

TOC required**201.000 Arkansas Independent Assessment (ARIA) System Overview****1-1-24**

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 and for certain populations to establish the per member per month payment to a managed care entity. As such, it assesses an individual's capabilities and limitations in performing activities of daily living, including 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, the independent assessment does not determine whether an individual is Medicaid eligible. 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 through Home and Community-Based Services (HCBS) waivers. It also is 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. It has been phased in over time for 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.

The assessment 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 in-person interview. 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 assessment 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 to ensure consistency and eliminate 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 assessment. [Click here to see an example results packet](#). Individuals can 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 also may 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. DHS and the vendor provide internal quality review of the assessment 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 assessment results determine initial eligibility for services, then are used to inform the amount of services the beneficiary is to receive.

For beneficiaries who receive HCBS services, the assessment results are used to develop the PCSP with the individual Medicaid beneficiary and establishes the per member per month payment to a managed care entity. 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 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 setting;
- 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 the individual's 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

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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 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.

The developmental disabilities screening process will sunset April 1, 2024.

202.000 Assessor Qualifications Overview

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All assessors who perform assessments 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. The ability to request and verify information from individuals being assessed
- C. Culturally sensitive to individuals assessed
- D. The necessary knowledge, skills and abilities to successfully perform and manage 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. Ability to verify the information received from the individual and the individual's family members, caregivers, and/or guardians by cross-referencing all available information

The assessor SHALL NOT be related by blood or marriage to the individual being assessed 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, or benefit financially from the provision of assessed needs.

203.000 Appeals

1-1-24

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://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/>

204.000 Severability

1-1-24

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.

210.100 Referral Process

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Independent assessment 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 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 send it to the vendor for a BH independent assessment
- 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. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete Behavioral

Health reassessments. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

210.200 Assessor Qualifications

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In addition to the qualifications listed in Section 202.000, 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

1-1-24

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 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 aged 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	

		<p>Intervention Score of 3 or 4</p> <p><u>AND</u></p> <p>Frequency Score of 4 or 5 in any ONE of the following Psychosocial Subdomains:</p> <p>Difficulties Regulating Emotions</p> <p>Susceptibility to Victimization</p> <p>Withdrawal</p> <p>Agitation</p> <p>Impulsivity</p> <p>Intrusiveness</p>	
		<u>OR</u>	
		<p>Mental Health Diagnosis Score of 4</p> <p><u>AND</u></p> <p>Intervention Score of 1, 2, 3 or 4</p> <p><u>AND</u></p> <p>Frequency Score of 1, 2, 3, 4 or 5 in the following Psychosocial Subdomain:</p> <p>Psychotic Behaviors</p>	
		<u>OR</u>	
		<p>Mental Health Diagnosis Score of 4</p> <p><u>AND</u></p> <p>Intervention Score of 4</p> <p><u>AND</u></p> <p>Frequency Score of 4 or 5 in the following Psychosocial Subdomain:</p> <p>Manic Behaviors</p>	
		<u>OR</u>	
		<p>Mental Health Diagnosis Score of 4</p> <p><u>AND</u></p> <p>PHQ-9 Score of 3 or 4 (Moderately Severe or Severe Depression)</p> <p><u>OR</u></p> <p>Geriatric Depression Score of 3 (>=10)</p>	

	<u>OR</u>	
	Mental Health Diagnosis Score of 4 <u>AND</u> 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 <u>AND</u> Injurious to Self: Intervention Score of 1, 2 or 3 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Injurious to Self: Intervention Score of 4 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Aggressive Toward Others, Physical: Intervention Score of 1, 2 or 3 <u>AND</u> Frequency Score of 1, 2, 3, 4 or 5	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Aggressive Toward Others, Physical: Intervention Score of 4 <u>AND</u> Frequency Score of 2, 3, 4 or 5
		<u>OR</u>	
		Mental Health Diagnosis Score ≥ 2 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 2, 3, 4, or 5	Mental Health Diagnosis Score ≥ 2 <u>AND</u> Psychotic Behaviors: Intervention Score of 3 or 4 <u>AND</u> Frequency Score of 3, 4 or 5

		in any ONE of the following Psychosocial Subdomains: Aggressive Toward Others, Verbal/Gestural Wandering/Elopement	
		<u>OR</u>	
		Mental Health Diagnosis Score >=2 <u>AND</u> Intervention Score of 2, 3 or 4 <u>AND</u> Frequency Score of 2, 3, 4, or 5 in any ONE of the following Psychosocial Subdomains: Socially Unacceptable Behavior Property Destruction	
		<u>OR</u>	
		Mental Health Diagnosis Score >=2 <u>AND</u> Intervention Score of 3 or 4 <u>AND</u> 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	
		<u>OR</u>	
		Mental Health Diagnosis Score >=2 <u>AND</u> PICA: Intervention Score of 4	

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

210.400**Possible Outcomes****1-1-24**

- 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 began receiving a PMPM that corresponds to the determined rate for the assigned tier.
 - b. The PASSE is responsible for providing care coordination and 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 began receiving a PMPM that corresponds to the determined rate for the assigned tier.
 - b. The PASSE is 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.

220.100 Independent Assessment Referral Process**1-1-24**

- A. Independent assessment referrals are initiated by the DHS 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 ARIA vendor. DDS will make referrals for the following populations:
 - 1. Beneficiaries receiving services under the Community and Employment Supports (CES) 1915(c) Home and Community-Based Services Waiver.
 - 2. Beneficiaries on the CES Waiver waitlist.
 - 3. Beneficiaries applying for or currently living in a private Intermediate Care Facility (ICF) for individuals with intellectual or developmental disabilities.
 - 4. Beneficiaries who are applying for placement at a state-run Human Development Center (HDC).

To continue to receive services within these populations, all individuals referred must undergo an independent assessment annually. A reassessment will be completed by staff employed by the independent assessment contractor utilizing the current approved assessment instrument (ARIA), which was approved prior to April 1, 2021, to assess functional need. An interview will be conducted in person for initial assessments, with the option of using telemedicine to complete reassessments for members with intellectual or developmental disabilities. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

- 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 only will be assessed or reassessed if they are seeking transition into the community.

220.200 Assessor Qualifications**1-1-24**

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**1-1-24**

- 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:
- Safety: Your ability to remain safe and out of harm's way
 - Behavior: Behaviors that could place you or others in harm's way
 - Self-Care: Your ability to take care of yourself, such as 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
<p><u>Safety Level High</u></p> <p>A. Self-Preservation Score > = 4 <u>AND</u></p> <p>B. Caregiving Capacity/Risk Score > = 6 <u>AND</u></p> <p>C. Caregiving/Natural Supports Score > = 6 <u>AND</u></p> <p>D. Mental Status Evaluation Score (in the home) = 3 or 4 <u>AND</u></p> <p>E. Mental Status Evaluation Score (in the community) = 2</p>	<p>A. Self-Preservation Score > = 16 <u>AND</u></p> <p>B. Caregiving Capacity/Risk Score = 11 <u>AND</u></p> <p>C. Caregiving/Natural Supports Score of = 7 <u>AND</u></p> <p>D. Mental Status Evaluation Score (in the home) Score = 5 <u>AND</u></p> <p>E. Mental Status Evaluation Score (in the community) Score = 3</p>
<p><u>Safety Level Medium</u></p> <p>A. Self-Preservation Score > = 4 <u>AND</u></p> <p>B. Caregiving Capacity/Risk Score > = 6 <u>AND</u></p> <p>C. Caregiving/Natural Supports Score > = 6 <u>AND</u></p> <p>D. Mental Status Evaluation Score (in the home) = 2 <u>AND</u></p> <p>E. Mental Status Evaluation Score (in the community) = 2</p>	
<p><u>Safety Level Low</u></p> <p>A. Self-Preservation Score > = 4 <u>AND</u></p> <p>B. Caregiving Capacity/Risk Score > = 6</p>	

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

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

<p>Withdrawal</p> <p>C. <u>AND</u> at least one of the following scores:</p> <p>Caregiving Capacity/Risk Score of ≤ 8</p> <p>Caregiving/Natural Supports Score of ≤ 3</p>	
<p><u>Self-Care Level High</u></p> <p>A. Neurodevelopmental Score of 2</p> <p><u>AND</u></p> <p>B. <u>Scores within stated range in at least THREE of any of the following:</u></p> <ol style="list-style-type: none"> 1. <i>ADL's</i>: <ul style="list-style-type: none"> 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. <i>Functional Communication</i>: <ul style="list-style-type: none"> Score of 2 or 3 in Functional Communication 3. <i>IADLs</i>: <ul style="list-style-type: none"> Score of 3 in any of the following IADLs (Meal Preparation, Housekeeping, Finances, Shopping) 4. <i>Safety</i>: <ul style="list-style-type: none"> Self-Preservation Score of ≥ 4 <p><u>AND</u> a score in at least one of the following areas:</p> <p>Caregiving Capacity/Risk Score of ≥ 9</p> <p>Caregiving/Natural Supports Score of ≥ 4</p> <p>Treatment/Monitoring Score of at least 2</p>	<p><u>Self-Care Level High</u></p> <p>A. Neurodevelopmental Score of 2</p> <p><u>AND</u></p> <p>B. Treatments/Monitoring Score of at least 2</p> <p>C. <u>AND</u> at least one of the following scores:</p> <p>Caregiving Capacity/Risk Score ≥ 10</p> <p>Caregiving/Natural Supports Score of ≥ 7</p>
<p><u>Self-Care Level Medium</u></p> <p>A. Neurodevelopmental Score of 2</p> <p><u>AND</u></p> <p>B. <u>Scores within stated range in at least THREE of any of the following:</u></p> <ol style="list-style-type: none"> 1. <i>ADLs</i>: <ul style="list-style-type: none"> Score of 1-11 in Eating 	

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

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.

220.310 Possible Outcomes**1-1-24**

- 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 began receiving a PMPM that corresponds to the determined rate for the assigned tier.
2. The PASSE is 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 began receiving a PMPM that corresponds to the determined rate for the assigned tier.
 - ii. The PASSE is 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, if deemed appropriate and an appropriate bed is available.
 - 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.

220.410 Battelle Developmental Inventory Screen**1-1-24**

- 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 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 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 220.200 and undergo training specific to administering the tool.

220.500**Complex Care****1-1-24****220.600****Referral Process****1-1-24**

Once a member is attributed to a PASSE, DHS may initiate a referral for a member to get a complex care assessment that will determine whether the member is eligible for Complex Care services. A PASSE member may be considered for the Complex Care if the member has been assessed or re-assessed as Tier 2 or 3 and if:

- A. A member has an intellectual/developmental disability AND a behavioral health need OR
- B. A member requires a higher level of care coordination and services due to court involvement OR
- C. A member's behavioral health needs are complex.

To continue to receive Complex Care services, members must receive a complex care assessment annually and be assessed as needing Complex Care services. A reassessment will be completed by appropriate DHS-approved staff using the appropriate Complex Care assessment tool. If a member does not meet the need for Complex Care services, the member will be placed back in Tier 3. An in-person interview will be conducted for initial assessments, with the option of using telemedicine to complete reassessments for members who meet the criteria for Complex Care. The telemedicine tool must meet the 1915(i) requirement for the use of telemedicine under 42 CFR 441.720 (a)(1)(i)(A) through (C).

220.700**Assessor Qualifications****1-1-24**

In addition to the qualifications listed in Section 202.000, Complex Care assessors must have a four (4) year bachelor's degree or be a Registered Nurse with at least one year of mental health experience.

230.100**Referral Process****1-1-24**

Independent assessment 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 do not require a personal care assessment to continue services. Requests for functional assessment shall be transmitted to 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:

- A. Finalize a referral and send it to the vendor for a PC independent assessment, or

- B. Provide notification to the requesting entity that more information is needed, and that the PC provider may resubmit the request with the additional information, or
- C. Provide notification to the requesting entity that 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.

Reassessments must be conducted in person or by telemedicine and occur annually but may occur more frequently if a change of circumstances necessitates such.

230.200 Assessor Qualifications

1-1-24

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

1-1-24

- A. Tier Definitions:
 - 1. Tier 0 means you did not score high enough in any of the activities of daily living (ADLs) such as eating, bathing, or 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 ADLs such as eating, bathing, toileting, to be eligible for the state's Personal Care services. A Tier 1 means that you need "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

1-1-24

Upon successful completion of an assessment, 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 assessment 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 assessment is not used to assign clients to a PASSE.

TOC not required**222.800 Schedule for Preventive Health Screens****1-1-24**

The ARKids First – B periodic screening schedule follows the guidelines for the EPSDT screening schedule and is updated in accordance with the recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. One visit per birth year for children ages 3 years through 18 years.

Age

3 years	7 years	11 years	15 years
4 years	8 years	12 years	16 years
5 years	9 years	13 years	17 years
6 years	10 years	14 years	18 years

Medical screens for children are required to be performed by the beneficiary's PCP or receive a PCP referral to an authorized Medicaid screening provider. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. [See Section 262.130](#) for procedure codes.

222.820 Infancy (Ages 1–9 Months)**1-1-24**

- A. History (Initial/Interval) to be performed at ages 1, 2, 4, 6, and 9 months.
- B. Measurements to be performed
 - 1. Height and Weight at ages 1, 2, 4, 6, and 9 months.
 - 2. Head Circumference at ages 1, 2, 4, 6, and 9 months.
- C. Sensory Screening, subjective, by history
 - 1. Vision at ages 1, 2, 4, 6, and 9 months.
 - 2. Hearing at ages 1, 2, 4, 6, and 9 months.
- D. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 1, 2, 4, 6, and 9 months; to be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- E. Physical Examination to be performed at ages 1, 2, 4, 6, and 9 months. At each visit, a complete physical examination is essential with the infant totally unclothed.
- F. Procedures - General

These may be modified depending upon the entry point into the schedule and the individual need.

1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluation or at the preferred age of 3-5 days. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
 2. Immunization(s) to be performed at ages 1, 2, 4, 6, and 9 months. Every visit should be an opportunity to update and complete a child's immunizations.
 3. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing of high risk factors.
- G. Other Procedures
1. Lead screening risk assessment to be performed at ages 6 and 9 months. Additionally, screening should be done in accordance with state law where applicable.
 2. Tuberculin surveillance to be performed at ages 1 and 6 months per recommendations of the American Academy of Pediatrics (AAP) Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high risk factors.
- H. Anticipatory Guidance to be performed at ages 1, 2, 4, 6, and 9 months. Age-appropriate discussion and counseling should be an integral part of each visit for care.
1. Injury prevention at ages 1, 2, 4, 6, and 9 months.
 2. Violence prevention at ages 1, 2, 4, 6, and 9 months.
 3. Sleep positioning counseling at ages 1, 2, 4, and 6 months. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS.
 4. Nutrition counseling at ages 1, 2, 4, 6, and 9 months. Age-appropriate nutrition counseling should be an integral part of each visit.
- I. Oral Health risk assessment: The Bright Futures/AAP "Recommendation for Preventative Pediatric Health Care," (i.e. Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. [View the Bright/AAP Periodicity Schedule.](#)
- Subsequent examinations should be completed as prescribed by the child's dentist and recommended by the Child Health Services (EPSDT) dental schedule.
- J. One (1) Developmental Screen to be performed before age 12 months using a validated tool recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. [View the Bright/AAP Periodicity Schedule.](#) Children may not receive more than one screen without an extension of benefits.

222.830 Early Childhood (Ages 12 Months–4 Years)

1-1-24

- A. History (Initial/Interval) to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
- B. Measurements to be performed
1. Height and Weight at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
 2. Head Circumference at ages 12, 15, 18, and 24 months.

3. Blood Pressure at ages 30 months*, 3 and 4 years.
*Note: For infants and children with specific risk conditions.
4. BMI (Body Mass Index) at ages 24 and 30 months, 3 and 4 years.
- C. Sensory Screening, subjective, by history
 1. Vision at ages 12, 15, 18, 24, and 30 months
 2. Hearing at ages 12, 15, 18, 24, and 30 months and age 3 years.
- D. Sensory Screening, objective, by a standard testing method
 1. Vision at ages 3 and 4 years. Note: If the 3-year-old patient is uncooperative, re-screen within 6 months.
 2. Hearing at age 4 years.
- E. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- F. Physical Examination to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. At each visit, a complete physical examination is essential, with the infant totally unclothed or with the older child undressed and suitably draped.
- G. Procedures – General

These may be modified depending upon the entry point into the schedule and the individual need.

 1. Immunization(s) to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. Every visit should be an opportunity to update and complete a child's immunizations.
 2. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing and follow up action if high risk to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
- H. Other Procedures

Testing should be done upon recognition of high-risk factors.

 1. Lead screening risk assessment to be performed at ages 12 and 24 months. Additionally, screening should be done in accordance with state law where applicable, with appropriate action to follow if high risk positive.
 2. Tuberculin test to be performed at ages 12 and 24 months and ages 3 and 4 years. Testing should be done upon recognition of high-risk factors per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
 3. Risk Assessment for Hyperlipidemia to be performed at ages 24 months and 4 years with fasting screen, if family history cannot be ascertained, and other risk factors are present, screening should be at the discretion of the physician.
- I. Anticipatory Guidance to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.
 1. Injury prevention to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years.

2. Violence prevention to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years.
 3. Nutrition counseling to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. Age-appropriate nutrition counseling should be an integral part of each visit.
- J. Oral Health Risk assessment: The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. [View the Bright/AAP Periodicity Schedule.](#)
- Subsequent examinations should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.
- K. Two (2) Developmental Screens to be performed no more than once per year between the ages of 13 to 48 months using validated tools recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. [View the Bright/AAP Periodicity Schedule.](#) Children may not receive more than one screen per twelve month period and no more than two screens without an extension of benefits.
- L. Autism Screen to be performed at age 18 and 24 months (or 30 months if screen was not completed at 24 months) using a standardized tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) or the Pervasive Developmental Disorders Screening Tests-II (PDDSDT-II) Stage1. Any additional test must be approved by DMS prior to use.

TOC not required**215.100 Schedule for Child Health Services (EPSDT) Medical/Periodicity Screening****1-1-24**

The periodic EPSDT screening schedule has been changed in accordance with the most recent recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. One visit per birth year for children ages 3 years through 20 years.

Age

3 years	8 years	13 years	18 years
4 years	9 years	14 years	19 years
5 years	10 years	15 years	20 years
6 years	11 years	16 years	
7 years	12 years	17 years	

Most medical and hearing screens for children require a PCP referral before the screens may occur. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. See [Section 242.100](#) for procedure codes.

215.310 Infancy (Ages 1–9 months)**1-1-24**

- A. History (Initial/Interval) to be performed at ages 1, 2, 4, 6, and 9 months.
- B. Measurements to be performed
 1. Height and Weight at ages 1, 2, 4, 6, and 9 months.
 2. Head Circumference at ages 1, 2, 4, 6, and 9 months.
- C. Sensory Screening, subjective, by history
 1. Vision at ages 1, 2, 4, 6, and 9 months.
 2. Hearing at ages 1, 2, 4, 6, and 9 months.
- D. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 1, 2, 4, 6, and 9 months. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- E. Physical Examination to be performed at ages 1, 2, 4, 6, and 9 months. At each visit, a complete physical examination is essential with the infant totally unclothed.
- F. Procedures - General

These may be modified depending upon the entry point into the schedule and the individual need.

1. Hereditary/Metabolic Screening to be performed at age 1 month, if not performed either during the newborn evaluation or at the preferred age of 3-5 days. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
2. Immunization(s) to be performed at ages 1, 2, 4, 6, and 9 months. Every visit should be an opportunity to update and complete a child's immunizations.
3. Hematocrit or Hemoglobin risk assessment at age 4 months with appropriate testing of high risk factors.

G. Other Procedures

1. Lead screening risk assessment to be performed at ages 6 and 9 months. Additionally, screening should be done in accordance with state law where applicable.
2. Tuberculin surveillance to be performed at ages 1 and 6 months per recommendations of the American Academy of Pediatrics (AAP) Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high risk factors.

H. Anticipatory Guidance to be performed at ages 1, 2, 4, 6, and 9 months. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention at ages 1, 2, 4, 6, and 9 months.
2. Violence prevention at ages 1, 2, 4, 6, and 9 months.
3. Sleep positioning counseling at ages 1, 2, 4, and 6 months. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS.
4. Nutrition counseling at ages 1, 2, 4, 6, and 9 months. Age-appropriate nutrition counseling should be an integral part of each visit.

I. Oral Health Risk Assessment:

The Bright Futures/AAP "Recommendation for Preventative Pediatric Health Care," (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. [View the Bright/AAP Periodicity Schedule.](#)

Subsequent examinations should be completed as prescribed by the child's dentist and recommended by the Child Health Services (EPSDT) dental schedule.

J. One (1) Developmental Screen to be performed before age 12 months using a validated tool recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. [View the Bright/AAP Periodicity Schedule.](#)

215.320 Early Childhood (Ages 12 months–4 years)

1-1-24

- A. History (Initial/Interval) to be performed at ages 12, 15, 18, 24, and 30* months and ages 3 and 4 years.
- B. Measurements to be performed
1. Height and Weight at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.

2. Head Circumference at ages 12, 15, 18, and 24 months.
 3. Blood Pressure at 30 months* and ages 3 and 4 years
* Note for infants and children with specific risk conditions.
 4. BMI (Body Mass Index) at ages 24 and 30 months, and ages 3 and 4 years.
- C. Sensory Screening, subjective, by history
1. Vision at ages 12, 15, 18, 24, and 30 months
 2. Hearing at ages 12, 15, 18, 24, and 30 months and age 3 years.
- D. Sensory Screening, objective, by a standard testing method
1. Vision at ages 3 and 4 years. Note: If the 3-year-old patient is uncooperative, re-screen within 6 months.
 2. Hearing at age 4 years.
- E. Developmental/Surveillance and Psychosocial Behavioral Assessment to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
- F. Physical Examination to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. At each visit, a complete physical examination is essential, with the infant totally unclothed or with the older child undressed and suitably draped.
- G. Procedures – General
- These may be modified depending upon the entry point into the schedule and the individual need.
1. Immunization(s) to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. Every visit should be an opportunity to update and complete a child's immunizations.
 2. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing and follow up action if high risk to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
- H. Other Procedures
- Testing should be done upon recognition of high-risk factors.
1. Lead screening risk assessment to be performed at ages 12 and 24 months. Additionally, screening should be done in accordance with state law where applicable, with appropriate action to follow if high risk positive.
 2. Tuberculin test to be performed at ages 12 and 24 months and ages 3 and 4 years. Testing should be done upon recognition of high-risk factors per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
 3. Risk Assessment for Hyperlipidemia to be performed at ages 24 months and 4 years with fasting screen. If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
- I. Anticipatory Guidance to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.
2. Violence prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.
3. Nutrition counseling to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. Age-appropriate nutrition counseling should be an integral part of each visit.

J. Oral Health Risk Assessment:

The Bright Futures/AAP “Recommendation for Preventative Pediatric Health Care,” (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. [View the Bright/AAP Periodicity Schedule.](#)

Subsequent examinations should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.

- K. Two (2) Developmental Screens to be performed no more than once per year between the ages 13 months and 48 months using validated tools recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule [View the Bright/AAP Periodicity Schedule.](#)
- L. Autism Screen to be performed at ages 18 and 24 months (or 30 months if screen was not completed at 24 months) using a standardized tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) or the Pervasive Developmental Disorders Screening Tests-II (PDDSDT-II) Stage1. Any additional test must be approved by DMS prior to use.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT _____
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **EMAIL** _____

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE _____

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 no, please explain:

(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 reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

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

Current Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
 Federal Funds _____
 Cash Funds _____
 Special Revenue _____
 Other (Identify) _____

Total _____

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

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

6. What is the total estimated cost by fiscal year to a state, county, or 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

\$ _____

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; **The Division of Medical Services (DMS) is adding a requirement to EPSDT for primary care providers (PCPs) to perform a developmental screening for children based upon the American Academy of Pediatrics (AAP) guidelines in alignment with the Bright Futures Periodicity Schedule; updating the ARKids First-B manual to indicate the use of the Bright Futures Periodicity Schedules and American Academy of Pediatrics guidelines; and updating the Arkansas Independent Assessment (ARIA) manual to capture current assessment and referral requirements..**

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute; **Adding the developmental screen will enhance early identification of developmental needs for children and increase the quality of referrals for specialized services.**

(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; **N/A**

(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; **N/A**

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

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

(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. **The Agency monitors State and Federal rules and policies for opportunities to reduce and control cost.**