



Division of Developmental Disabilities Services
P.O. Box 1437, Slot N501, Little Rock, AR 72203-1437
P: 501.682.8665 F: 501.682.8380 TDD: 501.682.1332

MEMORANDUM

TO: Interested Persons and Providers

FROM: Thomas Tarpley, Director, Division of Developmental Disabilities Services

DATE: August 21, 2024

SUBJ: Autism Services for Children on Medicaid

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments no later than September 21, 2024 .

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: [Proposed Rules & Public Notices](#).

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, 20-77-124, and 25-10-129. The proposed effective date of the rule is January 1, 2025.

The Director of the Division of Developmental Disabilities Services (DDS) promulgates the renewal of Arkansas' 1915(c) Medicaid Autism Waiver approved by the Centers for Medicare & Medicaid Services (CMS), along with two accompanying Medicaid Provider Manuals and a State Plan Amendment (SPA). The renewal followed an independent, third-party autism services rate study on services provided through the Autism Waiver program or applied behavior analysis therapy services (ABA therapy). Those programs deliver similar services by similarly credentialed professionals but with significant variance in the rates paid.

The rate study determined that a rebasing of Arkansas Medicaid rates for the Autism Waiver was appropriate. 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 services under each program. The resultant proposed rates vary depending upon the service rendered. A full fiscal analysis is contained within the Autism Waiver that is part of this rule, and the newly rebased rates are reflected throughout the Autism Waiver and manuals. As part of the rate implementation, three procedure codes for ABA therapy (97152, 97154, and 97158) that are currently available will end. The financial impact of the rebasing of the Autism Waiver rates in conjunction with the establishment of an ABA therapy services Medicaid is cost neutral.

The Autism Waiver renewal also includes required updates that have occurred since the last amendment, updated cost neutrality demonstration based on the rebasing of rates, and other clarifying information. The Autism Waiver Medicaid Manual is revised to include the updates and changes included within the renewed Autism Waiver.

A new ABA Therapy Medicaid Manual is promulgated to establish eligibility, clinician qualifications, supervision, service delivery, service delivery documentation, billing, extension of benefit, and benefit limit parameters in connection with the performance of ABA therapy services. New forms for ABA Therapy will be used by physicians for all referrals for evaluations and treatment prescriptions for ABA therapy services. A beneficiary receiving Autism Waiver services is prohibited from receiving ABA therapy services.

Pursuant to Governor's Executive Order 23-02 the following rules are repealed: (1) FBI Background Check Form, and (2) First Connections Program Under Part C of the Individuals with Disabilities Act.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the

proposed rule at [ar.gov/dhs-proposed-rules](https://www.ark.gov/dhs-proposed-rules). This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than September 21, 2024. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at [ar.gov/dhszoom](https://www.ark.gov/dhszoom).

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502201653

Melissa Weatherton
Director of Specialty Medicaid Services

SECTION II - AUTISM WAIVER CONTENTS

200.000	AUTISM WAIVER GENERAL INFORMATION
201.000	Arkansas Medicaid Participation Requirements for Autism Waiver Providers
201.100	Individual Service Provider Participation Requirements
201.200	Group Service Provider Participation Requirements
201.300	Providers in Arkansas and Bordering States
202.000	AUTISM WAIVER PROVIDER REQUIREMENTS
202.100	Intensive Intervention Providers
202.200	Consultative Clinical and Therapeutic Provider Participation Requirements
202.300	Interventionist Participation Requirements
202.400	Lead Therapist Participation Requirements
202.500	Line Therapist Participation Requirements
202.600	Clinical Services Specialist (CSS) Participation Requirements
203.000	Supervision
204.000	Documentation Requirements
204.100	Documentation Requirements for all Medicaid Providers
204.200	Autism Waiver Service Documentation Requirements
204.300	Electronic Signatures
210.000	PROGRAM ELIGIBILITY
211.000	Scope
212.000	Beneficiary Eligibility Requirements
212.100	Age Requirement
212.200	Qualifying Diagnosis
212.300	Institutional Level of Care
220.000	PROGRAM SERVICES
221.000	Non-covered Services
222.000	Covered Services
222.100	Individual Assessment, Treatment Development, and Monitoring Services
222.200	Consultative Clinical and Therapeutic Services
222.300	Lead Therapy Intervention Services
222.400	Line Therapy Intervention Services
222.500	Therapeutic Aides and Behavioral Reinforcers
222.600	Telemedicine Services
223.000	Plan of Care
224.000	Individualized Treatment Plan
250.000	REIMBURSEMENT
251.000	Method of Reimbursement
251.100	Fee Schedules

200.000 AUTISM WAIVER ~~PROGRAM~~-GENERAL INFORMATION

201.000	Arkansas Medicaid Certification-Participation Requirements for Autism Waiver Providersgram	4-22-201-1- 25
201.100	Individual Service Provider Participation Requirements	1-1-25

All Autism Waiver providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual, as well as the following criteria, to be eligible to participate in the Arkansas Medicaid Program:

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. Autism Waiver providers must be certified~~Obtain certification by~~as an Autism Waiver provider from Arkansas Department of Human Services, the Division of Developmental Disabilities Services (DDS) or its contracted vendor as having met all Centers for Medicare and Medicaid Services (CMS) approved provider criteria, as specified in the Autism Waiver document, for the service(s) they wish to provide.

NOTE: ~~Certification by the Division of Developmental Disabilities Services (DDS) or its contracted vendor does not guarantee enrollment in the Medicaid Program.~~

All Autism Waiver providers must submit current certification and/or licensure to the Provider Enrollment Unit along with their application to enroll as a Medicaid provider. **View or print the provider enrollment and contract package (Application Packet). View or print Provider Enrollment Unit contact information.**

Copies of certifications and renewals required by the Division of Developmental Disabilities Services (DDS) or its contracted vendor must be maintained by Autism Waiver Providers to avoid loss of provider certification. **View or print the Provider Certification contact information.**

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.

201.3400 Providers of Autism Waiver Services in Arkansas and Bordering and Non-Bordering States

10-1-21-1-25

~~An Autism Waiver provider must be physically located in the state of Arkansas or physically located in a bordering state and serving a trade area city. Trade area cities are limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee; and Texarkana, Texas.~~

~~Arkansas Medicaid does not provide Autism Waiver services in non-bordering states. 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 ENROLLMENT CRITERIAAUTISM WAIVER PROVIDER REQUIREMENTS

202.100 ASD-Intensive Intervention Providers**4-22-201-1-
25**

~~An Autism Spectrum Disorder (ASD) Intervention Provider must:~~

- ~~A. Be licensed by the state of Arkansas to provide Early Intervention Day Treatment (EIDT) services to children~~

OR

~~Be certified by the state of Arkansas to provide services under the Developmental Disabilities Services (DDS) Community Employment Supports (CES) Waiver program.~~

- ~~B. Be enrolled with Arkansas Medicaid to provide ASD Intervention Provider services.~~

- ~~A. The ASD-Intensive Intervention providers will serve as the billing provider while employing the consultant, lead and line therapists who serve as the performing provider of waiver services. 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.~~

202.3200 Consultants/Interventionist Participation Requirements**4-22-201-1-
25**

~~An qualified Consultant/Interventionist performing Individual Assessment, Treatment Development, and Monitoring Services must:~~

- ~~A. Hold a certificate from the Behavior Analyst Certification Board (BCAB) as a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA), and~~

- ~~A. Have a minimum of two (2) years' of experience performing one (1) or more of the following for children with autism spectrum disorder:~~

- ~~1. dDeveloping individualized treatment;~~
- ~~2. /pProviding intensive intervention services; or~~
- ~~3. -eOverseeing the an intensive intervention program; for children with Autism Spectrum Disorder (ASD) and~~

OR

- ~~B. Hold either:~~

1. ~~a~~ A minimum of a mMaster's (or more advanced) degree in ~~P~~psychology, ~~S~~speech-Llanguage ~~P~~pathology, ~~O~~ccupational ~~T~~therapy, ~~S~~special ~~E~~ducation, or related field; or
2. ~~and have a minimum of two (2) years of experience providing intensive intervention or overseeing the intensive intervention program for children with ASDA certificate as a board certified behavior analyst (BCBA) from the Behavior Analyst Certification Board.~~

202.4300 Lead Therapists Participation Requirements

4-22-201-1-
25

A. ~~qualified~~ A Lead Therapist performing Lead Therapy Intervention services must:

1. ~~Hold a minimum of a b~~ Bachelor's (or more advanced) degree in ~~E~~education, ~~/S~~special ~~E~~ducation, ~~P~~psychology, ~~S~~speech-Llanguage ~~P~~pathology, ~~O~~ccupational ~~T~~therapy, or ~~a~~ related field; and
2. One of the following:
 - a. Have completed one hundred twenty (120) hours of specified Autism ~~S~~spectrum ~~D~~isorder (ASD) training; or-
 - b. Have both:
 - i. Received an Autism Certificate offered by the University of Arkansas; and

Introduction to ASD (A maximum of 12 hours on this topic)

Communication Strategies, including alternative and augmentative strategies

Sensory Processing disorders and over-arousal response

Behavior analysis/positive behavioral supports, including data collection, reinforcement schedules, and functional analysis of behavior

Evidence-based interventions

Techniques for effectively involving and collaborating with parents

OR

Have completed an Autism Certificate Program, and

- ii. Have a A minimum of two (2) years of experience in intensive intervention programing for services to children with ASDautism spectrum disorder.

B. In a hardship situation, the Division of Developmental Disabilities Services (DDS) or its contracted vendor may issue allow an provisional certification 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. ~~to enable services to be delivered in a timely manner.~~ A hardship situation exists when a child beneficiary is in needs of 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)Provisional certification of a particular staff person requires that the total number of training hours be completed within the firstone (1) year of service.~~

202.5400 Line Therapists Participation Requirements

4-22-201-1-
25

A. ~~A-qualified~~ 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 ~~specified Autism Spectrum Disorder (ASD)~~ training; and
 1. ~~Introduction to ASD (A maximum of 12 hours on this topic)~~
 2. ~~Communication Strategies, including alternative and augmentative strategies~~
 3. ~~Sensory Processing disorders and over-arousal response~~
 4. ~~Behavior analysis/positive behavioral supports, including data collection, reinforcement schedules, and functional analysis of behavior~~
 5. ~~Evidence-based interventions~~
 6. ~~Techniques for effectively involving and collaborating with parents, and~~
4. Have a minimum of two (2) years' ~~of~~ experience working ~~directly~~ with children.

B. In a hardship situation, ~~the Division of Developmental Disabilities Services (DDS)~~ or its contracted vendor may ~~issue a provisional certification to enable services to be delivered in a timely manner~~ 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 ~~child is in~~ beneficiary needs ~~of~~ 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). ~~Provisional certification of a particular staff person requires that the total number of training hours be completed within the first one (1) year of service.~~

202.6500

Consultative Clinical and Therapeutic Services Specialist (CSS)
Providers Participation Requirements

4-22-201-1-
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.

~~The Consultative Clinical and Therapeutic Service provider must be an Institution of Higher Education (4 year program) with the capacity to conduct research specific to Autism Spectrum Disorders (ASD). The provider must:~~

- ~~Be staffed by professionals who will serve as Clinical Service Specialists and are Board Certified Behavior Analysts or have Master's degree in Psychology, Special Education, Speech Language Pathology, or a related field and three (3) years of experience in providing interventions to young children with ASD;~~
- ~~Have a central/home office located within the state and have the capacity to provide services in all areas of the state;~~
- ~~Have a graduate-level curriculum developed and a minimum of three (3) years of experience in providing training toward a graduate certificate in Autism Spectrum Disorders, recognized by the Arkansas Department of Higher Education; and~~
- ~~Be enrolled with Arkansas Medicaid to provide Consultative Clinical and Therapeutic Services.~~

B. ~~This provider must be independent of the intervention service provider (community-based organization) in order to provide checks and balances in situations where progress is not being achieved, where significant maladaptive behavior exists, or where significant risk factors are noted.~~

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****2043.1000 Required Documentation Requirements for all Medicaid Providers****10-1-21-1-25**

See section 140.000 of this Arkansas Medicaid manual for the documentation that is required for all Arkansas Medicaid providers. Autism Waiver providers must create and maintain written records. Along with the required enrollment documentation, which is detailed in Section 141.000, the records, outlined in Section 203.100, must be included in the beneficiary's case files maintained by the provider.

2034.1200 Autism Waiver Service Documentation in Beneficiary's Case Files Requirements**4-22-201-1-25**

Autism Waiver providers must develop and maintain sufficient written documentation 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 to support each service for which billing is made. This documentation, at a minimum, must consist of:

- A. A copy of 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 specific services rendered
- I. Signed consent by a parent/legal guardian's signed election to receive Autism Waiver services;
- J. The parent/guardian's signed choice of provider form;
- K. The quarterly reviews conducted by the clinical services specialist;
- L. 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 ~~The date and actual time the services were rendered~~

~~E. The name and title of the individual who provided the service~~

~~F. The relationship of the service to the treatment regimen of the beneficiary's treatment plan~~

~~G. Updates describing the beneficiary's progress or lack thereof. (Updates should be maintained on a daily basis or at each contact with or on behalf of the beneficiary.) Progress notes must be signed and dated by the provider of the service~~

~~H. Completed forms as required by the Arkansas Department of Human Services, Division of Developmental Disabilities Services (DDS) or its contracted vendor.~~

~~I. Time sheets of the individual(s) providing the service(s).~~

~~Additional documentation and information may be required dependent upon the service to be provided.~~

2034.2300 Electronic Signatures

10-1-121-1-
25

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

210.000 PROGRAM COVERAGEELIGIBILITY

211.000 Scope

4-22-201-1-
25

The purpose of the Autism Waiver is to provide one-on-one, intensive early intervention treatment in a natural environment setting for to beneficiaries betweenages eighteen (18) months through and seveneight (87) years of age with a diagnosis of Autism-autism Spectrum spectrum Ddisorder (ASD). ~~The waiver participants must meet the ICF/IID level of care and have a diagnosis of ASD.~~

~~When providing services to children under the Autism Waiver, only natural home and community settings that provide inclusive opportunities for the child with ASD will be utilized. The setting will primarily be the child's home, but other community locations, identified by the parent (such as the park, grocery store, church, etc.) may be selected based on the skills and behaviors of the child that need to be targeted.~~

~~The community-based services offered through the Autism waiver are as follows:~~

- ~~A. Individual Assessment/Treatment Development/Monitoring~~
- ~~B. Therapeutic Aides and Behavioral Reinforcers~~
- ~~C. Lead Therapy Intervention~~
- ~~D. Line Therapy Intervention~~
- ~~E. Consultative Clinical and Therapeutic Services~~

~~The waiver program is operated by the Division of Developmental Disabilities Services (DDS) or its contracted vendor under the administrative authority of the Division of Medical Services.~~

212.000 Beneficiary Eligibility Requirements 1-1-25

212.1000 Eligibility Assessment Age Requirement ~~10-1-21~~ 1-1-25

~~The client intake and assessment process for the Autism Waiver includes a determination of financial eligibility, a level of care determination, the development of an individualized plan of care and documentation of the participant's choice between home and community-based services and institutional services.~~ 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. ~~Financial eligibility for the Arkansas Medicaid Program must be verified as part of the participant's intake and assessment process for admission into the Autism Waiver program. Medicaid eligibility is determined by the Department of Human Services (DHS) Division County Operations.~~

212.3200 Institutional Level of Care ~~Determination~~ 4-22-201 1-1-25

~~Each beneficiary on this waiver must be diagnosed with Autistic Disorder (View ICD codes), based on the diagnostic criteria set forth in the most recent edition of the Diagnostic Statistical Manual (DSM). The initial and annual determinations of eligibility will be determined utilizing the same criteria used for a child with Autism Spectrum Disorder (ASD) being admitted to the state's ICF/IID facilities.~~ 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.

2423.3000 Plan of Care

4-22-201-1-25

- A. The Division of Developmental Disabilities Services or its contracted vendor must develop Each beneficiary eligible for the Autism Waiver must have an individualized plan of care for each beneficiary. The authority to develop an Autism Waiver plan of care is given by the Division of Developmental Disabilities Services (DDS) or its contracted vendor.
- ~~A copy of the plan of care, prepared by the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator and the waiver participant's parent or guardian, is forwarded to the Autism Spectrum Disorder (ASD) service provider(s) chosen by the participant. Each provider is responsible for developing an Individual Treatment Plan in accordance with the participant's service plan. Each Autism Waiver service must be provided within an established timeframe and according to the participant's service plan. The original plan of care will be maintained by the Division of Developmental Disabilities Services (DDS) or its contracted vendor.~~
1. The ASD 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:

1A. 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; effective date of Autism Waiver eligibility;

5B. The medical and other services to be provided, their amount, frequency, scope, and duration; of each intensive intervention service; and

6. The parent/guardian's choice of intensive intervention service provider(s).

C. The name of the service provider chosen by the beneficiary to provide each service; A beneficiary's plan of care must be updated at least annually and any time the beneficiary is not progressing as expected.

D. The election of community services by the waiver beneficiary; and

E. The name of the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator responsible for the development of the beneficiary's plan of care.

The treatment plan must be designed to ensure that services are:

- A. Individualized to the beneficiary's unique circumstances;
- B. Provided in the least restrictive environment possible;
- C. Developed within a process ensuring participation of those concerned with the beneficiary's welfare;
- D. Monitored and adjusted as needed, based on changes to the waiver plan of care, as reported by the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator;
- E. Provided within a system that safeguards the beneficiary's rights; and
- F. Documented carefully, with assurance that appropriate records will be maintained.

NOTE: Each service included on the Autism Waiver plan of care must be justified by the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator. This justification is based on medical necessity, the beneficiary's physical, mental, and functional status, other support services available to the beneficiary, cost effectiveness, and other factors deemed appropriate by the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator.

Each Autism Waiver service must be provided according to the beneficiary plan of care. As detailed in the Medicaid Program provider contract, providers may bill only after services are provided.

Revisions to a beneficiary's plan of care may only be made by the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator. A revised plan of care will be sent to each appropriate provider.

Regardless of when services are provided, services are considered non-covered and do not qualify for Medicaid reimbursement unless the provider and the service are authorized on an

~~Autism Waiver plan of care. Medicaid expenditures paid for services not authorized on the Autism Waiver plan of care are subject to recoupment.~~

~~**NOTE: No waiver services will begin until all eligibility criteria have been met and approved.**~~

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.

220.000 DESCRIPTION OF SERVICES**220.100 Autism Waiver Services****4-22-20**

- A. ~~Individual Assessment/Treatment Development/Monitoring~~
 - A ~~Consultant, hired by the ASD Intensive Intervention community provider performs this service, which include the following components:~~
 - 1. ~~Assess each child to determine a comprehensive clinical profile, documenting skills deficits across multiple domains including language and communication, cognition, socialization, self care, and behavior. The instruments used will be individualized to help the child's presenting symptoms as determined by the Consultant but must include at a minimum the Verbal Behavior Milestones Assessment and Placement Program (VB-MAP) or the Assessment of Basic Language and Learning Skills Revised (ABLLS-R at least every four (4) months). Other instruments and clinical judgement of the Consultant may also be utilized so as long as they render a detailed profile of the child's skills and deficits across multiple domains.~~
 - 2. ~~Use this detailed clinical profile to develop the Individualized Treatment Plan (ITP) that guides the day to day delivery of evidence-based interventions and the daily data collection. The Consultant must develop the ITP based on the assessment, utilizing exclusively evidence-based practices, and train Lead and Line Therapists to implement the intervention(s) and collect detailed data regarding the child's progress. The evidence-based practices that will be utilized in this program are those recognized in the National Autism Center's National Standards Project, which included, but are not limited to:~~
 - a. ~~Behavioral Interventions~~
 - b. ~~Cognitive Behavioral Intervention Package~~
 - c. ~~Comprehensive Behavioral Treatment for Young Children~~
 - d. ~~Language Training~~
 - e. ~~Modeling~~
 - f. ~~Naturalistic Teaching Strategies~~
 - g. ~~Parent Training Package~~
 - h. ~~Peer Training Package~~
 - i. ~~Pivotal Response Treatment~~
 - j. ~~Schedules~~
 - k. ~~Scripting~~
 - l. ~~Self Management~~
 - m. ~~Social Skills Package~~
 - n. ~~Story Based Intervention~~

~~As additional research on intervention strategies expands the list of accepted practices, additional options may be added to the menu for use by providers. The specific selection of strategies will be individualized for each child based on an evaluation conducted by the Consultant at the onset of service implementation. The individualized program will be documented in the Individual Treatment Plan.~~

- ~~3. Monitoring services will be performed by the Consultant on at least a monthly basis. Monitoring responsibilities will include the oversight of the implementation of evidence-based intervention strategies by the lead therapist, the line therapist, and the family; educating family members and key staff regarding treatment; on-site reviewing of treatment effectiveness and implementation fidelity; use data collected to determine the clinical progress of the child and the need for adjustments to the ITO, as necessary; and modifying assessment information, as necessary.~~

~~B. Therapeutic Aides and Behavioral Reinforcers~~

~~The Consultant will assess the availability of necessary therapeutic aides and behavioral reinforcers in the home. If the Consultant determines that availability is insufficient for implementation of the Individual Treatment Plan, the Consultant will purchase those therapeutic aides necessary for use in improving the child's language, cognition, social, and self-regulatory behavior.~~

~~**NOTE: If the two (2) year minimum participation is not completed, all aides/materials purchased for implementation of treatment must be returned to the Consultant. These aides/materials are to be left with the participant upon successful completion of the waiver program.**~~

~~C. Lead Therapy Intervention~~

~~The Lead Therapist is responsible for assurance that the treatment plan is implemented as designed; weekly monitoring of implementation and effectiveness of the treatment plan; reviewing all data collected by the Line Therapist and parent/guardian; providing guidance and support to the Line Therapist(s); receiving parent/guardian feedback and responding to concerns or forwarding to appropriate person and notifying the Consultant when issues arise.~~

~~D. Line Therapy Intervention~~

~~The Line Therapist is responsible for on-site implementation of the interventions as set forth in the treatment plan; recording of data as set forth in the treatment plan and reporting progress/concerns to the Lead Therapist/Consultant as needed.~~

~~E. Consultative Clinical and Therapeutic Services~~

~~The Autism Spectrum Disorder (ASD) Clinical Services Specialist will provide Consultative Clinical and Therapeutic Services. These services are therapeutic services to assist unpaid caregivers (parents/guardians) and paid support staff (staff involved in intensive intervention services) in carrying out the Individual Treatment Plan, as necessary to improve the beneficiary's independence and inclusion in their family and community.~~

~~These professionals will provide technical assistance to carry out the Individual Treatment Plan and monitor the beneficiary's progress resulting from implementation of the plan. If review of treatment data on a specific beneficiary does not show progress or does not seem to be consistent with the skill level/behaviors of the beneficiary, as observed by the Clinical Services Specialist, the Clinical Services Specialist will either provide additional technical assistance to the parents and staff implementing the intervention or contact the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator responsible for the beneficiary to schedule a conference to determine if the Intervention Plan needs to be modified. Since the Clinical Services Specialists are independent of the provider agency hiring the consultant and other staff, this service provides a safeguard for the beneficiary regarding the intervention. This service will be provided in the beneficiary's home or community location, based on the Individual Treatment Plan, or via the use of distance technology, as appropriate.~~

- ~~A. Individual Assessment, Program Development/Training Plan Implementation, and Monitoring of Intervention Effectiveness~~
~~— The maximum benefit limit is ninety (90) hours per plan of care year.~~
- ~~B. Therapeutic Aides and Behavioral Reinforcers~~
~~— There is a maximum reimbursement of \$1,000.00 per participant per lifetime. These aides/materials are left with the participant upon successful completion of the Waiver program.~~
- ~~C. Lead Therapy~~
~~— The maximum benefit limit is six (6) hours per week.~~
- ~~D. Line Therapy~~
~~— The maximum benefit limit is twenty five (25) hours per week.~~
- ~~E. Consultative Clinical and Therapeutic Services~~
~~— The maximum benefit limit is thirty-six (36) hours per plan of care year.~~

230.000 BILLING INSTRUCTIONS

230.100 Introduction to Billing 7-1-20

The Autism waiver providers use the CMS-1500 claim form to bill the Arkansas Medicaid Program, on paper, for services provided to eligible Medicaid beneficiaries. Each claim should contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

230.200 Autism Waiver Procedure Codes 4-22-20

[Click here to view the Autism Waiver procedure codes.](#)

230.300 National Place of Service (POS) Codes 10-1-12

The national place of service (POS) code is used for both electronic and paper billing.

Place of Service	POS Codes
Patient's Home	12
Other	99

230.400 Billing Instructions – Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the fiscal agent's claims department. [View or print fiscal agent claims department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

230.410 Completion of CMS-1500 Claim Form**4-22-20**

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's date of birth as given on the Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary resides.
STATE	Two-letter postal code for the state in which the beneficiary resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.

Field Name and Number	Instructions for Completion
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.
	Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. — OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. — DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. — NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for Chiropractic services. Enter the referring physician's name and title.
17a. — (blank)	Not required.
17b. — NPI	Enter NPI of the referring physician.
18. — HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. — ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. — OUTSIDE LAB?	Not required
— \$ CHARGES	Not required.
21. — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>

Field Name and Number	Instructions for Completion
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two digit national standard place of service code. See Section 262.100 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable. For anesthesia, when billed with modifier(s) P1, P2, P3, P4, or P5, hours and minutes must be entered in the shaded portion of that detail in field 24D.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.

Field Name and Number	Instructions for Completion
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F the sum of all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

230.500 ~~Special Billing Procedures~~

40-1-12

Not applicable to this program.

SECTION II - APPLIED BEHAVIOR ANALYSIS THERAPY CONTENTS

200.000 APPLIED BEHAVIOR ANALYSIS THERAPY GENERAL INFORMATION

- 201.000 Arkansas Medicaid Participation Requirements for Applied Behavior Analysis Therapy Providers
- 201.100 Individual Service Provider Participation Requirements
- 201.200 Group Service Provider Participation Requirements
- 201.300 Providers in Arkansas and Bordering States
- 201.400 Providers in States Not Bordering Arkansas

202.000 APPLIED BEHAVIOR ANALYSIS THERAPY PROVIDER REQUIREMENTS

- 202.100 Board-Certified Behavior Analyst (BCBA) Participation Requirements
- 202.200 Board-Certified Assistant Behavior Analyst (BCaBA) Participation Requirements
- 202.300 Registered Behavior Technician (RBT) Participation Requirements
- 203.000 Documentation Requirements
- 203.100 Documentation Requirements for all Medicaid Providers
- 203.200 Applied Behavior Analysis Therapy Service Documentation Requirements
- 204.000 Electronic Signatures
- 205.000 Required Referral to First Connections pursuant to Part C of Individuals with Disabilities Education Act (IDEA)
- 206.000 Required Referral to Local Education Agency pursuant to Part B of Individuals with Disabilities Education Act (IDEA)

210.000 PROGRAM ELIGIBILITY

- 211.000 Scope
- 212.000 Beneficiary Eligibility Requirements
- 212.100 Age Requirement
- 212.200 Qualifying Diagnosis
- 212.300 Referral to Evaluate
- 212.400 Treatment Prescription
- 212.500 Comprehensive Assessment

220.000 PROGRAM SERVICES

- 221.000 Non-covered Services
- 222.000 Covered Services
- 222.100 Behavior Identification Assessment Services
- 222.200 Applied Behavior Analysis Therapy Treatment Services
- 222.300 Adaptive Behavior Treatment with Protocol Modification Services
- 222.400 Family Adaptive Behavior Treatment Services
- 223.000 Telemedicine Services
- 224.000 Individualized Treatment Plan

230.000 PRIOR AUTHORIZATION

- 231.000 Prior Authorization for Applied Behavior Analysis Therapy Services
- 232.000 Administrative Reconsideration and Appeal

250.000 REIMBURSEMENT

- 251.000 Method of Reimbursement
- 251.100 Fee Schedules

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.**

222.400 Family Adaptive Behavior Treatment Services

1-1-25

- 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.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

January 1, 2025

CATEGORICALLY NEEDY

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 services to treat Autism Spectrum Disorder (ASD) are only one component of services provided in accordance with 42 CFR 440.130.
- (2) ABA therapy services must be prescribed by:
 - a. The beneficiary's Arkansas Medicaid assigned primary care provider (PCP);
 - b. A substitute physician; or
 - c. An affiliated physician or PCP operating under the same Arkansas Medicaid group provider as the Arkansas Medicaid assigned PCP.
- (3) ABA therapy treatment services include the following components:
 - a. Providing ABA therapy treatment services directly to the beneficiary in accordance with the beneficiary's individualized treatment plan (ITP);
 - b. Collecting data and recording session notes in accordance with the ITP; and
 - c. Reporting progress and concerns to the supervising board-certified behavioral analyst, if applicable.
- (4) ABA therapy treatment 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:

Effective Date:01-01-2025

Supersedes TN:NEW

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

January 1, 2025

MEDICALLY NEEDY

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 services to treat Autism Spectrum Disorder (ASD) are only one component of services provided in accordance with 42 CFR 440.130.
- (2) ABA therapy services must be prescribed by:
 - a. The beneficiary's Arkansas Medicaid assigned primary care provider (PCP);
 - b. A substitute physician; or
 - c. An affiliated physician or PCP operating under the same Arkansas Medicaid group provider as the Arkansas Medicaid assigned PCP.
- (3) ABA therapy treatment services include the following components:
 - a. Providing ABA therapy treatment services directly to the beneficiary in accordance with the beneficiary's individualized treatment plan (ITP);
 - b. Collecting data and recording session notes in accordance with the ITP; and
 - c. Reporting progress and concerns to the supervising board-certified behavioral analyst, if applicable.
- (4) ABA therapy treatment 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:

Effective Date:01-01-2025

Supersedes TN:NEW

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, 202~~5~~4

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. 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

1. Expanded capacity by 50 slots to provide intensive early intervention treatment for additional children diagnosed with Autism Spectrum Disorder (ASD) Changes the autism spectrum disorder diagnosis requirements from all three (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.
- 1.
2. Changes the term for the individual performing Individual Assessment, Treatment Development, and Monitoring services from a "Consultant" to an "Interventionist" to avoid confusion with the Clinical Services Specialist that performs Consultative Clinical and Therapeutic services Combined Plan Implementation and Monitoring in with Individual Assessment, Program Development/Training/Monitoring for a total of 90 hours/360 units/year.
3. Covers changes to the Memorandum of Understanding between Division of Medical Services and Division of Developmental Disabilities Services Changed maximum age to "through 7."
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 service rates based on results of independent, third-party rate study.
- 3.
- Lead Therapy Intervention - \$7.50 per unit to \$15.60 per unit
- Line Therapy Intervention - \$4.50 per unit to \$12.75 per unit
- 4-6. 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

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

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

Draft ID: AR.026.02.00

D. Type of Waiver (select only one):

Model-Regular Waiver

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

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)

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 treatment for in natural environments to children ages from eighteen (18) months through to eight (78) 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. These therapy services are habilitative in nature and are not available to children through the AR Medicaid State Plan. These Autism Waiver services are designed to maintain allow Medicaid eligible participants children to live in the community at home in order to~~ and preclude or postpone institutionalization. Specifically, these services are ~~offered available to children beneficiaries who:~~

- ~~1.) with~~ Have an ASD diagnosis;
- ~~2.) who m~~ Meet the ICF/IID institutional level of care criteria;
- ~~3.) a~~ Are the appropriate between eighteen (18) months and eight (8) years of age; and
- ~~4.) whose~~ Have a parent's/guardian agree to actively participating in the implementation of the service plan.

~~The services offered through the Autism Waiver program offers the following services are:~~

- ~~1.) Individual Assessment, /Plan Treatment Development, /Team Training/ 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 (4) services are ~~provided performed~~ by the certified Autism Waiver community service ~~Intensive Intervention~~ providers ~~selected by the parent/guardian~~. Consultative Clinical and Therapeutic Services are provided by Clinical Services Specialists working ~~with for an four year~~ Institution of Higher Education ~~university program~~.

~~The goal is to design a system for delivery of intensive one-on-one interventions for young children that 1) utilize proven strategies and interventions that are positive, respectful and safe; 2) include and empower parents/guardians to participate; 3) prepare children with functional skills in natural environments; 4) include independent checks and balances; and 5) provide services in the most effective and cost efficient way.~~

The Autism Waiver program is operated by the Arkansas Department of Human Services, Division of Developmental Disabilities Services ("DDS"). ~~DDS who~~ contracts with a third-party vendor (the "Vendor") to ~~oversee many~~ assist in the day-to-day operation and administration functions of the Autism Waiver; including without limitation administering Under this arrangement, the vendor oversees assessments the evaluation instruments and collecting the data used for to determine whether an applicant meets level of care and eligibility requirements for the Waiver, the developingment of the Pplan of Ccare ("POC"), and certifyngies Autism Waiver service providers.

Vendor assigns each beneficiary an Autism Waiver Coordinator who develops Tthe POC outlining the intensive intervention services to be provided; to the beneficiary by the selected certified community service provider who will provide those services, and the parent(s)/guardians(s)' participation agreement. 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, naturalistic 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.

~~The Intensive Intervention provider, specifically, the Consultant hired by that provider, then creates an Individual Treatment Plan (ITP) that operationalizes the POC. The Intensive Intervention provider's linetherapist day to day treatments and therapies with oversight by the lead therapist.~~

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

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 statewideness 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

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

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:

~~In accordance with 42 CFR 441.304(f) the State published a public notice of rulemaking in the statewide Arkansas Democrat-Gazette newspaper, December 12-14, 2019. A public hearing was held on January 7, 2020 at 4:00 p.m. at the Darragh Center Auditorium, Main Library, 100 Rock Street, Little Rock, AR 72201. There were no attendees. The amended waiver was also posted at (<https://www.medicaid.state.ar.us/general/comment/comment.aspx>) the Division of Medical Services (DMS) website to allow general public comment. Comments and responses are listed below; 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 October 18, 2023, at 1:00 p.m. and public comment may be submitted at the hearing. No comments submitted.~~

~~Comment: I am writing to comment on the proposed Arkansas Autism Waiver policy update for March 1st 2020. Please consider the following comments for the revision of the Arkansas Autism Waiver Medicaid Provider Manual.~~

~~Response: Thank you for your comment.~~

~~Comment: The description of where services should be rendered is inaccurate and should state ““When providing services to children under the Autism Waiver, only natural and community settings that provide inclusive opportunities for the child with ASD will be utilized. Such settings include the home, parks, grocery stores, library, restaurants, ball parks or other settings that are not segregated.~~

~~Response: Thank you for your comment. The second sentence of the second paragraph of Section 211.000 of the Autism Waiver Medicaid Manual will be amended in its entirety to read: “The setting will primarily be the child’s home; but other community locations, identified by the parent (such as the park, grocery store, church, etc.) may be selected based on the skills and behaviors of the child that need to be targeted.”~~

~~Comment: A. 2. The list of Evidence-Based Practices is incomplete, as it only lists the 2nd Edition, leaving all Evidence-Based Practices approved in the 1st Edition out of the policy. Referencing the National Autism Center’s National Standards Project would be effective in providing the listing that is regularly updated to reflect the most current established, emerging and not established treatment practices.~~

~~Response: Thank you for your comment. The third and fourth sentences of Section 220.100(A)(2) will be combined to read “The evidence-based practices that will be utilized in the program are those recognized in the National Autism Center’s National Standards Project, which include, but are not limited to:”~~

~~Response: Thank you for your comment. A Section 220.100(A)(3) of the Proposed Autism Waiver Provider Manual will be added which reads, “Monitoring services will be performed by the Consultant on at least a monthly basis. Monitoring responsibilities will include the oversight of the implementation of evidence-based intervention strategies by the lead therapist, the line therapist and the family; educating family members and key staff regarding treatment; on-site~~

~~reviewing of treatment effectiveness and implementation fidelity; use data collected to determine the clinical progress of the child and the need for adjustments to the ITP, as necessary; and modifying assessment information, as necessary.” Additionally, the title of 220.100 will be changed to “Autism Waiver Services” and Section 220.300 will be deleted and be moved to create Section 220.100(E) since Consultative Clinical and Therapeutic Services are one of the five services offered under the Autism Waiver.~~

~~***Additional comments are listed in the "Optional" subsection.***~~

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:

RousePitman

First Name:

AlexandraElizabeth

Title:

Director of ~~Rules And Policies Over The Office of Rules Promulgation~~ Division of Medical Services

Agency:

Office of Legislative and Intergovernmental Affairs, Department of Human Services

Address:

~~PO Box 1427, Slot S-295~~ 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:

Alexandra.Rouseelizabeth.pitman@dhs.arkansas.gov

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

Last Name:

~~Stone~~ Weatherton

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:

~~thomas.tarpley~~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:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone: Ext: ☒ TTY

Fax:

E-mail:

Attachments

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:

~~Comment 2: The list of Evidence Based Practices is incomplete, as it only lists the 2nd Edition, leaving all Evidence Based Practices approved in the 1st Edition out of the policy. Referencing the National Autism Center's National Standards Project would be effective in providing the listing that is regularly updated to reflect the most current established, emerging and not-established treatment practices.~~

~~Response: Thank you for your comment. The third and fourth sentences of Section 220.100(A)(2) will be combined to read "The evidence-based practices that will be utilized in the program are those recognized in the National Autism Center's National Standards Project, which include, but are not limited to:"~~

~~Comment 3: Per proposed policy, the removal of the consultant role found in the redacted Section C, removes the ongoing oversight of the treatment team, ongoing family training, their ability to address strategies with staff, monthly on site monitoring of the treatment of fidelity of programming, and their ability to modify the treatment plan to best meet the needs of the child.~~

~~e The role of the consultant is defined in the 1915(c) document on page 66, "This service also includes the oversight of implementation of evidence-based intervention strategies by the lead therapist, the line therapist and the family; ongoing education of family members and key staff regarding treatment; monthly on-site (in-home and community settings) monitoring~~

of treatment effectiveness and implementation fidelity; modification of the ITP, as necessary; and modification of assessment information, as necessary. Monitoring under this service is for the purpose of modifying the ITP and is conducted monthly by the Consultant.”

Response: Thank you for your comment. A Section 220.100(A)(3) of the Proposed Autism Waiver Provider Manual will be added which reads, “Monitoring services will be performed by the Consultant on at least a monthly basis. Monitoring responsibilities will include the oversight of the implementation of evidence based intervention strategies by the lead therapist, the line therapist and the family; educating family members and key staff regarding treatment; on-site reviewing of treatment effectiveness and implementation fidelity; use data collected to determine the clinical progress of the child and the need for adjustments to the ITP, as necessary; and modifying assessment information, as necessary.” Additionally, the title of 220.100 will be changed to “Autism Waiver Services” and Section 220.300 will be deleted and be moved to create Section 220.100(E) since Consultative Clinical and Therapeutic Services are one of the five services offered under the Autism Waiver.

Comment: 4The language in the 1915(c) document removed the non-profit status in 2017. This can be first found in the 1915(c) on page 67,” Includes any organization formed as a collaborative organization made up of a group of licensed/certified providers, as described.

Response: Thank you for your comment. Section 202.100 of the Autism Waiver Medicaid Manual will be amended by removing Section 202.100(B), and removing in its entirety the paragraph in Section 202.100 that begins with “This criterion also applies...” and ends with “...the organization to participate in the program.” Additionally, Page 67 of the Autism Waiver Application in the “Other Standard” section will be amended to remove the first sentence “Must have a minimum of three years’ experience providing services to individuals with ASD.” Page 70 of the Autism Waiver Application in the “Other Standard” section will be amended to remove the first sentence “The organization must have a minimum of three (3) years’ experience providing services to individuals with ASD.” Finally, Page 72 of the Autism Waiver Application in the “Other Standard” section will be amended to remove the first sentence “Must have a minimum of two (2) years’ experience providing services to children with ASD.”

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.

~~The state assures that this waiver will be subject to any provisions or requirements included in the state's most recent / and or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.~~

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Comment: Thank you for the opportunity to address items listed in the AUTISM 1-19 document. Please see the items below that I would like to address as inconsistent with the language and scope of the 1915(c) Home and Community Based Waiver Application.

Response: Thank you for your comment.

~~202.100 C- Per proposed policy, “This criterion also applies to any non-profit organization formed as a collaborative organization.”~~

~~Comment: The language in the 1915(c) document removed the non-profit status in 2017. This can be first found in the 1915(c) on page 67, "Includes any organization formed as a collaborative organization made up of a group of licensed/certified providers, as described above".~~

~~Response: Thank you for your comment. Section 202.100 of the Autism Waiver Medicaid Manual will be amended by removing Section 202.100(B), and removing in its entirety the paragraph in Section 202.100 that begins with "This criterion also~~

~~applies..." and ends with "...the organization to participate in the program." Additionally, Page 67 of the Autism Waiver Application in the "Other Standard" section will be amended to remove the first sentence "Must have a minimum of three years' experience providing services to individuals with ASD." Page 70 of the Autism Waiver Application in the "Other Standard" section will be amended to remove the first sentence "The organization must have a minimum of three (3) years' experience providing services to individuals with ASD." Finally, Page 72 of the Autism Waiver Application in the "Other Standard" section will be amended to remove the first sentence "Must have a minimum of two (2) years' experience providing services to children with ASD."~~

~~210.00 Scope Per proposed policy, "When providing services to children under the Autism Waiver, only natural home and community settings that provide inclusive opportunities for the child with ASD will be utilized. Such settings include the home, schools or daycares, parks, etc."~~

~~Comment: The locations in the 1915(c) are listed on page 89, "The settings include locations such as the child's home, church, places where the family shops, restaurants, ball parks, etc., all of which meet the new settings definition. There are no segregated settings utilized in this program." Parental presence and participation is a requirement through the autism waiver. This is noted in several instances in the 1915(c) document, as an example from page 94, "Since the parent/guardian will be present and actively involved in treatment provided through the Autism Waiver," the parent is required to remain at any natural community location with the child.~~

~~Response: Thank you for your comment. The second sentence of the second paragraph of Section 211.000 of the Autism Waiver Medicaid Manual will be amended in its entirety to read: "The setting will primarily be the child's home; but other community locations, identified by the parent (such as the park, grocery store, church, etc.) may be selected based on the skills and behaviors of the child that need to be targeted."~~

~~220.100 Intensive ASD Intervention Provider Per proposed policy, "A Consultant, hired by the Division of Developmental Disabilities Services (DDS) or its contracted vendor, community-based organization, performs this service."~~

~~Comment: A consultant in the autism waiver program is not hired by the Division of Developmental Disabilities or its contracted vendor. They are hired by the community-based billing organization. The proposed policy language does not reflect the wording of the 1915(c) document that can be found on page 66, "A Consultant, hired by the Arkansas Autism Partnership (AAP) provider, community-based organization."~~

~~Response: Thank you for your comment. Section 220.100 will be amended by deleting the introductory paragraph starting with "A Consultant, hired by..." and ending with "...which includes the following components:", and inserting an introductory paragraph at the top of Section 220.100(A) above Section 220.100(A)(1) which reads, "A Consultant hired by the ASD Intensive Intervention community provider performs this service, which include the following components:". Additionally, the first sentence of Page 66 of the Autism Waiver Application will be amended to read "A Consultant hired by the ASD Intensive Intervention community provider performs this service, which include the following components:".~~

~~230.20 Autism Waiver Procedure Codes~~

~~Comment: Requesting verification that the procedure codes utilized for the Autism Waiver services will be intensive early intervention codes. The Autism Waiver is an intensive early intervention program and not an Applied Behavior Analysis service. This is defined on page 5 of the 1915(c) document in the Brief Waiver Description, "The Autism Waiver provides intensive one-on-one treatment for children ages 18 months through 7 years with a diagnosis of autism spectrum disorder (ASD). The therapy services are habilitative in nature and are not available to children through the AR Medicaid State Plan. These services are designed to maintain Medicaid-eligible participants at home in order to preclude or postpone institutionalization. Specifically, these services are offered to children with ASD who meet the institutional level of care criteria, are the appropriate age, and whose parent's agree to actively participate in the treatment plan.~~

~~Response: Thank you for your comment. Section 230.200 "Autism Waiver Procedure Codes" will remain a section in the Autism Waiver Medicaid Manual, but that Section will include only the sentence "Click here to view the Autism Waiver procedure codes.", which will have a hidden hyperlink to the a webpage containing the Autism Waiver procedure codes.~~

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

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 State Medicaid Agency, Department of Human Services, Division of Medical Services (“DMS”) is the state’s Medicaid agency. The Arkansas Department of Human Services, and the Division of Developmental Disabilities 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 Agreement (“MOU Agreement”) in place to ensure establish the respective obligations and responsibilities of each agency in connection with collaborative partnership between agencies regarding the operation and administration of the Autism Waiver. The Agreement delineates the Autism Waiver will be operated by DDS through their contracted vendor under the administrative authority of DMS. DMS will approve Waiver policies, rules and regulations. DMS has the final authority regarding all administrative matters.~~

~~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 again 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 development governing waiver program~~
- ~~10. Quality assurance and quality improvement~~

~~The term of the MOU is one (1) year and it automatically renews for additional one (1) year periods 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 operation and administration of the Autism Waiver as long as any MOU obligations performed by Vendor are performed pursuant to a written, legally binding contract containing adequate performance measures. The MOU requires DDS to conduct regular reviews of 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 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 an amendment as soon as possible. DMS and DDS, as well as DDS’s contracted vendor, have a common and concurrent interest in providing eligible Medicaid children with access to Autism Waiver services through qualified providers, while ensuring that the integrity of the Medicaid Program is maintained. Both agencies will administer the Autism Waiver so as to meet the following assurances:~~

- ~~-the health and welfare of participants;~~
- ~~-Plans of Care (POC) responsive to participants needs;~~
- ~~-That only qualified providers serve Autism Waiver participants;~~
- ~~-That the State conducts level of care need determinations consistent with the need for institutionalization;~~
- ~~-That the State Medicaid Agency retains administrative authority over the Autism Waiver program; and~~
- ~~-That the State provides financial accountability for the Autism Waiver.~~

~~DHS and DMS monitor the Agreement to assure that the provisions specified therein are executed. Both DMS and DDS, through its contracted vendor, provide information and data needed to carry out the Agreement.~~

~~Pursuant to the Agreement, DMS and DDS, in part through its contracted vendor, conduct routine, ongoing oversight of the Autism Waiver programs. DHS reviews and approves any policies DDS and its contracted vendor puts in place to carry out the terms of the Agreement and the Autism Waiver program.~~

Provisions of the Agreement are as follows:

DDS, as the Operating Agency, has the following responsibilities, carried out through its contracted vendor:

evaluation of medical need criteria (DHS form 703) for Waiver services by reviewing developmental assessment information provided with the participant's application. Arkansas Medicaid makes the eligibility determination after reviewing medical and financial eligibility information;

administers assessments, as necessary, to make recommendations to Arkansas regarding participants' Level of Care;

develops Plans of Care (POC) for each participant enrolled in the Autism Waiver; and

(1) certifies eligible provider agencies for participation as providers in the Autism Waiver program with Arkansas Medicaid oversight and monitoring.

DDS' contracted vendor utilizes a database that houses information on all certified providers. The Division of Medical Services (DMS) maintains and monitors a separate database of all providers who have applied for certification. DDS also has access to its vendor's database and randomly pulls provider certification records on a quarterly basis to check for errors.

DDS uses the sampling guide "A Practical Guide for Quality Management in Home and Community Based Waiver Programs" developed by the Human Services Research Institute and the Medstat group for CMS in 2006. A systematic random sampling of the active provider group is drawn whereby every nth name in the group is selected for inclusion in the sample for provider certification review. The sample size is based on a 95% confidence level with a margin of error of +/- 5%. An online calculator is used to determine the appropriate sample size for the population.

During monitoring, if a pattern of errors is identified, DDS will require its vendor to submit and implement a corrective action plan to ensure the pattern is not repeated.

Non-compliance with the Agreement:

If DDS discovers that its contracted vendor is not complying with the terms of the Agreement, DDS may require the contracted vendor to submit and implement a corrective action plan. Under the terms of the contract, DDS reserves the right to delay, withhold or reduce payment to its vendor; or to terminate the agreement at any time depending on the severity and nature of non-compliance.

DDS continuously evaluates its contracted vendor's management processes to ensure compliance. The following describes the roles of each entity:

The Division of Provider Support and Quality Assurance (DPSQA)'s Office of Long Term Care (OLTC) conducts 100% review of initial level of care determinations performed by DDS's contracted vendor and makes the final eligibility determination.

DDS's contracted vendor conducts 100% review of participant case records and provider certification files. These reviews focus on the CMS quality assurance framework and performance measures. After each review, the contracted vendor develops and implements a remediation plan, if necessary, within a designated timeframe. DDS conducts quarterly oversight reviews of a sampling of participant case records or provider certification files.

DMS quality assurance staff utilize other systems, such as the Medicaid Management Information Systems (MMIS) and the Arkansas Department of Human Services, Division of County Operations' eligibility system, ANSWER, to monitor quality and ensure it performs the assigned operational and administrative waiver functions in accordance with the MOU and compliance with Autism Waiver requirements standards.

Other DMS staff, such as Program Integrity, conducts utilization reviews, investigates potential fraud, and other requested focused reviews of Autism Waiver providers and DDS's contracted vendor, as warranted. A report of findings is produced and transmitted to the party in question for remedial action, as necessary.

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 non-profit organization ("Vendor") to assist with certain aspects of the day-to-day administrative and operational functions of the Autism Waiver. Vendor assists DDS with the following operational and administrative waiver functions: in conducting eligibility and level of care assessments, overseeing the development of plans of care, and certifying Autism Waiver providers. This contracted vendor also performs reviews of services delivered under the Waiver and maintains the wait list.

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).

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 is has primary responsible for oversight responsibility of over the contracted third-party vendor contracted to assist with the day-to-day administrative and operational Autism Waiver functions. The contract has performance measures that the vendor is required to meet and DDS conducts regular reviews of the vendor. Additionally, the vendor submits quarterly reports to DDS for review.~~

~~DMS, as the State Medicaid Agency oversees operation of the Waiver, maintains ultimate administrative authority over the Autism Waiver and provides a second line of oversight for the 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. DDS's contracted vendor submits quarterly reports to DDS for review. Additionally, DDS conducts quarterly reviews of a sample of provider certification files and Autism Waiver beneficiary charts to ensure compliance with the terms of this Waiver.~~

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 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"/> <input 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 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 checked="" type="checkbox"/> <input type="checkbox"/>	<input checked="" 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 active, unduplicated participants served within approved limits specified in the Autism Waiver. Numerator: Number of active, unduplicated participants served within approved limits; Denominator: Number of active/unduplicated participants.~~

Data Source (Select one):

~~Other~~

~~If 'Other' is selected, specify:~~

~~MMHS~~

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" 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= <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

~~Other~~

~~If 'Other' is selected, specify:~~

~~ACES Report of Active Cases (Point in Time)~~

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):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative
		Sample Confidence Interval =
Other Specify: Division of County Operations <input checked="" type="checkbox"/>	Annually <input type="checkbox"/>	Stratified Describe Group: <input type="checkbox"/>
	Continuously and Ongoing <input type="checkbox"/>	Other Specify: <input type="checkbox"/>
	Other Specify:	

Data Aggregation and Analysis: ☐

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

Performance Measure:

Number and percent of policies and ~~or~~ 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 ~~before prior implementation~~; Denominator: Number of policies and procedures developed by DDS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Policy Development Quality Assurance Request Forms 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 =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	Other Specify:	

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
Other Specify:	Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and percent of initial Level of Care (LOC) assessments completed using the approved instrument. Numerator: Number of LOC assessments completed using the approved instrument; Denominator: Number of LOC assessments reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Quarterly QA Report (Chart Reviews)

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% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
		DDS will conduct a review on 10% of the charts reviewed by DDS's contracted vendor for the quarter.
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input 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
Other Specify: DDS's contracted vendor	Annually

	<input type="checkbox"/> Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and percent of participant Plans of Care (POCs) completed by DDS's contracted vendor in the time frame specified. Numerator: Number of POCs completed by DDS's contracted vendor in the time frame specified; Denominator: Number of POCs reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Chart Reviews)

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	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity <input checked="" type="checkbox"/>	Quarterly <input type="checkbox"/>	Representative Sample <input type="checkbox"/> Confidence Interval =
Other <input type="checkbox"/> Specify: DDS's contracted vendor	Annually <input checked="" type="checkbox"/>	Stratified <input type="checkbox"/> Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Sub-State Entity	Quarterly
Other Specify: DDS's contracted vendor	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

Number and percent of participants with delivery of at least two Autism Waiver services per month as specified in the Plan of Care (POC). Numerator: Number of participants with at least two Autism Waiver Services per month; Denominator: Number of participants served.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Minimum Waiver Services Report

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval=
Other Specify: <input type="checkbox"/>	Annually <input type="checkbox"/>	Stratified Describe Group: <input type="checkbox"/>
	Continuously and Ongoing	Other Specify: <div></div>
<input checked="" type="checkbox"/>	<input type="checkbox"/> Other Specify:	<input type="checkbox"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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
Other Specify: <input type="text"/> DDS's contracted vendor	<input type="checkbox"/> Annually <input type="checkbox"/> Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Level of Care (LOC) assessments completed by DDS' contracted vendor in the time specified in the Agreement. Numerator: Number of LOC assessments completed by DDS' contracted vendor in time frame; Denominator: Number of LOC assessments reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Average Days Report

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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
DDS's contracted vendor		
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Medicaid Quarterly QA Report (Chart Reviews)

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 checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval=
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other	
	Specify:	

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Monthly Activity Report

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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval=
Other Specify: DDS's contracted vendor	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of provider applications for which the provider obtained appropriate licensure/certification in accordance with the specified Autism Waiver qualifications prior to providing services. Numerator: Number of provider certifications issued; Denominator: Number of providers

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Provider File Review

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 type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	Representative Sample Confidence Interval =
Other Specify: DDS's contracted vendor	<input type="checkbox"/> Annually	Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Quarterly QA Report (Chart Reviews)

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% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify:	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify: DDS will conduct a 10% sample of charts reviewed by its contracted vendor.
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<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: DDS's contracted vendor	<input type="checkbox"/> Annually
	Continuously and Ongoing
	Other 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 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 of 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 conducts chart reviews on 10% of the Autism Waiver participants' records and produces reports of the results. These reports include issues such as untimely level of care re-evaluations, incomplete service plans, and incorrect billings to Medicaid. These reports are shared with DDS' contracted vendor. DDS's contracted vendor is responsible for implementing remedial action to prevent future occurrences of the same issues and if necessary, developing a corrective action plan to address any issues not resolved through remediation. The corrective action plan may include training, policy corrections, and provider billing adjustments. In cases where the numbers of active participants and unduplicated participants served in the Autism Waiver are not within approved limits, remediation may include Waiver amendments, or possibly implementing a waiting list.

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. DDS and its contracted vendor hold quarterly meetings to discuss and address individual problems associated with administrative authority, as well as problem correction and remediation.

DMS reviews and approves all policies and procedures developed by DDS's contracted vendor prior to implementation. In cases where a new or updated policy or procedure was not reviewed and approved by DMS prior to implementation, remediation includes DMS reviewing of the policy or procedure upon discovery, and approving or removing the policy or procedure, 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.

Remediation to address participants not receiving at least two waiver services per month in accordance with the Plan of Care (POC) includes case closure, conducting monitoring visits, revising a plan of care to add a service, checking provider billing and providing training. Remediation associated with provider certifications that are not current according to the Agreement include closing provider numbers, recouping payments for services and recertifying providers upon discovery, if appropriate.

DDS's contracted vendor conducts remediation efforts in these efforts and the transmittal tool used for case record reviews documents and tracks remediation.

ii. Remediation Data Aggregation

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

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

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"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<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"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism		1	7
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<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:

- ~~Children between eighteen (18) months and seven (7) years, who have been~~ 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) ~~of put out by the American Psychiatric Association, and who meet the ICF IID level of care criteria. 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.~~
- ~~A beneficiary's ASD~~ The diagnosis of ASD must be from at least two (2) of the following three (3) licensed professionals, either each individually or as a team: ~~have been provided by multiple professionals, including a physician, psychologist, and speech-language pathologist, either individually or as a team. The ASD diagnosis must be the primary contributing factor to the beneficiary's delays, deficits, or maladaptive behaviors to qualify for the Autism Waiver.~~
- ~~A beneficiary's level of care evaluation must demonstrate the beneficiary requires an ICF/IID institutional level of care. Participants will be terminated from the Autism waiver after either a total of three (3) consecutive years of service, or upon their eighth birthday, whichever comes first.~~
- ~~A beneficiary must be between eighteen (18) months and eight (8) years of age.~~
- ~~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.~~
- ~~Participants~~ A beneficiary must ~~enter~~ be determined eligible for the Autism Waiver program on or before their fifth (5th) birthday to allow for the maximum ~~of three (3) years of services prior to reaching the Autism Waiver maximum age limitation on their eighth (8th) birthday~~ treatment to occur. ~~The three year maximum service limitation is specified in Arkansas Act 1008 of 2015 enacted in the 90th Session of the Arkansas General Assembly.~~

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 State's transition planning procedures 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 end of the participant's program end date or if the participant fails to meet the level of care criteria before the 3-year maximum is met. 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 Parents/guardians 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 will also be responsible for assisting the beneficiary and parent/guardian with coordinating the transitioning to other services providers. A transition conference with any new service provider is scheduled if/when requested by the parent/guardian, the participant's Consultant may participate in a transition conference with the agency who will be providing services following Autism Waiver termination.

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	270 00
Year 2	270 00
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 50
Year 2	180 50
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") ~~has been accepting applications, on behalf of DDS administers evaluation instruments, and collects data that is used to determine whether an applicant meets the Autism Waiver eligibility requirements throughout the life of the Autism Waiver program, and currently maintains a waiting list for services. 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, Thea waiting list will be established opened and services will be provided to children identified as program eligible until the maximum number of slots has been filled. DDS's contracted v~~When a waiting list exists, Vendor will continue to accepting 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 children will be moved into available slots in the order they were added to the services on a first come, first serve basis. Once all slots are filled, a waiting list will be maintained until an available slot opens.

An applicant child must be ~~admitted to the program enrolled in an Autism Waiver slot~~ on or before his or her fifth (5th) birthday ~~in order to allow for the maximum of three (3) years of treatment services before aging out reach the Autism Waiver maximum age limitation at their his or her eighth (8th) birthday. Without a Any entry age requirement for entrance to the program prevents an applicant child could get processed for services from enrolling in an Autism Waiver slot immediately prior to his or her eighth (8th) birthday, leaving insufficient time to recruit staff and provide Autism Waiver services prior to the applicant reaching the maximum age limitation before he or she ages out of the Autism Waiver program.~~

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIA 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:

- 1) ~~Title IV-E Children.~~
- 2) ~~Children Specified at 42 CFR 435.118.~~

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 individual'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:

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:

- 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

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.

Answers provided in Appendix B-4 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 (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.

Appendix B: Participant Access and Eligibility

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:

~~Employees of DDS's contracted vendor who perform initial evaluations~~ 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 be either (1) a licensed Registered Nurse, or (2) have at least a Bachelor's degree in psychology, speech language pathology, occupational therapy, education or related field.~~

~~They must also have a minimum of two years' experience with services for young children with autism spectrum disorder (ASD).~~

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. A 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. Children served in the Autism Waiver must be diagnosed with Autism Spectrum Disorder (ASD), based on the diagnostic criteria set out in the most recent edition of the DSM (Diagnostic and Statistical Manual). The initial determination of eligibility is determined utilizing This is the same level of care criteria used to establish a beneficiary's eligibility for admission into one of a child with ASD being admitted to the state's ICF/IID facilities. These include the DHS 703 form (The Evaluation of Medical Need), social history and psychological assessments. The annual level of care ("LOC") reevaluation process is conducted in the exact same manner as the initial LOC evaluation process.

DDS's contracted vendor will assist in determining eligibility for both initial and continuing eligibility for the Autism Waiver. The LOC assessment is completed by DDS's contracted vendor using the DHS 703 Form. The completed DHS 703 is submitted to the DPSQA, Office of Long Term Care (OLTC). OLTC will complete the Decision for Nursing Home/Waiver Placement (Form DHS 704). Once the LOC determination is made, DDS's contracted vendor will develop the Plan of Care (POC) with the family.

Supporting documentation required for DDS's contracted vendor to complete the DHS 703 form include appropriate assessments of intelligence and adaptive behavior. Any standardized assessment of intellect and adaptive behavior deemed appropriate by the licensed professionals completing the evaluation will be considered. Additionally, the presence of ASD must be identified by delineation of the DSM Criteria present or through the use of a formalized instrument such as the CARS, ADOS or ADI-R. Assessments submitted must be administered by appropriately licensed professionals as required for the administration of the particular instruments utilized. It should be noted that these evaluations, resulting in a diagnosis of ASD, can be completed by any clinical or developmental center or private vendor of the parent's choice, so long as appropriately licensed professionals conduct the assessment. This information must be submitted to the contracted vendor and reviewed prior to the initial on-site meeting between the contracted vendor's staff and the parents/guardians of the child. If additional information is needed, the family will be notified in writing prior to the scheduling of the first on-site meeting.

On-site refers to in-home and community settings. The location will primarily be the child's home; but other community locations, identified by the parent (such as the park, grocery store, church, etc.) may be selected based on the skills and behaviors of the child that need to be targeted.

Once the diagnosis of ASD is confirmed by DDS's contracted vendor, the initial contact will be scheduled. During this on-site visit, the level of care (LOC) determination will be made by the contracted vendor based on significant deficits in adaptive functioning and/or the presence of significant behavioral challenges. 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 child will be found to meet the LOC eligibility with a score of seventy (70) or less in any two (2) of the Vineland II Survey Interview domains is deemed to require an institutional level of care for Autism Waiver eligibility purposes. Vineland Scores above seventy (70) that falling within the 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 of the Vineland II will not preclude a child's eligibility for the Autism Waiver. For example, a child diagnosed with ASD with a Vineland domain score of seventy-four (74) for the Communication Domain where the confidence level interval is five (5) points would be deemed to meet the institutional level of care threshold for that domain for the child's developmental age, would be eligible.

An applicant/beneficiary age 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. Score between 21 and 24 indicates the presence of significant behavioral challenges. Children with a Maladaptive Behavior Index Score in this range are considered eligible for the Autism Waiver, if the child also has a Vineland II Domain score for two of the three adaptive behavior domains (Communication, Daily Living Skills, Socialization) of 85 or less. Children with Vineland adaptive behavior scores falling within the range of the test's a domain's confidence interval for the applicant's/beneficiary's child's developmental age are also deemed to meet the institutional level of care threshold for that domain in this case will also qualify as eligible.

For children under the age of 3, a Temperament Atypical Behavior Scale (TABS) assessment must be used to assess for the presence of significant behavioral challenges. 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 and a TABS score of eight (8) and above on the TABS is also deemed to require an institutional level of care for Autism Waiver eligibility purposes indicates a child has significant dysfunctional behaviors, and qualifies for the Autism Waiver, if the score is coupled with qualifying adaptive scores from the Vineland II.

**Arkansas Division of Medical Services (DMS)
Applied Behavior Analysis (ABA) Therapy Services
for Medicaid Eligible Beneficiaries under Age 21
INITIAL EVALUATION REFERRAL (DMS-641 ER)**

The primary care provider (PCP) or substitute/affiliated physician must use this form to refer patients for the evaluation required to demonstrate initial eligibility for applied behavior analysis (ABA) therapy services.

***A DMS-641 ER referral is only required for a patient's initial evaluation referral for ABA therapy services. A DMS-641 ER is not required for providers to perform required reevaluations for patients currently receiving ABA therapy services pursuant to an active treatment prescription (DMS-641 TP).**

Patient Name: _____ Medicaid ID #: _____

Patient Date of Birth: _____ Date Patient Last Seen In Office: _____

PCP or Substitute/Affiliated Physician Name (*Please Print*) _____ Provider Medicaid ID # _____

Is the referring practitioner the patient's Arkansas Medicaid assigned PCP? ☐ Yes (one must be checked) ☐ No

If "No," include the assigned PCPs name/Medicaid # and reason unavailable: _____

Diagnosis related to ABA Therapy:

Primary Diagnosis: Autism Spectrum Disorder ICD 10 Code: F84.0

Secondary Diagnosis: _____ ICD 10 Code: _____
(if applicable)

_____ ICD 10 Code: _____
(if applicable)

Licensed Professionals who Diagnosed Autism Spectrum Disorder (ASD):

Please indicate the licensed professional who diagnosed the patient's ASD by checking the appropriate boxes (**at least 2 boxes must be checked**):

☐ Physician (PCP must be a physician to check)

☐ Psychologist

☐ Speech-language Pathologist

Basis for referral (i.e. description of maladaptive behaviors observed, screen used/results, skill deficits, etc.):

PCP or Substitute/Affiliated Physician Signature

Date

**Instructions for Completing
Form DMS-641 ER – Applied Behavior Analysis (ABA) Therapy Services
INITIAL EVALUATION REFERRAL**

Physician or Physician's office must always complete the following:

- Patient Name – Enter the patient's full name.
 - Medicaid ID # – Enter the patient's Medicaid ID number.
 - Patient Date of Birth – Enter the patient's date of birth.
 - Date Patient Was Last Seen In Office – Enter the date of the patient's last office visit. This could have been for a complete physical examination, a routine check-up, or office visit for other reasons.
 - Primary Care Provider (PCP) or Substitute/Affiliated Physician Name and Medicaid ID Number – Print the name of the referring PCP or substitute/affiliated physician and their Medicaid ID number.
 - Is Referring Practitioner the Assigned PCP – Check the box indicating whether the referring practitioner signing the DMS-641ER is the patient's Arkansas Medicaid assigned PCP.
 - If a substitute physician or affiliated PCP/physician is issuing a patient's referral, then the name and Medicaid # of the patient's Arkansas Medicaid assigned PCP must be provided along with the reason the assigned PCP is unavailable. See Sections 171.600 and 212.300 of the Applied Behavior Analysis Therapy Service Medicaid manual regarding permitted substitutes for a patient's assigned PCP.
 - Diagnosis/ICD 10 Code – The patient's primary diagnosis must be autism spectrum disorder to be eligible for applied behavior analysis services, and the PCP or substitute/affiliated physician should enter any secondary (if applicable) diagnoses and corresponding international classification of diseases (ICD) – 10th revision code(s) applicable to the diagnosis.
 - Licensed Professionals who Diagnosed Autism Spectrum Disorder: An ASD diagnosis (as defined by Ark. Code Ann. § 20-77-124) requires at least two (2) of the listed licensed professionals to either independently or as part of a team conclude the patient fully meets the ASD diagnostic criteria under the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The referring PCP or substitute/affiliated physician must check the boxes of the licensed professionals who diagnosed the patient's ASD.
 - Basis for Referral – Enter the reason that the PCP or substitute/affiliated physician is referring the patient for evaluation. Examples would include without limitation the patient's diagnosis, the results of an administered developmental screen, a description of clinical observation of patient, etc.
 - PCP or Substitute/Affiliated Physician Signature and Date – The referring PCP or substitute/affiliated physician must sign and date the DMS-641 ER in their original signature.
- * Medicaid's criteria for electronic signatures as stated in Arkansas Code 25-31-103 must be met. Providers will be compliant if a scanned copy of the original document is kept in a format that can be retrieved for a specific beneficiary.

**Arkansas Division of Medical Services (DMS)
Applied Behavior Analysis (ABA) Therapy Services
for Medicaid Eligible Beneficiaries under Age 21
TREATMENT PRESCRIPTION (DMS-641 TP)**

The primary care provider (PCP) or substitute/affiliated physician must use this form to prescribe applied behavior analysis (ABA) therapy services to a patient. ABA therapy providers are responsible for renewing treatment prescriptions in accordance with Section 212.400 of the Applied Behavior Analysis Therapy Medicaid manual.

Patient Name: _____ Medicaid ID #: _____

Patient Date of Birth: _____ Date Patient Last Seen In Office: _____

PCP or Substitute/Affiliated Physician Name *(Please Print)* _____ PCP or Substitute/Affiliated Physician Medicaid ID # _____

Is the prescribing practitioner the patient's Arkansas Medicaid assigned PCP? ☐ Yes (one must be checked) ☐ No

If "No," include the assigned PCPs name/Medicaid # and reason unavailable: _____

Diagnosis related to ABA Therapy:

Primary Diagnosis: Autism Spectrum Disorder ICD 10 Code: F84.0

Secondary Diagnosis: _____ ICD 10 Code: _____
(if applicable)

_____ ICD 10 Code: _____
(if applicable)

Applied Behavior Analysis (ABA) Therapy Treatment
_____ Minutes per week
_____ Duration (months)

Is the patient currently receiving/prescribed day habilitative, occupational therapy, physical therapy, or speech-language pathology services?

☐ Yes ☐ No
(one must be checked)

If "Yes," please indicate each service the patient is currently receiving/prescribed, and in which setting(s) each service is provided (i.e. EIDT, school, private clinic/outpatient, rehabilitation clinic, etc.):

Scheduled follow-up visit: _____

I hereby certify that I have carefully reviewed the comprehensive evaluation and recommended individualized treatment plan (ITP) and believe the prescribed frequency, intensity, and duration of ABA therapy treatment services are reasonable and appropriate for this patient. If this is a continuing plan, I certify that I believe the prescribed services will result in the patient continuing to progress towards their ITP goals and objectives.

PCP or Substitute/Affiliated Physician Signature _____

Date _____

**Instructions for Completing
Form DMS-641TP - Applied Behavior Analysis (ABA) Therapy Services
TREATMENT PRESCRIPTION**

Primary Care Provider (PCP) office must complete the following:

- Patient Name – Enter the patient’s full name.
 - Medicaid ID # – Enter the patient’s Medicaid ID number.
 - Date Patient Was Last Seen In Office – Enter the date you last saw this patient. (This could be either for a complete physical examination, a routine check-up, or office visit for other reasons.)
 - Primary Care Provider (PCP) or Substitute Physician Name and Medicaid ID Number – Print the name of the prescribing PCP or Substitute Physician and their Medicaid ID number.
 - Is Prescribing PCP the Patient’s Assigned PCP – Check the box indicating whether the prescribing PCP signing this DMS-641TP is the patient’s Arkansas Medicaid assigned PCP.
 - The patient’s Arkansas Medicaid assigned PCP must sign a patient’s initial DMS-641TP prescription for ABA therapy services. The use of a substitute physician is not allowed.
 - If a substitute physician is issuing a patient’s renewal prescription, then the name and Medicaid # of the patient’s Arkansas Medicaid assigned PCP must be provided along with the reason the assigned PCP is unavailable. See Sections 171.600 and 212.400 of the Applied Behavior Analysis Therapy Service Medicaid manual regarding permitted substitutes for a patient’s assigned PCP.
 - Diagnosis/ICD 10 Code – The patient’s primary diagnosis must be autism spectrum disorder to be eligible for applied behavior analysis services, and the PCP or substitute/affiliated physician should enter any secondary (if applicable) diagnoses and corresponding international classification of diseases (ICD) – 10th revision code(s) applicable to the diagnosis.
 - Applied Behavior Analysis (ABA) Therapy Prescribed – Enter the prescribed number of minutes per week and the duration (in months) of the ABA therapy treatment services.
 - Day habilitative, occupational, physical, and speech therapy services – Check the appropriate box(es) indicating whether the patient is already prescribed/receiving day habilitation, occupational therapy, physical therapy, or speech-language pathology services. If the patient is already prescribed one of those services, indicate the setting(s) in which each service is currently provided to the patient.
 - Scheduled follow-up visit – The scheduled follow-up visit date related to this treatment prescription should be entered. This will typically be scheduled within 30 days of the expiration date of this treatment prescription to allow the PCP to review of the results of patient’s required reevaluation as part of determining the medical necessity of continuing ABA therapy services.
 - PCP or Substitute/Affiliated Physician Signature and Date – The prescribing PCP or substitute/affiliated physician must sign and date the DMS-641 TP in their original signature.
- * Medicaid’s criteria for electronic signatures as stated in Arkansas Code 25-31-103 must be met. Providers will be compliant if a scanned copy of the original document is kept in a format that can be retrieved for a specific beneficiary.

RULES SUBMITTED FOR REPEAL

Rule #1: FBI Background Check Form

**Rule #2: First Connections Program Under Part C of
the Individuals With Disabilities Act**

**ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF CHILD CARE & EARLY CHILDHOOD EDUCATION**

REQUEST FOR:

FBI RECORDS CHECK

A completed state criminal records check form, a completed fingerprint card FD-258 and a check or money order (made payable to ASP or Arkansas State Police) MUST be attached for EACH fingerprint check needed.
Checks/money orders cannot be combined for multiple fingerprint checks.

If you have any questions, or wish to dispute the results, please contact your Licensing Specialist immediately.

(FACILITY USE ONLY)	(DHS USE ONLY)
FACILITY REQUESTING REPORT	NAME OF LICENSING SPECIALIST REQUESTING THE CHECK
MAILING ADDRESS	TITLE COUNTY
CITY STATE ZIP	TELEPHONE NUMBER
FACILITY DIRECTOR & TELEPHONE NUMBER	DATE OF REQUEST

TO BE COMPLETED BY THE PERSON TO BE CHECKED

NAME OF PERSON TO BE CHECKED: _____
 (LAST NAME) (FIRST NAME) (MIDDLE NAME)

MAIDEN NAME: _____ ALIASES: _____

DOB: (____/____/____) (____) SON: (____) PHONE #: (____) - ____
 MONTH DATE YEAR

DRIVER'S LICENSE or GOV'T ID #: ____/____ RACE: _____ SEX: (MALE / FEMALE)

COMPLETE ADDRESS: _____
 (Physical residential address) STREET CITY STATE ZIP

PLACE OF EMPLOYMENT: _____

"I hereby authorize the Department of Human Services to conduct a criminal background check on myself through the Federal Bureau of Investigations, and for the FBI and Arkansas State Police to release any criminal history information to the Division of Child Care and Early Childhood Education. I also understand that the Identification Bureau of the Arkansas State Police may maintain the fingerprints submitted in an automated fingerprint identification system."

SIGNATURE OF PERSON TO BE CHECKED

DATE

PLEASE CHECK THE APPROPRIATE BOX:

Division of Child Care & Early Childhood Education Applicant:

☐ Owner/Operator
 (Licensee/Board Member/Director)

☐ Child Care Facility Employee

☐ Volunteer who is left alone with
 children, considered in the staff/child ratio or
 given supervisory/disciplinary control over
 children

STATE POLICE USE ONLY - DO NOT WRITE IN OR BELOW THIS BOX

~~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.

REPEAL-EO 23-02

- (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;~~

REPEAL-EO 23-02

- ~~(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).~~

REPEAL-EO 23-02

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).~~

REPEAL-EO 23-02

~~(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.~~

REPEAL-EO 23-02

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.~~

REPEAL-EO 23-02

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.

REPEAL-EO 23-02

- (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)
- REPEAL-EO 23-02**
- ~~(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.~~

REPEAL-EO 23-02

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.~~

REPEAL-EO 23-02

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.~~

REPEAL-EO 23-02

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;~~

- ~~(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)~~

REPEAL-EO 23-02

~~(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~~

REPEAL-EO 23-02

- ~~(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.~~
- (2) ~~REPEAL-EO 23-02~~
- (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.~~

REPEAL EO 23-02

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.

- ~~(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.~~

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.~~
- REPEAL EO 23-02

 - ~~(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.~~

REPEAL-EO 23-02

- ~~(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.~~

REPEAL EO 23-02

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).~~

REPEAL-EO 23-02

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;~~

REPEAL-EO 23-02

- ~~(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)

REPEAL-EO 23-02

 - (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.~~

REPEAL-EO 23-02

~~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.~~

REPEAL-EO 23-02