EXHIBIT G

DEPARTMENT OF HUMAN SERVICES, DEVELOPMENTAL DISABILITIES SERVICES

SUBJECT: CHMS Medicaid Provider Manual, DDTCS Medicaid Provider Manual, CHMS State Plan Amendments, DDTCS State Plan Amendments, DDS Standards for Certification, Investigation, and Monitoring

DESCRIPTION: DDS is the lead agency for CHMS and DDTCS programs in Arkansas. As such, DDS is responsible for overseeing the programs and certifying and monitoring DDS center-based services. These changes modify the CHMS Medicaid Provider Manual, the DDTCS Medicaid Provider Manual, the State Plan for CHMS and DDTCS programs, and the DDS Standards for Certification, Investigation and Monitoring. DDS proposes the following changes to all of the documents:

1. Incorporating the annual Independent Assessment for beneficiaries receiving DDTCS or CHMS.

2. Changing eligibility requirements for DDTCS and CHMS services to require the Independent Assessment.

In addition to the above changes, DDS proposes the following changes to the CHMS and DDTCS Medicaid Provider Manual:

1. Revise information regarding Part C of the Individuals with Disabilities Education Act (IDEA).

2. Revise information regarding Part B of the Individuals with Disabilities Education Act (IDEA), including election to opt-in or opt-out to provide or not provide special education related services in accordance with Part B to all children with disabilities it is serving aged three (3) until entry into kindergarten.

3. Heighten staff to beneficiary ratios in the classroom setting.

The DDS Standards for Certification, Investigation and Monitoring were also updated to incorporate the requirement for weekly progress notes, at a minimum.

PUBLIC COMMENT: A public hearing was held on August 8, 2017. The public comment period expired on August 11, 2017. The Department provided the following summary of the public comments it received:

Question: Please talk about the new DDTCS plan. Ratio staff to consumer, etc.
Response: The DDTCS Manual details the changes, as does the summary.

Question: We have heard a rumor that special education classes will no longer exist under new plans.
Response: Special Education continues to be the responsibility of the Department of Education.

I am writing in regard to changes in the DDTCS/CHMS manual, specifically DDS-Stnds-Redline.doc, CHMS-2-17up.doc, and DDTCS-2-17.doc.
Comment: Let me begin by stating that I have two vested interests in these changes. I have a great-niece and great-nephew who have received services at the Community School of Cleburne County (CSOCC). I know firsthand the critical work that is done in the lives of small children to ensure that they have the best possible opportunity to develop necessary skills for a successful transition to public school kindergarten.

As a former kindergarten teacher in the Russellville Public Schools, I am fully aware of how imperative it is that proper and thorough evaluations be conducted in order to assure each child of a correct assessment of skills and needs, so that these can be adequately addressed throughout the school year. In my particular case, we conducted a "screening" process for each child entering kindergarten that lasted approximately 90 minutes and included assessments by no less than five certified personnel and a Registered Nurse.

Additionally, the parents were interviewed so that a fair assessment of home life, background information (such as childhood illnesses, allergies and special physical needs) and more could be conducted. We compiled all of this information and met as a group to discuss our findings and create a written report on the children that was then given to our principal, so that a fair match could be made between these students and the teachers who would guide them through their kindergarten year.

Not only was this in-depth assessment conducted for every child entering kindergarten, but each person who was involved in this evaluation process received approximately 20 hours of training specifically for this setting. Many of us already possessed Master of Education degrees in Early Childhood Education and/or Educational Administration. But we still sat through extensive training just for this specific exercise.

Here are my concerns with regard to the changes I am seeing in these documents:

1. I am not certain WHO will be conducting this "screening"; however, it appears that it likely will be a "third party." Will these persons be properly trained to make such an assessment? Will they be certified educators who have received additional training in how to evaluate the needs of children – especially those who may have specific physical, mental, verbal and developmental challenges – both readily observable and covert?
Response: The contract requires the Assessment vendor to hire assessors that meet the following qualifications: (1) two years of experience with the DD/ID population, and (2) meet the requirements of a Qualified Developmental Disability Professional (QDDP). The vendor will be conducting training of each hired assessor. This vendor, Optum, has conducted assessments in many other states and is familiar with the assessment process and how to train assessors.

Will this "screening" be thorough and given the proper time necessary to fully evaluate the child's needs? Will someone visit with the parents and assess background information, such as housing situations, family dynamics, history of possible abuse and neglect, etc.

Response: The screen will be the Batelle Developmental Inventory-2, and will be used to determine if the child needs to receive a full evaluation at the CHMS/DDTCS facility. Parents may be present when the screen is conducted, if they are available.

2. Where will this "screening" be conducted? It is my understanding that many of the clients at the CSOCC must be physically collected and transported to the school for the evaluations that are presently administered. Clearly, if the testing takes place in another city – Conway, Searcy – or even Little Rock – there will be many potential clients who will be unable to make arrangements to attend – and by default, the child will not even be assessed for possible habilitation.

Response: The vendor, Optum, will work with the CHMS or DDTCS coordinating the screen, as well as the parents of the child being screened, to accommodate their preferences for location. We anticipate that most of these screens will occur at the CHMS or DDTCS location. Optum will have assessors located throughout the state and those assessors will be traveling to the city or town where the child resides; it is not expected that the parent needs to travel to a centralized location.

3. If an adequate amount of time is not given to the "screening" many children could potentially be eliminated or mistakenly evaluated based on a few minutes of quick judgment. Any child can have a "good day" for a few minutes – but if given time to warm up and settle in, he/she may present completely differently. I know of one child who screamed and was so terrified during his initial screening that many of the evaluations could not be done. He had to return another time for all tests to be completed fairly and thoroughly. Would he be eliminated as "uncooperative" under the new system?

Response: The screen will not eliminate a child as "uncooperative." The screen is similar to the process used now by many facilities to determine if a child needs a full evaluation for services. The assessor will be trained in how to conduct the assessment to ensure accurate results.

4. Any time you involve Primary Care Physicians, you add yet another layer of "red tape" to the process and risk children getting lost in the shuffle. What if the PCP does not respond quickly and with the proper information? How will the institutions know what has/has not been determined? HIPPA laws prevent representatives of these institutions from asking for – and receiving – much of the needed information. The potential for children to slip through the cracks looms large, in my opinion.

Response: The current process requires a physician to refer a child to a DDTCS or CHMS for an evaluation and services. The screening will not add a new layer to that requirement. If the child is referred for the screen and evaluation by the physician and the screen shows the child needs a full evaluation, then the CHMS or DDTCS

may perform that full evaluation. Just as they do now, they will need to send that evaluation (and the results of the screen) to the physician for a prescription for services. This is a Medicaid service, and under the federal regulations it must be "medically necessary," therefore the physician does need to be involved in the process.

5. If children are denied services at schools like the Community School of Cleburne County and Easter Seals – what then? How will these children receive the necessary tutelage to prepare them for entrance into public school kindergarten? I can assure you that the last thing our kindergarten teachers need is an influx of students with needs that require physical, occupational and speech therapies, behavior modification, and other highly-skilled remediation for which they are not adequately trained – all while trying to meet the educational needs of the other students in their classroom.
Response: The goal of the screen is not to deny children needed services, but to ensure that children receive those services in the least restrictive setting possible, which is best practice. If a child is better served in a regular daycare with physical therapy, occupational therapy, or speech therapy services, then this is the setting the child should be in.

6. Finally, this appears to be a plan that will only serve to harm those who are in lower socio-economic brackets – those who cannot afford private therapies and daycare programs – especially those that would provide the necessary therapies and remedial services necessary to ensure that these children enter public school kindergarten on any semblance of a level playing field with their peers. This will add yet another burden to these children AND the public school teachers who serve them.
Response: Please see the answer immediately above.

Question: Terminology regarding the 3rd Party Vendor functions for children ages 3-entry in kindergarten needs clarification. Will they conduct only screening or will they conduct comprehensive assessments? There are references to independent assessment in this manual, but it has been my understanding that Optum will only be doing screening for children ages 3-entry in kindergarten.
Response: Optum, the third party vendor, will conduct developmental screens, specifically the Batelle Developmental Inventory-2, on children who are referred to the DDTCS or CHMS program. These screens will determine whether a child should receive a full evaluation by the DDTCS or CHMS for services.

Question: Will there be another review and comment to consider a Manual for the merging of DDTCS and CHMS? Will DDS Standards for Certification, Investigation and Monitoring be revised again to address the merger?
Response: This Rule change does not include the DDTCS-CHMS successor program. We anticipate that the rules and manuals for the successor program will be put out for public comment in early 2018.

Question: The level of service for any child should be based on the needs of the child. The specific needs of the child should be outlined in the IPP through the goals/objectives of the IPP. The goals/objectives should be determined based on the results of the

evaluation procedures. Should the physician not use this information to determine the level of services? Results of screening procedures will not provide sufficient detail to determine how much service a child needs or what goals/objective should be included in the IPP. If a child passes a screening and the physician feels evaluation procedures are needed, can the physician still refer for evaluation?
Response: Based on conversations with providers, we have determined that the developmental screen will determine whether a child should receive a full evaluation by the DDTCS or CHMS. If the child does receive a full evaluation, that evaluation, along with the results of the screen will be sent to the physician for a prescription for services.

Question: The Manuals address retrospective reviews of speech, occupation and physical therapy. Is there a review of day habilitation to ensure appropriate eligibility instructional content, implementation and progress?
Response: Yes, for all CHMS services prior approval is required. All other services are subject to retrospective review.

Question: There is no mention anywhere regarding a requirement of an agreement with the LEA for programs that Opt-Out for the provision of special education.
Response: There is no requirement for a program that elects to opt-out to enter into an agreement with the LEA for the provision of special education services. The only requirement is that programs electing to opt-out must deliver the required referrals to the appropriate LEA. DDS would highly encourage programs that opt-out to attempt to enter into agreements with LEAs for the provision of special education services; however, DDS cannot require LEAs to enter into such contracts.

Question: How will DDS know how many children are served by providers, who the children are, and what services they receive? To my knowledge, there is no requirement for providers to submit this data to the DDS.
Response: This information is contained in claims data submitted through MMIS and housed in the Data Support Solutions (DSS) warehouse.

Question: The procedures for Opt-In/Opt-Out for DDS providers for the provision of special education services have not been developed at this time. It is my understanding providers will be required by March 1, 2018, to make a declaration of intent with regard to the provision of special education services.
Response: DDS will provide more information on how a facility can opt-in/opt-out of providing special education services on or around January 1, 2018.

Question: There is nothing to indicate that sanctions can be imposed for non-compliance for providers that Opt-In for the provision of special education services.
Response: The manual specifies that the facility can lose Part B funds if it fails to comply.

Question: Will these Standards be revised at which time the Medicaid Manual for the EDIT (merger of DDTCS and CHMS) is developed and out for comment and review and the Opt-In/Opt-Out procedures have been developed?
Response: This Rule change does not include the DDTCS-CHMS successor program. We anticipate that the rules and manuals to the successor program will be put out for public comment in early 2018.

Question: What happens on October 1? Will children that are already enrolled be grandfathered in under their current enrollment until it expires?
Response: Yes, current enrollees would not be expected to meet the new eligibility criteria or undergo an independent assessment until their plan of care date expired.

Question: For CHMS/Diagnosis/Evaluation Services, this section has nothing to do with day treatment eligibility. This is the section of the manual that allows CHMS providers to provide diagnostic testing for children regardless of whether they want to enroll in day treatment. Add language that says this section does not apply to day treatment eligibility.
Response: Agreed.

Question: Language in 203.100(D)(4) says that PCP referral is for 6 months, but the IA is good for 12 months. This needs to be changed.
Response: Agreed, this will be clarified.

Question: In Section 212.000, CHMS Providers do not agree that the state can change the original intent of the screening for physician referral to a full eligibility determination. We will be having legal counsel review the process to ensure this is possible. If it is determined that the state does have the right to make this change, we are asking for the responsibility of coordinating the process of sending the child for the screening. See separate proposal about why providers should send for screening instead of physicians.
Response: We do agree that both CHMS and DDTCS facilities are better equipped to coordinate the developmental screen process and will clarify the language in the manual to reflect that.

Question: We are asking DDS to remove language that says they qualify for at least one hour – they are either eligible or not.
Response: Agreed.

Question: In section 213.200, regarding the ECDS, it currently reads, "12 hours of completed college courses in 'one' of the following." We recommend that it be changed from "one" to "any" of the following areas. So, they can be combined from the different areas. Also, we need 1 – 50 ECDS per child. We don't need the 1 – 30 ECDS to child. That is a Department of Education standard for writing up IPPs.
Response: We agree with these comments as first steps to increasing the qualifications for an ECDS.

EXHIBIT G

Question: We would like ratios changed back to what we presented in our original manual changes. CHMS providers still have core service requirements to provide therapy and nursing, so children will be in and out of the classroom all throughout the day OR the therapist and/or nurse is in the classroom providing services to the children. The ratios below are more appropriate for our services because of the extra required on-site professionals in the classroom throughout the day.
We recommend:
0-18 months 1 to 4
19-36 months 1 to 7
3-6 years 1 to 10
Class size needs to remain twice the current CCL ratios. Otherwise, programs will have to reduce their capacities and discharge children that still qualify on the first day the new manual goes into effect. Families will have to find immediate placement elsewhere. Not to mention, providers built facilities based on the rules that were in place at the time. And, as long as they meet ratios should be able to keep maximum class sizes. What is the timeline for meeting the new ratio criteria? These manuals will be promulgated days before October 1. It may take longer than a couple of weeks to get new staff hired and in place.
Response: The ratios have been considered and discussed. Because of the high needs of this population, we believe the stricter ratios that are currently used by DDTCS providers should be followed.

Comment: Eligibility should read:
Child Health Management Services are delivered to those children with the most significant medical and/or developmental diagnoses and those presenting with multiple/complex conditions. In addition to the developmental screening, children enrolling in CHMS services are required to meet one of the following criteria:
A. Frequent nursing services;
B. Close physician monitoring (availability for consultation in addition to frequent face-to-face contact);
C. Special nutritional services requiring consultation with parents and staff and/or possible special menu planning and adapted feeding regimen;
D. Constant coordination of care (in communication with the PCP) within the interdisciplinary team to maximize provision of individual services and appropriate therapy services and
E. Additional family contact for education and support.
F. Therapy services from at least one discipline (occupational, physical, or speech).
If this eligibility is remaining, then AFMC and providers must be given clear objective criteria to meet in order to prior authorize B, C, D, and E above so children can enroll under these areas. CHMS providers have never been able to get a PA approved for any of those line items due to lack of objective criteria.
Response: Agreed.

Comment: It is my understanding that children enrolling into CHMS also meet eligibility for CHMS by meeting the definition of DD determined in this section and that the eligibility screening testing will give us the scores for the children to qualify based on A. 2. c and d. Does A. 2. A (intellectual disability) work for CHMS for our current cognition testing?
Response: The child's diagnosis and the results of the developmental screen can be used to establish whether the child meets this definition, in addition, if CHMS performs testing that would show a delay in two of the five domains, that testing can also be used to establish eligibility.

Question: In second paragraph of section 218.300, the end needs to say: "physician's prescription, which authorizes day treatment."
Response: Agreed.

Comment: Why do we need a PA if we are getting an eligibility determination? The PA will be verifying the work of the third party developmental screener. Although I know we have to keep a PA number because cannot make any code changes in MMIS at this time, DDS and AFMC could find a way to do a verification to provide a PA # that would be similar to what they are doing with the therapy PA's. CHMS providers are also asking if we can have the annual PA'd cap on our day treatment codes removed. In July 2016, our day treatment codes were put under daily caps. As of that date, our day treatment codes have been under both a daily cap and an annual cap. If we cannot remove the daily caps because of a CMS decision due to NCCI edits, then we ask that the annual caps can be removed. Both caps put too much restriction on our day treatment codes.
Response: At this time, no MMIS changes can be made. We are looking at ways to change the PA process for CHMS facilities next spring/summer when the new MMIS system has stabilized.

Comment: Add back the parent interview code for psych (90791 U1 & U9).
Response: Agreed.

Comment: In Section 218.200 /Individual Treatment Planning:
"For those children receiving day treatment services on a daily or weekly basis, the individualized treatment plan will be written for a period of 12 months and will be updated as needed. The treatment plan for children birth to 3 years of age may be in the form of the state accepted Individualized Family Services Plan (IFSP)." The IFSP is a federal Part C requirement. The plan for infants and toddlers enrolled in programs outside of Part C must be called something else.
Response: Agreed.

Comment: In Section 205.000 / Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA):
Federal regulations under Part C of the IDEA require "primary referral sources" to refer any child suspected of having a developmental delay or disability for early intervention services. A CHMS is considered a primary referral source under Part C of IDEA regulations.

Infants and toddlers are referred to a CHMS by a primary referral source, and the CHMS serves as an alternate form of early intervention not recognized under IDEA. Federal regulations do not describe, identify, or define segregated service settings, so a CHMS is not identified as a primary referral source in the IDEA.
Response: Agreed.

Comment: Each CHMS must, within two (2) working days of first contact, refer all infants and toddlers from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability.

The referral must be made to the DDS First Connections Central Intake Unit, which serves as the State of Arkansas' single point of entry to minimize duplication and expedite service delivery. Each CHMS is responsible for maintaining documentation evidencing that a proper and timely referral to First Connections has been made.

It is burdensome and confusing for families as well as a duplication of efforts to refer children already receiving CHMS services when Part C services cannot be provided in conjunction with day habilitation services and families must choose one program or the other.

Preferred: Each CHMS must, within two (2) working days of receipt of referral of an infant or toddler thirty-six (36) months of age or younger, present the family with DDS-approved information about the Part C program, First Connections, so that the parent/guardian can make an informed choice regarding early intervention options. Each CHMS must maintain appropriate documentation of parent choice in the child record.
Response: Agree that the preferred language is more appropriate.

Comment: I am concerned about the lack of details, such as what type of screen this will be. How can a short screen determine whether my child's functionality would benefit from day habilitation? Also, I ask for the credentials of the people performing the screen to be qualified clinicians. I'm concerned that parents and physicians need training to ensure that disruption in services does not occur. I am concerned that in opting out, a parent must relinquish the child's IDEA rights for as long as the child attends that center and/or as long as that center chooses to be opted out. On top of that, I'm concerned that services could be disrupted, especially if a parent chooses not to relinquish those rights and must find another place of service. Also, this may remove the freedom of choice for the parent if there is not another place of service nearby. Last, I'm concerned that disruption of services might occur as a child is transitioned into the school system.

I'm concerned that parents, therapists, educators, and advocates need training to ensure that disruption in services does not occur.
Response: The screen will be the Batelle Developmental Inventory-2, and will be used to determine if the child needs to receive a full evaluation at the CHMS/DDTCS facility. Parents may be present when the screen is conducted, if they are available.

Comment: DDTCS Medicaid Manual – I support the implementation of an independent screen completed by DHS third party vendor to determine eligibility of children for referral for day habilitation/treatment services.

Comment: DHS is proposing the requirement of a developmental screen in order to determine eligibility for Child Health Management Services and Developmental Day Treatment Clinic Services. This developmental screen is in addition to the current prescription/ referral by the beneficiary's primary care physician requirement. Though a particular screening tool is mentioned in the Independent Assessment Manual, there is no commitment to using that tool and no other information provided on what the developmental screen would capture that would be different or somehow an enhancement to the information that is already being provided by a beneficiary's primary care physician.

Our concern regarding a new requirement of a developmental screen before a beneficiary begins to receive services, even though the beneficiary has already received a prescription for services from his or her primary care physician, is that it could lead to a delay in very important intervention services. DRA recommends that DHS provide additional information regarding the specific developmental screening tool and information sought by the screen, as well as timelines for completing, to ensure that the screen does not delay access to services and so that beneficiaries can meaningfully comment on this proposed change.

Response: The screen will be the Batelle Developmental Inventory-2, and will be used to determine if the child needs to receive a full evaluation at the CHMS/DDTCS facility. Parents may be present when the screen is conducted, if they are available.

Comment: The manuals for both the Child Health Management Services and Developmental Day Treatment Clinic Services both have proposed language included for referrals and provision of special education services pursuant to the IDEA. In reviewing, it appears that the information included in the DDTCS manual actually includes the language from the CHMS manual and was not amended to reflect the DDTCS language. DRA recommends that DHS review and revise as necessary. Otherwise, DRA believes it is important for DHS to add the IDEA requirements to the manuals and to include the very important information regarding identifying children as soon as possible in order to provide access to early intervention services. It is helpful for both CHMS and DDTCS settings to understand their obligations when it comes to these services in addition to the obligations of the Local Educational Agency. Furthermore, the inclusion of timelines for not only providing services while in a CHMS or DDTCS setting but also for referrals in preparation of entry into the public school setting will help to ensure that proper transition planning and continuity of services will occur.

Response: Medicaid funded programs must be based off of medical necessity. IDEA is based on educational necessity. Therefore we cannot include requirements that are based exclusively on educational necessity.

The agency states that the state plan pages will require CMS approval; as of August 23, 2017, that approval is pending. The proposed effective date is October 1, 2017.

FINANCIAL IMPACT: Refer to the Financial Impact Statement for the Independent Assessment, as it incorporates the financial impact of requiring the developmental screen for all DDTCS/CHMS beneficiaries.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 20-76-201, the Department of Human Services ("the Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. *See* Ark. Code Ann. § 20-76-201(1). The Department shall also make rules and regulations and take actions as are necessary or desirable to carry out the provisions of Title 20, Chapter 76, Public Assistance Generally, of the Arkansas Code. *See* Ark. Code Ann. § 20-76-201(12).

EXHIBIT G

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

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Developmental Disabilities Services

DIVISION DIRECTOR Melissa Stone

CONTACT PERSON Elizabeth Pitman

ADDRESS P.O. Box 1437, Slot N502

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

NAME OF PRESENTER AT COMMITTEE MEETING Melissa Stone

PRESENTER E-MAIL Melissa.stone@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?

CHMS Medicaid Provider manual, DDTCS Medicaid Provider manual, CHMS State Plan Amendments, DDTCS State Plan Amendments, DDS Standards for Certification, Investigation, and Monitoring

2. What is the subject of the proposed rule?

Modify and update all of the aforementioned manuals and the State Plan to require beneficiaries undergo an independent developmental scree. The eligibility requirements were also modified to require eligibility be based on the developmental screen.

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.

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. _____

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. _____

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. § 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? The purpose is to modify the manuals, certification standards, and State Plan to incorporate the independent developmental screen.

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). http://humanservices.arkansas.gov/ddds/Pages/default.aspx

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

Date: August 8, 2017
Time: 4:30 p.m.
Place: Arkansas Enterprises for the Developmentally Disabled
105 East Roosevelt Road
Little Rock, AR 72206

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
August 11, 2017

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
October 1, 2017

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. Recipients of CHMS and DDTCS services, their parents/guardians, Community Programs, Service Providers, and other interested parties.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Arkansas Department of Human Services

DIVISION Division of Developmental Disabilities Services

PERSON COMPLETING THIS STATEMENT Elizabeth Pitman

TELEPHONE 501-682-4936 **FAX** 501-682-8380 **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 Certification Standards for First Connections

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

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ 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	Total	0

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

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	Total	0

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

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

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

Current Fiscal Year	Next Fiscal Year
$ 0	$ 0

Please see the Financial Impact Statement for the Independent Assessment, as it incorporates the financial impact of requiring the developmental screen for all DDTCS/CHMS beneficiaries.

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.