TOC required

201.000 Arkansas Medicaid Certification Requirements for Autism Waiver Program

~~10-1-123~~-1-20

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:

Autism Waiver providers must be certified by the Division of Developmental Disabilities Services (DDS) or its contracted vendor~~Partners for Inclusive Communities (Partners)~~ 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~~Partners~~ 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~~Partners~~ must be maintained by Autism Waiver Providers to avoid loss of provider certification. **View or print the ~~Partners~~ Provider Certification contact information.**

202.000 ENROLLMENT CRITERIA

202.100 ~~Autism~~ ASD Intensive Intervention Providers

~~10-1-123~~-1-20

An Autism Spectrum Disorder (ASD) Intervention Provider must:

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

OR

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

B. Have a minimum of ~~three (3)~~two (2) years of experience providing services to individuals with ASD~~autism~~, and

C. Be enrolled with Arkansas Medicaid to provide ~~Autism~~ ASD Intervention Provider services.

This criterion also applies to any non-profit organization formed as a collaborative organization made up of a group of licensed and / or certified providers, as described. In the case of a collaborative organization, the individual experience of its members will be considered to qualify the organization to participate in the program~~, based on the criteria above.~~

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

202.200 Consultants

~~10-15-123~~-1-20

A qualified Consultant must:

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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

B. Have a minimum of two (2) years of experience developing/providing intensive intervention or overseeing the intensive intervention program for children with Autism Spectrum Disorder (ASD)~~autism~~

OR

Hold a minimum of a master's degree in Psychology, Speech-Language Pathology, Occupational Therapy, ~~or~~ Special Education, or related field and have a minimum of two (2) years of experience providing intensive intervention or overseeing the intensive intervention program for children with ~~autism~~ASD.

202.300 Lead Therapists ~~10-15-12~~3-1-20

A qualified Lead Therapist must:

A. Hold a minimum of a bachelor's degree in Education/Special Education, Psychology, Speech-Language Pathology, Occupational Therapy, or a related field, and

B. Have completed 120 hours ~~or~~ of specified Autism Spectrum Disorder (ASD) ~~autism~~ training. ~~including:~~

1. Introduction to ~~Autism~~ 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

OR

Have completed an Autism Certificate Program, and

C. Have a minimum of two (2) years of experience in intensive intervention program~~ings~~ for children with ASD~~autism~~.

In a hardship situation, the Division of Developmental Disabilities Services (DDS) or its contracted vendor~~Partners~~ may issue a provisional certification to enable services to be delivered in a timely manner. A hardship situation exists when a child is in need of services and staff is not available who meet all training/experience requirements. Provisional certification of a particular staff person requires that the total number of training hours be completed within the first year of service.

202.400 Line Therapists ~~10-15-12~~3-1-20

A qualified Line Therapist must:

A. Hold a high school diploma or GED, ~~and~~

B. Have completed 80 hours of specified Autism Spectrum Disorder (ASD) ~~autism~~ training ~~including:~~

1. Introduction to ~~Autism~~ 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

C. Have a minimum of two (2) years of experience working directly with children ~~with autism.~~

In a hardship situation, the Division of Developmental Disabilities Services (DDS) or its contracted vendor~~Partners~~ may issue a provisional certification to enable services to be delivered in a timely manner. A hardship situation exists when a child is in need of services and staff is not available who meet all training/experience requirements. Provisional certification of a particular staff person requires that the total number of training hours be completed within the first year of service.

202.500 Consultative Clinical and Therapeutic Service Providers

~~10-1-12~~3-1-20

A. 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:

1. ~~B~~Be staffed by professionals who will serve as Clinical Service Specialists and are Board Certified Behavior Analysts or have ~~from multiple disciplines with a minimum of a M~~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~~Autism Spectrum Disorders~~
2. Have a central/home office located within the state and have the capacity to provide services in all areas of the state;
3. 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
4. Be enrolled with Arkansas Medicaid to provide Consultative Clinical and Therapeutic Services.
4. ~~Be an institution with experience in providing a graduate-level certificate (autism certificate) for individuals to work with children with autism. These waiver services will be provided by multi-disciplinary professionals with a minimum of a master's degree in Psychology, Special Education, Speech-Language Pathology or related field and experience in providing/overseeing intervention with young children with autism.~~

B. ~~Be enrolled with Arkansas Medicaid to provide Consultative Clinical and Therapeutic Services.~~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.

203.100 Documentation in Beneficiary's Case Files

~~10-1-12~~3-1-20

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

A. A copy of the beneficiary's treatment plan

B. The specific services rendered

C. Signed consent by a parent/legal guardian to receive services

D. 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

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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 Division of Developmental Disabilities Services (DDS) or its contracted vendor~~Partners and~~

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.

210.000 PROGRAM COVERAGE

211.000 Scope

~~10-1-12~~3-1-20

The purpose of the Autism Waiver is to provide one-on-one, intensive early intervention treatment for beneficiaries ages eighteen (18) months through ~~six~~ seven (~~6~~7) years with a diagnosis of Autism Spectrum Disorder (ASD) ~~autism~~. The waiver participants must meet the ICF/IID level of care and have a diagnosis of ~~autism~~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. Such settings include the home, schools or daycares, parks, etc.

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

A. Individual Assessment/Treatment Development/Monitoring

B. ~~Provision of~~ Therapeutic Aides and Behavioral Reinforcers

~~C. Plan Implementation and Monitoring of Intervention Effectiveness~~

C~~D~~. Lead Therapy Intervention

D~~E~~. Line Therapy Intervention

E~~F~~. Consultative Clinical and Therapeutic Services

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

212.200 Level of Care Determination

~~10-1-15~~3-1-20

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) ~~autism~~ being admitted to the state's ICF/IID facilities.

212.300 Plan of Care

~~10-1-12~~3-1-20

Each beneficiary eligible for the Autism Waiver must have an individualized plan of care. The authority to develop an Autism Waiver plan of care is given by the Division of Developmental Disabilities Services (DDS) or its contracted vendor~~to the Division of Medical Services designee, Partners~~. A copy of the plan of care, prepared by the Division of Developmental Disabilities Services (DDS) or its contracted vendor's Autism Waiver Coordinator ~~(Partners)~~ and the waiver participant's parent or guardian, is forwarded to the Autism Spectrum Disorder (ASD) ~~Autism~~ service provider(s) chosen by the participant. Each provider is responsible for developing an

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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~~Partners~~.

The ~~Autism~~ ASD plan of care must include:

A. Beneficiary identification information, including full name, address, date of birth, Medicaid number, and effective date of Autism Ww~~w~~aiver eligibility,

B. The medical and other services to be provided, their amount, frequency, scope, and duration,

C. The name of the service provider chosen by the beneficiary to provide each service,

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~~Partners'~~ 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~~Partners'~~ 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 ~~Partners'~~ 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~~Partners~~ 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~~Partners'~~ 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.

220.000 DESCRIPTION OF SERVICES

220.100 Intensive ~~Autism~~ ASD Intervention Provider ~~10-1-123-1-20~~

A Consultant, hired by the Division of Developmental Disabilities Services (DDS) or its contracted vendor, community-based organization, performs this service, which includes the following components:~~The Intensive Autism Intervention Provider is responsible for providing these services:~~

A. Individual Assessment/Treatment Development/Monitoring

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 include those recognized in the National Autism Center's National Standards Project, 2nd Edition. Established interventions include:
    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

~~1. The Consultant will assess the waiver participant by completing an adaptive assessment and a functional behavioral assessment. The Consultant will develop an Individual Treatment Plan based on the assessment utilizing exclusively evidence-based practices and will train key personnel to implement the intervention(s) and collect detailed data regarding the child's progress. Training will be offered to Lead and Line Therapists and parents/guardians.~~

~~2. The evidence-based practices that will be utilized in this program include those recognized in the National Autism Center's Report on Evidence Based Practices and those published in the text *Evidence-Based Practices and Treatments for Children with Autism* by Reichow, Doehring, Cicchetti and Volkmar (2009). The following practices are considered appropriate for inclusion in the intervention plans of children served in this waiver:~~

~~a. Prompting~~

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b. Antecedent-Based Interventions,
c. Time delay
d. Reinforcement
e. Task Analysis
f. Discrete Trial Training
g. Functional Behavior Analysis
h. Functional Communication Training
i. Response Interruption/Redirection
j. Differential Reinforcement
k. Social Narratives
l. Video Modeling
m. Naturalistic Interventions
n. Peer Mediated Intervention
o. Pivotal Response Training
p. Visual Supports
q. Structured Work Systems
r. Self Management

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.

B. Provision of Therapeutic Aides and Behavioral Reinforcers

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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. Plan Implementation and Monitoring of Intervention Effectiveness

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The Consultant is responsible for: oversight of implementation of evidence-based intervention strategies by the Lead and Line Therapists and family; ongoing education of family members and key staff on strategies used in treatment; response to concerns of family members and key staff regarding treatment; monthly on-site monitoring of treatment effectiveness and implementation fidelity; modification of treatment plan as necessary and modification of assessment information as necessary.

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CD. Lead Therapy Intervention

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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.

DE. Line Therapy Intervention

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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.

220.200 Benefit Limits

~~10-1-12~~3-1-20

A. Individual Assessment, Program Development/Training, Plan Implementation, and Monitoring of Intervention Effectiveness

The maximum benefit limit is ~~32 units per day/92 units per year.~~90 hours per plan of care year.

B. ~~Provision of T~~therapeutic Aaides and Bbehavioral Rreinforcers

There is a maximum reimbursement of $1,000.00 ~~(1 package)~~ per participant per lifetime. These aides/materials are to ~~be~~ left with the participant upon successful completion of the W~~w~~aiver program.

~~C. Plan Implementation and Monitoring of Intervention Effectiveness~~

~~The maximum benefit limit is 22 units per day/22 units per month.~~

C~~D~~. Lead Therapy ~~Intervention~~

The maximum benefit limit is ~~6 hours per week~~24 units per day/24 units per week.

D~~E~~. Line Therapy ~~Intervention~~

The maximum benefit limit is ~~25 hours per week.~~24 units per day/120 units per week.

E. Consultative Clinical and Therapeutic Services

The maximum benefit limit is 36 hours per plan of care year.

220.300 Consultative Clinical and Therapeutic Services

~~10-1-12~~3-1-20

The Autism Spectrum Disorder (ASD) ~~Autism~~ 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 ~~Operating Agency's (UAMS Partners)~~ 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, ~~telephone~~ as appropriate.

230.000 BILLING INSTRUCTIONS

230.100 Introduction to Billing

~~10-1-12~~3-1-20

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 beneficiary. Procedure codes can be found by following this link: **View or print the procedure codes for therapy services.**

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Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

~~230.200 Autism Waiver Procedure Codes~~ ~~10-1-12~~

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~~The following procedure codes and any associated modifier(s) must be billed for the Autism Waiver Services.~~

~~Procedure Code~~	~~Required Modifiers~~	~~Description~~	~~Unit of Service~~	~~National POS Codes~~
~~T2024~~	~~U1~~	~~Individual Assessment, Program Development/Training~~	~~15 minutes/ 92 units per year~~	~~12, 99~~
~~T1999~~		~~Therapeutic Aides and Behavioral Reinforcers~~	~~1 package/ lifetime~~	~~12,99~~
~~T2024~~	~~U2~~	~~Plan Implementation and Monitoring of Intervention Effectiveness~~	~~15 minutes/22 units a month~~	~~12, 99~~
~~H2019~~	~~U1~~	~~Autism Lead Therapy~~	~~15 minutes/ 24 units a week~~	~~12, 99~~
~~H2019~~	~~U2~~	~~Autism Line Therapy~~	~~15 minutes/120 units a week; 24 units a day~~	~~12, 99~~
~~T2025~~	~~U1~~	~~Consultative Clinical and Therapeutic Services~~	~~15 minutes/144 units per year~~	~~12, 99~~

230.410 Completion of CMS-1500 Claim Form ~~12-15-143-1-20~~

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 Nname, 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.
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.

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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.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
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	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. 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.
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.
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.

TOC required

201.000 Arkansas Medicaid Certification Requirements for Autism Waiver Program 3-1-20

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:

Autism Waiver providers must be certified by 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.**

202.000 ENROLLMENT CRITERIA

202.100 ASD Intensive Intervention Providers 3-1-20

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. Have a minimum of two (2) years of experience providing services to individuals with ASD, and

C. Be enrolled with Arkansas Medicaid to provide ASD Intervention Provider services.

This criterion also applies to any non-profit organization formed as a collaborative organization made up of a group of licensed and / or certified providers, as described. In the case of a collaborative organization, the individual experience of its members will be considered to qualify the organization to participate in the program.

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

202.200 Consultants 3-1-20

A qualified Consultant 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

B. Have a minimum of two (2) years of experience developing/providing intensive intervention or overseeing the intensive intervention program for children with Autism Spectrum Disorder (ASD)

OR

Hold a minimum of a master's degree in Psychology, Speech-Language Pathology, Occupational Therapy, Special Education, or related field and have a minimum of two (2) years of experience providing intensive intervention or overseeing the intensive intervention program for children with ASD.

202.300 Lead Therapists 3-1-20

A qualified Lead Therapist must:

A. Hold a minimum of a bachelor's degree in Education/Special Education, Psychology, Speech-Language Pathology, Occupational Therapy, or a related field, and

B. Have completed 120 hours of specified Autism Spectrum Disorder (ASD) training.

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

OR

Have completed an Autism Certificate Program, and

C. Have a minimum of two (2) years of experience in intensive intervention programing for children with ASD.

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. A hardship situation exists when a child is in need of services and staff is not available who meet all training/experience requirements. Provisional certification of a particular staff person requires that the total number of training hours be completed within the first year of service.

202.400 Line Therapists 3-1-20

A qualified Line Therapist must:

A. Hold a high school diploma or GED,

B. Have completed 80 hours of specified Autism Spectrum Disorder (ASD) training

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

C. Have a minimum of two (2) years of experience working directly with children.

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. A hardship situation exists when a child is in need of services and staff is not

available who meet all training/experience requirements. Provisional certification of a particular staff person requires that the total number of training hours be completed within the first year of service.

202.500 Consultative Clinical and Therapeutic Service Providers 3-1-20

A. 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:

1. 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
2. Have a central/home office located within the state and have the capacity to provide services in all areas of the state;
3. 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
4. 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.

203.100 Documentation in Beneficiary's Case Files 3-1-20

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

A. A copy of the beneficiary's treatment plan

B. The specific services rendered

C. Signed consent by a parent/legal guardian to receive services

D. 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 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.

210.000 PROGRAM COVERAGE

211.000 Scope 3-1-20

The purpose of the Autism Waiver is to provide one-on-one, intensive early intervention treatment for beneficiaries ages eighteen (18) months through seven (7) years with a diagnosis

of Autism Spectrum Disorder (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. Such settings include the home, schools or daycares, parks, etc.

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.

212.200 Level of Care Determination 3-1-20

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.

212.300 Plan of Care 3-1-20

Each beneficiary eligible for the Autism Waiver must have an individualized plan of care. 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.

The ASD plan of care must include:

A. Beneficiary identification information, including full name, address, date of birth, Medicaid number, and effective date of Autism Waiver eligibility,

B. The medical and other services to be provided, their amount, frequency, scope, and duration,

C. The name of the service provider chosen by the beneficiary to provide each service,

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.

220.000 DESCRIPTION OF SERVICES

220.100 Intensive ASD Intervention Provider 3-1-20

A Consultant, hired by the Division of Developmental Disabilities Services (DDS) or its contracted vendor, community-based organization, performs this service, which includes the following components:

A. Individual Assessment/Treatment Development/Monitoring

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 include those recognized in the National Autism Center's National Standards Project, 2nd Edition. Established interventions include:
    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.

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.

220.200 Benefit Limits 3-1-20

A. Individual Assessment, Program Development/Training Plan Implementation, and Monitoring of Intervention Effectiveness

The maximum benefit limit is 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 to left with the participant upon successful completion of the Waiver program.

C. Lead Therapy

The maximum benefit limit is 6 hours per week

D. Line Therapy

The maximum benefit limit is 25 hours per week.

E. Consultative Clinical and Therapeutic Services

The maximum benefit limit is 36 hours per plan of care year.

220.300 Consultative Clinical and Therapeutic Services 3-1-20

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.

230.000 BILLING INSTRUCTIONS

230.100 Introduction to Billing 3-1-20

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 beneficiary. Procedure codes can be found by following this link: **View or print the procedure codes for therapy services.**

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

230.410 Completion of CMS-1500 Claim Form 3-1-20

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.
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.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation

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	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. 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.
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.
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.

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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
Autism Waiver

C. Waiver Number:AR.0936

D. Amendment Number:

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

03/01/20

Approved Effective Date of Waiver being Amended: 12/07/17

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

1) To add 30 additional slots to the Waiver
2) To increase the number of unduplicated participants to account for the increase in slots
3) Revise the cost neutrality demonstration to reflect actual Waiver costs are less than originally projected, which allowed the State to add the additional slots.
4) To reflect that DDS took over the administration of the Autism Waiver and is now the operating Agency.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	5-B; 6-I; 7-A, B; 8; Attachment 2
☒ **Appendix A Waiver**	A-1; A-2b; A-3; A-7; Quality Improvement

Component of the Approved Waiver	Subsection(s)
Administration and Operation	
☒ Appendix B Participant Access and Eligibility	B-3a; B-3b; B-3f; B-6c, d, f, i, j; Quality Improvement; B-7b
☒ Appendix C Participant Services	C-1/C-3; C-2a, b, f, Quality Improvement; C-4a
☒ Appendix D Participant Centered Service Planning and Delivery	D-1a, b, c, d, e, f, g, i; D-2a; Quality Improvement;
☐ Appendix E Participant Direction of Services	
☒ Appendix F Participant Rights	F-1; F-3b, c
☒ Appendix G Participant Safeguards	G-1b, c, d; G-2a, b, c; Quality Improvement;
☒ Appendix H	H-1a, b
☒ Appendix I Financial Accountability	I-1; Quality Improvement; I-2d
☒ Appendix J Cost-Neutrality Demonstration	J-2a; J-2d

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☒ **Increase/decrease number of participants**
- ☒ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

  Specify:

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

1. Request Information (1 of 3)

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

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

Autism Waiver

C. Type of Request: amendment

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.026.01.02**

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/17
Approved Effective Date of Waiver being Amended: 12/07/17

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 in42 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 Eligiblity 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 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.

The services offered through the Autism Waiver program are 1)Individual Assessment/Plan Development/Team Training/ Monitoring; 2)Therapeutic Aides and Behavioral Reinforcers; 3)Lead Therapy; 4)Line Therapy; and 5) Consultative Clinical and Therapeutic Services. The first four services are provided by Intensive Intervention providers. Consultative Clinical and Therapeutic Services are provided by Clinical Services Specialists working with a four-year 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 Division of Developmental Disabilities Services (DDS) who contracts with a vendor (the "vendor") to oversee many functions of the Waiver. Under this arrangement, the vendor oversees assessments for level of care and eligibility for the Waiver, the development of the Plan of Care (POC), and certifies Autism Waiver providers. The POC outlines the services to be provided, the provider who will provide those services, and the parent(s)/guardian(s)' participation agreement. 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 line therapist provides the 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. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness 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 in-patients 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) we published the following public notice of rule making in the statewide Arkansas Democrat Gazette newspaper, _____, and posted a web-based electronic file of the entire Autism Waiver, at (https://www.medicaid.state.ar.us/general/comment/comment.aspx) the Division of Medical Services (DMS) website to allow general public comment.

"NOTICE OF RULE MAKING

[will put public comment information here]

There are no Federally-recognized Tribal Governments in Arkansas.

The autism renewal application was submitted to CMS on _____.

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: Golden

First Name: Mac

Title: Attorney Specialist for the Office of Rules Promulgation

Agency: Office of Rules Promulgation, Department of Human Services

Address: PO Box 1427, Slot S295

Address 2:

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 320-6383 **Ext:** ☐ **TTY**

Fax: (501) 404-4619

E-mail: Mac.E.Golden@dhs.arkansas.gov

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

Last Name: Stone

First Name: Melissa

Title: Director

Agency: Division of Developmental Disabilities Services, Department of Human Services

Address: PO Box 1437

Address 2: Slot N501

City: Little Rock

State: **Arkansas**

Zip: 72201

Phone: (501) 682-8665 **Ext:** ☐ **TTY**

Fax: (501) 682-8380

E-mail: thomas.tarpley@dhs.arkansas.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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: Stehle

First Name: Dawn

Title: Deputy Director of Health and Medicaid Director

Agency: Department of Human Services

Address: P.O. Box 1437

Address 2:

Slot S401

City: Little Rock

State: **Arkansas**

Zip: 72203-1437

Phone: (501) 683-4997 **Ext:** ☒ **TTY**

Fax: (501) 682-1197

E-mail: dawn.stehle.dhs.arkansas.gov

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:

This Amendment adds 30 slots to the Waiver.

Upon approval of the Amendment, the current waiting list will be reviewed and services will be provided to the children identified as eligible on the waiting list on a first come, first serve basis (those who have been waiting the longest will be offered services first). DDS's contracted vendor will continue to accept application until all Waiver slots are filled. Once the slots are filled, a waiting list will be resumed and maintained by DDS's contracted vendor, with children being offered a slot once it becomes available, on a first come, first serve basis.

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 of Arkansas submitted and received final approval, on a statewide transition plan in accordance with the requirements found at 42 CFR 441.301(c) & 441.710. This plan can be found at http://humanservices.arkansas.gov/daas/Pages/HCBS-Settings-Home.aspx.

Arkansas assures that the settings transition plan will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. Arkansas will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment.

Due to the nature of the Autism Waiver, it has been determined that the Autism Waiver complies with HCBS requirements. The Autism Waiver provides one-on-one, intensive early intervention treatment including individual assessment, treatment development, therapeutic aides, behavioral reinforcement, plan implementation, monitoring of intervention effectiveness, lead therapy, line therapy, and consultative clinical and therapeutic services for beneficiaries 18 months through 7 years of age who have been diagnosed with autism and meet ICF/IID level of care. All of the waiver services provide a team approach to intervention for children with Autism Spectrum Disorders (ASD). The intervention team includes the parents/guardians as active interventionists for their child, with requirements for them to be present and implement the intervention strategies for a minimum of 14 hours per week.

All of the settings for this waiver comply with HCBS requirements because they are all natural community settings that provide inclusive opportunities for the children with autism served by the waiver. These settings include locations such as the child's home, church, places where the family shops, restaurants, ball parks, etc. There are no segregated settings utilized in this program. This waiver does not offer services for children in residences other than their natural home with their parent/guardian. The homes, where the majority of services occur, are where the children live with their families. This waiver utilizes no residential settings operated by the State or private providers that are offered as out-of-home alternatives for living situations. The other natural community settings where services occur are not specialized or segregated settings but rather places where the family frequents and where the child with ASD has difficulty functioning. The community settings are tied to specific treatment goals where children need to learn functional skills or replacement behaviors to be able to be included in natural community locations.

Ongoing Assessment of Settings

The Division of Provider Support and Quality Assurance (DPSQA), Office of Long Term Care (OLTC) Licensure unit is responsible for onsite visits for environmental regulatory requirements. The DPSQA OLTC Licensure unit licenses the facilities to operate as an Assisted Living Facility or an Adult Day Care or Adult Day Health Care facility and approve the number of slots that individuals may utilize in these settings. The DPSQA Provider Certification Unit certifies the providers to provide care under the waiver(s) once they are enrolled to be Medicaid providers. On-going compliance with the assessment of settings will be monitored collectively with DMS, DDS and DPSQA staff.

Licensed and certified settings are subject to periodic compliance site-visits by the DPSQA Provider Certification Unit. HCBS Settings requirements will be enforced during those visits. DPSQA expects every residential and non-residential setting to receive a visit at least once every three years. These visits will include a site survey and beneficiary experience surveys with a select number of Medicaid beneficiaries. The agency's registered nurses, case managers, and provider certification staff has been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for agency employees. Ongoing training for providers on the HCBS Settings rule will be provided during biannual provider workshops hosted by the DPSQA Provider Certification Unit, as well as through annual meetings of provider membership organizations and via updates to the Arkansas HCBS website.

Settings found to have deficiencies will be required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. Providers who wish to appeal our findings can follow the appeal rights process described in Section 160.00 Administrative Reconsideration and Appeals of the Arkansas Medicaid Provider Manual (https://www.medicaid.state.ar.us/provider/docs/all.aspx). New waiver providers will also be subject to an assessment of compliance with the HCBS Settings requirements before being approved to provide services for the waiver.

Regularly scheduled on-site visits completed by the DPQSQA Licensure and Certification unit, that oversees HCBS regulatory requirements, will occur to ensure HCBS Settings compliance. DDS and DPSQA expect every residential setting to receive a visit at least once every three years, in addition to the current random home visit procedure (minimum 10% per staff caseload) of DPSQA Licensure and Certification unit. These visits will include a site survey and beneficiary experience surveys with a select number of Medicaid beneficiaries. DDS Community and Employment Supports Waiver staff and DDS Licensure and Certification staff have been trained on the HCBS Settings rule. Information on the HCBS Settings rule will be included in annual training opportunities for DDS and DPSQA staff. Ongoing training for providers on the HCBS Settings rule will be

provided through annual meetings of provider membership organizations and via updates to the Arkansas HCBS website.

Settings found to be out of compliance with the new regulations during these routine reviews will be required to submit and have approved a corrective action plan which includes a timeframe for its completion. Failure to complete that plan may jeopardize the agency's certification and participation in the waiver program. Providers who wish to appeal our findings can follow the appeal rights process described in DDS Policy 1076 Appeals.

PUBLIC COMMENT

Website

The Statewide Transition Plan (STP), including the timeline and narrative, was available for public review and comment August 17, 2016 through September 15, 2016. The STP was posted online at http://www.medicaid.state.ar.us/general/comment/comment.aspx. This was the URL throughout the 30-day public comment period. The state assures that the link provided to the public directed individuals to the STP during the public comment period. All components of the STP – narrative, timeline chart, and public comments and responses – were made available to the public through a functional URL. The Medicaid website page with hyperlinks remained consistent throughout and provided the appropriate hyperlinks to the documents at all times.

Public Notice

A notice referencing the STP was published in the statewide newspaper, Arkansas Democrat-Gazette, on August 17, 2016 through August 19, 2016. The entire STP was not published in the newspaper; however, the notice stated: "The Statewide Transition Plan is available for review at the Division of Medical Services (DMS), 2nd floor Donaghey Plaza South, 700 South Main Street, P.O. Box 1437, S-295, Little Rock, Arkansas 72203-1437, by telephoning 501-320-6429 or can be downloaded at http://www.medicaid.state.ar.us/general/comment/comment.aspx." The state provided instructions via the public notice, during the stakeholder meeting, and on the website with regard to how comments could be submitted. The public notice stated: "Comments may be provided during the 30-day comment period, (August 17, 2016 – September 15, 2016), during the stakeholder meeting, in writing to DMS at the address indicated above or by email to becky.murphy@dhs.arkansas.gov. All comments must be submitted by no later than September 15, 2016."

Public Hearing/Stakeholder Meeting

In addition, the State held a Statewide Transition Plan Large Stakeholder Meeting (open to the public) on August 23, 2016 to receive comments. The public notice published in the statewide newspaper on August 18, 2016 stated: "Comments may be provided during the 30 –day comment period, (August 17, 2016 - September 15, 2016), during the stakeholder meeting, in writing to DMS at the address indicated above or by email to becky.murphy@dhs.arkansas.gov."

Print Format

The STP was made available to the public in printed format to be picked up in person at the state DHS office, in printed format during the stakeholder meeting, mailed, emailed, and posted on the state Medicaid website. It was also distributed and discussed during several follow up meetings and teleconferences. Participants of the various meetings included key stakeholders, family members, and advocacy representatives from around the state.

Communication/Stakeholder Input

After the 30-day public comment period, a summary of the public comments and the state's responses to the public comments were posted for the public to review on the state's Medicaid website. They were also sent to each commenter.

The State reviewed and considered all comments received; summarized all comments, including those which agree or disagree with the state's determination about compliance with the settings requirements; and made changes, as appropriate, to the STP.

Comments/Responses

No comments were received which specifically addressed the Autism Waiver AR. 0936

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

○ **The waiver is operated by the state Medicaid agency.**

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Division of Developmental Disabilities Services

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

Appendix A: Waiver Administration and Operation

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) and the Division of Developmental Disabilities Services (DDS) have an Interagency Agreement ("Agreement") in place to ensure a 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 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:

(1) 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;
(2) administers assessments, as necessary, to make recommendations to Arkansas regarding participants' Level of Care;
(3) develops Plans of Care (POC) for each participant enrolled in the Autism Waiver; and
(4) 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 Division of County Operations' eligibility system, ANSWER, to monitor quality and compliance with Autism Waiver 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 contracts with a non-profit organization to assist 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.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

DDS is responsible for oversight of the contracted vendor. 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, and provides a second line of oversight for the contract.

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:

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	☒	☐	☒
Waiver enrollment managed against approved limits	☒	☒	☐

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

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 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **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 Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
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	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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:
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☐ **Operating Agency**	☒ **Monthly**	☐ **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 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **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:
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **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 DMS prior to implementation. Numerator: Number of policies and procedures by DDS reviewed by DMS before 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

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:	☐ **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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **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:
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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **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 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **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

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 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 policies or procedures were not reviewed and approved by DMS, remediation includes DMS review of the policy or procedure upon discovery, and approving or removing the policy or procedure, as appropriate.

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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **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
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	1	7	☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

1. Children between eighteen (18) months and seven (7) years, who have been diagnosed with Autism Spectrum Disorder (ASD), as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association, and who meet the ICF-IID level of care criteria.

2. The diagnosis of ASD must have been provided by multiple professionals, including a physician, psychologist and speech-language pathologist, either individually or as a team.

3. 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.

4. Participants must enter the program on or before their fifth birthday to allow for the maximum of three years 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 State's transition planning procedures will be initated three months prior to the 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. Parents/guardians will be provided information about other services, supports and appropriate referrals available (i.e., state plan services, other waiver alternatives, and programs available through the Local Education Agency). The Autism Waiver Coordinator will be responsible for coordinating the transition to other services. If 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	200
Year 2	200
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	150
Year 2	150
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 has been accepting applications on behalf of DMS throughout the life of the Autism Waiver program, and currently maintains a waiting list for services. The waiting list will be opened and services will be provided to children identified as program eligible until the maximum number of slots has been filled. DDS's contracted vendor will continue accepting applications and children will be moved into services on a first come, first serve basis. Once all slots are filled, a waiting list will be maintained until an available slot opens.

A child must be admitted to the program on or before his or her fifth birthday in order to allow for the maximum of three years of treatment before aging out at his or her eighth birthday. Without any age requirement for entrance to the program, a child could get processed for services immediately prior to his or her eighth birthday, leaving insufficient time to recruit staff and provide services 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

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

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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 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: 2

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 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).

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.

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 the same criteria used for 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.

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.

A child will be found to meet the LOC eligibility with a score of 70 or less in any two of the Vineland II Survey Interview domains.

Scores above 70 that fall within the confidence interval of the Vineland II will not preclude a child's eligibility for the Autism Waiver. For example, a child diagnosed with ASD with a score of 74 for the Communication Domain where the confidence level is 5 points for the child's developmental age, would be eligible.

A Maladaptive Behavior Index 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 scores falling within the range of the test's confidence interval for the child's developmental age 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. A TABS score of 8 and above 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.

It should be noted that the contracted vendor may be administering the Vineland II and the TABS or interpreting results of instruments already included in the child's assessment battery if the instruments have been administered within the past six months for initial eligibility.

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

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

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

Children with ASD ages 18 months through 7, are referred for the Arkansas Autism Waiver by physicians, county health nurses, Developmental Disabilities Services case managers, staff of provider agencies, or parents/family members who have become aware of the program through promotional activities. These activities may include distribution of programmatic brochures, notifications distributed via listservs, postings on websites or blogs, notices in hard copy and electronic newsletters, newspaper notices, public service announcements and other efforts of service providers, advocacy and State Agency staff.

The determination of a child's eligibility for the Autism Waiver requires multiple components. First is the determination of medical eligibility, or that the child is within the specified age range (18 months to age five years) and has a qualifying diagnosis of ASD. Once enrolled in the program, the child may remain in the program until he/she reaches his/her 8th birthday or until the child has received 3 years of services, whichever comes first. A child must be admitted to the program on or before his/her 5th birthday in order to allow time for the maximum of three (3) years of treatment prior to aging out.

The second component is the determination of financial eligibility for participation in the Medicaid program.

The third component is the level of care (LOC) determination. This determination is based on significant delays in adaptive functioning in activities of daily living, socialization and communication; or moderate delays in adaptive functioning coupled with a clinically significant Maladaptive Behavior Index score.

The initial phase of medical eligibility determination is conducted through a "desk audit" with documentation of the qualifying diagnosis and age submitted by the parent/guardian. Once the documentation is received it is reviewed by DDS's contracted vendor for confirmation that the child meets the diagnostic and age requirements for participation.

The LOC assessment is completed by DDS's contracted vendor through direct contact with the parent/guardian and the child. This direct contact may include telephone conversations, for preliminary data collection on adaptive functioning; as well as an on-site visit, for completion of data collection, confirmation of parental choice, confirmation of parental agreement to participation requirements (Parent/Guardian Participation Agreement), and development of the Plan of Care (POC). This is submitted to the Office of Long Term Care (OLTC) for a final level of care determination.

Financial eligibility is conducted by eligibility specialists in the DHS County Offices and may occur simultaneously with the LOC determination.

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.

The Evaluation of Medical Need Criteria (DHS form 703) is completed by DDS's contracted vendor. The Decision for Nursing Home Waiver Placement form (DHS form 704) is completed by the Division of Provider Support and Quality Assurance (DPSQA), Office of Long Term Care (OLTC). All steps will be completed prior to any child's approval for admission to the program or initiation of services.

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

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

A tickler file is created for level of care (LOC) reassessments. Ninety days prior to the expiration of the LOC, the process for reevaluation is triggered and is then completed by DDS's contracted vendor and forwarded to OLTC.

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

A waiver participant's record, including initial evaluation and all reevaluation documentation will be maintained by DDS's contracted vendor for the duration of the participant's participation in the Autism Waiver program, plus an additional five-year period.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of applicants who had an initial level of care (LOC) determination indicating the need for ICF/IID LOC prior to receipt of services. Numerator: number of applicants who received LOC determinations prior to services; Denominator: Total number of applicants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
Number and percent of Autism Waiver participants who received an annual level of care (LOC) redetermination within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. Numerator: Number of participants receiving annual redeterminations within 12 months; Denominator: number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **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 Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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: 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
Number and percent of participants' initial and annual re-evaluation level of care (LOC) determination forms that were completed as required by the state.
Numerator: Number of participants with LOC forms completed correctly;
Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of participants' level of care (LOC) determinations made by a qualified evaluator. Numerator: Number of participants with LOC made by a qualified evaluator; Denominator: Number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percentage of participants' level of care (LOC) determinations made where the LOC criteria was accurately applied. Numerator: Number of participants' LOCs with correct criteria. Denominator: Number of participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Monthly Level of Care 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **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.

The state currently implements a system of monitoring that assures timeliness, accuracy, appropriateness and quality. Data is collected from individual participant assessments, aggregated to produce summation reports, and compared with periodic, randomly sampled chart reviews and sampled field audit reviews.

Participant records undergo chart reviews performed by DDS's contracted vendor. Monthly activity reports track assessment activity and quality of information reporting from monthly chart reviews produced by clinical staff, submitted to DDS's contracted vendor for analysis of timeliness and accuracy. Individual assessments are also used as the base data for a 45 Day Report, which tracks all Autism Waiver applications and flags any due for assessment at or within 45 days. In addition, DDS's contracted vendor maintains a daily log of assessments and reassessments sent to the DMS Office of Long Term Care (OLTC) for medical determination. Data from all assessment and review activity is aggregated to produce an annual Chart Review Summary, Level of Care Monthly Report and Annual Accuracy Report. Periodic chart reviews on randomly sampled cases are performed throughout the year, as well as field audits of records sampling. Results are submitted to DDS.

Level of Care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future. DDS's contracted vendor involves medical personnel in the process and determination by performing record reviews of individual participants and synthesizing data from monthly reports. Chart audits are performed regularly and results are aggregated for the Chart Review Summary Report.

Enrolled participants are re-evaluated at least annually. DDS's contracted vendor utilizes a system which generates notices of cases due for re-evaluation. DDS's contracted vendor records the number of re-assessments due on the Monthly Activity Report. The same chart review process described above is utilized for the re-evaluation process. Cases are identified for re-evaluation through a manual tickler system and through electronically generated reports.

The assessment process and instruments described in the Autism Waiver are applied appropriately and according to the approved description to determine participant level of care. Chart reviews include an audit of the assessment and reassessment functions and their alignment with waiver guidelines and timeframes. Findings are aggregated and included in the annual Chart Review Summary.

The Annual Report is a compilation of the results of the random chart selection by DDS staff in which all aspects of the Autism Waiver policy are reviewed. Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas, including level of care determinations.

b. Methods for Remediation/Fixing Individual Problems

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

DDS and its contracted vendor hold quarterly team meetings to discuss and address individual problems associated with level of care (LOC) determinations and system improvement, as well as problem correction and resolution. DDS has a contract with its vendor to perform duties of the Autism Waiver. The agreement includes measures related to LOC determinations and redeterminations for the Autism Waiver.

The system currently in place for new applicants to enter the Autism Waiver program does not allow for services to be delivered prior to an initial LOC determination. Therefore, performance measures related to these processes must always result in 100% compliance and do not allow for the possibility of remediation.

LOC redeterminations are required annually using the DHS-703 and applying the ICF/IID LOC criteria. Remediation in these areas includes ongoing training by DDS's contracted vendor for its staff who perform the LOC assessments to ensure that the proper ICF/IID admission criteria is applied and that the initial and annual re-evaluations are completed within required time frames.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The choice between institutional care or Autism Waiver services will be offered to each participant's parent/legal guardian by the Autism Waiver Coordinator employed by DDS's contracted vendor, during a face-to-face visit. The Freedom of Choice Form will document the decision of the parent/guardian. The choice will remain in effect until such time as the parent/guardian changes his/her mind and notifies the Autism Waiver Coordinator.

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

The completed Freedom of Choice form is kept in the participant's record maintained by DDS's contracted vendor.

Appendix B: Participant Access and Eligibility

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

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

All Department of Human Services (DHS) forms are available in English and Spanish. The forms can be translated into other languages when the need arises. DHS maintains an ongoing contract with Communications Plus and Interpreter Services for translation services.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consultative Clinical and Therapeutic Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Consultative Clinical and Therapeutic Services assist parents/guardians and paid support staff involved in the intensive intervention service with carrying out the Individual Treatment Plan (ITP) as necessary to improve the child's independence and inclusion in their family and community. "Intensive Intervention service" refers to the individualized treatment strategies selected for a Waiver Participant following his or her individual assessment. The strategies must be selected from what are considered evidence-based interventions, as outlined in the National Autism Center's National Standards Project, 2nd Edition. Established interventions include: behavioral interventions, cognitive behavioral intervention package, comprehensive behavioral treatment for young children, language training, modeling, naturalistic teaching strategies, parent training package, peer training package, pivotal response treatment, schedules, scripting, self-management, social skills package, and story-based interventions. In addition to these listed interventions, DDS will utilize new interventions that are found to be effective and incorporated into future revisions of the report. Each selected intervention must be documented on the participant's ITP.

This service is carried out by Clinical Services Specialists (CSS). The CSS provides technical assistance to carry out the ITP and reviews the child's progress toward the established treatment goals and objectives to determine efficacy of the treatment strategies being utilized. If review of treatment data on a specific child does not show progress or does not seem to be consistent with the skill level/behaviors of the child, 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 schedule a conference to determine if the ITP 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 child regarding the intervention. This service will be delivered in the child's home or community location, based on the ITP, or via the use of distance technology, as appropriate.

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

Limited to 36 hours (144 units) per year.

The services proposed in this waiver are not provided under the IDEA Parts B or C. These services are provided through an intensive, one-on-one model in the childs home by highly qualified interventionists. Additionally, these treatment interventions do not address educational goals and objectives.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Institution of Higher Education (4-year)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services

Provider Category:

Agency

Provider Type:

Institution of Higher Education (4-year)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An Institution of Higher Education (4-year program) with the capacity to conduct research specific to Autism Spectrum Disorders (ASD).

The Provider Institution must be:
1) staffed by professionals who are Board Certified Behavioral Analysts or who have a Masters degree in psychology, special education, speech-language pathology or a related field and 3 years of experience in providing interventions to young children with ASD (who will serve as the Clinical Services Specialists);
2) have a central/home office located within the state and have the capacity to provide services in all areas of the state;
3) have a graduate level curriculum developed and a minimum of 3 years' of experience in providing training toward a graduate certificate in ASD, recognized by the Arkansas Department of Higher Education.

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 a significant maladaptive behavior exists, or where significant risk factors are noted.

The Provider must enroll with Medicaid to provide Consultative Clinical and Therapeutic Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS's contracted vendor

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Assessment/ Treatment Development/ Monitoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

A Consultant, hired by the Arkansas Autism Partnership (AAP) provider, community-based organization, performs this service, which includes the following components:
(1) Assess each child to determine a comprehensive clinical profile, documenting skills deficits across multiple domains including language/communication, cognition, socialization, self-care and behavior. The instruments used will be individualized to the childs presenting symptoms as determined by the Consultant but must include at a minimum the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) or the Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) at least every 4 months. Other instruments and clinical judgment of the Consultant may also be utilized so long as they render a detailed profile of the child's skills and deficits across multiple domains.

(2) Use this detailed clinical profile provides 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 trains Lead and Line Therapists to implement the intervention(s) and collect detailed data regarding the child's progress.

(3) Use data collected to determine the clinical progress of the child and the need for adjustments to the ITP.

Data collected varies based on the child's individual need, his her presenting clinical profile, and the ITP developed to meet his or her needs. The data collected on every goal is targeted to measure the success of the intervention and the participant's progress toward the ITP goals. While data does vary, there is consistent use of the Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) with all children served by the Autism Waiver. The ABLLS-R tracks skills development in 25 domains, including receptive language, vocal imitation, requests, labeling, spontaneous vocalization, social interaction, dressing, eating, grooming, toileting, gross and fine motor skills. This data is collected at least once every four (4) months and is used to track progress of the child in the intervention.

Additional data is collected when clinical conditions warrant such, as with the presence of maladaptive behavior. For example, if a child demonstrates head-banging behavior, data collection, as part of the Behavior Intervention Plan, would likely focus on the frequency of head banging, as well as Antecedents and Consequences related to the head banging. By analyzing this data and determining the function served by the target behavior, the treatment team can determine what replacement skills should be taught in the child's intervention to successfully eliminate his or her need for the self-injurious behavior.

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.

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

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

Limited to 90 hours (360 units) per year.

The services proposed in this waiver are not provided under the IDEA Parts B or C. These services are provided through an intensive, one-on-one model in the childs home by highly qualified interventionists. Additionally, these treatment interventions do not address educational goals and objectives.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intensive Intervention Provider (Community-based organization)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Assessment/ Treatment Development/ Monitoring

Provider Category:

Agency

Provider Type:

Intensive Intervention Provider (Community-based organization)

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Early Intervention Day Treatment (EIDT) Services to children.

Certificate *(specify):*

Certified to provide Home and Community Based Services (HCBS) under the Community and Employment Supports (CES) Waiver.

Other Standard *(specify):*

Must have a minimum of three years' experience providing services to individuals with ASD.

Includes any organization formed as a collaborative organization made up of a group of licensed/certified providers, as described above. In the case of a collaborative, the individual experience of its members will be considered to qualify the organization to participate in the program.

Additionally: the personnel hired by these providers to act as Consultants must meet one of the following to be considered qualified professionals/paraprofessionals:

(1) Hold a certificate from the Behavior Analyst Certification Board (BACB) as a BCBA (Board Certified Behavior Analyst) or BCaBA (Board Certified Assistant Behavior Analyst), plus have a minimum of 2 years' experience developing/providing intensive intervention or overseeing the intensive intervention program for children with ASD; or

(2) Hold a minimum of a Master's degree in Psychology, Speech-Language Pathology, Occupational Therapy or Special Education or related field, plus have a minimum of 2 years' experience developing/providing/overseeing intensive interventions for children with ASD.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS's contracted vendor will certify providers.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. DDS's contracted vendor will monitor that personnel meet applicable standards and maintain a database of qualified personnel involved in the program for the purpose of referrals as new children are added to the program and for the purpose of monitoring supply and demand across the State.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Lead Therapy Intervention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Lead Therapy Intervention includes the following activities:
(1) Assurance that the Individual Treatment Plan (ITP) is implemented as designed;
(2) Weekly monitoring of the implementation and effectiveness of the ITP;
(3) Reviewing all data collected by the Line Therapists and the parents/guardians;
(4) Providing guidance and support to the Line Therapists;
(5) Receiving parents/guardians feedback and responding to concerns or forwarding them to the appropriate person or agency; and
(6) Notifying the assigned Consultant when issues arise.

Monitoring under this service is conducted for the purpose of determining implementation fidelity. Any problems noted by the Lead Therapist will be reported to the Consultant who will make any necessary adjustments in the ITP.

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

6 hours (24 units) per week.

The services proposed in this waiver are not provided under the IDEA Parts B or C. These services are provided through an intensive, one-on-one model in the childs home by highly qualified interventionists. Additionally, these treatment interventions do not address educational goals and objectives.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intensive Intervention Provider (Community-based organization)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Lead Therapy Intervention

Provider Category:

Agency

Provider Type:

Intensive Intervention Provider (Community-based organization)

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Early Intervention Day Treatment (EIDT) Services.

Certificate *(specify):*

Certified to provide Home and Community Based Services (HCBS) under the Community and Employment Supports (CES) Waiver.

Certified by DDS's contracted vendor to provide Autism Waiver Services.

Other Standard *(specify):*

The organization must have a minimum of three (3) years' experience providing services to individuals with ASD.

Includes any organization formed as a collaborative organization made up of a group of licensed/certified providers as described above. In the case of a collaborative, the individual experience of its members will be considered to qualify the organization to participate in the program.

Additionally, the personnel hired by these providers as Lead Therapists must meet the following standards to be considered qualified professionals/paraprofessionals:

(1) Hold a minimum of a bachelor's degree in education/special education, psychology, speech-language pathology, occupational therapy or related field,
(2) Have completed 120 hours of specified autism training or have completed the Autism Certificate offered by the University of Arkansas, and
(3) Have a minimum of 2 years' experience in intensive intervention programming for children with ASD.

*Note: In a hardship situation, a provider may be issued a provisional certification to enable services to be delivered in a timely manner. A hardship situation exists when a child is in need of services and staff is not available who meet all training/experience requirements. Provisional certification of a particular staff person requires that the total number of training hours be completed within the first year of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS's contracted vendor.

Certified providers will be responsible for hiring qualified personnel to implement the programs. DDS's contracted vendor will monitor that personnel meet applicable standard and maintain a database of qualified personnel involved in the program for the purpose of referrals as new children are added to the program and for the purpose of monitoring supply and demand across the State.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Line Therapy Intervention

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Line Therapy involves the following activities:
(1) On-site (both in-home and community settings) implementation of the intensive intervention services according to the Individual Treatment Plan (ITP);
(2) Recording data according to the ITP; and
(3) Reporting progress/concerns to the Lead Therapist or Consultant, as needed.

Line therapy services and line therapists are overseen at multiple levels within the program. The primary mechanism for oversight is the lead therapist, who is in the home each week to observe the performance of the Line Therapist and review the data. The Consultant and Clinical Services Specialist also provide oversight for the Line Therapist. Participating parent(s)/guardian(s) are also able to report any concerns regarding the Line Therapist to the Lead Therapist, the Consultant, the Clinical Services Specialists, or the Autism Waiver Coordinator employed by DDS's contracted vendor.

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

25 hours (100 units) per week

The services proposed in this waiver are not provided under the IDEA Parts B or C. These services are provided through an intensive, one-on-one model in the childs home by highly qualified interventionists. Additionally, these treatment interventions do not address educational goals and objectives.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Intensive Intervention Provider (Community-based organization)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Line Therapy Intervention

Provider Category:

Agency

Provider Type:

Intensive Intervention Provider (Community-based organization)

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Early Intervention Day Treatment (EIDT) Services.

Certificate *(specify):*

Certified to provide services to provide Home and Community Based Services (HCBS) under the Community and Employment Supports (CES) Waiver program.

Certified by DDS's contracted vendor to provide Autism Waiver Services.

Other Standard *(specify):*

Must have a minimum of two years' experience providing services to children with ASD.

Includes any organization formed as a collaborative organization made up of a group of licensed/certified providers as described above. In the case of a collaborative, the individual experience of its members will be considered to qualify the organization to participate in the program.

Additionally, the personnel hired by these providers as Line Therapists must meet the following standards to be considered qualified professionals/paraprofessionals:

(1) Hold a high school diploma or GED,
(2) Have completed 80 hours of specified autism training, and
(3) Have a minimum of 2 years' experience with children.

*Note: In a hardship situation, a provisional certification may be issued to enable services to be delivered in a timely manner. A hardship situation exists when a child is in need of services and staff is not available who meet all training/experience requirements. Provisional certification of a particular staff person requires that the total number of training hours be completed within the first year of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS's contracted vendor will certify Autism Waiver providers.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. DDS's contracted vendor will monitor that personnel meets applicable standards and maintain a database of qualified personnel involved in the program for the purpose of referrals as new children are added to the program and for the purpose of monitoring supply and demand across the state.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Therapeutic Aides and Behavioral Reinforcers

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

This service, provided by the AAP Provider's hired Consultant, includes the provision of necessary therapeutic aides and behavioral reinforcers in the home. If the Consultant determines that availability of such aides and reinforcers is insufficient for implementation of the Individual Treatment Plan (ITP), the Consultant will determine what therapeutic aides are needed and provide those therapeutic aides for use in improving the child's language, cognition, social and self-regulatory behavior.

Examples of items that might be provided as therapeutic aides or behavioral reinforcers include, but are not limited to: picture cards, games selected for social interaction, stickers, tokens, books, cause-effect toys, blocks or other building materials, crayons/markers, age-appropriate toys for pretend play, behavioral reinforcers, etc.

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

Limited to a maximum of $1,000.00 per participant, per lifetime. May only be provided in situations where insufficient materials are available as determined by the provider.

Items provided will remain with the child at the conclusion of the program so long as satisfactory participation requirements are met. Satisfactory participation is not connected to the childs progress but rather compliance with attending the treatment sessions, assisting with the intervention, data collection, etc. If the child does not complete the program as required, the therapeutic aides will be retained by the provider for use with another child in the program.

The services proposed in this Waiver are not provided under the IDEA Parts B or C. These services are provided through an intensive, one-on-one model in the childs home by highly qualified interventionists. Additionally, these treatment interventions do not address educational goals and objectives.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-based organizations

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community-based organizations

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Early Intervention Day Treatment (EIDT) services.

Certificate *(specify):*

Certified to provide home and community based services (HCBS) under the Community and Employment Support Waiver program.

Certified by DDS's contracted vendor to provide Autism Waiver Services.

Other Standard *(specify):*

Includes any organization formed as a collaborative organization made up of a group of licensed/certified providers as described above. In the case of a collaborative, the individual experience of its members will be considered to qualify the organization to participate in the program.

Additionally, the personnel hired as Consultants must meet one of the following standards to be considered qualified professionals/paraprofessionals:

(1) Hold a certificate from the Behavior Analyst Certification Board (BACB) as a BCBA (Board Certified Behavior Analyst) or BCaBA (Board Certified Assistant Behavior Analyst). plus have a minimum of 2 years' of experience developing/providing intensive intervention or overseeing the intensive intervention program for children with autism; or
(2) Hold a minimum of a Master's degree in Psychology, Speech-Language Pathology, Occupational Therapy, Special Education or related field, plus have a minimum of 2 years' experience providing intensive intervention or overseeing the intensive intervention program for children with ASD.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDS's contracted vendor will certify providers.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. DDS's contracted vendor will monitor that personnel meet applicable standard and maintain a database of qualified personnel involved in the program for the purpose of referrals as new children are added to the program and for the purpose of monitoring supply and demand across the state.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

- (●) **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ( ) **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

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

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

Appendix C: Participant Services

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

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

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

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

All Autism Waiver providers employing persons providing direct services shall not knowingly employ a person who has been found guilty or has pled guilty or nolo contendere to any disqualifying criminal offense.

Each Autism Waiver provider must obtain from each employee and from each applicant for employment a signed authorization permitting disclosures to the provider of criminal history information as defined in Ark. Code Ann. 12-12-1001.

Each provider receiving payment under the Autism Waiver program must, as a condition of continued participation in the program, comply with this rule requiring criminal history checks for new employees, and requiring periodic (at least every five years) criminal history checks for all employees. The scope of the criminal background checks is national. This requirement applies to any employee who in the course of employment may have direct contact with a participant. At the time of initial certification and annual re-certification, providers must submit a list of all direct care staff and the dates of their last criminal background check.

Before making a temporary or permanent offer of employment, an Autism Waiver provider shall inform applicants and employees that continued employment is contingent upon the results of the periodic criminal record checks and that the applicant or employee has the right to obtain a copy of the report from the Identification Bureau of the Department of Arkansas State Police.

If an Autism Waiver provider intends to make an offer of employment to the applicant, the applicant shall complete a criminal history check form. The provider shall then, within five (5) days, forward the criminal history check form to the Bureau accompanied by the appropriate payment and request the Bureau to complete a criminal history checks on persons caring for the elderly or persons with disabilities. The provider may make an offer of temporary employment to an applicant pending receipt of notification from the Bureau.

If the results of the criminal history check establish that the applicant was found guilty of , or pled nolo contendere (no contest) to a disqualifying offense under Ark. Code. Ann., Section 20-38-105, then the Autism waiver provider may not employ, or continue to employ, the applicant.

In addition, the Arkansas Medicaid Program requires criminal background checks on all Medicaid providers, regardless of provider type, prior to Medicaid enrollment. This process is accomplished through the state's claims processing contractor.

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

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

Abuse registry screening of all Autism Waiver providers providing intensive intervention services are monitored at initial certification and annual re-certification. This is a required part of the certification and re-certification process. In addition, agency providers must submit a list of all direct care of services staff and dates of their last criminal background checks. Each year, agency providers are recertified and must sign Provider Assurances stating the criminal background checks are performed on their employees. This signed assurance form is maintained in the provider's file.

A central registry check of both the Child Maltreatment and Adult Maltreatment and criminal background checks will be reviewed by DDS's contracted vendor during the certification and recertification process. Both registries are maintained by DHS. All positions that directly interact with children are subject to registry screenings, as well as any other position specified by statute. The registry checks are the responsibility of the individual entities required to obtain the registry clearance.

As part of the provider certification review, DDS verifies that the provider file contains the list of direct care staff and the dates the criminal background checks were completed.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of

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

☐ **Self-directed**

☐ **Agency-operated**

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

◉ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

○ **Other policy.**

Specify:

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

Autism Waiver provider enrollment is open and continuous. Any individual or agency interested in becoming an Autism Waiver provider can contact DDS's contracted vendor for information and to obtain certification materials. There are no restrictions applicable to requesting this information.

The provider certification process is open and available to any interested party. All providers must meet the state's certification requirements and the Arkansas Medicaid enrollment criteria. Requirements for certification are detailed in all provider certification applications. Medicaid enrollment requirements are detailed in the Medicaid provider contact, which is included in the application packet.

Potential providers are allotted as much time as needed to complete the certification materials. Once the provider certification application packet is complete and correct, DDS's contracted vendor processes applications and forwards them to the Medicaid fiscal agent responsible for provider enrollment functions, for Medicaid enrollment. Providers must be recertified each year.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
Number and percent of certified providers files, by provider type, which contain a copy of the required provider assurances in accordance with waiver provider qualifications. Numerator: Number of providers files with copy of assurances; Denominator: Total number of providers files.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider certification files

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: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	Specify:

Performance Measure:
Number and percent of providers, by type, which obtained the appropriate certification in accordance waiver provider qualifications prior to delivering services.
Numerator: Number of providers with appropriate certification prior to delivery of services; denominator: Number of new providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers, by provider type, which obtain re-certification in accordance with waiver provider qualifications. Numerator: Number of providers with recertification; Denominator: Total number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider certification database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

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

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

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

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

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

Performance Measure:
Number and percent of providers meeting waiver provider training requirement as evidenced by the signature on the provider assurances. Numerator: Number of providers indicating training by signature on provider assurances; Denominator: Total number of providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Certification 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

DDS contracted vendor		
	☒ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **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.

On behalf of DDS, DDS's contracted vendor issues Autism Waiver provider certifications for one year; providers must be re-certified annually. Providers must supply a copy of all applicable licenses and certificates as proof of certification. Chart reviews assure that certification remains current. All providers must be certified as Autism Waiver providers and enrolled as Medicaid providers.

The state identifies and rectifies situations where providers do not meet requirements. Through monitoring certification expiration dates within MMIS and continuing communication with the Medicaid fiscal agent responsible for provider enrollment functions, monthly reports are reviewed to identify providers whose participation is terminated for inactivity or violations. Participation in provider training is documented and monitored with monthly activity reports.

DMS's provider enrollment unit verifies that providers meet required certification standards and adhere to other state standards when they are enrolled. Additionally, DDS staff does a quarterly review of 10% of provider files to ensure compliance with these standard. DDS's contracted vendor maintains a database to trace certification dates of all participating and active providers.

Each month the provider choice list is updated to identify providers who are new, continuing or who have been reinstated in the Autism Waiver program. The parents will be presented with a provider choice list for Intensive Autism Intervention services at each assessment and reassessment to give clients a free choice of providers for each service included in the plan of care. This choice will remain in place util such time as the parent chooses to change. A parent can change providers at any point. Since there is only one provider for the Consultative Clinical and Therapeutic Services, the parent will be made aware of who will provide this service and advised that there is no choice available. If more than one provider becomes available, the choice process will be put into place for the Consultative Clinical and Therapeutic Services provider as well.

Training requirements are explained in the provider assurances and signed by each provider. In addition, DDS's contracted vendor is responsible for contacting new providers within the first 30 days of new enrollment to provide information regarding proper referrals, eligibility criteria, documentation requirements, forms, reporting, general information about the Autism waiver, Section II of the Autism Medicaid provider manual, claims processing problems, etc. Within three months of appearing on the provider choice list, staff of DDS's contracted vendor must meet with each new provider face-to-face to discuss all of the above and any problems noted by the provider within the first three months of program participation.

DDS's contracted vendor must contact each established provider at least twice per year, either face-to-face or via telephone, to discuss any problems, program policy or general information.

DDS's contracted vendor must schedule at least two in-services per year with all new and established providers. The in-service must be a scheduled meeting with an agenda, sign-in sheet, evaluation, etc. that discusses at a minimum all of the information above.

The Medicaid fiscal agent provides DDS's contracted vendor access to Provider Certification Status. This data is reviewed monthly and compared with DDS's contracted vendor's provider database and provides a second monitoring tool for compliance.

The Medicaid contract signed by each waiver provider states compliance with required enrollment criteria is mandatory. Failure to maintain required certification results in loss of their Medicaid provider activity. Each provider is notified in writing at least two months and again 30 days prior to the certification expiration date that renewal is due and failure to maintain proper certification will result in loss of Medicaid enrollment.

Provider assurances signed by each provider prior to certification and at each recertification includes quality controls regarding orientations. The provider agrees to require each employee to attend orientation training prior to allowing the employee to deliver any Autism Waiver service. This orientation shall include, but not be limited to, descriptions of the purpose and philosophy of the Autism Waiver program; discussion and distribution of the provider agency's written code of ethics; activities which shall and shall not be performed by the employee; instructions regarding Autism Waiver record keeping requirements; the importance of the POC; procedures for reporting changes to the client's condition; discussion, including potential legal ramifications of the client's right

to confidentiality.

All waiver providers are responsible for all provider requirements as detailed in Sections II of the Autism Waiver Medicaid Provider Manual. Section I of the Autism Waiver Medicaid Provider Manual (specifically Sections 140 and 150) details all provider participation requirements, and penalties/sanctions applicable for non-compliance that are applicable to all provider types.

DDS reviews quarterly reports submitted by its contracted vendor. DDS conducts chart reviews for a 10% sample of beneficiary charts, as well as file reviews for a 10% sample of provider certification files each quarter.

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 holds quarterly team meetings with its contracted vendor to discuss and address individual problems related to qualified providers, as well as problem correction and remediation. DDS has an agreement with its vendor that includes measures related to the qualified providers that are certified to provide services under the waiver.

DDS's contracted vendor requires that all providers obtain recertification annually in order to continue providing services. In cases where providers are not recertified, remediation includes certifying the provider upon discovery that the provider was not recertified, closing the provider, recouping payment for services provided after certification expired and allowing the client to choose another provider.

Upon certification and recertification, providers are required to sign Provider Assurances, which include assurances that the agency will provide to its employees the required amount and type of training needed to provide Autism Waiver services. If the provider refuses to sign this form, DDS's contracted vendor will deny the provider's certification or recertification. In some cases, DMS will impose provider sanctions on those failing to meet this requirement.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDS's contracted vendor	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **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 Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

☒ **Other Type of Limit.** The state employs another type of limit.

Describe the limit and furnish the information specified above.

All Autism Waiver services are limited to a maximum of 3 years or until the child's 8th birthday, because research indicates that when young children receive 2 to 3 years of intensive services, such as those in this Waiver program, the gains are significant. A review of existing programs in Wisconsin, Colorado, South Carolina and Montana and other stakeholder research found that early, intense intervention programs with children 18 months through 7 years of age provided the best outcomes and prevent or lessen the need for future Medicaid services. The overwhelming body of research on intensive intervention for children with ASD indicates that these services are most effective when provided to preschool age children and that intensive treatment produced a significant increase in new skill acquisition for children between 2 and 7 years of age.

At the end of the 5-year waiver renewal period, DMS and DDS, with input from other stakeholders, will determine the feasibility of renewing the Autism Waiver program based on the results seen over the next five years.

Once a child reaches his or her 3-year limit on Autism Waiver services or his or her 8th birthday, whichever comes first; if it is determined the child needs additional services, the child will be transitioned to a different model provided through the educational system and provided information regarding application to the DDS-CES Waiver and EPSDT services.

Research on intensive intervention supports the likelihood that 3 years of intensive intervention will produce such significant gains that the children will no longer meet the LOC standard necessary for participation in a waiver program. If there is a small group of children where this is not the case, the likelihood is that this type of intensive intervention is not appropriate for those children. If such is the case they will be transitioned to a different model of services provided through the Local Education Agencies and given information regarding application to the DDS-CES Waiver or ICF/IID services (public and private). Such services are individualized and based on the child's needs and can be delivered over a prolonged period of time, utilizing more broad-based strategies that include interventions that are not only evidence-based but also those that have been seen as promising practices for children with disabilities.

At the beginning of the 3-year program, parents/guardians are informed that the Autism Waiver is a 3-year program and that children age out on their 8th birthday or at the end of three years, whichever comes first. Three months prior to the end of the program, the participants' parents/guardians will be notified and provided information regarding additional resources available.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

This waiver utilizes no residential settings that are offered as out-of-home alternative living situations.

Instead, the Autism Waiver utilizes only natural home and community settings that provide inclusive opportunities for the children with ASD served by this Waiver. 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.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Autism Waiver Plan of Care

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

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☒ **Other**
Specify the individuals and their qualifications:

DDS's contracted vendor employees Autism Waiver Coordinators to create the Plans of Care. Autism Waiver Coordinators must have a minimum of a bachelor's degree in Psychology, Nursing, Speech-Language Pathology, Education or related field plus two years' experience associated with provision of services to children with ASD.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

1) At this time, there are only two entities of home and community based waiver Consultative Clinical and Therapeutic Services that are willing and qualified enity to develop person-centered service plans in the state. One of these is DDS's contracted vendor.

2) The state Medicaid Agency must approve any entity that develops the person-centered service plan and provides waiver services. Arkansas Medicaid has approved the these two entities to be responsible for the development of person-centered service plans.

3) While Arkansas Medicaid delegates the responsibility for certifying providers to DDS's contracted vendor, the Arkansas Division of Medical Services (DMS) reviews provider certifications prior to allowing the provider to enroll with Medicaid. In addition, DDS's contracted vendor maintains a separate database of all providers who apply for certification and designated DDS employees have access to this database. DDS reviews 10% of provider certification files on a quarterly basis.

4) The use of three separate organizations to create the plans of care POCs and the Individual Treatment Plan (ITP) and to provide oversight is one safeguard that is put in place to prevent conflict of interest. The POCs are developed by the Autism Waiver Coordinators employed by DDS's contracted vendor. These POCs focus on the services and name the provider, chosen by the family, who will provide those services. DDS's contracted vendor provides and documents the family's choice of institution versus community services and choice of providers. The chosen Community-based Provider creates the Individual Treatment Plan (ITP) which focuses on the specific treatments and interventions that will be used for that child. Oversight of the ITP is provided by the Clinical Services Specialist. This oversight ensures that the treatments selected are clinically appropriate for the child and that the interventions are being implemented with fidelity.

5)DDS oversees the plan of care development process by completing quarterly reviews on 10% of all beneficiary charts to ensure services are consistent with waiver participants' needs and are being provided as outlined in the POC and ITP.

6) DDS's contracted vendor provides and documents the free choice of providers form and decision. Arkansas will ensure full disclosure to participants and assures that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development.

7) In accordance with the state's fair hearing and appeals process described in Appendix F, participants may dispute the state's assertion that there is no other entity or individual other than the participant's service provider who can develop the person-centered service plan.

8) Arkansas requires the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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

During the planning process, the parent/guardian of the child, caregivers, professional service providers and others of the parent/guardian's choosing may provide input. The information obtained will be used by the Autism Waiver Coordinator, employed by DDS's contracted vendor, to develop the Plan of Care (POC) in collaboration with the parent/guardian.

The parent/guardian will receive a copy of the POC upon completion. Copies will be provided to others who participated in its development at the parent/guardian's request. Copies will also be provided to the provider agency selected by the parent/guardian to implement the services and to the Consultative Clinical and Therapeutic Services provider.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

DDS's contracted vendor employs Autism Waiver Coordinators to develop the Plan of Care (POC) in collaboration with the parent/guardian based on the assessment of the waiver participant's strengths and needs and the parent/guardian's preferences. The strengths and needs of the participant will be assessed through use of instruments such as the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II) and the Temperament and Atypical Behavior Scale (TABS) both of which will be a part of the child's assessment battery for determining Level of Care (LOC) eligibility. The Vineland-II provides detailed information regarding the child's strengths and weaknesses in areas including communication, daily living skills, socialization, motor skills and maladaptive behavior. The TABS provides additional detail regarding atypical behavior by assessing four categories of behavior: detached, hypersensitive-active, under reactive and dysregulated. Since the parent/guardian is the primary informant for completing these assessments, the parent/guardian's perspective and concerns will be central to the discussion with the Autism Waiver Coordinator during POC development.

The POC is developed prior to the delivery of any Autism Waiver service; and must be updated at least annually.

Parents/guardians are informed at the time of enrollment of the services offered through the Autism Waiver. If there are amendments to the Waiver that impact the services available, the updated information will be provided to all participants at such time as amendments are approved and ready for implementation.

Participation in the planning process by parents/guardians, knowledgeable professionals, and others of the parent/guardian's choosing assures that the POC addresses the individual needs of the child. The POC must include a statement of the child's need, the service(s) designed to meet that need, the amount, frequency and duration of the service(s), and the type of provider who will furnish the service(s).

The POC must include roles and responsibilities of the Autism Waiver Coordinator, the Consultative Clinical and Therapeutic Services Specialist (also referred to as the Clinical Services Specialist), and the parent/guardian for the services included in the POC. The Autism Waiver Coordinator will have primary responsibility for coordinating the services but must rely on the parent/guardian to choose a service provider from among those available and participate fully in the intervention by complying with the terms of the Parent/Guardian Participation Agreement. This agreement will outline specific participation requirements to be fulfilled by the parent/guardian with a minimum of fourteen (14) hours per week required as a condition of participation in the program. The Clinical Services Specialist will be primarily responsible for providing independent review of implementation of the Individual Treatment Plan (ITP) developed by the Consultant.

The 14 hours required of parents/guardians includes times and routines that will be agreed upon between the parent and the provider and delineated specifically as part of the ITP. The specific activities/strategies will be individualized for each child and outlined in the ITP. Training will be provided to the parents/guardians by the provider to equip the parents/guardians to fulfill this requirement.

At a minimum, the Autism Waiver Coordinator will have monthly contact with a member of the Intervention Team (Consultant, Lead Therapist, Line Therapist, or parent/guardian) either face-to-face, or by phone. At a minimum, the Clinical Services Specialist will conduct fidelity reviews to determine appropriate implementation of the strategies included in the child's POC. Ongoing contact will be scheduled as appropriate given the needs of the team. Teams who are struggling to meet fidelity will have more frequent contact. On-site refers to in-home and community settings. The location will be primarily the childs home but other community locations, identified by the parent, such as the park, grocery store, church, etc. might be included. Specific locations will be selected based on the skills and behaviors of the child that need to be targeted. If either of these individuals determine that there are problems with the treatment, contact will be made with the Consultant who designed the ITP and the Intervention Team members, as appropriate. If any members of the team report that the Parent/Guardian Participation Agreement is not being followed, a meeting with the parent/guardian will be scheduled to review the terms for participation in the program, explain the consequences of failing to comply with the terms of participation, and develop a plan detailing the deadline for compliance with the terms of participation. This meeting will be documented as an attachment to the Parent/Guardian Participation Agreement. If the parent/guardian fails to meet the deadline for compliance or chooses not to participate according to the terms of the agreement, the child will be removed from the program following a 10 day notice.

Participants may be involuntarily disenrolled in cases where failure to participate in the program occurs since without parental participation there is a risk of ineffective treatment and potential jeopardy for health and welfare of the Autism Waiver participant. Each case will be evaluated on a case-by-case basis. This decision will be made as a joint decision by the Autism Waiver Coordinator and the Clinical Services Specialist only after the parent/guardian has been counseled and

offered an opportunity for corrective action. This counseling will occur during an on-site visit with the parent/guardian and will be documented on the Parental Participation Agreement Form. If the ITP or schedule for delivery of services can be modified to better facilitate program participation, the Autism Waiver Coordinator and parent/guardian will make such adjustments. The Autism Waiver Coordinator will then forward the modifications to the agency providing the childs services.

The following circumstances may result in involuntary disenrollment:
Failure to provide information on the child that is needed for development of the POC or ITP(strengths, weaknesses, behaviors, etc.)
Failure to attend training on the child's ITP provided by the Consultant
Failure to meet scheduled appointments for delivery of therapy
Failure to implement treatment strategies in accordance with the ITP

Changes to the POC will be made as needed by the Autism Waiver Coordinator when the results of the monitoring or when information obtained from the parent/guardian or members of the treatment team indicates the need for a change. A copy of the revised POC will be provided to the parent/guardian, the Consultant, and the Clinical Services Specialist.

Appendix D: Participant-Centered Planning and Service Delivery

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

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The participant's needs, including potential risks are identified as part of the assessment process conducted by DDS's contracted vendor prior to the development of the Plan of Care (POC). An adaptive behavior scale (Vineland II-Expanded Edition) and a measure of behavioral targets (Temperament and Atypical Behavior Scale) are administered at each home visit when children are admitted into the program and upon annual redetermination of eligibility. These assessment instruments identify issues that present risk factors for the child, such as self-injurious behavior, aggressive/destructive behavior, elopement behavior, inability to communicate needs/wants, and food aversion/pica behavior.

As these individualized factors are identified, they are listed on the Plan of Care (POC) to enable the Consultant to develop specific treatment interventions to address these issues. These interventions will be included on the Individual Treatment Plan (ITP), as well as preventative strategies to avoid emergencies and deescalate behaviors. These intervention strategies focus on positive approaches to supporting appropriate behavior, avoiding the use of restraint, seclusion and other punitive practices. Additionally, a behavior intervention plan is developed to remediate behavioral issues that create risk factors for the child.

DDS's contracted vendor collects ongoing data on these treatment goals and analyzes it, as part of the development of intervention by the treatment team, including the Consultant, Lead/Line Therapists and Clinical Services Specialist (CSS) to determine progress toward removal of risk factors.

In situations where behaviors create risk for emergency situations, the team (including the parents) are trained on strategies for responding in the event of an emergency. If emergency situations occur, they are documented in the database and are reviewed by the team, the CSS and Autism Waiver Coordinator to determine if changes in treatment are needed to avoid recurrence of the emergency. Since the parent/guardian will be present and actively involved in treatment provided through the Autism Waiver, his/her relationship and intimate knowledge of the child will be utilized to avoid emergency situations.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

DDS's contracted vendor employs staff who provides parents/guardians the names of provider agencies, the contact person for the program and telephone numbers/email addresses for contact. From this list, parents/guardians may select the provider of their choice. The parent/guardian's choice of provider will be documented on the Plan of Care (POC).

Furthermore, staff from DDS's contracted vendor discuss with parents a list of questions they could ask when interviewing potential providers. This list includes questions such as: How many years' experience do you have serving children with ASD? How many children have you served in the Autism Waiver program to date? What are the credentials of the staff you use (Consultants, Lead/Line Therapists)? If you are selected, how long will it take for you to have staff hired and deliver services? How much involvement can I have in the selection process of staff who will work with my child?

DDS's contracted vendor's staff are available after the home visit to discuss any questions/concerns the parents have regarding the provider selection process.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Plan of Care (POC) is developed following a format developed by DDS's contracted vendor and approved by DDS. The POC includes the child's name and all demographic and identifying information. It designates whether it is the initial POC or a renewal, specifies the home visit date (when the POC is developed), and displays the start and end date for the authorized services.

The POC also specifies each service provided under the Autism Waiver and the authorized number of units for the participant. It includes a description of the child's risk factors and the parent(s)/guardian(s)' personal goals for their child. It lists the provider agency selected by the parent/guardian to provide services, and describes any other Medicaid services the child might be receiving, as reported by the parent/guardian.

The POC is developed during a home visit with the Autism Waiver Coordinator employed by DDS's contracted vendor and the parent(s)/guardian(s). When complete, it is immediately uploaded to the AAP Database where it is reviewed by the CSS, the provider agency assigned, and staff hired to serve the child. Access to the record in the database is tied to a confidentiality agreement that must be signed by each person granted access. Access to records is controlled by one designated person with DDS's contracted vendor and is restricted to only those persons working directly with the child and those with administrative oversight for the program, including DMS and DDS designated staff.

Once a parent selects a provider agency during the POC development and the POC is uploaded to the database, DDS's contracted vendor notifies the provider that they have been selected by the family. The provider then has immediate access to the POC and can initiate contact with the family to begin the process of hiring staff and providing services.

Since the child's eligibility is reassessed each year, the POC is developed on an annual basis. The process is the same.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**

○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

☐ **Medicaid agency**

☒ **Operating agency**

☐ **Case manager**

☒ **Other**

Specify:

DDS's contracted vendor.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

At a minimum, the Autism Waiver Coordinator, employed by DDS's contracted vendor, will have monthly contact with a member of the Intervention Team (Consultant, Lead Therapist, Line Therapist, and/or parent/guardian), either face-to-face or by phone. If there are problems identified, contact will be made with the Consultant who designed the Individualized Treatment Plan (ITP) to address the issue(s). All contacts will be documented as case notes in the child's file maintained at DDS's contracted vendor.

Additionally, the Individual Treatment Plan (ITP) will be monitored by the Clinical Services Specialist, a professional independent of both the provider agency delivering the intensive intervention and the administrative agency. This professional will review for programmatic fidelity, data accuracy, use of evidence-based interventions and child progress. If the Clinical Services Specialist identifies problems with the implementation of the ITP, those issues will be addressed with the appropriate member(s) of the Intervention Team. If the identified issues are related to program compliance (for example, lack of provision of services identified in the POC, use of unqualified providers, failure to cooperate with terms of Parent/Guardian Participation Agreement), the Clinical Services Specialist will contact the Autism Waiver Coordinator to solicit their involvement in resolving the issue(s).

The plan of care (POC, or service plan) and the individualized treatment plan (ITP, or treatment plan) are two different documents. The POC is developed by the Autism Waiver Coordinator and addresses issues around the provision of services such as amount, frequency and duration of both waiver services and state plan services; client's risks and goals; client's choice of services and providers; contact person and emergency backup plans and appropriate signatures. The POC is focused on the services and who will provide them.

The ITP is developed by the Consultant following a thorough evaluation of the child and includes the following: specific treatment goals and objectives in domains such as communication/language, socialization, self-care/self-regulation, and cognition as wells as detailed instructions for implementation and data collection. Additionally, the ITP includes the results of a functional analysis of behavior, a positive behavior supports plan for maladaptive behavior, and a behavioral reinforcer survey, if needed. It also includes the goal(s) to be implemented by the parent/guardian. The ITP is focused on the specifics of the treatment/intervention for the child that comes as a result of the POC.

Since the parent will be present during the intervention in this program, there is no risk that the child will be unattended if there is an emergency that prevents the Line Therapist from keeping the appointment for the treatment. Also, since this is a tiered service, the Lead Therapist could be scheduled to cover for the Line Therapist if situations where the Line Therapist is unable to maintain an appointment time. As an additional back-up strategy, the parent is required to participate in this program with a minimum of 14 hours of intervention per week. This intervention could occur during a time when the Line Therapist is unavailable so the child continues to receive the treatment. Since the Line Therapist, Lead Therapist and parent are all trained in implementation of the treatment by the Consultant, substitution of personnel will still allow the child to receive appropriate intervention.

Participants needs, including potential risks associated with their situations, are assessed during the planning process and considered during POC development. The POC includes a section for a description of the plan to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver/supporter.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed who had POCs that addressed risk factors. Numerator: number of participants' POCs that addressed risk factors; Denominator: number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

DDS contracted vendor		
	☒ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants reviewed who had POCs that addressed personal goals. Numerator: number of participants' POCs that addressed personal goals; Denominator: number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
DDS contracted vendor	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants reviewed who had POCs that were adequate and appropriate to their needs as indicated by the assessment(s). Numerator: number of participants with POCs that addressed their needs; Denominator: number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of POC development procedures that were completed as described in the Waiver procedures. Numerator: number of participants' POCs completed according to Waiver procedures; Denominator: number of records

reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of POCs that were reviewed and revised, as warranted, on or before the Waiver participant's annual review date. Numerator: number of participants' POCs that were reviewed and revised before annual review date; Denominator: number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants reviewed who received services in the type, scope, amount, frequency and duration specified in his or her POC. Numerator: Number of participants' who received services a specified in his or her POC; Denominator: number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants' records reviewed with an appropriately completed POC that specified choice was offered between institutional care and Autism Waiver services and among Waiver services. Numerator: Number of participants' POCs that documented a choice between institutional care and Waiver services and among Waiver services; Denominator: Number of records reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Case Record Reivew

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: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants' records reviewed with appropriately completed and signed freedom of choice forms that specified choice of providers was offered. Numerator: number of participants with freedom of choice forms that document choice of providers was offered; Denominator: number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and**	☐ **Other**

	Ongoing	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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **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.

The state currently operates a system of review that assures completeness, appropriateness, accuracy and freedom of choice. This system focuses on client-centered service planning and delivery, client rights and responsibilities, and client outcomes and satisfaction.

Individual charts are reviewed by DDS's contracted vendor for completeness and accuracy and resulting data is made available for the production of the Chart Review Summary Report. DDS conducts a review of a random 10% sample of reports to confirm that POCs are updated and revised as warranted by changes in the client's needs.

DMS and DDS also use billing data from MMIS to compare with the random review of approved individualized POCs to check for amount, duration and frequency of services rendered.

Charts are reviewed to assure that a Freedom of Choice form was presented to the client, that provider assurances against coercion and solicitation have been signed, and that a complete list of providers has been made available to the client.

Chart reviews of the overall program files are thorough and include a review of all required documentation regarding compliance with the POC development assurance and delivery. Reviews include, but are not limited to, completeness of the POC; timeliness of the POC developments process; appropriateness of all medical and non-medical services; consideration of clients in the POC development process; clarity and consistency; compliance with program policy regarding all aspects of POC development, changes and renewal.

Some measures have multiple factors that are reviewed to determine if the area is in compliance. These measures are directly related to the CMS waiver assurance areas.

DDS's contracted vendor monitors 25% of their active caseload on an annual basis. This process also provides an additional level of service plan review for compliance and service delivery. DDS contracted vendor reviews the recipient profiles from MMIS on a quarterly basis. This profile is compared to the plan of care and reviewed for lack of service billing, under utilization or overpayment, and appropriate provider of services. The Quarterly Recipient Profiles process is a completely separate process from the chart review process reflected in the Annual Report. It provides an additional monitoring tool utilized to verify plan of care compliance and appropriate billing practices. Discrepancies are identified, changes are made as necessary and proper action is taken.

DDS assures compliance with the service plan subassurances through a review of a random 10% sample of all active waiver participants' case records. Reference performance measures three and four under Appendix A, under administrative authority.

b. Methods for Remediation/Fixing Individual Problems

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

DDS and its contracted vendor hold quarterly team meetings to discuss and address individual problems related to POC development, as well as problem correction and remediation. Additionally, they have an Interagency Agreement that includes measures related to the POCs.

In cases where clients' POCs are inadequate or inappropriate, do not address clients' personal goals or risk factors, are not completed in accordance with Waiver procedure, or are not reviewed or revised as needed, remediation includes revising the POC accordingly and providing additional training to staff who complete POCs. This remediation also applies when clients do not receive the type, scope, frequency and duration of services as specified in the POC, or when clients are not offered choice between institutional care and Waiver services and among Waiver services when the POC is developed.

In addition, the POC form includes information on the client's personal goals, risks and choices (between institutional care and Waiver services, and among Waiver services), and completeness of this form is checked during the chart review process.

If a client's record does not include a completed and signed Freedom of Choice form indicating that a choice of providers was offered, remediation includes completing the Freedom of Choice form accordingly and additional staff training in this area. The contract between DDS and its contracted vendor also contains provisions for corrective action to be taken or damages to be assessed if performance indicators are not met.

The tool used to review waiver client's record captures and tracks remediation in these areas.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ○ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ◉ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Waiver participants are advised on the DCO-700 (Notice of Action) or the system-generated Notice of Action of their right to appeal when adverse action is taken to deny, suspend, reduce or terminate services. The notice is issued by the Division of County Operations (DCO). The notice explains the participant's right to a fair hearing, how to file for a hearing, and the participant's right to representation. Notices of adverse actions and the opportunity to request a fair hearing are kept in the participant's eligibility case record. If the participant files for a fair hearing during the advanced notice period, services may continue at the participant's request until a decision is made on the appeal. If the findings of the appeal are not in the participants favor, and the participant had elected the continuation of benefits, the participant may owe the State of Arkansas restitution through an overpayment.

During the initial and annual recertification process, DDS contracted vendor explains to the participant the choice of home and community-based waiver services vs. institutional services, the Waiver participant is provided with a program brochure which also includes instructions for filing an appeal.

Assistance to the participant during the fair hearing process is available via the HCBS Ombudsman, targeted case manager, personal representative or attorney, if applicable, and legal aide.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a)

the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

DDS contracted vendor is responsible for taking and addressing complaints related to the Autism Waiver.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Complaints are resolved expeditiously as received by the appropriate party. The type of complaint determines how the complaint is handled. Complaints concerning abuse and neglect are routed to the Child Protective Services Unit immediately for appropriate action. Complaints about provider staff not providing the services required and complaints about how the Waiver operates are reviewed by DDS's contracted vendor's administrative staff to determine if there is a problem and whether the issue can be resolved based on laws, regulations and policies. Complaints are recorded by the party receiving the information.

Every effort is made to resolve the issue as quickly as possible, but each issue must be resolved within 30 business days from the date the complaint was received. A follow-up call or correspondence is made with the reporter, if appropriate, to discuss how the issue was resolved, provided this can be accomplished without violating confidentiality rules. The participant or his/her representative is informed of his/her right to appeal any decision and that filing a complaint is not a prerequisite or substitute for a fair hearing.

A complaint database is maintained by DDS's contracted vendor to register any type of complaint related to the Autism Waiver, from any source. Waiver participants and others may register complaints by calling a toll-free number or by writing to the DDS contracted vendor.

Based on the data entered within the complaint database, complaints may be
1) tracked by type of complaint (service, provider, etc.);
2) tracked by complaint source (participant, county office, family, etc.); and
3) monitored for trends, action taken to address complaint, access, quality of care, health and welfare.

The complaint database provides a means to address any type complaint filed by any source.

DDS's contracted vendor employs staff to enter information pertaining to complaints made by participants against providers providing services to them, against DHS county offices pertaining to their financial eligibility determination, against their own staff or targeted case managers working with them, or participant complaints pertaining to their medical need/level of care eligibility determination. Information that is entered into the database includes the complaint source and his/her contact information, participant information, person or provider against whom the complaint is being made , the person who received the complaint, the person to whom the complaint is assigned for investigation, the complaint being made, and the action taken relative to investigation findings. The following reports can be generated from this database:

1.) Complaint Report for each complaint received;

2.) Completed complaint processing form for each complaint received.

3.) Complaints received listing person/provider names sorted by date received;

4.) Listing of complaints received for specific providers sorted by date received;

5.) Total counts per provider of complaints received sorted alphabetically by provider name;

6. Total counts of complaints received grouped by month/year;

7.) Total counts of complaints received by county;

8.) Total counts of complaints received for waiver providers grouped by service name;

9.) Total counts of complaints received for specific providers;

10.) Complaints completed listing names/providers for whom/which the complaints have been made grouped by waiver service name;

11.) Provider totals of complaints completed sorted alphabetically by provider name;

12.) Total counts of complaints completed grouped by month/year.

The complaint database was developed for tracking complaints; providing trends; and monitoring access, quality of care, health, and welfare.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The focal point for incident management in Arkansas is Child Protective Services (CPS), which is located in the Division of Children and Family Services (DCFS). CPS works with a legislative mandate to accept reports, investigate, substantiate and resolve incidents of abuse, neglect and exploitation of children in Arkansas. All DDS staff, staff of DDS's contracted vendor, providers and their staff and anyone receiving reimbursement for work with a Medicaid participant are identified in the law at Arkansas Code Title 12 Chapter 18, the Child Maltreatment Act, as mandatory reporters. Mandatory reporters are required by law to report incidents immediately.

The Department of Human Services (DHS) has a department-wide database to report incidents throughout the ten Divisions (including the Division of Developmental Disabilities Services, Division of Medical Services, Division of Children and Family Services, Division of County Operations and others) that affect the health and welfare of program participants. This Incident Reporting System (IRIS) is used to document incidents in real time and has the ability to generate management reports quickly and efficiently. Incidents that have, or are expected to, receive media attention are to be reported via telephone to the DHS Communications Director within one hour, regardless of the hour. Incidents regarding suicide, death from adult abuse, maltreatment or exploitation, or serious injury are to be reported to the DHS Chief Counsel via telephone within one hour, regardless of the hour. An investigation must begin within two business days of the incident following DHS Policy 1106.0. A formal report on IRIS must be submitted no later than the end of the second business day following the incident.

The Arkansas Child Maltreatment Hotline must accept reports of alleged maltreatment. If the nature of a child maltreatment report (Priority I or II) suggests that a child is in immediate risk, the investigation will begin immediately or as soon as possible. DCFS has jurisdiction to investigate all cases of child maltreatment in conjunction with Arkansas State Police Crimes Against Children Division (CACD) who is responsible to assess most Priority I allegations of child maltreatment. DCFS is responsible for ensuring the health and safety of the children even if the primary responsibility for the investigation belongs to CACD. The DHS County Supervisor/designee assigns the report to a Family Service Worker(s) or a Unit Group who will conduct the assessment. The Family Service Worker will begin the Child Maltreatment Assessment immediately and no later than 24 hours after receipt of report by the Hotline, if severe maltreatment (Priority I) is indicated. All other Child Maltreatment Assessments must being within 72 hours of the report. A Health and Safety Assessment is completed in conjunction with the Child Maltreatment Assessment. An investigative determination shall be made within thirty days. If the circumstances of the child present an immediate danger of severe maltreatment, the Family Service Worker will take the child into protective custody for up to 72 hours.

DDS's contracted vendor reviews and evaluates all incident reports involving a participant in the Autism Waiver to ensure correct procedures and timeframes are followed. In the event provider staff has failed to notify proper authorities such as the Child Abuse Hotline, or the police department, DDS's contracted vendor ensures the notifications are made immediately. If an incident warrants investigation, DDS's contracted vendor investigates and submits findings of the review to the DDS. The contracted vendor also notifies the Autism Waiver Provider involved.

The provider is required to submit a plan of correction to DDS through its contracted vendor, who will perform necessary follow-up to monitor progress toward compliance.

Deaths and critical incidents are reported as received by DDS's contracted vendor to DDS.

Incidents are reported using the IRIS system, the Child Abuse Hotline or the Incident Report Form DHS 1910. The Incident Report Form DHS 1910 is used in the absence of computer transmission capability. The forms are transmitted to the appropriate Division contact (for Autism Waiver participants it is DDS's contracted vendor) for entry into IRIS.

Incidents of child abuse called into the Child Abuse Hotline are investigated by the Arkansas State Police CACD.

Incidents of child maltreatment reported using the IRIS system or the Incident Report Form DHS 1910 are investigated by the Division of Children and Family Services (DCFS) with some information shared between DCFS and DDS's contracted vendor if the report involves an Autism Waiver participant.

Any other incidents that may affect the health and safety of Autism Waiver participants and occurrences that interrupt or prevent the delivery of Autism Waiver services must be reported to DDS, through its contracted vendor.

DDS's contracted vendor will be given access to IRIS to query incidents reported for Autism Waiver participants. DDS's contracted vendor will use the IRIS database to monitor incidents for participants in the Autism Waiver program and will

address any concerns according to the following timeframes:

As soon as the incident report is received by DDS's contracted vendor, it must be reviewed and prioritized. DDS Policy 1091 requires that investigations begin within 24 hours (next business day) from time of receipt.

Within five working days from the start of the investigation, telephone contact with the complainant is required. If unable to contact by telephone and the complainant is known, a certified letter is sent to the complainant requesting the complainant contact DDS's contracted vendor within three working days of the date of the letter.

Within ten working days of receipt of the report, DDS's contracted vendor must gather information and complete their investigation. If timely contact with the involved parties is not possible, the process may be extended an additional ten days.

Within fifteen working days of completion of the investigation, DDS's contracted vendor must submit a written report to the affected entity (if applicable) and DDS.

Within five working days of receipt of the written report, the affected entity may request a meeting with DDS or its contracted vendor to discuss the findings. If DDS or its contracted vendor determines there is credible evidence to support the complaint, DDS's contracted vendor will request a time bound plan of correction and ensure necessary follow-up to monitor progress toward compliance.

All critical incidents reported to DDS's contracted vendor (regardless of type) are reviewed, triaged and prioritized within 24 working hours. In instances of alleged abuse or neglect, there is immediate referral to the applicable Arkansas Protective Services Agencies with deferral to these constraining requirements (in accordance with their policies). Specific to critical internal incidents, the completion timeframe is within 10 working days. Exceptions may occur if circumstances justify an extension. All extensions will be monitored with the annual report to DDS and will identify any system problems that may require policy changes. All internal issues are investigated by DDS's contracted vendor with a report to DDS for final approval.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A brochure developed and provided by the Child Protective Services (CPS) Unit is provided to the Waiver applicant and his/her family when initial contact is made. Duplicate copies of the brochure are available should additional copies be needed to provide to the applicant's/participant's other family members or friends. The brochure includes information on what constitutes abuse, the signs and symptoms of abuse, the persons required to report abuse, and how reports should be made.

The Autism Waiver Coordinator employed by DDS's contracted reviewer reviews the information in the CPS brochure with participants/family members in annual contacts after participation in the Autism Waiver program begins. Duplicate copies of the brochure are available.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

DDS's contracted vendor will have access to the IRIS database. All relevant information about Autism Waiver participants is reviewed by DDS's contracted vendor staff designated to do so.

Information from all complaints entered into the complaint database, including information on resolution of the incidents is reviewed by DDS's contracted vendor staff. Results of these complaint reviews that identify a situation in which the Autism Waiver participant was compromised are further investigated with appropriate action taken, if necessary. The complaint database will generate monthly and annual reports to the program administrator for DDS's contracte vendor, who reviews these reports to identify patterns and make systematic corrections when necessary.

The participant and other relevant parties are informed of investigation results by telephone or in writing.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DDS's contracted vendor will assume responsibility for compiling all incident reports from all sources into a single source for review and action. DDS's contract reviewer will review this single source to identify patterns and make systematic corrections when necessary. Critical incidents and events are reviewed on a case-by-case basis by administrative staff. A monthly report is compiled based on incidents and events keyed into the Complaint Database.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The Autism Waiver Coordinator employed by DDS's contracted vendor, the Clinical Services Specialist, and the Consultant are all responsible for monitoring for unauthorized use of restraints or seclusion as treatment/intervention strategies during regular contact with participants. Autism Waiver Coordinators will have monthly contact with participants and Clinical Services Specialists will have quarterly contact with participants. Information about the prohibition of restraints and seclusion will be included in the training of all providers and in the program description provided to parents/guardians. If there is any report of the use of these unauthorized techniques, an immediate investigation will be conducted by the Autism Waiver Coordinator and approprate action taken to ensure that their use is immediately discontinued.

The only use of physical intervention allowable under this program is as an emergency intervention to protect the safety of the child. An "emergency" is defined as a situation which poses imminent risk of injury to the child or another person. Physical intervention is allowable only during the context of the emergency and only for the duration of that emergency. It cannot be used as a contingent punitive consequence for non-cooperative or non-compliant behavior.

Prevention of unauthorized use of physical intervention in this Waiver program is a top priority. The documentation regarding this issue will be reviewed during 100% of the administrative on-site contacts. Additionally, any reports of such use via telephone will be followed with an on-site visit to discuss the situation, address the regulations of the program, and develop a strategy to prevent future occurrence. This will be documented in the case notes and possibly in the individual treatment plan, if the situation reflects a need for modification of the plan.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i

and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Autism Waiver Coordinator employed by DDS's contracted vendor, the Clinical Services Specialist, and the Consultant will be responsible for monitoring for unauthorized use of restrictive interventions during regular contact with participants. Information about the prohibition of the use of restrictive interventions will be included in the training of all providers and in the program description provided to parents/guardians. If there is any report of the use of these unauthorized techniques, an immediate investigation will be conducted by the Autism Waiver Coordinator and approprate action taken to ensure that their use is immediately discontinued.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Autism Waiver Coordinator employed by DDS contracted vendor, the Clinical Services Specialist, and the Consultant will be responsible for monitoring for unauthorized use of seclusion during regular contact with participants. Information about the prohibition of the use of seclusion will be included in the training of all providers and in the program description provided to parents/guardians. If there is any report of the use of these unauthorized techniques, an immediate investigation will be conducted by the Autism Waiver Coordinator and appropriate action taken to ensure that their use is immediately discontinued.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*

○ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ○ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
  Complete the following three items:

  (a) Specify state agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed where the participant and/or family or legal guardian received information about how to report abuse, neglect, exploitation and other critical incidents as specified in the waiver application.
Numerator: Number of participants receiving information on abuse, neglect, exploitation and critical inidents; Denominator: Number of records reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incidents that were reported within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Number of critical incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of unpreventable and preventable causes. Numerator: number of deaths with unpreventable causes; Denominator: number of deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Unexpected Death 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):*
☐ **State Medicaid**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
Number and percent of complaints addressed within required timeframe.
Numerator: number of complaints addressed in required timeframe; Denominator: Number of complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of substantiated complaints. Numerator: number of substantiated complaints; Denominator: Number of complaints

Data Source (Select one):
Other
If 'Other' is selected, specify:
Complaint Database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incident reviews/investigations that were initiated and completed according to program policy and state law. Numerator: Number of critical incident investigations intitiated/completed according to policy/law; Denominator:

Number of critical incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: DDS 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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of critical incident requiring review/investigation where the state adhered to follow-up methods as specified. Numerator: number of critical incident reviews/investigations that had appropriate follow-up; Denominator: number of critical incidents reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

DDS contracted vendor		
	☒ **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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

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.

Arkansas addresses this assurance with a three-step process that involves chart review, ongoing communication with Child Protective Services (CPS), and DDS audits of Waiver participants' records. Monthly chart reviews are performed by DDS's contracted vendor to assure that they report incidences of abuse or neglect, that safety and protection are addressed at initial assessment and periodic reassessment, and reported in the Chart Review Summary Report. CPS reports specific cases of abuse and neglect affecting Waiver participants to Waiver staff. And finally, findings are reported to DDS.

DDS's contracted vendor maintains a complaint database to track complaints of all types, including abuse and neglect reports.

The IRIS system is used by DDS's contracted vendor to report incidents involving state staff, including incidents that involve abuse and neglect of Waiver participants.

DDS's contracted vendor is required to review the CPS information with participants and other parties of interest during each assessment and reassessment process. Compliance with this requirement is documented on the Plan of Care (POC) in each chart. Compliance is a part of the chart review and annual reporting process.

The process for reporting child maltreatment, as established in Arkansas Code Title 12 Chapter 18, the Child Maltreatment Act, is that anyone who has reasonable cause to suspect that a child has been subjected to abuse, sexual abuse, neglect, sexual exploitation or abandonment by the caregiver of the child (a parent, guardian, custodian, or foster parent) is responsible for making a report to the Arkansas Child Abuse Hotline at 1-800-482-5964. Mandatory reporters under state law include such individuals as physicians, nurses, social workers, psychologists, therapists, teachers, counselors, etc. In addition to those persons and officials required to report suspected child maltreatment, any other person may make a report if the person has reasonable cause to suspect that a child has been abused or neglected.

Policy requires compliance and mandates DHS staff report alleged abuse to Child Protective Services. All reports of alleged abuse, follow-ups and all actions taken to investigate the alleged abuse, along with all reports to CPS must be documented in the participant's chart. Chart reviews include verification of this requirement and are included on the annual report.

DMS's compliance unit can conduct a review of any billing processes under the Waiver.

b. Methods for Remediation/Fixing Individual Problems

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

DDS and its contracted vendor meet quarterly to discuss and address problems related to participant health and welfare, as well as problem correction and remediation. The contract between DDS and its contracted vendor includes measures related to Waiver participant health and welfare.

Remediation efforts, in cases where clients or their family members or legal guardians have not received information about how to report abuse, neglect, exploitation or critical incidents, include providing the appropriate information to the client and family member or legal guardian upon discovery that this information has not previously been provided and providing additional training for DDS's contracted vendor staff.

In cases where critical incidents were not reported within required timeframes, DDS's contracted vendor provides remediation, including reporting the critical incident immediately upon discovery, and providing additional training and counseling to staff.

If critical incident reviews and investigations are not initiated and completed according to program policy and state law, remediation includes initiating and completing the investigation immediately upon discovery and providing additional training and counseling to staff. When appropriate follow-up to critical incidents is not conducted according to methods discussed in the Waiver application, DDS's contracted vendor will provide immediate follow-up to the incident and staff training as remediation.

DDS's contracted vendor provides remediation in cases of investigation and review of unexplained, suspicious and untimely deaths that did not result in identification of preventable and unpreventable causes to include staff and provider training, implementing additional services and imposing provider sanctions. DDS's contracted vendor plans a review of the Unexpected Death report to ensure that remediation of preventable deaths is captured and that remediation data is collected appropriately.

Remediation for complaints that were not addressed within required timeframes includes DDS's contracted vendor addressing the complaint immediately upon discovery and providing additional staff training.

The case record review tool captures and tracks remediation in all of these areas.

All substantiated incidents are investigated by the Program Director for DDS's contracted vendor or his/her designee.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☒ **Other** Specify: DDS contracted vendor	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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 Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able

to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DDS analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DDS will meet with DMS or its contracted vendor to discuss what system or program changes are necessary based on the nature of the problem, complexity of the solution, and financial impact. If it is determined that a system change is needed, a customer service request (CSR) will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DMS. MMIP prioritizes system changes to MMIS and coordinates implementation with the Medicaid fiscal agency. An action plan is developed and information is shared with the appropriate stakeholders for comments. Implementation of the plan is the final step. The MMIP unit and DDS will monitor the system changes. An online CSR Management system is used to monitor and track the status of customer service requests.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: DDS's contracted vendor	☒ **Other** Specify: Ongoing, as neeeded

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

Meetings are held with DMS, DDS, and DDS's contracted vendor, as needed, to develop needed CSRs, review progress, develop new elements and components and test system changes. The meetings involve participation in current programming activities on an as needed basis with the assigned DHS information technology consulting firm, Medicaid's fiscal agent, DDS, DDS contracted vendor, and others deemed appropriate.

DMS, as the state Medicaid agency, with input from DDS, analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DDS will meet with its contracted vendor to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and safety issue, etc.), complexity of the solution (does it require an amendment to the waiver application), and the financial impact. If it is determined that a system change is needed, a computer service request will be submitted to the Medicaid Management Information and Performance Unit (MMIP) within DMS and a priority status assigned. MMIP prioritizes system changes to MMIS and coordinates implementation with the States fiscal agent. An action plan is developed and information is shared with the appropriate stakeholders for comment. Implementation of the plan is the final step. The MMIP Unit and DDS monitor the system changes. An online CSR Management System is used to monitor and track the status of computer service requests.

As a result of the discovery process:
(1) The interagency agreement may be revised to clarify roles and responsibilities between DMS and DDS. The agreement between the two divisions will be reviewed at least annually. DDS will in turn review the contract with its vendor, at least annually, and revise as needed.

(2) Medicaid related issues are documented by DDS's contracted vendor, reviewed by DDS, and recorded on a quarterly report to identify, capture and resolve billing and claims submission problems. Error reports are worked and billing issues are resolved by DDS's contracted vendor. DDS reviews reports for proper resolution. These activities occur on a daily basis, and reviews occur monthly by DDS.

A separate Quality Assurance Unit was formed within the DMS to monitor and advise Home and Community-Based Waiver Program Operating Agencies.

DDS will produce a report of the findings for each quarter and distribute to its contracted vendor. DDS and its contracted vendor will meet quarterly to discuss and address any issues/findings for that quarter.

In December of each year, DDS, with its vendor, runs a report to identify the number of active Autism Waiver participants. DDS conducts a review of 10% of the charts on a quarterly basis. As part of the review of active Autism Waiver participants' records, DDS verifies the following:

Health and welfare
Plans of care
Qualified provider
Level of care
Financial accountability

DDS and its contracted vendor ensure enrollment stays within approved limits by monitoring both the number of active and the number of unduplicated participants served within the approved limits. The monthly ACES Report of Active Cases and queries run from MMIS are utilized to determine the number of active and the number of unduplicated participants served at any point in time.

Any findings discovered in the review are transmitted to DDS's contracted vendor for resolution. DDS contracted vendor will respond to DDS describing the action taken to resolve the finding and submitting any documentation relevant to the resolution. If resolution of the finding requires a systems change or improvement, DDS will work with its contracted vendor to implement the change or improvement. Changes or improvements requiring promulgation are published for 30 days to allow stakeholders an opportunity to comment. Any revisions to policy are transmitted to providers utilizing a provider manual update, an official notice or a remittance advice message. If resolution requires additional provider training, DDS's contracted vendor will conduct the training and notify DDS.

DDS maintains a Monitoring/Tracking database to document and track findings. DDS will share review results

with its contracted vendor and will track any necessary remediation and improvement. DDS also reviews quarterly reports of the results of DDS's contracted vendor's monitoring activities. DDS and its contracted vendor meet quarterly to discuss findings of the reports and any issues or concerns. At these meetings priorities are established and strategies are developed for any necessary remediation and improvement.

At the end of each Waiver year, DMS and DDS compile an annual report based on discovery findings from the reviews. The annual report includes any key findings, including status of remediation and improvement activities.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DDS and its contracted vendor monitor the Quality Improvement Strategy (QIS) on an ongoing basis and review the QIS annually. A review consists of analyzing reports and progress toward stated initiatives, resolution of individual and systematic issues found through discovery and notating desired outcomes. When change in the strategy is indicated, a collaborative effort is set in motion to complete a revision to the QIS which may include submission of a Waiver amendment. DDS utilizes the QIS during the QA reviews.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Expenditure reports from the claims database are reviewed for those clients whose chart's were reviewed during a specific month, DDS pulls a random sampling of approximately of 10% of participant's charts each quarter. DDS reviews the plan of care data in its contracted vendor's database to compare what was billed Medicaid. MMIS claims data are audited periodically for program policy alignment. Claims processing worksheets are reviewed when a billing issue/error is brought to DMS or DDS attention. The DMS Program Integrity Unit may review claims paid in accordance with the waiver participant's POC, if there is an overpayment to a provider or suspicion of fraud. And finally, the DMS Program Integrity Unit includes a review of claims paid in accordance with Waiver participants' Plans of Care (POCs).

DDS, through its contracted vendor, reviews 100% of the claims for autism waiver recipients based upon their annual plan of care date. The charts are looked at for their plan of care year expenditures and program files. Items that are reviewed include Level of Care Assessment, Plan of Care, Medicaid Management Information Systems client profile, Freedom of Choice, & Provider Qualifications. DDS's contracted vendor submits a quarterly and annual report summarizing this information for review and approval by DDS.

Cognos billing database is utilized to run a report of individual autism waiver recipient plan of care year and is broken out into the following categories: Service Consultative Clinical and Therapeutic Services, Service Individual Assessment/Treatment Development, Lead Therapy Intervention, Line Therapy Intervention and Service Plan Implementation and Monitoring of Intervention Effectiveness. These expenditures for the individual autism waiver recipients are compared against the approved levels for autism waiver services to create a utilization report.

Autism waiver recipient charts are provided to DDS's contract reviewer on a monthly basis. If an assurance has not been met it is noted in the transmittal requesting operating agency to come into compliance. If over utilization is a problem, the providing agency will submit a check to Medicaid and explanation for overutilization as it ties to which services. DMS/OPD will provide a transmittal to DDS's contracted vendor for corrective action.

Assurances include:
Participant waiver enrollment
Waiver enrollment managed against approved limits
Waiver expenditures managed against approved levels
Level of care evaluation
Review of Participant service plans
Prior authorization of waiver services
Utilization management
Qualified provider enrollment
Execution of Medicaid provider agreements
Establishment of a statewide rate methodology
Rules, policies, procedures and information development governing the waiver program
Quality assurance and quality improvement activities

DMS has utilized their Division of Policy and Quality Assurance to review certifications of providers. DDS's contracted vendor has now created a Database that houses information on all certified providers. The Division of Developmental Disability Services (DDS) will now take a more active role in reviewing that information by obtaining a username to login to that database and monitor the certified providers.

Monitoring is conducted on an on-going basis and is tracked through the monthly activity report and the quarterly participant profiles.

Tracking of the number of monitoring visits is now a part of the monthly activity report.

Monitoring of financial reports is also on-going as reports are produced and reviewed monthly.

An independent audit is required annually of the provider agency when:

State expenditures are $100,000 or more;

Federal expenditures are $300,000 or more; or

The contract the Department of Human Services (DHS) has with the provider agency requires an independent audit, regardless of funding level.

If the federal expenditures are $300,000 or more, the audit must be performed in accordance with OMB Circular A-133, which implemented the Single Audit Act, as amended. A Government Auditing Standards (GAS) audit must be performed if DHS funding provided is $100,000 or more of federal, state, or federal and state combined. In addition, the DMS Program Integrity Unit conducts an annual random review of HCBS waiver programs. If the review finds errors in billing, and fraud is not suspected, Medicaid recoups the money from the Waiver provider. If fraud is suspected, the DMS Program Integrity Unit refers the Waiver provider to the Arkansas Attorney General's Office for appropriate action.

The DHS Office of Chief Counsel, Audit Section is responsible for reviewing all independent audits. The provider's audit report is reviewed by the Audit Section to determine whether:

Requirements of applicable authorities and those contained in agency policy were met;

Material weaknesses in internal control exist;

Material noncompliance with the provision of grants, contracts, and agreements occurred; and

The report included findings, recommendations, and responses thereto by management.

Material weaknesses and non compliance, other findings, recommendations, and responses will be recorded and communicated to DMS. DMS will take appropriate action to resolve audit findings within 90 days of the referral of the finding from the Audit Section.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
Number and percent of Waiver claims reviewed that were paid using the correct rate.
Numerator: Number of claims paid at the correct rate; Denominator: number of claims

Data Source *(Select one):*

Other
If 'Other' is selected, specify:
Recipient Claims History Profile

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:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *10% of recipients charts and claims history are reviewed per 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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number of failed MMIS edit checks which are corrected to assure appropriate payment. Numerator: Number of corrected MMIS edit checks; Denominator: Number of edit checks

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Weekly Worksheets

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:* *DDS contracted vendor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Daily LTCU Update Error 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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *DDS contracted vendor*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Daily Waiver Update Error 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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☒ ***Other*** *Specify:* *DDS 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):*
☐ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☒ ***Other***	☐ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
Specify: *DDS contracted vendor*	
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

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

N/A

b. Methods for Remediation/Fixing Individual Problems

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

DDS and its contract vendor hold quarterly team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation.

The performance measure for number and percent of waiver claims paid using the correct rate will always result in 100% compliance because the rates for services are already set in MMIS; therefore, claims will not be paid at any other rate.

Remediation for failed MMIS checks not corrected to assure appropriate payment includes correcting the issue upon discovery, making system changes and training staff.

Remediation for claims for services not specified in the client's Plan of Care (POC) includes revising the client's POC, if necessary, recouping payment from the provider, imposing provider sanctions, training providers and conducting a client monitoring visit.

The tool used for case record review captures and tracks remediation in these areas.

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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☒ ***Other*** *Specify:* *DDS contracted vendor*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***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 Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment*

rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

A listing of certified providers for this type service was accessed through the licensure group for providers in Arkansas and bordering states. An electronic survey was then disseminated via Survey Monkey to all these providers with a number of questions, not the least of which was their current rate charged for such services. The rates utilized in this application were set based on the results of this survey in order to ensure that rates were based on the current market value for comparable services provided by similarly qualified professionals.

Rates for the Consultants and Lead therapists were determined by:
- Online survey sent to all certified providers in Arkansas and surrounding states of Louisiana, Texas, Oklahoma, Missouri, Tennessee, and Mississippi who currently provide home-based intensive interventions for children diagnosed with ASD. While rates varied a bit between individual providers, most Consultants reported billing $100/hr - $175/hr and most Lead therapists reported billing $50/hr - $65/hr. Of the 7 states surveyed, only one, Louisiana, required insurance coverage for such therapies, and so most of these therapies are funded entirely out of pocket, which would account for the range of fees. We then examined what other funding sources existed for these types of treatments and found that Tricare insurance covers such treatments in Arkansas and nationwide for active duty military personnel at a rate of $100/hr.

A handful of states have similar waiver programs to provide early intervention services for children with ASD. Of all these states, the two that have been operating such programs the longest are Wisconsin (since January 2004) and South Carolina (since June 2007). We contacted the state agency responsible for administering these programs in each state to find out how the programs are structured and to discuss reimbursement for providers. The two programs are similar in the kinds of interventions provided and the number of years children can be served in the waiver (3 years maximum). When asked what problems they have encountered with providing the services under the program both states reported difficulty recruiting and maintaining direct line staff. Based on our discussions with providers in both states, it became clear that reimbursement for direct line staff needed to be set higher to ensure we could attract skilled, motivated individuals to the program. An examination of reimbursement rates for the Tier I and II therapists in each program found significant differences in how the service is reimbursed. In Wisconsin, the rate for all 3 tiered professionals is bundled, and usually the top-tier consultant is the employer of the tier II and line therapists. The top-tier consultant takes a percentage of the bundled fee and then pays the tier II and line therapist. The difficulty with such a bundled rate is that (1) there is no assurance that the top-tier consultant is even making contact with the family/child or how often that is happening, and (2) there have been instances of fraudulent billing practices such as billing for travel time, and finally (3) direct line therapists are reimbursed at rates barely above minimum wage and so recruiting and maintaining staff for this position was made extremely difficult. South Carolina, on the other hand, developed a 3-tier/rate service which makes it far easier for the administering agency to review plans of care and billing records to ensure that the top-tier consultant and middle-tier therapist are maintaining contact with the family and are providing appropriate supervision for the line therapist. The reimbursement rates for services in the Arkansas waiver application are most similar to the South Carolina program.

The $1,000 flat rate for behavioral reinforcers was determined through discussions (focus group) with professionals credentialed at the Consultant level and delivering a similar service currently. This was an amount considered appropriate to support delivery of the Intensive Autism Intervention service for families who may not already have sufficient materials on hand in the home.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Waiver providers bill for the waiver services and are reimbursed directly through the MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The MMIS verifies participant waiver eligibility and current provider Medicaid enrollment for the date of service prior to paying a waiver claim. DDS's contracted vendor verifies quarterly services were provided according to the service plan through an internal monthly monitoring system and a review of participant profiles. All waiver claims are processed through the MMIS, using all applicable edits and audits, to assure claims are processed appropriately, timely, and compared to the Medicaid maximum allowable.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System***

(MMIS).

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- ◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

An institution of Higher Education, a State agency, will provide the Consultative Clinical and Therapeutic Services specified in the Autism Waiver.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under***

the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***not selected***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☒ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

(a)Tobacco Tax - Arkansas Act 180 of 2009; (b)Department of Human Services, Division of Developmental Disabilities; and (c)Intergovernmental Transfer (IGT).

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ○ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ◉ ***The following source(s) are used***

  Check each that applies:

  - ☒ ***Health care-related taxes or fees***
  - ☐ ***Provider-related donations***
  - ☐ ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Tobacco tax - Arkansas Act 180 of 2009

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of***

Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	34328.00	17828.00	52156.00	100739.00	34206.00	134945.00	82789.00
2	35354.00	18321.00	53675.00	103529.74	35153.47	138683.21	85008.21
3	21748.00	18829.00	40577.00	106397.52	36127.22	142524.74	101947.74
4	21748.00	19350.00	41098.00	109344.73	37127.95	146472.68	105374.68
5	21748.00	19886.00	41634.00	112373.58	38156.39	150529.97	108895.97

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*
		Level of Care:
		ICF/IID
Year 1	*200*	*200*
Year 2	*200*	*200*
Year 3	*270*	*270*
Year 4	*270*	*270*
Year 5	*270*	*270*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Most participants in the Autism Waiver will receive services for a three year period, the maximum allowed on this program. In some situations where the child is enrolled in the program later, he/she may only receive two years of service, the minimum required for program participation. Each participant will stay on the Waiver for 365 days per year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D reflects the number of participants the State will be able to serve in the Autism Waiver based on the allotted funding.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is computed based on SFY 2011 Actual Data on children aged 18 months through age 6 in the MMIS system with ASD as their primary or secondary diagnosis and the related member months. The Inflation % was obtained using The Consumer Price Index for medical services averaged over a 5 year period.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G reflects the average cost of the level of care that would be otherwise furnished to participants. Costs of all indirect services were removed to avoid double accounting of non-waiver expenses. All figures are based on actual expenses experienced in 2010.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' reflects the average cost of non-facility services that would be otherwise furnished to participants. Costs of all direct facility services were removed to avoid double accounting of non-waiver expenses. All figures are based on actual expenses experienced in 2010.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Consultative Clinical and Therapeutic Services	
Individual Assessment/ Treatment Development/ Monitoring	
Lead Therapy Intervention	
Line Therapy Intervention	
Therapeutic Aides and Behavioral Reinforcers	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:						699480.00
Consultative Clinical and Therapeutic Services	15 minutes	200	134.00	26.10	699480.00	
Individual Assessment/ Treatment Development/ Monitoring Total:						447615.00
Individual Assessment/Treatment Development	15 minutes	50	343.00	26.10	447615.00	
Lead Therapy Intervention Total:						1852500.00
Lead Therapy Intervention	15 minutes	200	1235.00	7.50	1852500.00	
Line Therapy Intervention Total:						3816000.00
Line Therapy Intervention	15 minutes	200	4240.00	4.50	3816000.00	
				GRAND TOTAL:		6865595.00
				Total Estimated Unduplicated Participants:		200
				Factor D (Divide total by number of participants):		34328.00
				Average Length of Stay on the Waiver:		365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Aides and Behavioral Reinforcers Total:						**50000.00**
Therapeutic Aides and Behavioral Reinforcers	1 package	50	1.00	1000.00	**50000.00**	

GRAND TOTAL:	**6865595.00**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**34328.00**
Average Length of Stay on the Waiver:	365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:						**783000.00**
Consultative Clinical and Therapeutic Services	15 minutes	200	150.00	26.10	**783000.00**	
Individual Assessment/ Treatment Development/ Monitoring Total:						**456750.00**
Individual Assessment/Treatment Development	15 minutes	50	350.00	26.10	**456750.00**	
Lead Therapy Intervention Total:						**1911000.00**
Lead Therapy Intervention	15 minutes	200	1274.00	7.50	**1911000.00**	
Line Therapy Intervention Total:						**3870000.00**
Line Therapy Intervention	15 minutes	200	4300.00	4.50	**3870000.00**	
Therapeutic Aides and Behavioral Reinforcers Total:						**50000.00**
Therapeutic Aides and Behavioral Reinforcers	1 package	50	1.00	1000.00	**50000.00**	

GRAND TOTAL:	**7070750.00**
Total Estimated Unduplicated Participants:	**200**
Factor D (Divide total by number of participants):	**35354.00**
Average Length of Stay on the Waiver:	365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:						**225504.00**
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	**225504.00**	
Individual Assessment/ Treatment Development/ Monitoring Total:						**1599669.00**
Individual Assessment/Treatment Development	15 minutes	270	227.00	26.10	**1599669.00**	
Lead Therapy Intervention Total:						**1344600.00**
Lead Therapy Intervention	15 minutes	270	664.00	7.50	**1344600.00**	
Line Therapy Intervention Total:						**2634120.00**
Line Therapy Intervention	15 minutes	270	2168.00	4.50	**2634120.00**	
Therapeutic Aides and Behavioral Reinforcers Total:						**68000.00**
Therapeutic Aides and Behavioral Reinforcers	1 package	68	1.00	1000.00	**68000.00**	

GRAND TOTAL:	**5871893.00**
Total Estimated Unduplicated Participants:	**270**
Factor D (Divide total by number of participants):	**21748.00**
Average Length of Stay on the Waiver:	365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:						**225504.00**
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	**225504.00**	
Individual Assessment/ Treatment Development/ Monitoring Total:						**1599669.00**
Individual Assessment/Treatment Development	15 minutes	270	227.00	26.10	**1599669.00**	
Lead Therapy Intervention Total:						**1344600.00**
Lead Therapy Intervention	15 minutes	270	664.00	7.50	**1344600.00**	
Line Therapy Intervention Total:						**2634120.00**
Line Therapy Intervention	15 minutes	270	2168.00	4.50	**2634120.00**	
Therapeutic Aides and Behavioral Reinforcers Total:						**68000.00**
Therapeutic Aides and Behavioral Reinforcers	1 package	68	1.00	1000.00	**68000.00**	

GRAND TOTAL:	**5871893.00**
Total Estimated Unduplicated Participants:	**270**
Factor D (Divide total by number of participants):	**21748.00**
Average Length of Stay on the Waiver:	365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services Total:						**225504.00**
Consultative Clinical and Therapeutic Services	15 minutes	270	32.00	26.10	**225504.00**	
Individual Assessment/ Treatment Development/ Monitoring Total:						**1599669.00**

GRAND TOTAL:	**5871893.00**
Total Estimated Unduplicated Participants:	**270**
Factor D (Divide total by number of participants):	**21748.00**
Average Length of Stay on the Waiver:	365

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Assessment/Treatment Development	15 minutes	270	227.00	26.10	1599669.00	
Lead Therapy Intervention Total:						1344600.00
Lead Therapy Intervention	15 minutes	270	664.00	7.50	1344600.00	
Line Therapy Intervention Total:						2634120.00
Line Therapy Intervention	15 minutes	270	2168.00	4.50	2634120.00	
Therapeutic Aides and Behavioral Reinforcers Total:						68000.00
Therapeutic Aides and Behavioral Reinforcers	1 package	68	1.00	1000.00	68000.00	

GRAND TOTAL:	5871893.00
Total Estimated Unduplicated Participants:	270
Factor D (Divide total by number of participants):	21748.00
Average Length of Stay on the Waiver:	365

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Developmental Disabilities Services
PERSON COMPLETING THIS STATEMENT Lucas Silva
TELEPHONE NO. 501-396-6469 **FAX NO.** _____ **EMAIL:** lucas.silva@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Autism Waiver and Autism Waiver Medicaid Provider Manual

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes x No _____

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes x No _____

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes x No _____
   If an agency is proposing a more costly rule, please state the following:

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

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

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and

   (d) Whether the reason is within the scope of the agency's statutory authority, and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$234,702	General Revenue	$476,240
Federal Funds	$547,638	Federal Funds	$1,111,226
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	

Other (Identify)_____	Other (Identify)_____
Total_____ $782,340	Total_____ $1,587,466

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

Current Fiscal Year	**Next Fiscal Year**
General Revenue_____	General Revenue_____
Federal Funds_____	Federal Funds_____
Cash Funds_____	Cash Funds_____
Special Revenue_____	Special Revenue_____
Other (Identify)_____	Other (Identify)_____
Total_____ $0	Total_____ $0

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

Current Fiscal Year	**Next Fiscal Year**
$_____ 0	$_____ 0

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

Current Fiscal Year	**Next Fiscal Year**
$_____ $234,702	$_____ $476,240

This 1915(c) waiver has a 70/30 Federal-State match. The state will incur 30-percent of the costs while the Federal Goverment will incur 70-percent.

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

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously

with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

Acts 2019, No. 874, § 15 provides that DDS "shall budget, allocate, and expend up to one million dollars ($1,000,000) for the elimination of the Autism Waiver Services Program waiting list". No additional funding was provided for this purpose. Therefore, DDS is expanding the number of Waiver slots to include all children on the waitlist.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

DDS will eliminate the Waitlist for Autism Waiver services by increasing the slots.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

As of the time Act 874 was passed, there were approximately 30 children on the Autism Waiver waitlist. By increasing the number of slots, DDS will be able to serve all children on the waitlist, as mandated by Act 874. Evidence suggests that children served through the Autism Waiver will need less intensive services later in life.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

Because we were mandated to eliminate the waitlist, there is no less costly alternative.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

CMS requires the state to state a number of "slots" or individuals that will be served by a home and community-based waiver, such as the Autism Waiver. To increase the number of children served, therefore, DDS must increase the number of slots through the public comment and promulgation process.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

CMS requires DDS to renew the Autism Waiver every five years, so this Waiver is continuously being reviewed to ensure that it is meeting CMS requirements and meeting the needs of Arkansas families.

Statement of Necessity and Rule Summary
Autism Waiver and the Autism Waiver Medicaid Provider Manual

Statement of Necessity

Acts 2019, No. 874, § 15, requires the Division of Developmental Disabilities Services (DDS) to eliminate the waiting list for the Autism Waiver Services Program. To implement Act 874, this promulgation adds 30 slots to the current participant limits of the Autism Waiver program. In addition, this promulgation updates language, benefit limits, procedure codes, and job requirements and qualifications for consultants providing services in the Autism Waiver Medicaid Provider Manual to reflect the Autism Waiver as approved by the Centers for Medicare and Medicaid Service.

Rule Summary

Effective January 1, 2020, the Autism Waiver and the Autism Waiver Medicaid Provider Manual are amended to:

- Update language to reflect Autism Spectrum Disorder (ASD), current program, and service names.
- Update requirements for providers and consultants under Enrollment Criteria.
- Pursuant to Acts 2019, No. 874, § 15, expand capacity to provide intensive early intervention treatment for 30 additional children diagnosed with Autism Spectrum Disorder (ASD).
- Increase the unduplicated number to account for the increased slots.
- Update benefit limits.
- Combine Plan Implementation and Monitoring service with Individual Assessment to create one service description: Individual Assessment/Plan Development/Team Training/Monitoring.
- Change scope of coverage's maximum age to "through seven (7) years"
- Recognize that evidence-based practices are from updated National Autism Center's National Standards Project, Second Edition.
- Reflect that the Division of Developmental Disabilities Services took over the administration of the Autism Waiver and is now the operating agency.