction and training were completed.~~

**604. ~~Audiology Services~~**

**REPEAL-EO 23-02**

- (a) ~~An audiology service is any service listed in the IFSP that:~~
- ~~(1) Identifies children with auditory impairments using appropriate screening techniques;~~
  - ~~(2) Measures the range, nature, and degree of hearing loss and communication function through audiological evaluation procedures;~~
  - ~~(3) Refers a child for necessary medical, habilitative, or rehabilitative auditory services;~~
  - ~~(4) Is an auditory training, aural rehabilitation, speech reading, listening device orientation or training, or other auditory service;~~
  - ~~(5) Is a hearing loss prevention service; or~~
  - ~~(6) Measures the child's need for amplification, including the selecting, fitting, and dispensing of appropriate listening and vibrotactile devices, and the evaluation of the effectiveness of those devices.~~

- (b) ~~Audiology services must be performed by an individual with a license in good standing from the Arkansas Speech-Language-Hearing Association.~~
- (c) ~~A Service Provider must maintain the following documentation in the child's service record for each audiology service performed:~~
  - (1) ~~The date and beginning and ending time for each audiology service;~~
  - (2) ~~The name(s) of the Parent and any participants in the audiology service;~~
  - (3) ~~The name(s) and credential(s) of the individual providing the audiology service;~~
  - (4) ~~A narrative of the instruction, training, and interaction provided to the participating Parent or other caregiver~~
  - (5) ~~The relationship of the audiology service to the goals and objectives described in the child's IFSP; and~~
  - (6) ~~If applicable, written progress notes on each audiology service session, signed or initialed by the individual providing the audiology service, describing the child's status with respect to their goals and objectives.~~

**605. ~~Family Training, Counseling, and Home Visits.~~**

**REPEALED 23-02**

- (a)
  - (1) ~~Family training, counseling, and home visits are support services provided by social workers, psychologists, and other qualified personnel to train and assist the Parent or other caregiver of a child in any area related to the special needs of the child as determined necessary by the IFSP team.~~
  - (2) ~~Family training, counseling, and home visit services exclude the required family training, counseling, and home visits provided to the child and family in connection with other Early Intervention Services.~~
- (b) ~~A Service Provider must maintain the following documentation in the child's service record for each family training, counseling session, or home visit performed:~~
  - (1) ~~The date and beginning and ending time for each training, session, or visit;~~
  - (2) ~~The names of the Parent and other caregivers that participated in the training, session, or visit;~~

- ~~(3) The name and credentials of the individual conducting the training, session or visit and, if the individual is not credentialed, the experience or other knowledge that qualifies them to conduct the training, session, or visit;~~
- ~~(4) The topics covered and any specific materials or instruction received during the training, session, or visit;~~
- ~~(5) The relationship of the training, session, or visit to the goals and objectives described in the child's IFSP;~~
- ~~(6) If applicable, written progress notes on each training, session, or visit signed or initialed by the individual conducting the training, session, or visit;~~
- ~~(7) If applicable, the receipt for the actual cost of any materials, training, session, or visit;~~
- ~~(8) If applicable, the receipt for the actual cost of any reimbursement submitted by the attending Parent or other caregiver; and~~
- ~~(9) Verification of the Parent or other caregiver participation such as a certificate of completion, sign-in sheet, or signature.~~

**606. Health Services.**

## REPEAL-EO 23-02

- ~~(a) A health service is a service that enables a child to receive or benefit from other Early Intervention Services.~~
  - ~~(1) Health services do not include services that are surgical or purely necessary to control or treat a medical condition.~~
  - ~~(2) Health services do not include medical services such as immunizations or other care that is routinely recommended for all infants and toddlers.~~
- ~~(b) A Service Provider must maintain the following minimum documentation in the child's service record for each health service performed:~~
  - ~~(1) The date and beginning and ending time for each health service;~~
  - ~~(2) The name of the Parent and other caregivers who participated in the health service;~~
  - ~~(3) The name and credentials of the individual providing the health service and, if the individual is not credentialed, the experience or other knowledge that qualifies them to perform the health service;~~

- ~~(4) A narrative of the instruction, training, and interaction provided to the participating Parent or other caregiver;~~
- ~~(5) The other Early Interventions Services on the IFSP that the health services enable the child to receive; and~~
- ~~(6) The relationship of the health service to the goals and objectives described in the child's IFSP.~~

**607. Medical Services.**

- ~~(a) A medical service is a diagnostic service provided by a licensed physician when necessary to assist the IFSP team in developing and implementing the IFSP.~~
- ~~(b) Medical services must be performed by a licensed physician in good standing with the Arkansas State Medical Board.~~
- ~~(c) A Service Provider must maintain the following documentation in the child's service record for each medical service performed:~~
  - ~~(1) A description, date, and beginning and ending time for each medical service;~~
  - ~~(2) The name of the Parent and other caregivers who participated in the medical service;~~
  - ~~(3) The name of the physician providing the medical service and the name of their employer;~~
  - ~~(4) A narrative of the instruction, training, and interaction provided to the participating Parent or other caregiver;~~
  - ~~(5) The relationship of the medical service to the goals and objectives described in the child's IFSP.~~

**608. Nursing Services.**

- ~~(a) Nursing services are assessments, services, and medication or treatment administrations that are necessary to enable a child to benefit from other Early Intervention Services.~~
- ~~(b) Nursing services must be performed by a licensed Registered Nurse in good standing with the Arkansas Board of Nursing.~~
- ~~(c) A Service Provider must maintain the following documentation in the child's service record for each nursing service performed:~~

- ~~(1) The date and beginning and ending time for each nursing service;~~
- ~~(2) The name of the Parent and other caregivers who participated in the nursing service;~~
- ~~(3) The name of the Registered Nurse providing the nursing service and the name of their employer;~~
- ~~(4) A narrative of the instruction, training, and interaction provided to the participating Parent or other caregiver~~
- ~~(5) The other Early Interventions Services on the IFSP that the nursing services enable the child to receive;~~
- ~~(6) The relationship of the nursing services to the goals and objectives described in the child's IFSP.~~

**609. Nutrition Services.**

~~(a)~~

~~(1) Nutrition services assess the nutritional needs of a child, develop and monitor plans to address those nutritional needs and refer a child to appropriate home and community resources to carry out the nutritional goals in their IFSP.~~

~~(2) Nutrition services exclude feeding services provided in connection with speech pathology and occupational therapy services.~~

~~(b) Nutrition services must be performed by an individual that is:~~

~~(1) A Registered Dietician in good standing with the American Dietetic Association;~~

~~(2) A provisionally certified Registered Dietician by the American Dietetic Association; or~~

~~(3) A licensed physician in good standing with the Arkansas State Medical Board.~~

~~(c) A Service Provider must maintain the following documentation in the child's service record for each nutrition service performed:~~

~~(1) The date and beginning and ending time for each nutrition service;~~

~~(2) The name of the Parent and other caregivers who participated in the nutrition service;~~

- ~~(3) The name and credentials of the individual providing the nutrition service and the name of their employer;~~
- ~~(4) A narrative of the instruction, training, and interaction provided to the participating Parent or other caregiver;~~
- ~~(5) The relationship of the nutrition service to the goals and objectives described in the child's IFSP.~~

**610. Occupational Therapy Evaluations and Services.**

~~(a)~~

- ~~(1) Occupational therapy evaluations and services address the functional needs of a child in their adaptive development, adaptive behavior, and play as well as sensory, motor, and postural development.~~
- ~~(2)~~
  - ~~(i) Occupational therapy evaluations must be performed by a licensed Occupational Therapist.~~
  - ~~(ii) Occupational therapy services must be performed by a licensed Occupational Therapist or Occupational Therapy Assistant.~~
- ~~(3) Occupational therapy evaluations and services must be performed by an individual who is a certified Occupational Therapy Service Provider.~~
- ~~(4) Any occupational therapy evaluation instrument administered must be from the First Connections approved list.~~

~~(b) Each Occupational Therapist and Occupational Therapy Assistant must:~~

- ~~(1) Hold an Occupational Therapy or Occupational Therapy Assistant license in good standing with the Arkansas State Medical Board;~~
- ~~(2) Complete all First Connections training requirements; and~~
- ~~(3) Enroll with the Arkansas Medicaid Program.~~

~~(c)~~

- ~~(1) An Occupational Therapy Assistant must be supervised by an Occupational Therapist.~~



- ~~(2) An Occupational Therapy Assistant must have their supervising Occupational Therapist's certification uploaded into CDS.~~
- ~~(d) An Occupational Therapist may supervise a maximum of three (3) Occupational Therapy Assistants at any time.~~
- ~~(1) An Occupational Therapist must work at the same Service Provider organization as any Occupational Therapy Assistant they are supervising.~~
- ~~(2) An Occupational Therapist must upload into CDS the certification of any Occupational Therapy Assistant they are supervising.~~
- ~~(3)~~
- ~~(i) An Occupational Therapist must complete a quarterly written evaluation on each Occupational Therapy Assistant they are supervising, which must include a complete evaluation of the Occupational Therapy Assistant's performance based on the supervising Occupational Therapist's in-person observation of a session with a child and Parent.~~
- ~~(ii) One (1) of the four (4) quarterly reports during each twelve (12) month period must be an annual written evaluation.~~
- ~~(e) Each completed occupational therapy evaluation and report must be uploaded into CDS. See Section 505.~~
- ~~(f) A Service Provider must maintain the following documentation in the child's service record for each occupational therapy service session:~~
- ~~(1) The date and beginning and ending time for each occupational therapy service session;~~
- ~~(2) The name of the Parent and other caregivers who participated in the occupational therapy service session;~~
- ~~(3) A description of the consulting and training provided to the participating Parent or other caregivers on the early intervention strategies described in the child's IFSP;~~
- ~~(4) The name and credentials of the Occupational Therapist (if any) and Occupational Therapy Assistant providing or observing the occupational therapy services each session;~~
- ~~(5) The relationship of each occupational therapy session to the goals and objectives described in the child's IFSP; and~~

- ~~(6) Written progress notes on each occupational therapy service session describing the child's status with respect to their goals and objectives, which must be signed or initialed by the Occupational Therapist or Occupational Therapy Assistant providing the occupational therapy services.~~

**611. Physical Therapy Evaluations and Services.**

~~(a)~~

- ~~(1) Physical therapy evaluations and services address the sensory motor function of a child through enhancement of their musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective adaptation to their Natural Environment.~~

~~(2)~~

- ~~(i) Physical therapy evaluations must be performed by a licensed Physical Therapist.~~
- ~~(ii) Physical therapy services must be performed by a licensed Physical Therapist or Physical Therapy Assistant.~~

- ~~(3) Physical therapy services must be performed by an individual who is a certified Physical Therapy Service Provider.~~

- ~~(4) Any physical therapy evaluation instrument administered must be from the First Connections approved list.~~

~~(b) Each Physical Therapist and Physical Therapy Assistant must:~~

- ~~(1) Hold a Physical Therapy or Physical Therapy Assistant license in good standing with the Arkansas State Medical Board;~~
- ~~(2) Complete all First Connections training requirements; and~~
- ~~(3) Enroll with the Arkansas Medicaid Program.~~

~~(c)~~

- ~~(1) A Physical Therapy Assistant must be supervised by a Physical Therapist.~~
- ~~(2) A Physical Therapy Assistant must have their supervising Physical Therapist's certification uploaded into CDS.~~

- ~~(d) A Physical Therapist may supervise a maximum of three (3) Physical Therapy Assistants at any time.~~
- ~~(1) A Physical Therapist must work at the same Service Provider organization as any Physical Therapy Assistant he or she is supervising.~~
- ~~(2) A Physical Therapist must upload into CDS the certification of any Physical Therapy Assistant they are supervising.~~
- ~~(3)~~
- ~~(i) A Physical Therapist must complete a quarterly written evaluation on each Physical Therapy Assistant they are supervising, which must include a complete evaluation of the Physical Therapy Assistant's performance based on the supervising Physical Therapist's in-person observation of a session with a child and Parent.~~
- ~~(ii) One (1) of the four (4) quarterly reports during each twelve (12) month period must be an annual written evaluation.~~
- ~~(e) Each completed physical therapy evaluation and report must be uploaded into CDS. See Section 505.~~
- ~~(f) A Service Provider must maintain the following documentation for each physical therapy service session:~~
- ~~(1) The date and beginning and ending time for each physical therapy service session;~~
- ~~(2) The name of the Parent and other caregivers who participated in the physical therapy service session;~~
- ~~(3) A description of the consulting and training provided to the participating Parent or other caregivers on the early intervention strategies described in the child's IFSP;~~
- ~~(4) The name and credentials of the Physical Therapist (if any) and Physical Therapy Assistant providing or observing the physical therapy services each session;~~
- ~~(5) The relationship of physical therapy session to the goals and objectives described in the child's IFSP; and~~
- ~~(6) Written progress notes on each physical therapy service session describing the child's status with respect to their goals and objectives, which must be signed or initialed by the Physical Therapist or Physical Therapy Assistant providing the physical therapy services.~~

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**612. Psychological Services.**

- (a) ~~Psychological services support parents and other caregivers in helping a child use appropriate behavior to meet needs by using evidence-based practices to improve the quality of the Parent-child relationship through changing Parent-child interaction patterns for children with behavioral and emotional disorders. Psychological services include consultation on child development as well as Parent training and education programs, including without limitation Parent-Child Interaction Therapy and coaching Parents in the use of therapeutic parenting practices proven to decrease problematic behaviors.~~
- (b) ~~A Service Provider of psychological services must meet one (1) of the following:~~
  - (1) ~~A licensed Psychologist in good standing with the Arkansas Psychology Board; or~~
  - (2) ~~A licensed Psychological Examiner in good standing with the Arkansas Psychology Board.~~
- (c) ~~A Service Provider must maintain the following minimum documentation for each psychological service performed:~~
  - (1) ~~The date and beginning and ending time for each psychological service;~~
  - (2) ~~The name of the Parent and other caregivers who participated in the psychological service;~~
  - (3) ~~The name and credentials of the individual providing the psychological service and the name of their employer;~~
  - (4) ~~A narrative of the instruction, training, and interaction provided to the participating Parent or other caregiver;~~
  - (5) ~~The relationship of the psychological service to determining the child's eligibility or the goals and objectives described in the child's IFSP.~~

**613. Sign Language and Cued Language Services.**

- (a) ~~Sign language and cued language services include auditory and oral language and transliteration services, as well as formal training and direct support to families learning sign or cued language.~~
- (b) ~~A Service Provider must maintain the following documentation for each sign language or cued language service performed:~~
  - (1) ~~The date and beginning and ending time for each sign language or cued language service;~~

- ~~(2) The name of the Parent and other caregivers who participated in the sign language or cued language service;~~
- ~~(3) A description of the consulting and training provided to the participating Parent or other caregivers on the early intervention strategies described in the child's IFSP;~~
- ~~(4) The name and credentials of the individual providing the sign language or cued language service and, if the individual is not credentialed, the experience or other knowledge that qualifies them to perform the sign language or cued language service; and~~
- ~~(5) The relationship of the sign language or cued language service to the goals and objectives described in the child's IFSP.~~

**614. Social Work Services.**

~~(a)~~

- ~~(1) Social work services evaluate a child's living conditions and patterns of family interaction, conduct social and emotional assessments of a child within the family context, and coordinate community resources and services to determine eligibility and enable a child to receive the maximum benefit from Early Intervention Services.~~

- ~~(2) Social work services do not include any activities that are able to be performed by the Service Coordinator.~~

~~(b) Social work services must be performed by a Licensed Clinical Social Worker in good standing with the Arkansas Board of Social Work.~~

~~(c) A Service Provider must maintain the following documentation for each social work service performed:~~

- ~~(1) The date and beginning and ending time for each social work service;~~
- ~~(2) The name of the Parent and other caregivers who participated in the social work service;~~
- ~~(3) A description of the consulting and training provided to the participating Parent or other caregivers on the early intervention strategies described in the child's IFSP;~~
- ~~(4) The name and credentials of the individual providing the social work service and the name of their employer; and~~

- ~~(5) The relationship of the social work service to determining the child's eligibility or the goals and objectives described in the child's IFSP.~~

**615. Developmental Therapy Evaluations and Services.**

~~(a)~~

- ~~(1) Developmental therapy evaluations and services provide specialized instruction to the child and Parent or other caregiver to promote the child's acquisition of skills in all developmental areas, daily living activities, and social interactions.~~

~~(2)~~

- ~~(i) Developmental therapy evaluations must be performed by an individual who is a certified Developmental Therapist Service Provider.~~
- ~~(ii) Developmental therapy services must be performed by an individual who is a certified Developmental Therapist or Developmental Therapy Assistant Service Provider.~~

~~(b)~~

~~(1)~~ **REPEAL-EO 23-02**

- ~~(i) A Developmental Therapist must have one (1) of the following:~~
- ~~(A) Early Childhood Special Education certification;~~
- ~~(B) A Masters of Developmental Therapy or Early Intervention; or~~
- ~~(C) An Alternate Learning Plan approved by and filed with the Arkansas Department of Education.~~
- ~~(ii) A Developmental Therapist must have completed all First Connections training, professional development, and Developmental Therapy Assistant in-person observation requirements.~~
- ~~(iii) A Developmental Therapist must be enrolled with the Arkansas Medicaid Program as both a DDS non-Medicaid Service Provider (type 76) and also as a First Connections Medicaid Service Provider (type 86).~~

~~(2)~~

- ~~(i) A Developmental Therapy Assistant must have one (1) of the following:~~

- ~~(A) Associates Degree in Early Childhood Development or a related field;~~
  - ~~(B) Two (2) years of documented experience working with children under five (5) years of age; or~~
  - ~~(C) Two (2) years of documented experience working with children with disabilities.~~
- ~~(ii) A Developmental Therapy Assistant must be supervised by a certified Developmental Therapist Service Provider and have the supervising Developmental Therapist's certification uploaded into CDS.~~
- ~~(iii) A Developmental Therapy Assistant must have completed all First Connections training and professional development requirements.~~
- ~~(iv) A Developmental Therapy Assistant must be enrolled with the Arkansas Medicaid Program as both a DDS non-Medicaid Service Provider (type 76) and also as a First Connections Medicaid Service Provider (type 86).~~
- ~~(c) A Developmental Therapist may supervise a maximum of three (3) Developmental Therapy Assistants at any time.~~
  - ~~(1) A Developmental Therapist must work with the same Service Provider organization as any Developmental Therapy Assistant they are supervising.~~
  - ~~(2) A Developmental Therapist must upload into CDS the certification of any Developmental Therapy Assistant they are supervising.~~
- ~~(d) Each completed developmental therapy evaluation and report must be uploaded into CDS. See Section 505.~~
- ~~(e) A Service Provider must maintain the following documentation for each development therapy service session:~~
  - ~~(1) The date and beginning and ending time for each developmental therapy session;~~
  - ~~(2) The name of the Parent and other caregivers who participated in the developmental therapy session;~~
  - ~~(3) A description of the consulting and training provided to the participating Parent or other caregivers on the early intervention strategies described in the child's IFSP;~~
  - ~~(4) The name and credentials of the Developmental Therapist (if any) and Developmental Therapy Assistant providing or observing the developmental therapy services each session;~~

- ~~(5) The relationship of each developmental therapy session to the goals and objectives described in the child's IFSP; and~~
- ~~(6) Written progress notes on each developmental therapy session describing the child's status with respect to his or her goals and objectives, which must be signed or initialed by the Developmental Therapist or Developmental Therapy Assistant providing the developmental therapy services.~~

**616. Speech-Language Pathology Evaluations and Services.**

~~(a)~~

- ~~(1) Speech-language pathology evaluations and services identify a child's communication or language disorders and delays in development of communication skills and any service for the habilitation, rehabilitation, or prevention of a child's communication or language disorder or delays in the development of a child's communication skills.~~

~~(2)~~

- ~~(i) Speech-Language Pathology evaluations must be performed by a licensed Speech-Language Pathologist.~~
- ~~(ii) Speech-Language Pathology services must be performed by a licensed Speech-Language Pathologist or Speech-Language Pathology Assistant.~~

- ~~(3) Speech-Language Pathology services can only be performed by an individual who is a certified Speech-Language Pathology Service Provider.~~

~~(b) Each Speech-Language Pathologist and Speech-Language Pathology Assistant must:~~

- ~~(1) Hold a Speech-Language Pathologist or Speech-Language Pathology Assistant license in good standing with the Arkansas State Medical Board;~~
- ~~(2) Complete all First Connections training requirements; and~~
- ~~(3) Enroll with the Arkansas Medicaid Program.~~

~~(c)~~

- ~~(1) A Speech-Language Pathology Assistant must be supervised by a Speech-Language Pathologist.~~



- ~~(2) A Speech-Language Pathology Assistant must have their supervising Speech-Language Pathologist's certification uploaded into CDS.~~
- ~~(d) A Speech-Language Pathologist may supervise a maximum of three (3) Speech-Language Pathology Assistants at any time.~~
- ~~(1) A Speech-Language Pathologist must work at the same Service Provider organization as any Speech-Language Pathology Assistant they are supervising.~~
- ~~(2) A Speech-Language Pathologist must upload into CDS the certification of any Speech-Language Pathology Assistant he or she is supervising.~~
- ~~(3) A Speech-Language Pathologist must upload into CDS any in-person observation documentation related to a Speech-Language Pathology Assistant they are supervising.~~
- ~~(e) Each completed speech-language pathology evaluation and report must be uploaded into CDS. See Section 505.~~
- ~~(f) A Service Provider must maintain the following documentation for each speech-language pathology service session:~~
- ~~(1) The date and beginning and ending time for each speech-language pathology session;~~
- ~~(2) The name of the Parent and other caregivers who participated in the speech-language pathology session;~~
- ~~(3) A description of the consulting and training provided to the participating Parent or other caregivers on the early intervention strategies described in the child's IFSP;~~
- ~~(4) The name and credentials of the Speech-Language Pathologist (if any) and Speech-Language Pathology Assistant providing or observing the speech-language pathology services each session;~~
- ~~(5) The relationship of speech-language pathology session to the goals and objectives described in the child's IFSP; and~~
- ~~(6) Written progress notes on each speech-language pathology session describing the child's status with respect to their goals and objectives, which is signed or initialed by the Speech-Language Pathologist or Speech-Language Pathology Assistant providing the speech-language pathology services.~~

**617. Transportation Services.**

- ~~(a) A transportation service involves covering the costs of travel necessary to enable a child and their Parent or other caregiver to receive an Early Intervention Service.~~

- (b) ~~A Service Provider must maintain the following documentation for each transportation service:~~
- ~~(1) The specific Early Intervention Service, date, location, and beginning and ending time for the Early Intervention Service session for which the transportation service was necessary;~~
  - ~~(2) The name of the Parent and other caregivers involved in a transportation service;~~
  - ~~(3) If applicable, the name of the vendor that provided the transportation service;~~
  - ~~(4) If applicable, the itemized receipt for any transportation service reimbursement submitted by the Parent or other caregiver; and~~
  - ~~(5) If applicable, signed verification by Parent or other caregiver of the amount of the transportation service payment.~~

**618. Vision Services.**

- (a) ~~Vision services involve the evaluation and assessment of a child's visual functioning.~~
- (b) ~~Vision services must be performed by an individual that is one (1) of the following:~~
- ~~(1) A licensed Ophthalmologist in good standing with the Arkansas Board of Optometry or the Arkansas Board of Ophthalmology; or~~
  - ~~(2) A certified Orientation Mobility Specialist.~~
- (c) ~~A Service Provider must maintain the following documentation for each vision service performed:~~
- ~~(1) The date and beginning and ending time for each vision service;~~
  - ~~(2) The name of the Parent and other caregivers who participated in the vision service;~~
  - ~~(3) The name and credentials of the individual providing the vision service and the name of their employer;~~
  - ~~(4) A narrative of the instruction, training, and interaction provided to the participating Parent or other caregiver;~~
  - ~~(5) The completed evaluation or assessment and accompanying report (See Section 505); and~~

- ~~(6) The relationship of the vision service to the goals and objectives described in the child's IFSP.~~

**619. Specialized Evaluation Services.**

~~(a)~~

- ~~(1) Specialized evaluation services relate to the performance of evaluations and assessments necessary for diagnostic purposes to assist the IFSP team in developing and implementing the IFSP.~~
- ~~(2) Specialized evaluation services do not include evaluations related to occupational therapy, developmental therapy, speech language pathology, physical therapy, or vision services.~~

~~(b) A Service Provider must maintain the following documentation for each specialized evaluation conducted:~~

- ~~(1) The date and beginning and ending time for each specialized evaluation;~~
- ~~(2) The name of the Parent and other caregivers who participated in the specialized evaluation;~~
- ~~(3) The name and credentials of the individual conducting the specialized evaluation and, if the individual is not credentialed, the experience or other knowledge that qualifies them to conduct the specialized evaluation; and~~
- ~~(4) The diagnostic purpose of the specialized evaluation and how it will assist the IFSP team in development and implementing the child's IFSP.~~

**620. Parent Education Services.**

~~(a) Parent education services are third-party support groups, conferences, and workshops that instruct a Parent or caregiver on how to enhance the child's development and enable the child to benefit from other Early Intervention Services.~~

~~(b) A Service Provider must maintain the following documentation for each Parent education service:~~

- ~~(1) The date and beginning and ending time for each support group, conference, or workshop;~~
- ~~(2) The name of the Parent and other caregivers who participated in the support group, conference, or workshop;~~

- ~~(3) The name and credentials of the individual or organization conducting the support group, conference, or workshop and, if the individual or organization is not credentialed, the experience or other knowledge that qualifies them to conduct the support group, conference, or workshop;~~
- ~~(4) The topics covered, and any specific materials or instruction received during the support group, conference, or workshop;~~
- ~~(5) The relationship of the support group, conference, or workshop to the goals and objectives described in the child's IFSP;~~
- ~~(6) If applicable, the registration form and itemized receipt for the actual cost of any materials, support group, conference, or workshop;~~
- ~~(7) If applicable, the itemized receipts for the actual cost of any reimbursement submitted by the Parent or other caregiver; and~~
- ~~(8) Verification of Parent or other caregiver participation and attendance, such as a certificate of completion, or sign-in sheet.~~

**~~621. Teleservices.~~**

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- ~~(a) Teleservices are one (1) of the following Early Interventions Services conducted via a telecommunication device in accordance with the requirements of this Section 621:~~
  - ~~(1) Developmental Therapy Services;~~
  - ~~(2) Occupational Therapy Services;~~
  - ~~(3) Physical Therapy Services;~~
  - ~~(4) Speech-Language Pathology Services; and~~
  - ~~(5) Sign Language and Cued Language Services.~~
- ~~(b) Developmental therapy, occupational therapy, physical therapy, and speech-language pathology evaluations must be performed through traditional in-person methods.~~
- ~~(c) The child service record must include the following documentation:~~
  - ~~(1) A detailed assessment of the child that determines they are an appropriate candidate for teleservices based on the child's age and functioning level;~~

- ~~(2) A detailed explanation of all on-site assistance or participation that will be used to ensure:~~
- ~~(i) The effectiveness of telemedicine service delivery is equivalent to face-to-face service delivery; and~~
  - ~~(ii) Telemedicine service delivery will address the unique needs of the child; and~~
- ~~(3) A plan and estimated timeline for returning service delivery to in-person if a client is not progressing towards goals and outcomes through telemedicine service delivery.~~
- ~~(d) The Service Provider is responsible for ensuring teleservices are the equivalent to in-person, face-to-face service delivery.~~
- ~~(1) The Service Provider is responsible for ensuring the calibration of all clinical instruments and the proper functioning of all telecommunications equipment.~~
  - ~~(2) All teleservices must be delivered in a synchronous manner, meaning through real-time interaction between the practitioner and the child and Parent or other caregiver via a telecommunication link.~~
  - ~~(3) A store and forward telecommunication method of service delivery where either the child and Parent or other caregiver or the practitioner records and stores data in advance for the other party to review at a later time is prohibited.~~
- ~~(e) Teleservices are subject to all the same limits and requirements as in-person, face-to-face delivery of the Early Intervention Service.~~

## **Subchapter 7. Incident and Accident Reporting.**

### **701. Incidents to be Reported.**

- (a) ~~A Service Provider must report all alleged, suspected, observed, or reported occurrences of any of the following events:~~
- ~~(1) Death of a child;~~
  - ~~(2) Serious injury to a child;~~
  - ~~(3) Child maltreatment;~~
  - ~~(4) Any event where an individual threatens or strikes a child;~~
  - ~~(5) Unauthorized use of restrictive intervention on a child, including seclusion or physical, chemical, or mechanical restraint;~~
  - ~~(6) Events involving a risk of death, serious physical or psychological injury, or serious illness to a child; and~~
  - ~~(7) Any act or omission that jeopardizes the health, safety, or quality of life of a child.~~
- (b) ~~Any Service Provider may report any other occurrences impacting the health, safety, or quality of life of a child.~~

### **702. Reporting Requirements.**

- (a) ~~A Service Provider must:~~
- ~~(1) Submit all reports of the following events within one (1) hour of the event:~~
    - ~~(i) Death of a child;~~
    - ~~(ii) Serious injury to a child; or~~
    - ~~(iii) Any incident that a Service Provider should reasonably know might be of interest to the public or the media.~~
  - ~~(2) Submit reports of all other incidents within forty-eight (48) hours of the event or the first Business Day if the accident occurs on weekend or holiday that prevents reporting within forty-eight (48) hours.~~
- (b) ~~A Service Provider must enter the incident report in the child's service record in CDS.~~

- ~~(c) Reporting under these standards does not relieve a Service Provider of complying with any other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.~~

**~~703. Notification to Guardians and Legal Custodians.~~**

- ~~(a) If not present at the time of the incident, a Service Provider must notify the guardian or legal custodian of a child of any reportable incident involving a child, as well as any injury or accident involving a child, even if the injury or accident is not otherwise required to be reported in this Section.~~
- ~~(b) A Service Provider should maintain documentation evidencing notification required in subdivision (a).~~

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## **Subchapter 8. Enforcement.**

### **801. Monitoring.**

(a)

(1) ~~DDS shall monitor a Service Provider to ensure compliance with these standards.~~

(2)

(i) ~~A Service Provider must cooperate with all monitoring and other regulatory activities performed or requested by DDS.~~

(ii) ~~Cooperation required includes without limitation cooperation with respect to investigations, surveys, site visits, reviews, and other regulatory actions taken by DDS to monitor, enforce, or take other regulatory action on behalf of DDS.~~

(b) ~~Monitoring includes without limitation:~~

(1) ~~CDS reviews, on-site surveys, and other visits including without limitation annual reviews and Parent surveys;~~

(2) ~~CDS and on-site child service record reviews;~~

(3) ~~Written requests for documentation and records required under these standards;~~

(4) ~~Written requests for information; and~~

(5) ~~Investigations related to complaints received.~~

(c) ~~DDS may contract with a third-party to monitor, enforce, or take other regulatory action on behalf of DDS.~~

### **802. Written Notice of Enforcement Remedy.**

~~DDS shall provide Written Notice of all enforcement remedies taken against the Service Provider to the manager appointed pursuant to Section 301.~~

### **803. Remedies.**

(a)

(1) ~~DDS shall not impose any enforcement remedies unless:~~



- ~~(i) The Service Provider is provided Written Notice and appeal rights pursuant to this Section 802 and Subchapter 10; or~~
    - ~~(ii) DDS determines that public health, safety, or welfare imperatively requires emergency action;~~
  - ~~(2) If DDS imposes an enforcement remedy as an emergency action before the Service Provider has notice and appeal rights pursuant to subdivision (a)(1), DDS shall:~~
    - ~~(i) Provide immediate Written Notice to the Service Provider of the enforcement action; and~~
    - ~~(ii) Provide the Service Provider with its appeal rights pursuant to Subchapter 10.~~
- ~~(b) If a Service Provider fails to comply with the standards, DDS may impose any of the following enforcement remedies for the Service Provider's failure to comply with the standards:~~
  - ~~(1) Plan of correction;~~
  - ~~(2) Directed in-service training plan;~~
  - ~~(3) Removal as choice of provider;~~
  - ~~(4) Transfer;~~
  - ~~(5) Monetary penalties;~~
  - ~~(6) Suspension of Service Provider certification;~~
  - ~~(7) Revocation of Service Provider certification;~~
  - ~~(8) Recoupment; and~~
  - ~~(9) Any remedy authorized by law or rule including, without limitation section 25-15-217 of the Arkansas Code.~~
- ~~(c) DDS shall determine the imposition and severity of these enforcement remedies on a case-by-case basis using the following factors:~~
  - ~~(1) Frequency of non-compliance;~~
  - ~~(2) Number of non-compliance issues;~~

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- ~~(3) Impact of non-compliance on a child's health, safety, or well-being;~~
  - ~~(4) Responsiveness in correcting non-compliance;~~
  - ~~(5) Repeated non-compliance in the same or similar areas;~~
  - ~~(6) Non-compliance with previously or currently imposed enforcement remedies;~~
  - ~~(7) Non-compliance involving intentional fraud or dishonesty; and~~
  - ~~(8) Non-compliance involving violation of any law, rule, or other legal requirement.~~
- ~~(d)~~
- ~~(1) DDS shall report any noncompliance, action, or inaction by the Service Provider to appropriate agencies for investigation and further action.~~
  - ~~(2) DDS shall refer non-compliance involving Medicaid billing requirements to the Division of Medical Services and the Arkansas Attorney General's Medicaid Fraud Control Unit.~~
- ~~(e) These enforcement remedies are not mutually exclusive, and DDS may apply multiple enforcement remedies simultaneously for a failure to comply with these standards.~~
- ~~(f) The failure to comply with an enforcement remedy imposed by DDS constitutes a separate violation of these standards.~~

**804. Removal as Choice of Provider.**

- ~~(a) DDS may cease to offer the Service Provider as a choice for one (1) or more Early Intervention Services.~~
- ~~(b) A Service Provider that is no longer offered as a choice of Service Provider may continue to provide Early Intervention Services to children they are already serving.~~

**805. Transfer.**

- ~~(a) DDS may require a Service Provider to transfer a child to another Service Provider if DDS finds that the Service Provider cannot or is not adequately providing Early Intervention Services to the child.~~
- ~~(b) If directed by DDS, a Service Provider must continue providing services until the child is transferred to their new Service Provider of choice.~~

- (c) ~~A transfer of a child may be permanent or for a specific term, depending on the circumstances.~~

**806. Monetary Penalties.**

- (a) ~~DDS may impose a civil monetary penalty on a Service Provider, not to exceed five hundred dollars (\$500) for each violation of the standards.~~

(b)

- (1) ~~DDS may file suit to collect a civil monetary penalty assessed pursuant to these standards if the Service Provider does not pay the civil monetary penalty within sixty (60) days from the date DDS provides Written Notice to the Service Provider of the imposition of the civil monetary penalty.~~
- (2) ~~DDS may file suit in Pulaski County Circuit Court or the circuit court of any county in which the Service Provider is located.~~

**807. Suspension and Revocation of Certification.**

(a)

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- (1) ~~DDS may temporarily suspend a Service Provider's certification if the Service Provider fails to comply with these standards.~~
- (2) ~~If a Service Provider's certification is suspended, the Service Provider must immediately stop providing Early Intervention Services until DDS reinstates its certification.~~

(b)

- (1) ~~DDS may permanently revoke a Service Provider's certification if the Service Provider fails to comply with these standards.~~
- (2) ~~If a Service Provider's certification is revoked, the Service Provider must immediately stop providing Early Intervention Services.~~

**808. Recoupment.**

- (a) ~~DDS may recoup any Part C Fund payments made to a Service Provider as reimbursement for Early Intervention Services if it is determined that the Service Provider failed to comply with these standards.~~

- (b) ~~The Arkansas Department of Human Services, Division of Medical Services may recoup any Medicaid payments made to a Service Provider for Early Intervention Services if it is determined that the Service Provider failed to comply with these standards or Medicaid requirements.~~

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**~~Subchapter 9. Closure.~~**

**~~901. Closure.~~**

~~(a)~~

- ~~(1) A Service Provider certification ends if a Service Provider permanently closes (whether voluntarily or involuntarily) and is effective the date of the permanent closure as determined by DDS.~~
- ~~(2) A Service Provider that intends to or does permanently close (whether voluntarily or involuntarily) must:~~
  - ~~(i) Provide Written Notice of the closure to First Connections at least thirty (30) Calendar Days prior to effective date of the proposed closure; and~~
  - ~~(ii) Arrange for the storage of child service records to satisfy the requirements of Section 304.~~

~~(b)~~

- ~~(1) A Service Provider that intends to voluntarily close temporarily may request to maintain its Service Provider certification for up to one (1) year from the date of the request.~~
- ~~(2) A Service Provider must still comply with subdivision (a)(2)'s requirements for notice and storage of child service records.~~
- ~~(3)~~
  - ~~(i) DDS may grant a temporary closure if the Service Provider demonstrates that it is reasonably likely to reopen after the temporary closure.~~
  - ~~(ii) DDS shall direct that the Service Provider permanently close if the Service Provider fails to demonstrate that it is reasonably likely to reopen after the temporary closure.~~
- ~~(4)~~
  - ~~(i) DDS may end a Service Provider's temporary closure if the Service Provider demonstrates that it is in full compliance with these standards.~~
  - ~~(ii) DDS shall end a Service Provider's temporary closure and direct that the Service Provider permanently close if the Service Provider fails to become fully compliant with these standards within one (1) year from the date of the request.~~

**Subchapter 10. Appeals.**

**1001. Reconsideration of Adverse Regulatory Actions.**

(a)

- (1) ~~A Service Provider may ask for reconsideration of any adverse regulatory action taken by DDS by submitting a written request for reconsideration to: Division of Disabilities Services, Attn: DDS Director, P.O. Box 1437, Slot N501, Little Rock, Arkansas 72203-1437.~~
- (2) ~~The written request for reconsideration of an adverse regulatory action taken by DDS must be submitted by the Service Provider and received by DDS within thirty (30) Calendar Days of the date the Service Provider received Written Notice of the adverse regulatory action.~~
- (3) ~~The written request for reconsideration of an adverse regulatory action taken by DDS must include without limitation the specific adverse regulatory action taken, the date of the adverse regulatory action, the name of the Service Provider against whom the adverse regulatory action was taken, the address and contact information for the Service Provider against whom the adverse regulatory action was taken, and the legal and factual basis for reconsideration of the adverse regulatory action.~~

(b)

- (1) ~~DDS shall review each timely received written request for reconsideration and determine whether to affirm or reverse the adverse regulatory action taken based on these standards.~~
- (2) ~~DDS may request, at its discretion, additional information as needed to review the adverse regulatory action and determine whether the adverse regulatory action taken should be affirmed or reversed based on these standards.~~

(c)

- (1) ~~DDS shall issue in writing its determination on reconsideration within thirty (30) days of receiving the written request for reconsideration or within thirty (30) days of receiving all information requested by DDS under subdivision (b)(2), whichever is later.~~
- (2) ~~DDS shall issue its determination to the Service Provider using the address and contact information provided in the request for reconsideration.~~

- (d) ~~DDS may also unilaterally decide to reconsider any adverse regulatory action any time it determines, in its sole discretion, that an adverse regulatory action was inappropriate.~~

**~~1002. Appeal of Regulatory Actions.~~**

- ~~(a) A Service Provider may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings (OAH) except for appeals related to the payment for Medicaid claims and services governed by the Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 to 1718, which shall be governed by that Act.~~
- ~~(b) OAH shall conduct administrative appeals of adverse regulatory actions pursuant to DHS Policy 1098 and other applicable laws and rules.~~
- ~~(c) A Service Provider may appeal any adverse regulatory action or other adverse agency action to circuit court as allowed by the Administrative Procedures Act, Ark. Code Ann. § 25-15-201 to 220.~~

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**FINANCIAL IMPACT STATEMENT**

**PLEASE ANSWER ALL QUESTIONS COMPLETELY.**

**DEPARTMENT** Department of Human Services

**BOARD/COMMISSION** Division of Developmental Disabilities Services

**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** Autism Services for Children on Medicaid

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 0  
 Federal Funds 0  
 Cash Funds \_\_\_\_\_  
 Special Revenue \_\_\_\_\_  
 Other (Identify) \_\_\_\_\_

Total \$ 0.00

**Next Fiscal Year**

General Revenue 0  
 Federal Funds 0  
 Cash Funds \_\_\_\_\_  
 Special Revenue \_\_\_\_\_  
 Other (Identify) \_\_\_\_\_

Total \$ 0.00

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

**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 \_\_\_\_\_

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.