ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Autism Intensive Intervention Provider**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal AUTISM-NEW-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
___	___	ALL	10-1-12

Explanation of Updates

A new Autism Waiver policy manual is available for all Autism Intensive Intervention Providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

SECTION II – AUTISM WAIVER CONTENTS

TOC required

200.000 AUTISM WAIVER PROGRAM GENERAL INFORMATION

201.000 Arkansas Medicaid Certification Requirements for Autism Waiver Program 10-1-12

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 University of Arkansas for Medical Sciences, Partners for Inclusive Communities (UAMS 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 UAMS Partners does not guarantee enrollment in the Medicaid program.

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

Copies of certifications and renewals required by UAMS Partners must be maintained by Autism Waiver Providers to avoid loss of provider certification. **View or print the UAMS Partners Provider Certification contact information.**

201.100 Providers of Autism Waiver Services in Bordering and Non-Bordering States 10-1-12

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

Arkansas Medicaid does not provide Autism Waiver services in non-bordering states.

202.000 ENROLLMENT CRITERIA

202.100 Autism Intensive Intervention Providers 10-1-12

An Autism Intervention Provider must:

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

OR

B. Be certified by the state of Arkansas to provide full array services under the Developmental Disabilities Services (DDS) Alternative Community Services Waiver program

C. Have a minimum of three (3) years experience providing services to individuals with autism

D. Be enrolled with Arkansas Medicaid to provide Autism 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. 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 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 10-1-12

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)

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

OR

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

D. Enroll with Arkansas Medicaid to receive a National Provider Identifier (NPI).

202.300 Lead Therapists 10-1-12

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

B. Have completed 120 hours or specified autism training including:

1. Introduction to Autism (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

C. Have completed an Autism Certificate Program

D. Have a minimum of two (2) years experience in intensive intervention programs for children with autism

E. Enroll with Arkansas Medicaid to receive a National Provider Identifier (NPI).

In a hardship situation, UAMS 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 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 10-1-12

A qualified Line Therapist must:

A. Hold a high school diploma or GED

B. Have completed 80 hours of specified autism training including:

1. Introduction to Autism (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

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

D. Enroll with Arkansas Medicaid to receive a National Provider Identifier (NPI).

In a hardship situation, UAMS 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 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

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. The provider must:

1. Be staffed by professionals from multiple disciplines with a minimum of a master's degree in Psychology, Special Education, Speech-Language Pathology, or a related field and 3 years of experience in providing interventions to young children with 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 3 years of experience in providing training toward a graduate certificate in Autism Spectrum Disorders, recognized by the Arkansas Department of Higher Education
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.

203.000 Required Documents 10-1-12

Autism Waiver providers must create and maintain written records. Along with the required enrollment documentation, which is detailed in Section 141.000, the records, outlined in Section 203.100, must be included in the beneficiary's case files maintained by the provider.

203.100 Documentation in Beneficiary's Case Files 10-1-12

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 UAMS 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.

203.200 Electronic Signatures 10-1-12

Medicaid will accept electronic signatures, provided the electronic signatures comply with Arkansas Code 25-31-103.

210.000 PROGRAM COVERAGE

211.000 Scope 10-1-12

The purpose of the Autism Waiver is to provide one-on-one, intensive early intervention treatment for beneficiaries ages eighteen (18) months through six (6) years with a diagnosis of autism. The waiver participants must meet the ICF/MR level of care and have a diagnosis of autism.

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

A. Individual Assessment, Program Development and Training

B. Provision of Therapeutic Aides

C. Plan Implementation and Monitoring of Intervention Effectiveness

D. Lead Therapy Intervention

E. Line Therapy Intervention

F. Consultative Clinical and Therapeutic Services

The waiver program is operated by the UAMS Partners under the administrative authority of the Division of Medical Services.

212.000 Eligibility Assessment 10-1-12

The client intake and assessment process for the Autism Waiver includes a determination of financial eligibility, a level of care determination, the development of an individualized plan of care and documentation of the participant's choice between home and community-based services and institutional services.

212.100 Financial Eligibility Determination 10-1-12

Financial eligibility for the Arkansas Medicaid Program must be verified as part of the participant's intake and assessment process for admission into the Autism Waiver program. Medicaid eligibility is determined by the Department of Human Services (DHS) Division County Operations.

212.200 Level of Care Determination 10-1-12

Each beneficiary on this waiver must be diagnosed with Autistic Disorder (299.00), 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 being admitted to the state's ICF/MR facilities.

212.300 Plan of Care 10-1-12

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 to the Division of Medical Services designee, UAMS Partners. A copy of the plan of care, the Autism Waiver Coordinator (Partners) and the waiver participant's parent or guardian, is forwarded to the Autism 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 UAMS Partners.

The Autism 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 UAMS 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 UAMS 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 UAMS 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 UAMS 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 UAMS 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 Intervention Provider 10-1-12

The Intensive Autism Intervention Provider is responsible for providing these services:

A. Individual Assessment, Program Development and Training

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
    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
3. 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

A. Provision of 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.

B. Plan Implementation and Monitoring of Intervention Effectiveness

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.

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 10-1-12

A. Individual Assessment, Program Development/Training

The maximum benefit limit is 32 units per day/92 units per year.

B. Provision of therapeutic aides and behavioral reinforcers

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 waiver program.

C. Plan Implementation and Monitoring of Intervention Effectiveness

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

D. Lead Therapy Intervention

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

E. Line Therapy Intervention

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

220.300 Consultative Clinical and Therapeutic Services 10-1-12

The 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 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 telephone as appropriate.

230.000 BILLING INSTRUCTIONS

230.100 Introduction to Billing 10-1-12

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.

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

The following procedure codes and any associated modifier(s) must be billed for the Autism Waiver Services. Prior authorization is required for all 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

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

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

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

230.400 Billing Instructions - Paper Only 10-1-12

DHS' fiscal agent offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. **View a sample form CMS-1500.**

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

Forward completed claim forms to the fiscal agent's claims department. **View or print fiscal agent claims department contact information.**

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

230.410 Completion of CMS-1500 Claim Form 10-1-12

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	

Field Name and Number	Instructions for Completion
TELEPHONE (Include Area Code)	
8. PATIENT STATUS	Not required.
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 beneficiary.
b. OTHER INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9a-d are required. Name of the insured beneficiary's employer and/or school.
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. RESERVED FOR LOCAL USE	Not used.
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. EMPLOYER'S NAME OR SCHOOL NAME	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 9a through 9d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Not required.
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.
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	Not required.
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 not required for DDS Alternative Community Services (ACS) Waiver services. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's inpatient hospitalization, enter the beneficiary's admission and discharge dates. Format: MM/DD/YY.
19. RESERVED FOR LOCAL USE	Not used.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Diagnosis code for the primary medical condition for which services are being billed. Up to three additional diagnosis codes can be listed in this field for information or documentation purposes. Use the International Classification of Diseases, Ninth Revision (ICD-9-CM) diagnosis coding, current as of the date of service.
22. MEDICAID RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Reserved for future use.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.

Field Name and Number	Instructions for Completion
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	Not required.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Section 272.100.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter in each detail the single number—1, 2, 3, or 4—that corresponds to a diagnosis code in Item 21 (numbered 1, 2, 3, or 4) and that supports most definitively the medical necessity of the service(s) identified and charged in that detail. Enter only one number in E of each detail. Each DIAGNOSIS POINTER number must be only a 1, 2, 3, or 4, and it must be the only character in that field.
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 #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
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 N O.	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."

Field Name and Number	Instructions for Completion
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. BALANCE DUE	From the total charge, subtract amounts received from other sources and enter the result.
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)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

230.500 Special Billing Procedures 10-1-12

Not applicable to this program.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecI-1-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
–	–	105.120	10-1-12
105.120	9-15-09	105.130	10-1-12
105.130	6-15-11	105.140	10-1-12
105.140	9-15-09	105.150	10-1-12

Explanation of Updates

Section 105.120 is added to include information about the Autism waiver.

Sections 105.130, 105.140, and 105.150 are updated to reflect new section numbers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

TOC required

105.120 Autism Waiver 10-1-12

The purpose of the Autism waiver is to provide one-on-one, intensive early intervention treatment for young children ages eighteen (18) months through six (6) years with a diagnosis of autism. The waiver participants must meet the ICF/MR level of care and have a diagnosis of autism.

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

1. Individual Assessment, Program Development and Training
2. Provision of Therapeutic Aides
3. Plan Implementation and Monitoring of Intervention Effectiveness
4. Lead Therapy Intervention
5. Line Therapy Intervention
6. Consultative Clinical and Therapeutic Services

The waiver program is operated by the University of Arkansas for Medical Sciences (UAMS) Partners under the administrative authority of the Division of Medical Services.

105.130 ConnectCare: Primary Care Case Management (PCCM) 10-1-12

ConnectCare is the Arkansas Medicaid Primary Care Case Management (PCCM) system. In ConnectCare, a Medicaid beneficiary selects and enrolls with a primary care physician (PCP) that has contracted with DMS to be responsible for managing the health care of a limited number (specified by the PCP) of Medicaid enrollees.

A PCP contracts with DMS to provide primary care, health education and case management for his or her enrollees. DMS pays the PCP a monthly per-enrollee case management fee in addition to the regular Medicaid fee-for-service reimbursement.

The PCP is responsible for referring enrollees to specialists and other providers; therefore, he or she is responsible for deciding whether a particular referral is medically necessary. A PCP may make such decisions in consultation with physicians or other professionals as needed and in accordance with his or her medical training and experience; however, a PCP is not required to make any referral simply because it is requested.

A PCP coordinates his or her enrollees' medical and rehabilitative services with the providers of those services. Medical and rehabilitative professionals to whom a PCP refers a patient are required to report to or consult with the PCP so that the PCP can coordinate care and monitor an enrollee's status, progress and outcomes.

Most Medicaid beneficiaries, and children participating in ARKids First-B, must enroll with a PCP to receive covered services. Some individuals are not required to enroll with a PCP. Few services are covered without PCP referral. See Sections 170.000 through 173.000 for details regarding ConnectCare.

105.140 DDS Alternative Community Services (ACS) 10-1-12

The Developmental Disability Services Alternative Community Services (DDS ACS) waiver program is for beneficiaries who, without the waiver's services, would require institutionalization. Participants must not be residents of a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF/MR).

DDS ACS eligibility requires a determination of categorical eligibility, a determination of level of care, the development of a plan of care and a cost comparison to determine the cost-

effectiveness of the plan of care. The DDS ACS program further requires advising the beneficiary that he or she may freely choose between waiver and institutional services.

Services supplied through this program are:

A. Supportive living
B. Respite care
C. Supplemental support services
D. Supported employment services
E. Environmental modifications
F. Adaptive equipment
G. Specialized medical supplies
H. Case management services
I. Transitional case management services
J Community transition services
K. Consultation services
L. Crisis intervention services

Detailed information may be found in the DDS ACS Waiver provider manual.

105.150 ElderChoices 10-1-12

ElderChoices is designed for beneficiaries aged 65 and older, who, without the waiver's services, would require an intermediate level of care in a nursing home. The services listed below are designed to maintain beneficiaries at home and preclude or postpone institutionalization.

A. Adult foster care
B. Homemaker services
C. Chore services
D. Home delivered meals
E. Personal emergency response system
F. Adult day care
G. Adult day health care
H. Respite care
I. Adult companion services

ElderChoices eligibility requires a determination of categorical eligibility, a determination of level of care, the development of a plan of care and a cost comparison to determine the cost-effectiveness of the plan of care. ElderChoices requires notifying the beneficiary that he or she may freely choose between waiver services and institutional services.

Refer to the ElderChoices provider manual for more detailed information.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal SecV-2-12**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
DMS-652	10-11	DMS-652	10-12
500.000	–	500.000	–

Explanation of Updates

DMS-652 is updated with the new provider categories in relation to the autism waiver.

Section 500.000 is updated to include contact information for the UAMS Partners Provider Certification.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

SECTION V – FORMS

500.000

Claim Forms

Red-ink Claim Forms

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
Alternatives Attendant Care Provider Claim Form - AAS-9559	Client Employer
Dental – ADA-J400	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	DMS-2606
Address Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	DMS-679A
Amplification/Assistive Technology Recommendation Form	DMS-686
Application for WebRA Hardship Waiver	DMS-7736
Approval/Denial Codes for Inpatient Psychiatric Services	DMS-2687
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	DDS/FS#0001.a
ARKids First Mental Health Services Provider Qualification Form	DMS-612
Assisted Living Waiver Plan of Care	AAS-9565
Authorization for Automatic Deposit	autodeposit
Authorization for Payment for Services Provided	MAP-8
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2633
Certification of Schools to Provide Comprehensive EPSDT Services	CSPC-EPSDT
Certification Statement for Abortion	DMS-2698
Change of Ownership Information	DMS-0688
Child Health Management Services Enrollment Orders	DMS-201
Child Health Management Services Discharge Notification Form	DMS-202
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	DMS-699A
CHMS Request for Prior Authorization	DMS-102
Claim Correction Request	DMS-2647
Consent for Release of Information	DMS-619
Contact Lens Prior Authorization Request Form	DMS-0101
Contract to Participate in the Arkansas Medical Assistance Program	DMS-653
DDTCS Transportation Log	DMS-638
DDTCS Transportation Survey	DMS-632
Dental Treatment Additional Information	DMS-32-A
Disclosure of Significant Business Transactions	DMS-689
Disproportionate Share Questionnaire	DMS-628
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	DMS-693
Early Childhood Special Education Referral Form	ECSE-R
EPSDT Provider Agreement	DMS-831
Evaluation Form Lower-Limb	DMS-646
Explanation of Check Refund	HP-CR-002

Form Name	Form Link
Gait Analysis Full Body	DMS-647
Home Health Certification and Plan of Care	CMS-485
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	DCO-645
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	DMS-2685
Individual Renewal Form for School-Based Audiologists	DMS-7782
Lower-Limb Prosthetic Prescription	DMS-651
Media Selection/E-Mail Address Change Form	HP-MS-005
Medicaid Claim Inquiry Form	HP-CI-003
Medicaid Form Request	HP-MFR-001
Medical Assistance Dental Disposition	DMS-2635
Medical Equipment Request for Prior Authorization & Prescription	DMS-679
Medical Transportation and Personal Assistant Verification	DMS-616
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	DMS-633
Notice Of Noncompliance	DMS-635
NPI Reporting Form	DMS-683
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	DMS-640
Ownership and Conviction Disclosure	DMS-675
Personal Care Assessment and Service Plan	DMS-618 English DMS-618 Spanish
Practitioner Identification Number Request Form	DMS-7708
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	DMS-2615
Primary Care Physician Managed Care Program Referral Form	DMS-2610
Primary Care Physician Participation Agreement	DMS-2608
Primary Care Physician Selection and Change Form	DMS-2609
Prior Authorization (PA) Request for Extension of Benefits-Prescription Drugs	DMS-0685-14
Procedure Code/NDC Detail Attachment Form	DMS-664
Prosthetic-Orthotic Lower-Limb Amputee Evaluation	DMS-650
Prosthetic-Orthotic Upper-Limb Amputee Evaluation	DMS-648
Provider Application	DMS-652
Provider Communication Form	AAS-9502
Provider Data Sharing Agreement – Medicare Parts C & D	DMS-652-A

Form Name	Form Link
Provider Enrollment Application and Contract Package	AppMaterial
Referral for Audiology Services – School-Based Setting	DMS-7783
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	DMS-2634
Referral for Medical Assistance	DMS-630
Request for Appeal	DMS-840
Request for Extension of Benefits	DMS-699
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	DMS-671
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	DMS-602
Request For Orthodontic Treatment	DMS-32-0
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	DMS-2692
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	DMS-601
Research Request Form	HP-0288
Service Log – Personal Care Delivery and Aides Notes	DMS-873
Sterilization Consent Form	DMS-615 English DMS-615 Spanish
Sterilization Consent Form – Information for Men	PUB-020
Sterilization Consent Form – Information for Women	PUB-019
Upper-Limb Prosthetic Prescription	DMS-649
Vendor Performance Report	Vendorperformreport
Verification of Medical Services	DMS-2618

In order by form number:

AAS-9502
AAS-9559
AAS-9565
Address Change
Autodeposit
CMS-485
CSPC-EPSDT
DCO-645
DDS/FS#0001.a
DMS-0101
DMS-0685-14
DMS-0688
DMS-102
DMS-201
DMS-202
DMS-2606
DMS-2608
DMS-2609
DMS-2610
DMS-2615
DMS-2618
DMS-2633
DMS-2634
DMS-2635
DMS-2647
DMS-2685
DMS-2687
DMS-2692
DMS-2698
DMS-32-A
DMS-32-0
DMS-601
DMS-602
DMS-612
DMS-615 English
DMS-615 Spanish
DMS-616
DMS-618 English
DMS-618 Spanish
DMS-619
DMS-628
DMS-630
DMS-632
DMS-633
DMS-635
DMS-638
DMS-640
DMS-646
DMS-647
DMS-648
DMS-649
DMS-650
DMS-651
DMS-652
DMS-652-A
DMS-653
DMS-664
DMS-671
DMS-675
DMS-673
DMS-679
DMS-679A
DMS-683
DMS-686
DMS-689
DMS-693
DMS-699
DMS-699A
DMS-7708
DMS-7736
DMS-7782
DMS-7783
DMS-831
DMS-840
DMS-873
ECSE-R
HP-0288
HP-AR-004
HP-CI-003
HP-CR-002
HP-MFR-001
HP-MS-005
MAP-8
Performance Report
Provider Enrollment Application and Contract Package
PUB-019
PUB-020

Arkansas Medicaid Contacts and Links

Click the link to view the information.

American Hospital Association
Americans with Disabilities Act Coordinator
Arkansas Department of Education, Health and Nursing Services Specialist
Arkansas Department of Education, Special Education
Arkansas Department of Human Services, Division of Aging and Adult Services
Arkansas Department of Human Services, Appeals and Hearings Section
Arkansas Department of Human Services, Division of Behavioral Health Services
Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit
Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit
Arkansas Department of Human Services, Children's Services

HP Enterprise Services Provider Assistance Center (PAC)

HP Enterprise Services Supplied Forms

Example of Beneficiary Notification of Denied ARKids First-B Claim

Example of Beneficiary Notification of Denied Medicaid Claim

First Connections Infant & Toddler Program, Developmental Disabilities Services

Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment

Health Care Declarations

ICD-9-CM, CPT, and HCPCS Reference Book Ordering

Immunizations Registry Help Desk

Medicaid ID Card Example

Medicaid Managed Care Services (MMCS)

Medicaid Reimbursement Unit Communications Hotline

Medicaid Tooth Numbering System

National Supplier Clearinghouse

Primary Care Physician (PCP) Enrollment Voice Response System

Provider Qualifications, Division of Behavioral Health Services

QSource of Arkansas

Select Optical

Standard Register

Table of Desirable Weights

UAMS Partners Provider Certification

U.S. Government Printing Office

ValueOptions

Vendor Performance Report

DIVISION OF MEDICAL SERVICES
MEDICAL ASSISTANCE PROGRAM
PROVIDER APPLICATION

As a condition for entering into or renewing a provider agreement, all applicants must complete this provider application. A true, accurate and complete disclosure of all requested information is required by the Federal and State Regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State Regulations to update the information submitted on the Provider Application.

Whenever changes in this information occur, please submit the change in writing to:

Medicaid Provider Enrollment Unit
HP Enterprise Services
P. O. Box 8105
Little Rock, AR 72203-8105

All dates, except where otherwise specified, should be written in the month/day/year (MMDDYY) format. Please print all information.

This information is divided into sections. The following describes which sections are to be completed by the applicant:

Section I	-	All providers
Section II	-	Facilities Only
Section III	-	Pharmacists/Registered Respiratory Therapist Only
Section IV	-	Provider Group Affiliations
Electronic Fund Transfer	-	All Providers (optional)
Managed Care Agreement	-	Primary Care Physician
W-9 Tax Form	-	All Providers
Contract	-	All Providers
Ownership and Conviction Disclosure	-	All Providers
Disclosure of Significant Business Transactions	-	All Providers

FOR OFFICE USE ONLY

Provider ID Number _____	Pending _____
Taxonomy Code _____	
Specialty Code _____	Computer _____
Provider Type _____	OK to Key _____
	Keyed _____
Effective Date _____	Maintenance Checked _____

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

(1) **Date of Application:** Enter the current date in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(2) **Last Name, First Name, Middle Initial, and Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

If entering any other name such as an organization, corporation or facility, enter the full name of the entity in item 3. NOTE: Item 2 or 3 must be completed, <u>BUT NOT BOTH</u>.

_____ _____ ____ _____
Last Name First Name M. I. Title

(3) **Group, Organization or Facility Name:** Enter full name of the entity.
Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

_____
Corporation Name

_____
Fictitious Name (Doing Business As)
Must submit documentation that the above fictitious name is registered with the appropriate board within your state, (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

(4) **Application Type:** Circle one of the following codes which coincide with fields 2 or 3:

0 = Individual Practitioner (i.e., physician, dentist, a licensed, registered or certified practitioner)
1 = Sole Proprietorship (This includes individually owned businesses.)
2 = Government Owned
3 = Business Corporation, for profit
4 = Business Corporation, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
5 = Private, for profit
6 = Private, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
7 = Partnership
8 = Trust
9 = Chain

*** NOTE: IF THE TAX FORM IS NOT ATTACHED THE APPLICATION WILL BE DENIED**

(5) **SSN/FEIN Number:** Enter the Social Security Number of the applicant or the Federal Employer Identification Number of the applicant. **IF ENROLLING AN INDIVIDUAL APPLICANT THIS FIELD MUST REFLECT A SOCIAL SECURITY NUMBER.**

____ _____ _____ - _____ _____ - _____ _____ _____ _____
Social Security Number

NOTE: If an individual has a Federal Employee Identification Number, you will need to complete two (2) applications and two (2) contracts. One (1) as an individual and one (1) as an organization.

____ _____ - _____ _____ _____ _____ _____ _____ _____
Federal Employee Identification Number

(6) **National Provider Identification Number (NPI) and Taxonomy Code:** Enter the National Provider Identification Number and the taxonomy code of the applicant.

_____
National Provider Identification Number

_____
Taxonomy Code

(7) **Place of Service - Street Address**

(A) Enter the applicant's service location address, include suite number if applicable. THIS FIELD IS MANDATORY.

_____

(B) Enter any additional street address. (SHOULD REFLECT POST OFFICE BOX IF UNDELIVERABLE TO A STREET ADDRESS)

_____

(C) City, State, Zip+4 Code - enter the applicant's city, state and zip+4 code. Use the Post Office's two letter abbreviation for State. Enter the complete nine digit zip code.

_____ _____ _____
City State Zip Code+4

(D) Telephone Number - enter the area code and telephone number of the location in which the services are provided.

_____ _____
Area Code Telephone Number

(E) Fax Number – enter the area code and fax number of the location in which the services are provided.

_____ _____
Area Code Fax Number

(8a) **Billing Street Address:** This is the billing address where your Medicaid checks, Remittance Statements (RA) and information will be sent. Use the same format as the place of service address, P. O. Box may be entered in billing address.

_____

_____ _____ _____
City State Zip Code+4

_____ _____
Area Code Telephone Number

_____ _____
Area Code Fax Number

(8b) **Provider Manuals and Updates:** Please review Section I sub-section 101.000; 101.200; 101.300 in your Arkansas Medicaid provider manual regarding provider manuals and updates. Choose the format in which you would like to receive manuals, manual updates, and official notices. The Arkansas Medicaid website (www.medicaid.state.ar.us) is updated weekly and the Arkansas Medicaid Provider Reference CD will be distributed quarterly. Providers selecting "Internet only" or "CD with e-mail notification" will receive e-mails notifying them of applicable manual updates, official notices, and remittance advice (RA) messages available at the website; these choices require an e-mail address and Internet access. Providers selecting "CD with paper supplements" will receive the Arkansas Medicaid Provider Reference CD and applicable manual updates and official notices in the mail; these providers can find RA messages with their RAs or at the Arkansas Medicaid website. Providers selecting "paper" will receive a paper copy of the manual and receive supplementary materials on paper to maintain their manual.

_____ Internet only* _____ CD with e-mail notification*

_____ CD with paper supplements _____ Paper

* Selection requires an e-mail address and Internet access.

E-mail address: _____

Please make sure your e-mail address will accept e-mail from hp.com. You may need to instruct your network administrator or e-mail provider to accept e-mails from hp.com. Arkansas Medicaid sends e-mail in bulk, and some e-mail services may block bulk e-mail unless instructed otherwise.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

MEDICARE VERIFICATION FORM

Before we can enroll a provider as an Arkansas Medicaid provider, we must have verification of **CURRENT** Medicare enrollment. **If you have documentation, i.e., EOMB, Medicare letter that is not over 6 months old and reflects the Medicare number and name of the enrolling provider,** please attach a copy of the information to the application. If you do not have documentation, please submit this form to your Medicare intermediary and instruct them to complete the information requested below. After Medicare has completed the requested information and returned this form to you, you must then return this form with your completed Medicaid application. **If your application is not returned with Medicare verification, enrollment in the Arkansas Medicaid Program will be denied.**

Provider's Name _____

(l) _____ _____ _____
Provider ID Number Effective Date End Date

(2) _____ _____
Social Security Number Tax I.D. Number

(3) _____
Specialty of Practice or Taxonomy Code

This inquiry was completed by:

Name of Medicare Intermediary _____

Address _____

Telephone # _____

Signature of Medicare Representative _____

_____
(Typed or Printed Name)

Date _____

(9) **County:** From the following list of codes, indicate the county that coincides with the place of service. If the services are provided in a bordering or out-of-state location, please use the county codes designated at the end of the code list.

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastian	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75

State	County Code	State	County Code	State	County Code
Louisiana	91	Oklahoma	94	Texas	96
Missouri	92	Tennessee	95	All other states	97
Mississippi	93				

(10) **Provider Category (A-C)**

Enter the two-digit **highlighted** code, from the following list, which identifies the services the applicant will be providing.

A) _____ B) _____ C) _____

Code	Category Description
N3	Advanced Practice Nurse – Pediatrics
N4	Advanced Practice Nurse – Women's Health
N6	Advanced Practice Nurse – Family
N7	Advanced Practice Nurse – Adult/Gerontological
N8	Advanced Practice Nurse – Psychiatric Mental Health
N9	Advanced Practice Nurse – Acute Care
N0	Advanced Practice Nurse– Nurse Practitioner - Other
03	Allergy/Immunology
A8	Alternatives for Adults with Physical Disabilities (Alternative) - Environmental Adaptations
A9	Alternatives for Adults with Physical Disabilities (Alternative) - Attendant Care Services
A4	Ambulatory Surgical Center
AA	Adolescent Medicine
05	Anesthesiology
AV	Autism Intensive Intervention Provider
AW	Autism Consultant
AX	Autism Lead/Line Therapist
AZ	Autism Clinical Service Specialist
AH	Living Choices Assisted Living Agency
AL	Living Choices Assisted Living Facility—Direct Services Provider
AP	Living Choices Assisted Living Pharmacist Consultant
64	Audiologist
C1	Cancer Screen (Health Dept. Only)
C2	Cancer Treatment (Health Dept. Only)
06	Cardiovascular Disease
C4	Child Health Management Services
CF	Child Health Management Services – Foster Care
35	Chiropractor
C8	Communicable Diseases (Health Dept. Only)
C3	CRNA
HA	ACS Waiver Environmental Modifications/Adaptive Equipment
HB	ACS Waiver Specialized Medical Supplies
HC	ACS Waiver Case Management/Transitional Case Management/Community Transition Services
HE	ACS Waiver Supported Employment
H7	ACS Waiver Supportive Living/Respite/Supplemental Support
HG	ACS Waiver Crisis Intervention
H9	ACS Waiver Consultation Services
IC	IndependentChoices
HF	ACS Waiver Organized HealthCare Delivery System
N5	DDS Non-Medicaid
V2	Dental
V1	Dental Clinic (Health Dept. Only)
V0	Dental - Mobile Dental Facility
X5	Dental - Oral Surgeon
V6	Dental - Orthodontia
07	Dermatology
V3	Developmental Day Treatment Center
DR	Developmental Rehabilitation Services
V5	Domiciliary Care
CN	DYS/TCM Group
CO	DYS/TCM Performing
E4	ElderChoices H&CB 2176 Waiver - Chore services
E5	ElderChoices H&CB 2176 Waiver - Adult Family Homes
E6	ElderChoices H&CB 2176 Waiver - Home maker
E7	ElderChoices H&CB 2176 Waiver - Home delivered hot meals
EC	ElderChoices H&CB 2176 Waiver - Home delivered frozen meals
E8	ElderChoices H&CB 2176 Waiver - Personal emergency response systems
E9	ElderChoices H&CB 2176 Waiver - Adult day care
EA	ElderChoices H&CB 2176 Waiver - Adult day health care
EB	ElderChoices H&CB 2176 Waiver - Respite care
E1	Emergency Medicine

E2	Endocrinology
E3	Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
F1	Family Planning
08	Family Practice
F2	Federally Qualified Health Center
10	Gastroenterology
01	General Practice
38	Geriatrics
16	Gynecology - Obstetrics
H1	Hearing Aid Dealer
H2	Hematology
H5	Hemodialysis
H3	Home Health
H6	Hospice
A5	Hospital - AR State Operating Teaching Hospital
W6	Hospital – Inpatient
W7	Hospital - Outpatient
CH	Hospital – Critical Access
IH	Hospital – Indian Health Services
IS	Hospital – Indian Health Services Freestanding
P7	Hospital - Pediatric Inpatient
P8	Hospital - Pediatric Outpatient
R7	Hospital - Rural Inpatient
HN	Hyperalimentation Enteral Nutrition – Sole Source
H4	Hyperalimentation Parenteral Nutrition – Sole Source
V8	Immunization (Health Dept. Only)
69	Independent Lab
55	Infectious Diseases
W3	Inpatient Psychiatric - under 21
WA	Inpatient Psychiatric - Residential Treatment Unit within Inpatient Psychiatric Hospital
WB	Inpatient Psychiatric - Residential Treatment Center
WC	Inpatient Psychiatric - Sexual Offenders Program
W4	Intermediate Care Facility
W9	Intermediate Care Facility – Infant Infirmaries
W5	Intermediate Care Facility - Mentally Retarded
11	Internal Medicine
L1	Laryngology
M1	Maternity Clinic (Health Dept. Only)
M4	Medicare/Medicaid Crossover Only
WI	Mental Health Practitioner – Licensed Certified Social Worker
W2	Mental Health Practitioner – Licensed Professional Counselor
R5	Mental Health Practitioner – Licensed Marriage and Family Therapist
62	Mental Health Practitioner - Psychologist
N1	Neonatology
39	Nephrology
13	Neurology
NI	Nuclear Medicine
N2	Nurse Midwife
N3	Nurse Practitioner – Pediatric
N4	Nurse Practitioner - OB/GYN
N6	Nurse Practitioner – Family Practice
N7	Nurse Practitioner - Gerontological
RK	Offsite Intervention Service - Outpatient Mental and Behavioral Health (ARKids ONLY)
X1	Oncology
18	Ophthalmology
X2	Optical Dispensing Contractor
X4	Optometrist
X6	Orthopedic
12	Osteopathy - Manipulative Therapy
X7	Osteopathy - Radiation Therapy
X8	Otology
X9	Otorhinolaryngology
22	Pathology
37	Pediatrics
P1	Personal Care Services
PA	Personal Care Services / Area Agency on Aging
PD	Personal Care Services / Developmental Disability Services

PE Personal Care Services / Week-end
PG Personal Care Services / Level I Assisted Living Facility
PH Personal Care Services / Level II Assisted Living Facility
R3 Personal Care Services / Residential Care Facility
PS Personal Care Services: Public School or Education Service Cooperative
P2 Pharmacy Independent
PC Pharmacy – Chain
PM Pharmacy – Compounding
PN Pharmacy – Home Infusion
PR Pharmacy – Long Term Care / Closed Door
PV Pharmacy – Administrated Vaccines
P3 Physical Medicine
48 Podiatrist
63 Portable X-ray Equipment
P6 Private Duty Nursing
PF Private Duty Nursing: Public School or Education Service Cooperative
28 Proctology
P4 Prosthetic Devices
V4 Prosthetic - Durable Medical Equipment/Oxygen
Z1 Prosthetic - Orthotic Appliances
26 Psychiatry
P5 Psychiatry - Child
29 Pulmonary Diseases
R9 Radiation Therapy - Complete
RA Radiation Therapy - Technical
30 Radiology - Diagnostic
31 Radiology - Therapeutic
R6 Rehabilitative Services for Persons with Mental Illness
RC Rehabilitative Services for Persons with Physical Disabilities
R1 Rehabilitative Hospital
RJ Rehabilitative Services for Youth and Children DCFS
RL Rehabilitative Services for Youth and Children DYS
CR Respite Care – Children's Medical Services
R4 Rheumatology
R2 Rural Health Clinic - Provider Based
R8 Rural Health Clinic - Independent Freestanding
S7 School Based Health Clinic - Child Health Services
S8 School Based Health Clinic - Hearing Screener
S9 School Based Health Clinic - Vision Screener
SA School Based Health Clinic - Vision & Hearing Screener
SB School Based Audiology
VV School Based Mental Health Clinic
SO School District Outreach for ARKids
S5 Skilled Nursing Facility
W8 Skilled Nursing Facility – Special Services
S6 SNF Hospital Distinct Part Bed
S1 Surgery - Cardio
S2 Surgery - Colon & Rectal
O2 Surgery - General
14 Surgery - Neurological
20 Surgery - Orthopedic
53 Surgery - Pediatric
54 Surgery - Oncology
24 Surgery - Plastic & Reconstructive
33 Surgery - Thoracic
S4 Surgery - Vascular
C5 Targeted Case Management - Ages 60 and Older
C6 Targeted Case Management - Ages 00 - 20
C7 Targeted Case Management - Ages 21 – 59
CM Targeted Case Management – Developmental Disabilities Certification – Ages 00 - 20
T6 Therapy - Occupational
T1 Therapy - Physical
T2 Therapy - Speech Pathologist
TO Therapy - Occupational Assistant
TP Therapy - Physical Assistant
TS Therapy - Speech Pathologist Assistant
A1 Transportation - Ambulance, Emergency

A2 Transportation - Ambulance, Non-emergency
A6 Transportation - Advanced Life Support with EKG
A7 Transportation - Advanced Life Support without EKG
TA Transportation - Air Ambulance/Helicopter
TB Transportation - Air Ambulance/Fixed Wing
TD Transportation - Broker
TC Transportation - Non-Emergency
TH Tuberculosis (Health Dept. Only)
34 Urology
V7 Ventilator Equipment

(11) **Certification Code:** This code identifies the type of provider the certification number in field 12 defines. If an entry is made in this field (11), an entry **MUST** be made in field 12 and 13 unless the entry is a 5. Please check the appropriate code.

0 = Mental Health [ ]
1 = Home Health [ ]
2 = CRNA [ ]
3 = Nursing Home [ ]
4 = Other [ ]
5 = Non-applicable [ ]

(12) **Certification Number:** If applicable, enter the certification number assigned to the applicant by the appropriate certification board/agency.

A CURRENT COPY OF THIS CERTIFICATION MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(13) **End Date:** Enter the expiration date of the applicant's current certification number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(14) **Fiscal Year:** Enter the date of the applicant's fiscal year end. This date is in month/day format.

____ ____/____ ____
MM DD

(15) **DEA Number:** If applicable, enter the number assigned to the applicant by the Federal Drug Enforcement Agency. Pharmacies must submit this information to be enrolled.

Required for Pharmacies only
A CURRENT COPY OF THIS CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____

(16) **End Date:** Enter the expiration date of the current DEA Number in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(17) **License Number:** If applicable, enter the license number assigned to the applicant by the appropriate state licensure board. If the license issued is a temporary license enter **TEMP**. If the license number is smaller than the fields allowed, leave the last spaces blank.

A CURRENT COPY OF THIS LICENSE MUST ACCOMPANY THIS APPLICATION.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

(18) **End Date:** Enter the expiration date of the applicant's current license in month/day/year format.

____ ____/____ ____/ ____ ____
MM DD Year

(19) **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA):** If applicable, enter the CLIA number assigned to the applicant. **A copy of the CLIA certificate is required in order to have your laboratory test paid**.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____ Computer _____
Provider Name _____ OK to Key _____
Keyed _____
Maintenance Checked _____

SECTION II: FACILITIES ONLY

(20) **Special Facility Program:** Check the appropriate value to depict if the applicant's facility is indigent care, teaching facility/university or UR plan. Special facility program values include:

*A	=	indigent care only	[ ]
**B	=	teaching facility/university only	[ ]
***C	=	UR plan only	[ ]
D	=	A/B	[ ]
E	=	A/C	[ ]
F	=	B/C	[ ]
G	=	A/B/C	[ ]
N	=	No special program	[ ]

* Indigent Care - Indicate whether the facility is qualified for the indigent care allowance.

NOTE: Facilities which serve a disproportionate number of indigent patients (defined as exceeding 20% Medicaid days as compared to a total patient day) may qualify for an indigent care allowance. If the facility meets the above criteria, please send the appropriate excerpt from the most current cost report that reflects total Medicaid days and total patient days.

** Teaching/University Facility - Indicate whether the facility is designated as a teaching/university affiliated institution and participates in three or more residency training programs.

*** Utilization Review Plan - Does the facility have a Utilization Review Plan applicable to all Medicaid patients?

(21) **Total Beds:** Enter the total number of beds in the facility.

_____
# of Beds

FOR OFFICE USE ONLY

Provider ID Number______________________________
Taxonomy Code ______________________________
Provider Name ______________________________

Pending ____________________
Computer ____________________
OK to Key ____________________
Keyed ____________________
Maintenance Checked ______________

SECTION III: PHARMACIST/REGISTERED RESPIRATORY THERAPIST ONLY

PHARMACIES - PLEASE INDICATE IF THIS APPLICANT IS A CHAIN-OWNED PHARMACY WITH 11 OR MORE RETAIL PHARMACIES NATIONALLY. (FRANCHISES WHICH ARE INDIVIDUALLY OWNED ARE NOT CHAIN-OWNED UNLESS ONE INDIVIDUAL OR CORPORATION OWNS 11 OR MORE RETAIL STORES.)

☐ **YES** ☐ **NO**

(22) Please list each pharmacist/registered respiratory therapist name, Social Security Number, license number and effective date of employment.

Please indicate by the pharmacist name whether that pharmacist is certified to administer Vaccines. If you are providing Vaccines, the pharmacy will need to be enrolled in the Medicare program. Please include the pharmacy Medicare Billing Provider ID Number on the Medicare Verification Form and attach proof of Medicare enrollment to the application. Please refer to the Medicare Verification Form for proof of Medicare requirements.

A copy of current registered respiratory therapist is required. Subsequent renewal must be provided when issued.

NOTE: Registered Respiratory Therapists must enter registration number in license number field.

____________________ __________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist | Social Security Number | _____ yes _____ no

______________________________ __________________
License/Registration Number | Effective Date of employment

____________________ __________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist | Social Security Number | _____ yes _____ no

______________________________ __________________
License/Registration Number | Effective Date of employment

____________________ __________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist | Social Security Number | _____ yes _____ no

______________________________ __________________
License/Registration Number | Effective Date of employment

____________________ __________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist | Social Security Number | _____ yes _____ no

______________________________ __________________
License/Registration Number | Effective Date of employment

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____ Computer _____
OK to Key _____
Provider Name _____ Keyed _____
Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

_____ _____ _____ _____
Last Name First Name M. I. Title

_____
Group Organization Name

_____ _____
Group Provider ID Number Effective Date (Applicant Joined Group)

_____ _____
Group Taxonomy Code Expiration Date (Applicant Left Group)

_____ _____ _____
City State Zip Code

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original or approved electronic signature of the individual provider is mandatory. (No stamped or copied signature is allowed; "approved electronic signature" is described at the Arkansas Medicaid website, https://www.medicaid.state.ar.us/.)

_____ _____ _____
Signature Title Date

_____ _____
Typed or Printed Name

_____
Provider ID Number

_____
Provider Taxonomy Code

Primary Care Physicians must complete the Primary Care Physician Agreement in order to have their managed care fees paid to a new group Provider ID Number. (See item 25)

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____ Computer _____
OK to Key _____
Provider Name _____ Keyed _____
Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

_____ _____ _____ _____
Last Name First Name M. I. Title

_____
Group Organization Name

_____ _____
Group Provider ID Number Effective Date (Applicant Joined Group)

_____ _____
Group Taxonomy Code Expiration Date (Applicant Left Group)

_____ _____ _____
City State Zip Code

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original or approved electronic signature of the individual provider is mandatory. (No stamped or copied signature is allowed; "approved electronic signature" is described at the Arkansas Medicaid website, https://www.medicaid.state.ar.us/.)

_____ _____ _____
Signature Title Date

_____ _____
Typed or Printed Name

_____
Provider ID Number

_____
Provider Taxonomy Code

Primary Care Physicians must complete the Primary Care Physician Agreement in order to have their managed care fees paid to a new group Provider ID Number. (See item 25)

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 waiver's 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.

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: new

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**

☐ **New to replace waiver**

Replacing Waiver Number:

☐ **Migration Waiver** - this is an existing approved waiver

Provide the information about the original waiver being migrated

Base Waiver Number:

Amendment Number (if applicable):

Effective Date: *(mm/dd/yy)*

Waiver Number: AR.0936.R00.00

Draft ID: AR.26.00.00

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

Regular Waiver

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

10/01/12

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 the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR 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 will provide intensive one-on-one treatment for children ages 18 months through 6 years of age with a diagnosis of autism. 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.
The services offered through the Autism waiver program are 1)Individual Assessment, Program Development/Training; 2)Therapeutic Aides and Behavioral Reinforcers; 3)Plan Implementation and Monitoring of Intervention Effectiveness; 4)Lead Therapy; 5)Line Therapy; and 6)Consultative Clinical and Therapeutic Services
The first five services will be provided by the Intensive Intervention providers and the Consultative Clinical and Therapeutic Services will be provided by fee-for-services providers.

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/MR.

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:

The Arkansas General Assembly convened a legislative task force on autism in 2008 as a result of Act 1198 of the 2007 Legislative Session. The purpose of this task force was to reveiw the services available in the state for children with autism and determine needed steps for remediation of any identified gaps. All Task Force meetings were open to the public and public comment was always solicited from attendees. The development of this Autism Waiver was the #1 priority from this group and was submitted in its official report to the General Assembly in August of 2009. Subsequently, as part of the development of this waiver community meetings were held with parents, professionals and service providers in fourteen sites across the state between January and April of 2010. Two meetings were held in each site, one during business hours and one in the evening, to maximize participation from parents and community members. Additionally, there were input sessions held with experts and an electronic survey was disseminated to those currently providing this service in Arkansas and bordering states. Status reports on the ongoing development of this waiver have been provided to the current Legislative Task Force on Autism at its meetings upon request. The minutes of the presentations and subsequent discussion has been

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:

Higgs

First Name:

Glenda

Title:

DHS DMS Medical Assistance Manager

Agency:

Arkansas Department of Human Services/Division of Medical Services

Address:

PO Box 1427, Slot S295

Address 2:

City:

Little Rock

State:

Arkansas

Zip:

72203-1437

Phone:

(501) 683-5776 **Ext:** ☐ **TTY**

Fax:

(501) 682-2450

E-mail:

glenda.higgs@arkansas.gov

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

Last Name:

Burnette, M.A., CCC-SLP

First Name:

Karan

Title:

Associate Director

Agency:

UAMS, Partners for Inclusive Communities (Partners)

Address:

2001 Pershing Circle, Suite 300

Address 2:

City:

North Little Rock

State:
Arkansas
Zip:

72114

Phone:

(501) 682-9900 **Ext:** ☐ **TTY**

Fax:

(501) 526-5938

E-mail:

burnettekaranb@uams.edu

8. Authorizing Signature

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

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

Signature:

Glenda Higgs

State Medicaid Director or Designee

Submission Date:

Apr 27, 2012

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

Last Name:

Allison, PhD

First Name:

Andrew

Title:

Director

Agency:

Arkansas Department of Human Services/Division of Medical Services

Address:

PO Box 1437, Slot S401

Address 2:

City:

Little Rock

State:
Arkansas
Zip:

72203-1437

Phone:

(501) 682-8740 **Ext:** ☐ **TTY**

Fax:

(501) 682-1197

E-mail:

andy.allison@arkansas.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A

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:

University of Arkansas for Medical Sciences (UAMS) - Partners for Inclusive Communities (Partners)

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 Medicaid Agency, Division of Medical Services (DMS) and the Operating Agency, University of Arkansas for Medical Sciences (UAMS) Partners for Inclusive Communities (Partners) have a Memorandum of Understanding (MOU) to ensure an understanding between agencies regarding the operation and administration of the Autism Waiver. The MOU delineates the waiver will be operated by Partners under the authority of DMS, who will exercise administrative authority, as well as, approve waiver policies, rules and regulations. DMS has the final authority regarding administrative matters.

DMS and PARTNERS have a common and concurrent interest in providing eligible Medicaid recipients with access to waiver services through qualified providers, while ensuring that the integrity of the Medicaid Program is maintained. The agencies will administer the waiver so as to meet the following assurances:

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.:*

   ⊙ **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:

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:

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
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	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Number and percent of active, unduplicated participants served within approved limits specified in the approved 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:
MMIS

Responsible Party for data collection/generation*(check each*	**Frequency of data collection/generation***(check each*	**Sampling Approach***(check each that applies):*

that applies):	*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:
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 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 LOC assessments completed by PARTNERS in the time specified in the agreement with the Medicaid Agency. Numerator: Number of LOC assessments completed by PARTNERS 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:	☐ **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:	☐ **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 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 participant service plans completed by PARTNERS in the time frame specified in the agreement with the Medicaid Agency. Numerator: Number of service plans plan completed by PARTNERS in time frame; Denominator: Number of service plans 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:	☑ **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 participants with delivery of at least two waiver services per month as specified in the service plan in accordance with the agreement with the Medicaid Agency. Numerator: Number of participants with at least two 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:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers applications for which the provider obtained appropriate licensure/certification in accordance with waiver qualification prior to service provision. Numerator: Number of provider certifications issued Denominator: Number of providers

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:
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:	☐ **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 policies and/or procedures developed by PARTNERS that are reviewed and approved by the Medicaid Agency prior to implementation. Numerator: Number of policies and procedures by PARTNERS reviewed by Medicaid before implementation; Denominator: Number of policies and procedures developed.

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 initial LOC assessments completed using the approved instrument according to the agreement with the Medicaid Agency. 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:
Medicaid Quarterly QA Report (Chart Reviews)

Responsible Party for data	**Frequency of data**	**Sampling Approach** *(check each*

collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*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:

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 State's 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.

DMS QA staff conducts chart reviews on 100% of the waiver participant's 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 share with the Partners. Partners 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 wavier are not within approved limits, remediation may include waiver amendments and possibly implementing a waiting list.

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:	☐ **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 a group 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 waiver target group, check each of the subgroups in the selected target group 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**			☐

⊙ **Mental Retardation or Developmental Disability, or Both**					
	☑	**Autism**	1	6	☐
	☐	**Developmental Disability**			☐
	☐	**Mental Retardation**			☐
○ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

1. children who have been diagnosed with an Autistic Disorder diagnosis, 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-MR level of care criteria
2. the diagnosis of autism must have been provided by multiple professionals, including a physician, psychologist and speech-language pathologist, either individually or as a team.
3. waiver participants will be terminated from the waiver after either a total of three consecutive years of service or upon reaching their seventh birthday; participants must enter the program on or before their fifth birthday to allow the two-year minimum treatment to occur

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 implemented three months prior to the end of the participant's waiver program end date or if the waiver participant fails to meet the level of care criteria before the 2-year minimum is met. Parents or the legal guardian(s) 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.

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	100
Year 2	150
Year 3	150

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	
Year 2	100
Year 3	100

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:

Initially, waiver applicants will be admitted to the waiver program based on a random selection process. Partners will begin accepting applications October 1, 2012. A deadline will be set for 20 business days after the waiver program is available for applications to be received by Partners and in the DHS County Offices across the state. All applications received by that date will be forwarded to the Operating Agency (Partners) for inclusion in the state-wide drawing for slots. Each application received will be assigned a number. The numbers (with no identifying information about the applicant) will be placed in the drawing. Numbers will be drawn and rank order assigned for every application in the pool. If there are more applications than slots for services, the additional applications will be placed on a waiting list based on the order of the number drawn. From this point forward, additional applications received in the county offices will be forwarded to the Operating Agency (Partners) and placed on the waiting list managed by the Operating Agency (Partners) and taken into the program as slots become available based on their date of application. Any child who reaches his/her fifth birthday while still on the waiting list will be removed from the waiting list as ineligible. Notice will be sent to the parents/guardians that such

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 10/01/12

a. The waiver is being (select one):

⊙ **Phased-in**

○ **Phased-out**

b. Phase-In/Phase-Out Time Schedule. *Complete the following table:*

Beginning (base) number of Participants: 0

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 100

Month	Base Number of Participants	Change	Participant Limit
Oct	0	10	10
Nov	10	10	20
Dec	20	10	30
Jan	30	10	40
Feb	40	10	50
Mar	50	10	60
Apr	60	10	70
May	70	10	80
Jun	80	10	90
Jul	90	10	100
Aug	100	0	100
Sep	100	0	100

Waiver Year 2
Unduplicated Number of Participants: 150

Month	Base Number of Participants	Change	Participant Limit
Oct	100	0	100
Nov	100	0	100
Dec	100	0	100
Jan	100	0	100
Feb	100	0	100
Mar	100	0	100
Apr	100	0	100
May	100	0	100
Jun	100	0	100
Jul	100	0	100
Aug	100	0	100
Sep	100	0	100

Waiver Year 3
Unduplicated Number of Participants: 150

Month	Base Number of Participants	Change	Participant Limit
Oct	100	0	100
Nov	100	0	100

Dec	**100**	0	**100**
Jan	**100**	0	**100**
Feb	**100**	0	**100**
Mar	**100**	0	**100**
Apr	**100**	0	**100**
May	**100**	0	**100**
Jun	**100**	0	**100**
Jul	**100**	0	**100**
Aug	**100**	0	**100**
Sep	**100**	0	**100**

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three
☑	☐	☐

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	**Oct**	
Phase-in/Phase-out begins	**Oct**	**1**
Phase-in/Phase-out ends	**Jul**	**1**

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ◉ **§1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

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

- ○ **No**
- ◉ **Yes**

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

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

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

Select one:

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

Specify percentage:

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in**

§1902(a)(10)(A)(ii)(XIII)) of the Act)

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

Specify:

Title IV-E Children.

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 spenddown 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 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(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 4)

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 4)

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 4)

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-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 an entity 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 PARTNERS will be a licensed Registered Nurse or have a master's degree in psychology, speech-language-pathology, occupational therapy, education or related field plus a minimum of two years experience with services for young children with autism. Results of this evaluation will be documented on the DHS 703.

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 this waiver will be diagnosed with Autistic Disorder, based on the diagnostic criteria set out in the most recent edition of the DSM (Disgnostic and Statistical Manual). The initial determination of eligibility will be determined utilizing the same criteria used for a child with autism being admitted to the state's ICF/MR facilities. These include the DHS-703 form (The Evaluation of Medical Need), social history and psychological assessments. The Autism Waiver Team at Partners will be responsible for determining both initial and continuing eligibility for the autism waiver. The Autism Waiver Team at Partners will include a multidisciplinary team of master's and doctoral level professionals in speech-language pathology, psychology, nursing and early childhood education. Supporting documentation required for Partners to complete the 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 Autistic Disorder 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

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 autism ages 18 months to age 5 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 list-serves, 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 Arkansas Autism Waiver requires multiple components. The first is the medical eligibility determination that the child has a qualifying diagnosis of autism and is within the specified age range (18 months to age 5 years). Once enrolled in the program, the child may remain in the program

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 reassessments. Ninety days prior to the expiration of the level of care, the process for reevaluation is triggered and will be completed by PARTNERS and forwarded to the 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 Partners for the duration of the participant's participation in the waiver program plus a five-year period.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 LOC determination indicating the need for ICF/MR 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:	☐ **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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e.,

data presented must be waiver specific).

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 participants who received an annual 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 wtihin 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:	☐ **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:	☐ **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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 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:	☐ **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 percentage of particiants 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:	☐ **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 percentage of participants LOC determinations made where the LOC criteria was accurately applied. Numerator: Numberof 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:	☐ **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:

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 PARTNERS staff. Monthly activity reports track assessment activity and quality of information reporting from monthly chart reviews produced by clinical staff, submitted to PARTNERS for analysis of timeliness and accuracy. Individual assessments are also used as the base data for a 45 Day Report, which track all waiver applications and flags any due for assessment at or within 45 days. In addition, PARTNERS maintains a daily log of assessments and reassessments sent to the DMS Office of Long Term Care for medical determination. Data from all assessment and

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

PARTNERS and DMS participate in quarterly team meetings to discuss and address individual problems associated with level of care determinations and system improvement, as well as problem correction and resolution. PARTNERS and DMS have an Memorandum of Understanding (MOU) that includes measures related to level of care determinations and redeterminations for the waiver.

The system currently in place for new applicants to enter the waiver program does not allow for services to be delivered prior to an initial level of care determination. Therefore, performance measures related to these processes will always result in 100% compliance and not allow for the possibility of 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:	☐ **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 waiver services will be offered each participant's parent/legal guardian by the Autism Waiver Coordinator employed by PARTNERS 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 notified 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 Freedom of Choice form is maintained in the participant's record at PARTNERS.

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, Program Development/Training**		
Other Service	**Lead Therapy Intervention**		
Other Service	**Line Therapy Intervention**		
Other Service	**Plan Implementation and Monitoring of Intervention Effectiveness**		
Other Service	**Provision of 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

Service Definition *(Scope):*

Therapeutic services to assist unpaid caregivers (parents/guardians) and paid support staff (staff involved in the intensive intervention services) in carrying out the Individual Treatment Plan as necessary to improve the child's independence and inclusion in their family and community. These highly qualified professionals will provide technical assistance to carry out the Individual Treatment Plan and will review 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 contact the Operating Agency's (Partners) Autism Waiver Coordinator responsible for the child 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 child regarding the intervention. This service will be delivered in the

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

Limited to 18 hours during the first quarter of service and 6 hours per quarter thereafter for a total of 36 hours.

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 child's 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	Higher Education

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:

Higher Education

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. Staffed by professionals from multiple disciplines with a minimum of a master's degree in psychology, special education, speech-language pathology or a related field and 3 years of experience in providing interventions to young children with Autism Spectrum Disorders. Must have a central/home office located within the state and have the capacity to provide services in all areas of the state. Must have a graduate level curriculum developed and a minimum of 3 years of experience in providing training toward a graduate certificate in Autism Spectrum Disorders, recognized by the Arkansas Department of Higher Education. 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

Verification of Provider Qualifications

Entity Responsible for Verification:

The Operating Agency (Partners) will recertify providers using the same process as used for the initial certification.

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, Program Development/Training

Service Definition *(Scope):*

Assess the waiver participant by completing an adaptive assessment and a functional behavioral assessment. The instruments used will be determined by the Consultant and may include tools such as the Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) or the Assessment of Basic Language and Learning Skills-Revised (ABLLS-R). 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, including language/communication, cognition, socialization, self-care and behavior. The Consultant will develop an Individual Treatment Plan based on the assessment utilizing exclusively evidence-based practices (as outlined in the provider manual) 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.

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

Limited to 23 hours per year at a rate of $104.40 per hour.

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 child's 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 non-profit corporations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Assessment, Program Development/Training

Provider Category:

Agency

Provider Type:

Community-based non-profit corporations

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Developmental Day Treatment Clinic Services (DDTCS) to children

Certificate *(specify):*

Certified by the State of Arkansas to provide full array services under the Developmental Disabilities Services (DDS) Home and Community-Based Waiver program

Other Standard *(specify):*

Must have a minimum of three years experience providing services to individuals with autism

Includes any non-profit 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Partners will be responsible for certifying providers as eligible to participate in the Autism Waiver Program.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. Partners and the Consultative Clinical and Therapeutic Services provider will both monitor that personnel meet applicable standard. Partners will also maintain a data-base 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 moitoring 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

Service Definition *(Scope):*

Assurance that the treatment plan is implemented as designed; weekly monitoring of implementation and effectiveness of treatment plan; reviewing all recorded data collected by the Line Therapist and the 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. The 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 Individual Treatment Plan.

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

6 hours 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 child's 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 non-profit corporation

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:

Community-based non-profit corporation

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Developmental Day Treatment Clinic Services (DDTCS) to children.

Certificate *(specify):*

Certified by the State of Arkansas to provide full array services under the Developmental Disabilities Services (DDS) Home and Community-Based Waiver program. Certified by the Operating Agency (Partners) to provide Autism Waiver Services.

Other Standard *(specify):*

Must have a minimum of three years experience providing services to individuals with autism

Includes any non-profit 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Partners will be responsible for certifying providers as eligible to participate in the Autism Waiver Program.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. Partners and the Consultative Clinical and Therapeutic Services provider will both monitor that personnel meet applicable standard. Partners will also maintain a data-base 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

Service Definition *(Scope):*

On-site (in-home and community settings) implementation of the interventions according to the treatment plan; recording of data according to the treatment plan; and reporting progress/concerns to the Lead Therapist/Consultant.

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

30 hours 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 child's 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 non-profit corporation

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:

Community-based non-profit corporation

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Developmental Day Treatment Clinic Services (DDTCS) to children.

Certificate *(specify):*

Certified by the State of Arkansas to provide full array services under the Developmental Disabilities Services (DDS) Home and Community-Based Waiver program. Certified by the Operating Agency (Partners) to provide Autism Waiver Services.

Other Standard *(specify):*

Must have a minimum of three years experience providing services to individuals with autism

Includes any non-profit 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Partners will be responsible for certifying providers as eligible to participate in the Autism Waiver Program.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. Partners and the Consultative Clinical and Therapeutic Services provider will both monitor that personnel meet applicable standard. Partners will also maintain a data-base 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:

Plan Implementation and Monitoring of Intervention Effectiveness

Service Definition *(Scope):*

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 treatment plan as necessry; and modification of assessment information as necessary. The monitoring under this service will be for the purpose of modifying the design of the Treatment Plan and is conducted monthly by the Consultant.

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

Limited to 5.5 hours per month.

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 child's 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 non-profit corporation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Plan Implementation and Monitoring of Intervention Effectiveness

Provider Category:

Agency

Provider Type:

Community-based non-profit corporation

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Developmental Day Treatment Clinic Services (DDTCS) to children.

Certificate *(specify):*

Certified by the State of Arkansas to provide full array services under the Developmental Disabilities Services (DDS) Home and Community-Based Waiver program. Certified by the Operating Agency (Partners) to provide Autism Waiver Services.

Other Standard *(specify):*

Must have a minimum of three years experience providing services to individuals with autism

Includes any non-profit 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Partners will be responsible for certifying providers as eligible to participate in the Autism Waiver Program.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. Partners and the Consultative Clinical and Therapeutic Services provider will both monitor that personnel meet applicable standard. Partners will also maintain a data-base 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:

Provision of Therapeutic Aides and Behavioral Reinforcers

Service Definition *(Scope):*

Provision of necessary therapeutic aides and behavioral reinforcers in the home. If the provider determines that availability is insufficient for implementation of the Individual Treatment Plan, the provider (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 include: 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 one-time maximum of $1,000.00 per participant; only in situations where insufficient materials are available. 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 child's 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 Operating Agency (Partners) 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 child's 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 non-profit corporations

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community-based non-profit corporations

Provider Qualifications

License *(specify):*

Licensed by the State of Arkansas to provide Developmental Day Treatment Clinic Services (DDTCS) to children.

Certificate *(specify):*

Certified by the State of Arkansas to provide full array services under the Developmental Disabilities Services (DDS) Home and Community-Based Waiver program. Certified by the Operating Agency (Partners) to provide Autism Waiver Services.

Other Standard *(specify):*

Includes any non-profit 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 non-profit providers to render the Intensive Autism Intervention Services must meet the following standard to be considered qualified professionals/paraprofessionals:

Verification of Provider Qualifications

Entity Responsible for Verification:

Partners will be responsible for certifying providers as eligible to participate in the Autism Waiver Program.

Certified provider agencies will be responsible for hiring qualified personnel to implement the programs. Partners and the Consultative Clinical and Therapeutic Services provider will both monitor that personnel meet applicable standard. Partners will also maintain a data-base 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.*

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 Autism provider of criminal history information as defined in Ark. Code Ann., Section 12-12-1001.

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 Partners during the certification and recertification process.

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.*

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 provider enrollment is open and continuous. Any individual or agency interested in becoming an Autism provider can contact PARTNERS 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 by PARTNERS are detailed in all provider certification applications. Medicaid enrollment requirements are detailed in the Medicaid provider contact, which is included in the application packet.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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, 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 (PARTNERS)

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 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 (PARTNERS)

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 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:	☐ **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:

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 Monthly 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:	☐ **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.

PARTNERS issues provider certifications for one year; providers must be recertified 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 by PARTNERS 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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

PARTNERS and DMS participate in quarterly team meetings to discuss and address individual problems related to qualified providers, as well as problem correction and remediation. PARTNERS and DMS have an Interagency Agreement that includes measures related to the qualified providers that are certified to provide services under the waiver.

PARTNERS requires that all providers obtain recertification annually in order to continue providing services. In cases where providers are not recertified, PARTNERS remediation includes certifying the provider upon discovery that the provider was not recertified, closing the provider, recouping payment for services

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:	☐ **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.

The services are limited to 3 years.
(a) the waiver services to which the limit applies
- Consultative Clinical and Therapeutic Services
- Individual Assessment, Program Development/Training

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:

Autism Waiver Coordinators, employed by PARTNERS, will have a minimum of a master's degree in Psychology, Nursing, Speech-Language Pathology, Education or related field plus two years experience associated with provision of services to young children with autism

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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 PARTNERS, 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):

The Plan of Care (POC) is developed by the Autism Waiver Coordinator in collaboration with the parent/guardian based on the assessment of the waiver participant's strengths/needs and the parent/guardian's preferences. The strengths/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 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 completion of these assessments, the parent/guardian's perspective and concerns will be central to the discussion with the Autism Waiver Coordinator during plan development.

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 child's needs, including potential risks, will be assessed during the planning process and considered during the development of the Plan or Care and the subsequent Individual Treatment Plan. The Treatment Plan will include a section for emergency intervention as well as preventive strategies to avoid emergencies and deescalate behaviors that could potentially lead to emergencies. These intervention strategies will focus on positive approaches to supporting appropriate behavior, thus avoiding the use of restraint, seclusion and other punitive practices. Since the parent/guardian will be present and actively involved in the treatment provided through this 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.

Parents/guardians will be provided a list of all available waiver providers from which they will be able to select the provider of their choice. The list will include contact person's names and telephone numbers. In situations where there are multiple providers available, parents/guardians will be encouraged to contact providers or further research the experience/reputation of these providers to make an informed choice. The parent/guardian's choice of provider will be documented on the Plan of Care.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The plan of care document and description of the planning process will be approved by the Medicaid agency prior to implementation. Copies of individual plans will be available upon request.

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:

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 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 intervention plan to address the issue(s). All contacts will be documented as case notes in the child's file maintained at PARTNERS.

Additionally, the Individual Treatment Plan 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

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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 service plans that were adequate and appropriate to their needs as indicated by the assessment(s). Numerator: number of participants with service plans that address 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:	☐ **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 participants reviewed who had service plans that addressed personal goals. Numerator: number of participants service plans that address 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:	☐ **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 participants reviewed who had service plans that addressed risk factors. Numerator: number of participants service plans that address 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:
	☑ **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:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Number and percent of service plan development procedures that are completed as described in the waiver application. Numerator: number of participants service plans 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:	☐ **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:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Number and percent of service plans that were reviewed and revised as warranted on or before waiver participant's annual review date. Numerator: number of participant's service plans 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:	☐ **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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 the service plan. Numerator: Number of participants' service plans who received service specified in the service plan; 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:
	☑ **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:

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 participant records reviewed with an appropriately completed plan of care that specified choice was offered between institutional care and waiver services and among waiver services. Numerator: Number of participant's service plans with 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:	☐ **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 waiver participant 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 with choice of providers; 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:
	☑ **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:

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 PARTNERS for completeness and accuracy and resulting data is made available for the production of the Chart Review Summary Report. A DMS QA audit is also conducted from a review of a random sampling of reports, to confirm that service plans are updated and revised as warranted by changes in the client's needs.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

PARTNERS and DMS participate in quarterly team meetings to discuss and address individual problems related to plan of care, as well as problem correction and remediation. PARTNERS and DMS have an Interagency Agreement that includes measures related to the plans of care as part of the waiver.

In cases where clients' plans of care are inadequate or inappropriate, do not address clients' personal goals or risk factors, are not completed as described in the waiver application, and are not reviewed or revised as needed, PARTNERS remediation includes revising the plan of care accordingly and providing additional training to staff who complete plans of care. This remediation also applies when clients do not receive the type, scope, frequency and duration of services as specified in the plan of care, or when clients are not offered choice between institutional care and waiver services and among waiver services when the plan of care

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:	☐ **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 participant's favor, and the participant had elected the continuation of benefits, the participant will owe the State of Arkansas restitution through an overpayment.

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:

The operating agency, UAMS Partners is reponsible for complaints pertaining 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 the PARTNERS 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 must be resolved within 30 business days from the date the complaint was made. A follow-up call or correspondence is made with the reporter, if appropriate, to discuss how the issue was resolved without violating confidentiality rules. The participant or his/her

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 waiver staff, 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 the 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

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 by PARTNERS 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.

PARTNERS 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.

The DHS Client Advocate reviews all incidents in the IRIS database and generates reports. Partners will have access to the IRIS database. All relevant information about Autism waiver participants is reviewed by PARTNERS waiver staff.

Information from all complaints entered into the complaint database, including information on resolution of the incidents is reviewed by PARTNERS waiver 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 Partners Waiver Program Administrator who reviews these reports to identify patterns and make systematic corrections when necessary.

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.

PARTNERS as the operating agency for the waiver, will assume responsibility for compiling all incident reports from all sources into a single source for review and action. PARTNERS waiver staff 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 2)

a. Use of Restraints or Seclusion. *(Select one)*:

⊙ **The State does not permit or prohibits the use of restraints or seclusion**

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

Both the Autism Waiver Coordinator and the Clinical Services Specialist will be 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 the 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 appropriate action taken to ensure that their use is immediately discontinued.

○ **The use of restraints or seclusion 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 or Seclusion. 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 or 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 restraints or 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-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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:

Both the Autism Waiver Coordinator and the Clinical Services Specialist 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 appropriate 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-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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:	☐ **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 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:	☐ **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 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:	☐ **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 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:
	☑ **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 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 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 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:	☐ **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 complaints addressed within required time frame. Numerator: number of complaints addressed in time frame; 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:	☐ **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:

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 DMS audits of waiver participants' records. Monthly chart reviews are performed by PARTNERS staff to assure that 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 DMS QA Administrator.
PARTNERS complaint database was designed to track complaints of all types, including abuse and neglect reports.
The IRIS system is used by PARTNERS to report incidents involving state staff, including incidents that involve abuse and neglect of waiver participants.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

PARTNERS and DMS meet quarterly to discuss and address problems related to client health and welfare, as well as problem correction and remediation. PARTNERS and DMS have an Interagency Agreement that includes measures related to client health and welfare for the waiver.

PARTNERS 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 PARTNERS staff.

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:	☐ **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 2)

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 QMS 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;
- 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

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.

DMS analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DMS will meet with PARTNERS 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 the DMS QA unit 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:	☑ **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.

PARNTERS and DMS employ staff to assist in system design. Meetings are held, 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, the PARTNERS waiver program director, DMS QA staff and others deemed appropriate.

DMS analyzes all discovery and remediation results to determine if a system improvement is necessary. If a possible system improvement is identified, DMS will meet with the operating agency (Partners) to discuss what system or program changes are necessary, if any, based on the nature of the problem (health and

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

PARTNERS and DMS 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 between PARTNERS and DMS is set in motion to complete a revision to the QIS which may include submission of a waiver amendment. DMS QA staff utilize the QIS during the QA reviews.

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 are reviewed monthly for each participant, and data is aggregated by PARTNERS. MMIS claims data are audited periodically for program policy alignment, and claims processing worksheets are audited, processed and returned on a daily basis. Discovery and monitoring also includes an ongoing review of CMS-372 reports and CMS-64 reports. And finally, the DMS Program Integrity Unit includes a review of claims paid in accordance with waiver participants' service plan.

Monitoring is conducted on an on-going basis and is tracked through the monthly activity report and the quarterly participant profiles.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability
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. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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 as specified in the waiver application. 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:
	☐ **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 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:
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:	☐ **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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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:	☐ **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:

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.

NA

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

PARTNERS and DMS participate in quarterly team meetings to discuss and address individual problems related to financial accountability, as well as problem correction and remediation. PARTNERS and DMS have an Interagency Agreement that includes measures related to financial accountability for the waiver. The performance measure for number and percent of waiver claims paid using the correct rate specified in the waiver application 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.

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:	☐ **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:

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. Waiver staff 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: *Complete item I-3-e.*

An institution of Higher Education, a State agency, will provide the Consultative Clinical and Therapeutic Services specified in this 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. *Select one:*

- (●) **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.**

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:

- [x] **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:

- [x] **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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

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	51490.00	18948.00	70438.00	94064.00	29818.00	123882.00	53444.00
2	33193.00	19523.00	52716.00	98024.00	33284.00	131308.00	78592.00
3	33193.00	20115.00	53308.00	102151.00	37156.00	139307.00	85999.00

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 7)

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	100	100
Year 2	150	150
Year 3	150	150

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 7)

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 7)

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 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 SFY 2011 Actual Data on children aged 18 months through age 6 in the MMIS system with Autism 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 7)

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, Program Development/Training	
Lead Therapy Intervention	
Line Therapy Intervention	
Plan Implementation and Monitoring of Intervention Effectiveness	
Provision of Therapeutic Aides and Behavioral Reinforcers	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 7)

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:						**375840.00**
Consultative Clinical and Therapeutic Services	15 minutes	100	144.00	26.10	**375840.00**	
Individual Assessment, Program Development/Training Total:						**240120.00**
Individual Assessment, Program Development/Training	15 minutes	100	92.00	26.10	**240120.00**	
Lead Therapy Intervention Total:						**936000.00**
Lead Therapy Intervention	15 minutes	100	1248.00	7.50	**936000.00**	
Line Therapy Intervention Total:						**2808000.00**
Line Therapy Intervention	15 minutes	100	6240.00	4.50	**2808000.00**	
Plan Implementation and Monitoring of Intervention Effectiveness Total:						**689040.00**
Plan Implementation and Monitoring of Intervention Effectiveness	15 minutes	100	264.00	26.10	**689040.00**	
Provision of Therapeutic Aides and Behavioral Reinforcers Total:						**100000.00**
Provision of Therapeutic Aides and Behavioral Reinforcers	1 package	100	1.00	1000.00	**100000.00**	
				GRAND TOTAL:		**5149000.00**
				Total Estimated Unduplicated Participants:		**100**
				Factor D (Divide total by number of participants):		**51490.00**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 7)

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:						**375840.00**
Consultative Clinical and Therapeutic Services	15 minutes	100	144.00	26.10	**375840.00**	
Individual Assessment, Program Development/Training Total:						**120060.00**
Individual Assessment, Program Development/Training	15 minutes	50	92.00	26.10	**120060.00**	
Lead Therapy Intervention Total:						**936000.00**
Lead Therapy Intervention	15 minutes	100	1248.00	7.50	**936000.00**	
Line Therapy Intervention Total:						**2808000.00**
Line Therapy Intervention	15 minutes	100	6240.00	4.50	**2808000.00**	
Plan Implementation and Monitoring of Intervention Effectiveness Total:						**689040.00**
Plan Implementation and Monitoring of Intervention Effectiveness	15 minutes	100	264.00	26.10	**689040.00**	
Provision of Therapeutic Aides and Behavioral Reinforcers Total:						**50000.00**
Provision of Therapeutic Aides and Behavioral Reinforcers	1 package	50	1.00	1000.00	**50000.00**	
				GRAND TOTAL:		**4978940.00**
				Total Estimated Unduplicated Participants:		**150**
				Factor D (Divide total by number of participants):		**33193.00**
				Average Length of Stay on the Waiver:		365

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 7)

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:						**375840.00**
Consultative Clinical and Therapeutic Services	15 minutes	100	144.00	26.10	**375840.00**	
Individual Assessment, Program Development/Training Total:						**120060.00**
Individual Assessment,					**120060.00**	

Program Development/Training	15 minutes	50	92.00	26.10		
Lead Therapy Intervention Total:						**936000.00**
Lead Therapy Intervention	15 minutes	100	1248.00	7.50	**936000.00**	
Line Therapy Intervention Total:						**2808000.00**
Line Therapy Intervention	15 minutes	100	6240.00	4.50	**2808000.00**	
Plan Implementation and Monitoring of Intervention Effectiveness Total:						**689040.00**
Plan Implementation and Monitoring of Intervention Effectiveness	15 minutes	100	264.00	26.10	**689040.00**	
Provision of Therapeutic Aides and Behavioral Reinforcers Total:						**50000.00**
Provision of Therapeutic Aides and Behavioral Reinforcers	1 package	50	1.00	1000.00	**50000.00**	

GRAND TOTAL:	**4978940.00**
Total Estimated Unduplicated Participants:	**150**
Factor D (Divide total by number of participants):	**33193.00**
Average Length of Stay on the Waiver:	365