#016.20

ARKANSAS REGISTER

Transmittal Sheet

* Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
State Capitol, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-3527
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of County Operations

Contact Linda Greer E-mail linda.greer@arkansas.gov Phone 501-682-8257

Statutory Authority for Promulgating Rules ACA 20-76-201 and Act 1198 of the 2007 Legislative Session

Rule Title: Medical Services Policy 26400-26450 and Form DCO-9700, TEFRA and Autism Waiver Application

Intended Effective Date
(Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 30 Days After Filing (ACA 25-15-204)
- ☒ Other October 1, 2012
  (Must be more than 30 days after filing date.)

Date

Legal Notice Published _____

Final Date for Public Comment July 12, 2012

Reviewed by Legislative Council _____

Adopted by State Agency October 1, 2012

Electronic Copy of Rule submitted under ACA 25-15-218 by:

Carla Droughn (Contact Person) carla.droughn@arkansas.gov (E-mail Address) 6-15-12 (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with Act 434 of 1967 the Arkansas Administrative Procedures Act. (ACA 25-15-201 et. seq.)

_____
Signature

(501) 682-8375 (Phone Number) Joni.Jones@arkansas.gov (E-mail Address)

DCO Director
Title

6/7/12
Date

Revised 8/2011 to reflect new legislation passed in 2011.

Notice of Rule Making

Pursuant to Arkansas Code, 20-76-201 and Act 1198 of the 2007 Legislative Session, the Director of the Division of County Operations hereby issues proposed Medical Services policy MS 26400-26450 and form DCO-9700 for an eligibility determination for the Autism Waiver.

Copies of the proposed change in the Medical Services Policy may be obtained by writing the Division of County Operations, P.O. Box 1437, Slot S-332, Little Rock, AR 72203, Attention: Office of Program Planning & Development. You may also access it on the DHS website http://humanservices.arkansas.gov/Pages/LegalNotices.aspx. All comments must be submitted in writing to the address(es) indicated above no later than July 12, 2012.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free); or to obtain access to these numbers through voice relay: 1-800-877-8973 (TTY Hearing Impaired).

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

Joni Jones,
Director, Division of County Operations

Date: 6/7/12

Summary of Rule

Medical Services Policy MS 26400 - MS 26450 and

Form DCO-9700, TEFRA and Autism Waiver Application for Assistance

The Autism waiver will provide Medicaid services to children with autism who are between the ages of eighteen (18) through six (6) years. Coverage will end the day before the child's seventh (7^{th}) birthday.

Medical Services policy MS 26400-MS 26450 provides policy and procedures for determining eligibility for the autism waiver program for children ages eighteen (18) months through six (6) years

Form DCO-9700, TEFRA and Autism Waiver Application for Assistance, will be used to apply for assistance in the TEFRA and Autism Waiver program.

The effective date is October 1, 2012.

26400 Autism Waiver

MS Manual 10-1-12

The Autism waiver provides one-on-one, intensive early intervention treatment for children ages eighteen (18) months through six (6) years who have a diagnosis of autism. The waiver participant must have a diagnosis of autism, a disability determination and meet the ICF/MR level of care.

For the first year of the program, there will only be 100 slots available. When the 100 slots are filled, the remainder of the applications will be put on a waiting list maintained by Partners for Inclusive Communities (Partners).

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

MS 26410 Waiver Services

MS Manual 10-1-12

The services offered through the Autism waiver are as follows:

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

These services are designed to maintain Medicaid eligible children at home in order to prevent or postpone institutionalization of the child.

MS 26420 Eligibility Criteria

MS Manual 10-1-12

To qualify for coverage under the Autism Waiver, a child must meet the following criteria:

1. Age-To apply for services, the child must be between eighteen (18) months and 5 years old. A child 5 years and 1 day old is over the age limit for application. If approved, coverage will be for a minimum of 2 years and a maximum of 3 years. If coverage has

not ended prior to the child's seventh (7th) birthday, coverage will end the day before the child's seventh (7th) birthday.

2. Citizenship or Alien Status-The child must be a US citizen or a qualified alien.

3. Residency-The child must be a resident of Arkansas.

4. Diagnosis-The child must have a medical diagnosis of autism by a speech-language pathologist, a physician, and a psychologist.

5. Disability-The child must have a disability determination from either the Social Security Administration (SSA) or the Medical Review Team (MRT).

6. Social Security Enumeration-The child must meet the Social Security Enumeration requirements as stated in MS 1390.

7. Income-The child's income must be at or below three times (300%) the SSI income level. Parental income will be disregarded.

8. Resources-The child's countable resources cannot exceed $2,000.00. Parental resources will be disregarded.

9. Child Support-Referral to or cooperation with child support is voluntary if the custodial parent does not receive Medicaid.

10. Cost Effectiveness-The average cost of services provided to the child in the community must be less than the cost of services for the child if he or she was in an institution. The Division of Medical Services determines the cost effectiveness.

11. Medical Necessity-The child must meet the ICF/MR level of care. The level of care will be determined by the Office of Long Term Care (OLTC), Utilization Review Team based on information submitted by Partners.

12. Plan of Care-Each child eligible for the Autism waiver must have an individualized plan of care. The plan of care will be developed by Partners and forwarded to the Autism service provider chosen by the child's parent(s) or guardian.

MS 26430 Application Process

MS Manual 10-1-12

If a parent or guardian inquires at the county office about the Autism Waiver, county office personnel will:

a. Provide the Autism Waiver brochure.
b. Inform the inquirer that he or she must contact Partners at the phone number listed on the brochure for more information or to start the application process.
c. If the child doesn't have a pending Medicaid application or an open Medicaid case, explain Medicaid/ARKids requirements and assist the parent or guardian if he or she wishes to apply for Medicaid or ARKids.

When the parent or guardian contacts Partners, Partners will:

a. Explain the program and program requirements.
b. Screen the applicant to determine if he or she meets the program criteria.
c. Send the following forms to the parent or guardian, if the child meets the therapeutic requirements:
    1. DCO-9700, TEFRA and Autism Waiver Application;
    2. If a disability determination is needed , a DCO-108C, Social Report for Children;
    3. DCO-106, Disability Worksheet; and
    4. DHS-4000, Authorization to Disclose Health Information.
d. Advise the parent or guardian to return completed forms to Partners.

Upon receipt of the application and documentation, Partners will:

a. Review the application and documentation to determine if the application should be denied based on Partners' autism diagnosis assessment.
b. Send the application and documentation to the Area TEFRA Processing Unit (ATPU).
c. Complete form DHS-703, Evaluation of Medical Need Criteria if the applicant meets Partners medical criteria and forward it to the Office of Long Term Care (OLTC). OLTC will document the level of care determination on the DHS-704 and return the form to Partners. Partners will forward the completed DHS-704 to the appropriate ATPU.

d. Send notification of ineligibility denial to ATPU via the DHS-3330 if the applicant does not meet medical criteria.

ATPU will:

a. Register all applications received from Partners in category 41 (Autism Non-SSI) or category 45 (Autism SSI).
b. Deny application and send the applicant's parent or guardian a system generated notice of denial, if the applicant is determined not to be eligible based on Partner's medical criteria,
c. Determine financial eligibility, if the child meets the autism criteria.
d. Forward medical records (Forms DCO-106, DCO-108C and DHS-4000) to MRT while determining financial eligibility, if a disability determination is required.
e. Determine financial eligibility and if found not eligible:
    1. Deny the application.
    2. Send the parent or guardian a system generated notice of denial and a DHS-3330 to Partners.
    3. Notify MRT to stop the disability determination if the determination has not been received.
f. Approve the application, if the applicant is medically and financially eligible:
    1. The Medicaid begin date will be the date the application is approved.
    2. Send the parent or guardian a system generated notice of approval and a DHS-3330 to Partners.

The application will be processed within 45 days or 90 days, if a MRT disability decision is required.

MS 26440 Reevaluation Process

MS Manual 10-1-12

Autism Waiver cases will be reevaluated every 12 months by the ATPU. ATPU will mail the parent or guardian a DCO-7779 to redetermine eligibility. A MRT disability redetermination may or may not be necessary at the time of the reevaluation. A need for a disability redetermination by MRT will be indicated on the DCO-109 received during the initial determination and case reviews, if applicable. When certification was made based on a previous SSI determination of disability and there has been no SSI payments or subsequent redetermination by SSA, a MRT disability redetermination will be made one year after the initial

certification for the Autism Waiver. All eligibility factors, except the autism diagnosis, will be redetermined at reevaluation.

If the reevaluation form is not returned, a DCO-700, Notice of Action, advising that the DCO-9700 must be received within 10 days or the case will be closed after the notice expires.

To insure that reevaluations are completed by the end of the twelfth month, the reevaluation process should be started in the 9th month from the date of the last approval or reevaluation.

MS 26450 Changes

MS 10-1-12

All changes (addresses, income decrease or increase, resources, etc.) will be processed by the ATPU.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
TEFRA and AUTISM WAIVER
Application for Assistance

If you need this material in a different format, such as large print, please contact your local DHS county office.
Si necesita este formulario en Espanol, llame al 1-800-482-8988 y pida la versión en Español.

What type of services are you requesting? ☐ **TEFRA** ☐ **Autism Waiver**

Child's Name:	Social Security Number	Male ☐ Female ☐	U.S. Citizen Yes ☐ No ☐
Date of Birth:	Age: _____years _____months		
Parent/Guardian:			
Current Address: City:	State:	Zip:	County:
Phone:	Email:		

1. **Does the child you are applying for have income?** ☐ **Yes** ☐ **No** **If yes, list the child's income below.**

Source of Income	Gross Amount (Before deductions)	How often?
Social security		
SSI		
Veteran's benefits		
Child support		
Other		

2. **Does the child you are applying for have resources?** ☐ **Yes** ☐ **No** **If yes, list the child's resources.**

Source of Resource	Amount or Value	Location of Resource
Cash, Checking, Savings or Christmas Club Account		
Stocks, Bonds, Trust Fund, Certificate of Deposit, Mutual Fund, etc.		
Other		

3. **Does the child you are applying for have health insurance?** ☐ **Yes** ☐ **No**
   If yes, please provide a copy of the front and back of the child's insurance card.

4. **Primary Care Physician** _____

   Autism Diagnosis ☐ **Yes** ☐ **No** **Date of Diagnosis** _____

5. **Do you expect a change in any of the above?** ☐ **Yes** ☐ **No** **If yes, what?** _____
   When? _____

For TEFRA only

Information needed to determine the TEFRA premium:

- Please attach the most recent Federal Income Tax Return and Schedule A for the child's parent(s).
- The total number of dependents that live in your household including yourself: _____

For Autism Waiver only

If this application is for the Autism Waiver, please attach an evaluation report from each of the following indicating that the child has a diagnosis of autism. Please place a check mark beside each item that is attached.

- ☐ Physician Report
- ☐ Psychologist Report
- ☐ Speech-language Pathologist Report
- ☐ Adaptive Behavior Assessment Report (such as Vineland)

Read carefully before you sign this application

The PRIVACY ACT of 1974 requires the Department of Human Services (DHS) to tell you: (1) whether disclosure of your SSN is voluntary or mandatory; (2) How DHS will use your SSN; and (3) The law or regulation that allows DHS to ask you for the SSN. We are authorized to collect from your household certain information including the social security number (SSN) of each eligible household member. For the TEFRA and Autism Program, this authority is granted under Federal Laws codified at 42 U.S.C. §§1320b-7(a) (1) and 1320b-7(b) (2). This information may be verified through computer matching programs. We will use this information to determine program eligibility, to monitor compliance with program rules, and for program management. This information may be disclosed to other Federal and State agencies and to law enforcement officials. If a claim arises against your household, the information on this application, including all SSNs, may be provided to Federal or State officials or to private agencies for collection purposes. * **EXCEPTION:** In the Medicaid Program, information is disclosed without the individual's written consent only to: authorized employees of this Agency, the Social Security Administration, the U.S. Department Of Health and Human Services, the individual's attorney, legal guardian, or someone with power of attorney; or an individual who the recipient has asked to serve as his representative AND who has supplied confidential information for the case record which helped to establish eligibility, or court of law when the case record is subpoenaed.

- I understand that I must help establish my eligibility by providing as much information as I can and in some situations I may be required to provide proof of my circumstances.
- I authorize the Department of Human Services (DHS) to obtain information from other state agencies and other sources to confirm the accuracy of my statements.
- I understand Social Security Numbers (SSNs) will be used in a computer match to detect and prevent duplicate participation. SSNs are also used in a match through the State Income and Eligibility Verification System to secure wage, unearned income and benefit information from the Social Security Administration, Department of Workforce Services, and Internal Revenue Service. Information received may be verified through other contacts when discrepancies are found by DHS and may affect eligibility or level of benefits.
- I understand that no person may be denied Medicaid benefits on the grounds of race, color, sex, age, disability, religion, national origin, or political belief.
- I may request a hearing from DHS if a decision is not made on my case within the proper time limit or if I disagree with the decision.
- I agree to notify the DHS county office within 10 days if I or any of my dependents cease to live in my home, if I move, or if any other changes occur in my circumstances.
- I authorize DHS to examine all records of mine or records of those who receive or have received Medicaid benefits through me to investigate whether or not any person has committed Medicaid fraud, or for use in any legal, administrative or judicial proceeding.

Assignment of Medical Support. I authorize any holder of medical or other information about me to release information needed for an Medicaid claim to DHS. I further authorize release of any information to other parties who may be liable for my medical expenses. As an eligibility condition, I automatically assign my right to any settlement, judgment, or award which may be obtained against any third party to DHS to the full extent of any amount which is paid by DHS for my behalf. I authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tortfeasors or insurers arising out of an Medicaid claim, be paid directly to DHS. My application for Medicaid benefits shall in itself constitute an assignment by operation of law and shall be considered a statutory lien of any settlement, judgment, or award received by me from a third party. A third party is any person, entity, institution, organization or other source who may be liable for injury, disease, disability or death sustained by me or others named herein, including estates of said individuals. I also assign all rights in any settlement made by me or on my behalf arising out of any claim to the extent medical expenses paid by DHS, whether or not a portion of such settlement is designated for medical expenses. Any such funds received by me shall be paid to DHS. A copy of this authorization may be used in place of the original.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE IS TRUE AND CORRECT. If I receive benefits to which I am not entitled because I withheld information or provided inaccurate information, such assistance will be subject to recovery by the Department of Human Services, and I may be subject to prosecution for fraud and fined and/or imprisoned.

Signature _____ Date_____