EXHIBIT H

DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: Arkansas Independent Assessment (ARIA) New-18 Manual

DESCRIPTION: This manual accompanies the PASSE provider manual and describes the ARIA tool that will be used to assess clients for PASSE assignment, Personal Care services, HDC placement, and developmental day treatment services.

This manual more fully describes the Arkansas Independent Assessment Tool (ARIA) being used to assess behavioral health clients, developmental disability clients, and personal care clients. The manual contains tiering logic that explains how the individual domains will be scored to arrive at a tier. Additionally, the manual contains the potential outcomes of the tiering results for all clients.

This manual incorporates the conflict-free case management require in 1915(c) Home and Community Based Services waivers and 1915(i) home and community based services state plan amendments that individuals be independently assessed for services. This manual also explains how populations will be assigned to a Provider-led Arkansas Shared Savings Entity (PASSE) based on their tier results.

PUBLIC COMMENT: DHS held three public hearings, one in Little Rock on August 20, 2018, one in Monticello on September 4, 2018, and one in Hope on September 6, 2018. The public comment period ended on September 12, 2018. DHS received the following comments and provided its responses:

DHS Responses to Public Comments Regarding the Independent Assessment Manual:

ARKANSAS HOSPITAL ASSOCIATION

Comment: Comments about the Arkansas Independent Assessment (ARIA)
Arkansas patients deserve a PASSE structure based upon an appropriate standardized assessment, evidence-based tier determination, and scientifically-grounded capitation approach.
The tier determination process, upon which all PASSE capitation calculations rest, is based on a scientifically untested assessment. The assessment selected, MnCHOICES, is a state-developed tool that was created to address specific policy decisions of the Minnesota Medicaid program, rather than as a general and broadly applicable assessment. In fact, MnCHOICES was created expressly and exclusively for the elderly population of Minnesota. It was not developed for use in children, youth, or the behavioral health or developmental disabilities populations, which have clinical and functional concerns that are distinct from those experienced by elderly people with age-related disabilities. As well, after a diligent and thorough search, the AHA could find no scientific evidence of the validity of MnCHOICES – in these or even its intended target population.
The selection of tier determination criteria from the assessment instrument is similarly problematic. We are unsure of how these criteria were identified or whether there is evidence that they meaningfully differentiate between participants and provide a good explanation of the amount of overall care needed by participants. Comparing roughly

aggregated averages is not a substitution for analyses of variance explanation and tests of internal and external validity. Basing capitation payments upon weak methodology increases the likelihood that capitated payments may not be sufficient to fully cover medical and supportive costs for some PASSE participants, putting their health and access to timely medical care at risk.

The AHA requests that DHS identify and implement evidence-based evaluation measures to ensure that the assessment system is accurately reflecting participant characteristics and that the tier determination methods adequately capture individual participant resource needs. The results of these evaluations should be used to guide program decisions and make changes to the assessment and tier determination process going forward. Taking these steps will help to ensure that the program's goals of managing and improving patient care are achieved to best serve the individual patients within this vulnerable population.

Response: The ARIA has now been tested for nearly a year and the accuracy of assessments are well supported by data. Of the total 36,940 independent assessments for behavioral health needs, DHS has received 139 beneficiary appeals and 100 provider appeals for tier assignment. 4 appeals went to a hearing, 2 of which the tier determination was upheld and 2 were reassessed.

Capitation rates are not based on ARIA. The DHS Actuaries developed the capitation rates based on Medicaid fee for service claims data.

Unknown

Comment: MnCHOICES should not be used as an assessment in Arkansas because Minnesota has alternative programs that Arkansas does not offer for those individuals who are unable to qualify due to intellect.

All the tiers have to mental score of 2 to 4 depending on age. This is NOT consistent with definition of DD.

Arkansas law says that a developmental disability is "an impairment of general intellectual functioning or adaptive behavior" that is a "substantial handicap to the person's ability to function without appropriate support services, including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training." It is caused by mental retardation or a closely related condition; cerebral palsy; epilepsy; autism; or dyslexia (difficulty learning to read and spell) resulting from cerebral palsy, epilepsy, or autism.* * Arkansas Code 16-123-102(3)

https://www.daas.ar.gov/pdf/daas-childguide-060407.pdf

Based solely on the proposed tier levels you would be excluding all those with closely related conditions

Please add tier levels that include those with closely related conditions or add an alternative assessment.

Response: The ARIA has been used for the DD Population since March 2018. More than 4,300 on the DD Population have been completed and 100% of those assessments resulted in a Tier II or Tier III determination.

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Mark George
Comment: 201.000(B). This is not a complete sentence.
Response: This will be corrected.

Comment: 220. l 00(a)(2) Clients do not apply to be on the CES Waiver Waitlist. They apply for the Waiver and, upon being determined eligible for the Waiver, are placed on the Waitlist. This should probably be two separate sentences ... those on the Waitlist, and those applying for the CES Waiver.
Response: We will strike through the wording, "or applying."

Comment: 220. l 00(8)(2) Should read that individuals in an HDC will only be "assessed or reassessed" if they are seeking transition into the community. Current residents of an HDC will not be initially assessed, so they cannot be "reassessed."
Response: We will add the wording, "assessed or."

Public Hearing Darragh Auditorium Little Rock, AR 8-20-18
Cindy Alberding
Comment: In the Independent Assessment document, it now says, "Including 24 hours a day, seven days a week paid supports and services." "Paid" is a new word from what we used to have with pervasive and some of those others. It always just said 24 hours or as needed level of care. So, I'm hoping that "including" means up to 24 hours paid supports, but I wonder why the word "paid" is in there now, if there is another meaning behind that.
Response: Yes, "up to" 24 hours of paid support through the CES waiver program.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule is November 1, 2018.

FINANCIAL IMPACT: There is no financial impact. The financial impact of the ARIA implementation has already been accounted for in previous rule filings regarding the personal care services and the ARIA tool. This manual expounds upon the tool itself but does not change the previous requirements to be assessed.

LEGAL AUTHORIZATION: DHS is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b). DHS and any entity with whom it contracts may rely on official publications of the U.S. Department of Health and Human Services for the administration of the Medicaid program and other rules, regulations, standards, guidance, or information that apply to the Medicaid program by reference in statute, promulgated regulation, rule, or official federal publication. *See* Ark. Code Ann. § 20-77-107(e).

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Act 775 of 2017, sponsored by Representative Aaron Pilkington, required DHS to submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care System. The Act authorized DHS to promulgate rules necessary to implement the system. *See* Ark. Code Ann. § 20-77-2708.

Case management services are regulated by federal law. *See* 42 CFR § 440.169, and § 441.18. DHS states that the proposed rule changes in the manual incorporate the conflict-free case management requirements in waivers and state plan amendments. Federal law protects against conflicts in cases where the same entity helps individuals gain access to services and provides services to that individual. *See* 42 CFR § 441.301(c). Generally, a state must devise conflict of interest protections, which must be approved by CMS. Additionally, individuals must be provided with a clear and accessible alternative dispute resolution process. DHS has sought approval from CMS, and formal approval is pending.

EXHIBIT 11

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Tami Harlan

CONTACT PERSON Elizabeth Pitman

ADDRESS P.O. Box 1437, Slot N501, Little Rock, AR 72201-1437

PHONE NO. 501-682-4936 **FAX NO.** 501-682-8380 **E-MAIL** elizabeth.pitman@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Paula Stone, Melissa Stone, Mark White

PRESENTER E-MAIL Paula.stone@dhs.arkansas.gov; melissa.stone@dhs.arkansas.gov; mark.white@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? **Arkansas Independent Assessment (ARIA) New-18 Manual**

2. What is the subject of the proposed rule? *This manual accompanies the PASSE provider manual and describes the ARIA tool that will be used to assess clients for PASSE assignment, Personal Care services, HDC placement, and developmental day treatment services.*

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

If yes, please provide the federal rule, regulation, and/or statute citation. 42 CFR 440.169 & 441.301

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☐ No ☒

If yes, what is the effective date of the emergency rule? _____

When does the emergency rule

expire? _____

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?

Yes ☐ No ☐

5. Is this a new rule? Yes ☒ No ☐
   If yes, please provide a brief summary explaining the regulation.

This manual more fully describes the Arkansas Independent Assessment Tool (ARIA) being used to assess behavioral health clients, developmental disability clients, and personal care clients. The manual contains Tiering logic that explains how the individual domains will be scored to arrive at a tier. Additionally, the manual contains the potential outcomes of the Tiering results for all clients.

Does this repeal an existing rule? Yes ☒ No ☐
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. *Please see summary above.*

Is this an amendment to an existing rule? Yes ☐ No ☒
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation.

Ark. Code Ann. 20-77-107

7. What is the purpose of this proposed rule? Why is it necessary?

This manual incorporates the conflict-free case management requirement in 1915(c) Home and Community Based Services waivers and 1915(i) home and community based services state plan amendments that individuals be independently assessed for services. This manual also explains how populations will be assigned to a Provider-led Arkansas Shared Savings Entity (PASSE) based on their tier results.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
   If yes, please complete the following:

Date: August 20, 2018; September 6, 2018

Time: 5:00 PM

Place: Central Library, Darragh Auditorium,
100 Rock Street
Little Rock, AR

Hempstead Hall, Blevins Suite,
University of Arkansas at Hope
2500 South Main Street
Hope, AR

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

September 12, 2018

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

November 1, 2018

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. *Attached*

13. Please provide proof of filing the rule with the Secretary of State and the Arkansas State Library as required pursuant to Ark. Code Ann. § 25-15-204(e). *Attached*

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. *Position unknown: PASSE entities, current CES Waiver providers, current OBH providers, current personal care providers and beneficiaries, beneficiaries who are going into the PASSE or their guardians/caregivers.*

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Elizabeth Pitman

TELEPHONE 501-682-4936 **FAX** _____ **EMAIL:** Elizabeth.pitman@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Arkansas Independent Assessment New-18 Manual

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

Financial impact of the ARIA implementation has already been accounted for in previous rule filings regarding the Personal care services and the ARIA tool. This manual expounds upon the tool itself but does not change the previous requirements to be assessed.

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		Next Fiscal Year	
General Revenue	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	0.00	Total	0.00

(b) What is the additional cost of the state rule?

Current Fiscal Year	Next Fiscal Year
0.00	0.00

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year
$ 0.00	$ 0.00
0.00	

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	Next Fiscal Year
$ 0.00	$ 0.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

SECTION II - ARKANSAS INDEPENDENT ASSESSMENT (ARIA)

CONTENTS

TOC required

200.000 OVERVIEW

201.000 Arkansas Independent Assessment (ARIA) System Overview 11-1-18

The Arkansas Independent Assessment (ARIA) system is comprised of several parts that are administered through separate steps for each eligible Medicaid individual served through one of the state's waiver programs, or state plan personal care services. The purpose of the ARIA system is to perform a functional-needs assessment to assist in the development of an individual's Person Centered Service Plan (PCSP), personal care services plan. As such, it assesses an individual's capabilities and limitations in performing activities of daily living such as bathing, toileting and dressing. It is not a medical diagnosis, although the medical history of an individual is an important component of the assessment as a functional deficiency may be caused by an underlying medical condition. In the case of an individual in need of behavioral health services, or waiver services administered by the Division of Developmental Services (DDS), the independent assessment does not determine whether an individual is Medicaid eligible as that determination is made prior to and separately from the assessment of an individual.

Federal statutes and regulations require states to use an independent assessment for determining eligibility for certain services offered though Home and Community Based Services (HCBS) waivers. It is also important to Medicaid beneficiaries and their families that any type of assessment is based on tested and validated instruments that are objective and fair to everyone. In 2017, Arkansas selected the ARIA system which is being phased in over time among different population groups. When implemented for a population, the ARIA system replaces and voids any previous IA systems.

The ARIA system is administered by a vendor under contract with the Arkansas Department of Human Services (DHS). The basic foundation of the ARIA system is MnCHOICES, a comprehensive functional assessment tool originally developed by state and local officials in Minnesota for use in assessing the long-term services and supports (LTSS) needs of elderly individuals. Many individuals with developmental disabilities (DD)/intellectual disabilities (ID) and individuals with severe behavioral health needs also have LTSS needs. Therefore, the basic MnCHOICES tool has common elements across the different population groups. DHS and its vendor further customized MnCHOICES to reflect the Arkansas populations.

ARIA is administered by professional assessors who have successfully completed the vendor's training curriculum. The assessor training is an important component of ensuring the consistency and validity of the tool. The assessment tool is a series of more than 300 questions that might be asked during an interview conducted in person. The interview may include family members and friends as well as the Medicaid beneficiary. How a question is answered may trigger another question. Responses are weighted based on the service needs being assessed. The MnChoices instrument is computerized and uses computer program language based on logic (an algorithm) to generate a tier assignment for each individual. An algorithm is simply a sequence of instructions that will produce the exact same result in order to ensure consistency and eliminate any interviewer bias.

The results of the assessment are provided to the individual and program staff at DHS. The results packet includes the individual's tier result, scores, and answers to all questions asked during the IA. **Click here to see an example results packet**. Individuals have the opportunity to review those results and may contact the appropriate division for more information on their

individual results, including any explanations for how their scores were determined. Depending upon which program the individual participates in, the results may also be given to service providers. The results will assign an individual into a tier which subsequently is used to develop the individual's PCSP. The tiers and tiering logic are defined by DHS and are specific to the population served (personal care, DD/ID, BH). DHS and the vendor provide internal quality review of the IA results as part of the overall process. The tier definitions for each population group/waiver group are available in the respective section of this Manual. In the case of an individual whose services are delivered through the Provider-led Arkansas Shared Savings Entity (PASSE), the tier is used in the determination of the actuarially sound global payment made to the PASSE. Beginning January 1, 2019, each PASSE is responsible for its network of providers and payments to providers are based on the negotiated payment arrangements.

For beneficiaries receiving state plan personal care, the IA determines initial eligibility for services, then is used to inform the amount of services the beneficiary is to receive.

For clients who receive HCBS services, the IA results are used to develop the PCSP with the individual Medicaid beneficiary. The Medicaid beneficiary (or a parent or guardian on the individual's behalf) will sign the PCSP. Depending upon which program the individual participates in, department staff or a provider is responsible for ensuring the PCSP is implemented. The DHS ARIA vendor does not participate in the development of the PCSP, nor in the provision of services under the approved plan.

There are four key features of every Medicaid home and community based services (HCBS) waiver:

A. It is an alternative to care in an institutional setting (hospital, nursing home, intermediate care facility for individuals with developmental disabilities), therefore the individual must require a level of services and supports that would otherwise require that the individual be admitted to an institutional setting;

B. The state must assure that the individual's health and safety can be met in a non-institutional;

C. The cost of services and supports is cost effective in comparison to the cost of care in an institutional setting; and,

D. The PCSP should reflect the preferences of the individual and must be signed by the individual or their designee.

The PCSP, as agreed to by the Medicaid beneficiary, therefore represents the final decision for setting the amount, duration and scope of HCBSs for that individual.

201.100 Developmental Screen Overview 11-1-18

Additionally, the vendor will perform developmental screens for children seeking admission into an Early Intervention Day Treatment (EIDT) program, the successor program to Developmental Day Treatment Clinic Services (DDTCS) and Child Health Management Services (CHMS) described in Act 1017 of 2013. Ark. Code Ann. § 20-48-1102. The implementation of the screening process supports Arkansas Medicaid's goal of using a tested and validated assessment tool that objectively evaluates an individual's need for services.

The developmental screen is the Battelle Developmental Inventory screening tool, which is a norm-referenced tool commonly used in the field to screen children for possible developmental delays. The state has established a broad baseline and will use this tool to screen children to determine if further evaluation for services is warranted. The screening results can also be used by the EIDT provider to further determine what evaluations for services a child should receive.

202.000 Assessor Qualifications Overview 11-1-18

All Assessors who perform IAs or developmental screens on behalf of the vendor must meet the following qualifications:

A. At least one-year experience working directly with the population with whom they will administer the assessment

B. Have the ability to request and verify information from individuals being assessed

C. Culturally sensitive to individuals assessed

D. Have the necessary knowledge, skills and abilities to successfully perform and manage Independent Assessments including organization, time management, ability to address difficult questions and problematic individuals, effective communication, and knowledge of adult learning strategies

E. Linguistically competent in the language of the individual being assessed or in American Sign Language or with the assistance of non-verbal forms of communication, including assistive technology and other auxiliary aids, as appropriate to the individual assessed or use the services of a telephonic interpreter service or other equivalent means to conduct assessments

F. Verify the information received from the individual and the individual's family members, caregivers, and/or guardians by cross-referencing all available information

G. SHALL NOT be related by blood or marriage to the individual or to any paid caregiver of the individual, financially responsible for the individual empowered to make financial or health-related decision on behalf of the individual, and would not benefit financially from the provision of assessed needs

203.000 Appeals 11-1-18

Appeal requests for the ARIA system must adhere to the policy set forth in the Medicaid Provider Manual Section 160.000 Administrative Reconsideration and Appeals which can be accessed at **https://medicaid.mmis.arkansas.gov/Provider/Docs/all.aspx.**

204.000 Severability 11-1-18

Each section of this manual is severable from all others. If any section of this manual is held to be invalid, illegal or unenforceable, such determination shall not affect the validity of other sections in this manual and all such other sections shall remain in full force and effect. In such an event, all other sections shall be construed and enforced as if this section has not been included therein.

210.000 BEHAVIORAL HEALTH SERVICES

210.100 Referral Process 11-1-18

Independent Assessment (IA) referrals are initiated by Behavioral Health (BH) Service providers identifying a beneficiary who may require services in addition to behavioral health counseling services and medication management. Requests for functional assessment shall be transmitted to the Department of Human Services (DHS) or its designee. Supporting documentation related to treatment services necessary to address functional deficits may be provided.

DHS or its designee will review the request and make a determination to either:

A. Finalize a referral and sent it to the vendor for a BH IA

B. Provide notification to the requesting BH service provider that more information is needed

C. Provide notification to the requesting entity

Reassessments will occur annually, unless a change in circumstances requires a new assessment.

210.200 Assessor Qualifications 11-1-18

In addition to the qualifications listed in Section 102.000, BH assessors must have a four (4) year Bachelor's degree or be a Registered Nurse with at least one year of mental health experience.

210.300 Tiering 11-1-18

A. Tier definitions:

1. Tier 1 means the score reflected that the individual can continue Counseling and Medication Management services but is not eligible for the additional array of services available in Tier 2 or Tier 3
2. Tier 2 means the score reflected difficulties with certain behaviors allowing eligibility for a full array of non-residential services to help the beneficiary function in home and community settings and move towards recovery.
3. Tier 3 means in the score reflected difficulties with certain behaviors allowing eligibility for a full array of services including 24 hours a day/7 days a week residential services, to help the beneficiary move towards reintegrating back into the community.

B. Tier Logic

1. Beneficiaries age 18 and over

	Tier 1 – Counseling and Medication Management Services	Tier 2 – Counseling, Medication Management, and Support Services	Tier 3 – Counseling, Medication Management, Support, and Residential Services
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score of 4 **AND** Intervention Score of 1 or 2 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA	Mental Health Diagnosis Score of 4 **AND** Intervention Score of 3 or 4 in any ONE of the following Psychosocial Subdomains: Injurious to Self Aggressive Toward Others, Physical Aggressive Toward Others, Verbal/Gestural Socially Unacceptable Behavior Property Destruction Wandering/Elopement PICA
		OR	

		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 4 or 5 in any ONE of the following Psychosocial Subdomains: Difficulties Regulating Emotions Susceptibility to Victimization Withdrawal Agitation Impulsivity Intrusiveness	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 1, 2, 3 or 4 **AND** Frequency Score of 1, 2, 3, 4 or 5 in the following Psychosocial Subdomain: Psychotic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Intervention Score of 4 **AND** Frequency Score of 4 or 5 in the following Psychosocial Subdomain: Manic Behaviors	
		OR	
		Mental Health Diagnosis Score of 4 **AND** PHQ-9 Score of 3 or 4 (Moderately Severe or Severe Depression)	

		OR Geriatric Depression Score of 3 (>=10)	
		OR	
		Mental Health Diagnosis Score of 4 **AND** Substance Abuse or Alcohol Use Score of 3	

When you see "**AND**", this means you must have a score in this area **AND** a score in another area. When you see "**OR**", this means you must have a score in this area **OR** a score in another area.

2. Beneficiaries Under Age 18

	Tier 1 – Counseling and Medication Management Services	**Tier 2 – Counseling, Medication Management, and Support Services**	**Tier 3 – Counseling, Medication Management, Support, and Residential Services**
Criteria that will Trigger Tiers			
Behavior	Does not meet criteria of Tier 2 or Tier 3	Mental Health Diagnosis Score >= 2 **AND** Injurious to Self: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score >=2 **AND** Injurious to Self: Intervention Score of 4 **AND** Frequency Score of 1, 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score >=2 **AND** Aggressive Toward Others, Physical: Intervention Score of 1, 2 or 3 **AND** Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score >=2 **AND** Aggressive Toward Others, Physical: Intervention Score of 4 **AND** Frequency Score of 2, 3, 4 or 5
		OR	
		Mental Health Diagnosis Score >=2 **AND** Intervention Score of 3 or 4	Mental Health Diagnosis Score >=2 **AND** Psychotic Behaviors:

		AND Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Aggressive Toward Others, Verbal/Gestural Wandering/Elopement	Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4 or 5
		OR	
		Mental Health Diagnosis Score >=2 **AND** Intervention Score of 2, 3 or 4 **AND** Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Socially Unacceptable Behavior Property Destruction	
		OR	
		Mental Health Diagnosis Score >=2 **AND** Intervention Score of 3 or 4 **AND** Frequency Score of 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Agitation Anxiety Difficulties Regulating Emotions Impulsivity Injury to Others, Unintentional Manic Behaviors Susceptibility to Victimization Withdrawal	
		OR	
		Mental Health Diagnosis Score >=2	

		AND **PICA**: Intervention Score of 4	
		OR	
		Mental Health Diagnosis Score >=2 **AND** **Intrusiveness**: Intervention Score of 3 or 4 **AND** Frequency Score of 4 or 5	
		OR	
		Mental Health Diagnosis Score > = 2 **AND** **Psychotic Behaviors**: Intervention Score of 1 or 2 **AND** Frequency Score of 1 or 2	
		OR	
		Mental Health Diagnosis Score >=2 **AND** Psychosocial Subdomain Score >=5 and <=7 **AND** Pediatric Symptom Checklist Score >15	

210.400 Possible Outcomes **11-1-18**

A. For a beneficiary receiving a Tier 1 determination:

1. Eligible for Counseling and Medication Management services and may continue Tier 1 services with a certified behavioral health service provider.
2. Not eligible for Tier 2 or Tier 3 services.
3. Not eligible for auto-assignment to a Provider-led Arkansas Shared Savings Entity (PASSE) or to continue participation with a PASSE.

B. For a beneficiary receiving a Tier 2 determination:

1. Eligible for services contained in Tier 1 and Tier 2.
2. Not eligible for Tier 3 services.
3. Eligible for auto-assignment to a PASSE or to continue participation with a PASSE.

a. On January 1, 2019, the PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.

b. The PASSE will be responsible for providing care coordination an assisting the beneficiary in accessing all needed services and, after January 1, 2019, for providing those services.

C. For a beneficiary receiving a Tier 3 determination:

1. Eligible for services contained in Tier 1, Tier 2 and Tier 3.

2. Eligible for auto-assignment to a PASSE or to continue participation with a PASSE.

a. On January 1, 2019, the PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.

b. The PASSE will be responsible for providing care coordination and assisting the beneficiary in accessing all needed services and, after January 1, 2019, for ensuring those services are provided.

220.000 DEVELOPMENTAL / INTELLECTUAL DISABILITIES SERVICES

220.100 Independent Assessment Referral Process 11-1-18

A. Independent Assessment (IA) referrals are initiated by the Division of Developmental Disabilities (DDS) when a beneficiary has been determined, at one time, to meet the institutional level of care. DDS will send the referral for a Developmental Disabilities (DD) Assessment to the current IA Vendor. DDS will make IA referrals for the following populations:

1. Clients receiving services under the Community and Employment Supports (CES) 1915(c) Home and Community Based Services Waiver.

2. Clients on or applying for the CES Waiver Waitlist.

3. Clients applying for or currently living in a private Intermediate Care Facility (ICF) for individuals with intellectual or developmental disabilities.

4. Clients who are applying for placement at a state-run Human Development Center (HDC).

To continue to receive services within these populations, all individuals referred will have to undergo the Independent Assessment.

B. All populations, except for those served at an HDC, will be reassessed every three (3) years.

1. An individual can be reassessed at any time if there is a change of circumstances that requires a new assessment.

2. Individuals in an HDC will only be reassessed if they are seeking transition into the community.

220.200 Assessor Qualifications 11-1-18

In addition to the qualifications listed in Section 202.000, DD assessors must have at least two-years' experience with the ID/DD population and meet the qualifications of a Qualified Developmental Disability Professional (QDDP).

220.300 Tiering 11-1-18

A. Tier Definitions:

1. Tier 2 means that the beneficiary scored high enough in certain areas to be eligible for paid services and supports.
2. Tier 3 means that the beneficiary scored high enough in certain areas to be eligible for the most intensive level of services, **including 24 hours a day/7 days a week** paid supports and services.

B. Tiering Logic:

1. DDS Tier Logic is organized by categories of need, as follows:
   a. Safety: Your ability to remain safe and out of harm's way
   b. Behavior: behaviors that could place you or others in harm's way
   c. Self-Care: Your ability to take care of yourself, like bathing yourself, getting dressed, preparing your meals, shopping, or going to the bathroom

Tier 2: Institutional Level of Care	Tier 3: Institutional Level of Care and may need 24 hours a day 7 days a week paid supports and services to maintain current placement
Safety Level High A. [Self-Preservation Score > = 4 **AND** B. Caregiving Capacity/Risk Score > = 6 **AND** C. Caregiving/Natural Supports Score > = 6 **AND** D. Mental Status Evaluation Score (in the home) = 3 or 4 **AND** E. Mental Status Evaluation Score (in the community) = 2]	A. [Self-Preservation Score > = 16 **AND** B. Caregiving Capacity/Risk Score = 11 **AND** C. Caregiving/Natural Supports Score of = 7 **AND** D. Mental Status Evaluation Score (in the home) Score = 5 **AND** E. Mental Status Evaluation Score (in the community) Score = 3]
Safety Level Medium A. [Self-Preservation Score > = 4 **AND** B. Caregiving Capacity/Risk Score > = 6 **AND** C. Caregiving/Natural Supports Score > = 6 **AND** D. Mental Status Evaluation Score (in the home) = 2 **AND** E. Mental Status Evaluation Score (in the community) = 2]	
Safety Level Low	

A. [Self-Preservation Score > = 4 **AND** B. Caregiving Capacity/Risk Score > = 6 **AND** C. Caregiving/Natural Supports Score > = 6 **AND** D. Mental Status Evaluation Score (in the home) = 1 **AND** E. Mental Status Evaluation Score (in the community) Score = 1]	
Behavior Level High A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 5 - < = 7 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement; **AND** C. Caregiving Capacity/Risk Score of > = 6 **AND** D. Caregiving/Natural Supports Score of > = 5] **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 5 - < = 7 in at least THREE of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions;	**Behavior Level High** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least THREE of the following Subdomains: Aggressive Toward Others Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior;

Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of > = 9 Caregiving/Natural Supports Score of > = 5]	Verbal/Gestural; Withdrawal
Behavior Level Low A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 3 - < = 4 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of < = 8 Caregiving/Natural Supports Score of < = 3] **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of >=5-<=7 in at least one of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional);	**Behavior Level Low** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least ONE of the following Subdomains: Aggressive Toward Others, Physical; Injurious to Self; Manic Behaviors; PICA; Property Destruction; Psychotic Behaviors; Susceptibility to Victimization; Wandering/Elopement] **OR** A. [Neurodevelopmental Score of 2 **AND** B. Psychosocial Subdomain Score of > = 8 - < = 9 in at least TWO of the following Subdomains: Aggressive Toward Others, Verbal/Gestural; Agitation; Anxiety; Difficulties Regulating Emotions; Impulsivity; Injury to Others (Unintentional); Intrusiveness; Legal Involvement; Socially Unacceptable Behavior;

Intrusiveness; Legal Involvement; Socially Unacceptable Behavior; Withdrawal C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of < = 8 Caregiving/Natural Supports Score of < = 3]	Withdrawal]
Self-Care Level High A. [Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following: 1. *ADL's:* Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers 2. *Functional Communication:* Score of 2 or 3 in Functional Communication 3. *IADLs:* Score of 3 in any of the following IADLs (Meal Preparation, Housekeeping, Finances, Shopping) 4. *Safety:* Self-Preservation Score of >=4 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of > = 9 Caregiving/Natural Supports Score of > = 4 [Treatment/Monitoring Score of at least 2]	**Self-Care Level High** A. [Neurodevelopmental Score of 2 **AND** B. Treatments/Monitoring Score of at least 2 C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score > = 10 Caregiving/Natural Supports Score of = 7]
Self-Care Level Medium A. [Neurodevelopmental Score of 2 **AND**	

B. Scores within stated range in at least THREE of any of the following: 1. *ADLs:* Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers 2. *Functional Communication:* Score of 1 in Functional Communication 3. *IADLs* Score of 3 in any of the following IADLs: (Meal Preparation, Housekeeping, Finances, Shopping) 4. *Safety:* Self-Preservation Score of > = 2 **AND** a score in at least one of the following areas: Caregiving Capacity/Risk Score of > = 9 Caregiving/Natural Supports Score of > = 4]	
Self-Care Level Low A. [Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of 1-11 in Eating Score of 1-11 in Bathing Score of 1-10 in Dressing Score of 1-11 in Toileting Score of 1-10 in Mobility Score of 1-10 in Transfers] **OR** [Neurodevelopmental Score of 2 **AND** Score of >=1 in any of the following:	**Self-Care Level Low** A. [Neurodevelopmental Score of 2 **AND** B. Scores within stated range in at least THREE of any of the following combinations: Score of at least 4 in Eating Score of at least 5 in Bathing Score of at least 4 in Dressing Score of at least 3 in Toileting Score of at least 4 in Mobility Score of at least 4 in Transfers C. **AND** at least one of the following scores: Caregiving Capacity/Risk Score of >= 10 Caregiving/Natural Supports Score of 7]

IADLs (Meal Preparation, Housekeeping, Finances, Shopping)]	

When you see "**AND**", this means you must have a score in this area **AND** a score in another area. When you see "**OR**", this means you must have a score in this area **OR** a score in another area.

220.300 Possible Outcomes 11-1-18

A. For beneficiaries on the CES Waiver, Waiver Waitlist, or in an ICF:

Both Tier 2 and Tier 3 determinations will result in the beneficiary being eligible for auto-assignment to a PASSE or to continue participation with a PASSE.

1. On January 1, 2019, the PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.
2. The PASSE will be responsible for providing care coordination and assisting the beneficiary in accessing all eligible services and, after January 1, 2019, for ensuring those services are delivered.

B. For beneficiaries seeking admission to an HDC:

1. Tier 2 Determination:
   a. Not eligible for admission into an HDC, will be conditionally admitted to begin transitioning to community settings.
   b. Eligible for auto-assignment to a PASSE or to continue participation with a PASSE.
      i. After January 1, 2019, the PASSE will receive a PMPM that corresponds to the determined rate for the assigned tier.
      ii. The PASSE will be responsible for providing care coordination and assisting the beneficiary in accessing all eligible services and, after January 1, 2019, for ensuring those services are provided.
2. Tier 3 Determination:
   a. Eligible for HDC admission.
   b. Not eligible for auto-assignment to a PASSE or to continue participation with a PASSE, if the client chooses admission to the HDC.

C. If the beneficiary does not receive a tier on the assessment, the vendor will refer him or her back to DDS for re-evaluation of institutional level of care.

220.400 Developmental Screens 11-1-18

All children birth through the eighth birthday, who are seeking initial enrollment or reenrollment in an Early Intervention Day Treatment (EIDT), or the predecessor programs, Developmental Day Treatment Clinic Services (DDTCS) or Child Health Management Services (CHMS) on or after July 1, 2018, must undergo a developmental screen to determine the necessity of further evaluation.

A provider can request that a child be "opted-out" of the screening process. An opt-out request will be approved if:

A. The child has one of the following diagnoses:

1. Intellectual disability;
2. Epilepsy/Seizure disorder;

3. Cerebral palsy;
4. Down Syndrome;
5. Spina Bifida; or
6. Autism Spectrum Disorder

B. The diagnosis is documented on a record that is signed and dated by a physician.

220.410 Battelle Developmental Inventory Screen 11-1-18

A. The screening tool that will be used by the vendor is the most recent edition of the Battelle Developmental Inventory (BDI) Screening Tool. The BDI screens children in the following five domains: adaptive, personal/social, communication, motor, and cognitive.

B. Definitions used for the screening process:

1. Cut Score - The lowest score a beneficiary could have for that age range and standard deviation in order to pass a particular domain.
2. Pass - The child's raw score is higher than the cut score, and the child is not referred for further evaluation
3. Refer – The child's raw score is lower than the cut score, and the child is referred for further evaluation of service need
4. Age Equivalent Score - The age at which the raw score for a subdomain is typical
5. Raw Score – Is the score the child actually received on that domain. It is compared to the cut score to determine if the child receives a pass or refer.
6. Standard Deviation - A measurement used to quantify the amount of variation; the standard deviation will be applied to the child's raw score so that their score can be compared to the score of a child with typical development.

C. The standard deviation of -1.5 will be applied to all raw scores. Any score that is more than 1.5 standard deviations below that of a child with typical development will be referred for further evaluation for EIDT services.

D. Assessors who administer the Battelle Developmental Inventory screen must meet the qualifications of a DD assessor, listed in Section X20.200 and undergo training specific to administering the tool.

220.420 Referral Process 11-1-18

A. BDI referrals are initiated by EIDT providers when a family or guardian is seeking EIDT day habilitation services for a child who may need those service. No EIDT day habilitation or assessment services can be billed until a child is referred for further evaluation by the BDI or is approved for an opt-out, as described in section 220.400. Requests for screens or opt-out requests must be entered at **https://ar-ia.force.com/providerportal/s/**.

B. For a request for a BDI screen, the vendor will have fourteen (14) days from the date of the referral to complete the screen. The vendor will schedule at least two days a month to be onsite at each EIDT provider's facility to complete BDIs for all referrals received before the cut-off date. The cut-off date is two (2) business days prior to the scheduled onsite visit by the vendor.

C. Opt-out requests submitted through the portal link above will be reviewed by DHS staff to determine if it meets the criteria set out in section 220.400 above.

1. If the Opt-Out request is approved by DHS, the vendor will send a results letter to the family indicating that the child may be referred for further evaluation.

2. If the opt-out request is denied by DHS, the referral will be sent out to the vendor so that a BDI can be completed at the next scheduled onsite visit.

230.000 PERSONAL CARE SERVICES

230.100 Referral Process 11-1-18

Independent Assessment (IA) referrals are initiated by Personal Care (PC) service providers identifying a beneficiary who may require PC services. After January 1, 2019, individuals who are enrolled in a PASSE will not require a personal care assessment to continue services. Requests for functional assessment shall be transmitted to the Department of Human Services (DHS) or its designee, and will require supporting documentation. Supporting documentation that must be provided include:

A. A provider completed form that has been provided by DHS; and

B. A referral form, if it is an initial referral.

DHS or its designee will review the request and make a determination to either:

A. Finalize a referral and send it to the vendor for a PC IA.

B. Provide notification to the requesting entity that more information is needed, and that the

C. PC provider may resubmit the request with the additional information.

D. Provide notification to the requesting entity the request is denied, for example, if a functional assessment has been performed within the previous ten (10) months and there is no change of circumstances to justify reassessment.

PC IA Reassessments must occur annually, but may occur more frequently if a change of circumstances necessitates such.

230.200 Assessor Qualifications 11-1-18

In addition to the qualifications listed in Section 202.000, PC assessors must be a Registered Nurse licensed in the State of Arkansas.

230.300 Tiering 11-1-18

A. Tiering Definitions:

1. Tier 0 means you did not score high enough in any of the Activities of Daily Living (ADLs) such as Eating, Bathing, Toileting, to meet the state's eligibility criteria for Personal Care Services. A Tier 0 means that you did not need any "hands on assistance" in being able to bathe yourself, feed yourself and dress yourself as examples.

2. Tier 1 means you scored high enough in at least one of the Activities of Daily Living (ADLs) such as Eating, Bathing, Toileting, to be eligible for the state's Personal Care Services. A Tier 1 means that you needed "hands on assistance" to be able to bathe yourself, dress yourself, or feed yourself, as examples.

B. Tiering Logic

	Tier 0	Tier 1

Functional Status (ADLs)	Score < 3 in all of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning	Score of > = 3 in at least ONE of the following ADLs: Eating, Bathing, Dressing, Personal Hygiene/Grooming, Mobility, Transferring, Toilet Use/Continence Support, Positioning

230.400 Possible Outcomes 11-1-18

Upon successful completion of an IA, the tier determination will determine eligibility of service levels. Possible outcomes include:

A. Tier 0 Determination

1. Not currently eligible for Personal Care services.
2. May be reassessed when a change in circumstances necessitates a re-assessment.

B. Tier 1 Determination

1. Currently eligible for up to 256 units (64 hours) per month of personal care services.
2. The PC IA is submitted to DHS or its designee who reviews it, along with any information submitted by the provider to authorize the set amount of service time per month.

The PC IA is not used to assign clients to a PASSE.