NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. Sections Affected **Rulemaking Action**

R9-28-301	Amend
R9-28-303	Amend
R9-28-305	Amend

2. The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statute: A.R.S. § 36-2932

Implementing statute: A.R.S. § 36-2936

3. The effective date of the rules:

The rules are effective 60 days from date of filing with the Secretary of State.

4. A list of all previous notices appearing in the *Register* addressing the final rules:

Notice of Docket Opening: 16 A.A.R. 1810, September 10, 2010

Notice of Proposed Rulemaking: 16 A.A.R. 1798, September 10, 2010

Notice of Public Information: 16 A.A.R. 1811, September 10, 2010

5. The name and address of agency personnel with whom persons may communicate regarding the rulemaking:

Name: Mariaelena Ugarte

Address: AHCCCS

Office of Administrative Legal Services

701 E. Jefferson, Mail Drop 6200

Phoenix, AZ 85034

Telephone: (602) 417-4693

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule:

The AHCCCS Administration has reviewed the validity of the PAS tools used to evaluate an individual's medical and functional eligibility for the ALTCS Program. Under the terms of the AZ demonstration project under section 1115 of the Social Security Act coverage for long term care services are limited to persons who require an institutional level of care or who are at immediate risk of institutionalization. Under federal law and the terms of the demonstration project "institutions" mean a licensed nursing facility or an intermediate care facility for the mentally retarded. The PAS tool described in this rule is the means by which AHCCCS ensures that the federal standard is met. The PAS tools are intended to reflect the current consensus of the medical community and experts in developmental disability on best practices for reliably assessing the need for institutional care. As the opinion of those experts advance, the PAS tools should be updated to reflect the new consensus. A decision was made last year to update and revise the PAS tool used for children with developmental disabilities under age six. The new tool has been developed and piloted and is now being finalized. The developmental evaluation in the tool has been expanded and updated. Developmental items used in the tool are based on questions from several standardized, up-to-date and commonly accepted assessment tools. The tool has been piloted in-house and the analysis for a new scoring methodology has been completed. Because the current rules very specifically describe the elements and scoring routine of the current PAS tools, it is necessary to update the rules.

The new PAS tool incorporates the following: use of a new scoring algorithm with age-specific weights, greater use of developmental milestones with new milestones added at more frequent age-intervals, use of age-appropriate developmental milestones in place of adult oriented variables, updated weights for variables from the previous PAS instruments, and new variables that recognize behaviors or developmental delays related to autism spectrum disorder.

7. A reference to any study relevant to the rule that the agency reviewed and either relied on in its evaluation of or justification for the rule or did not rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:

AHCCCS/ALTCS retained a PAS consultant, Andrew Cohen from Pacific Health Policy Group, and convened a panel of experts to update and revise the PAS tool for children with developmental disabilities under six years of age. The standard for establishing medical and functional eligibility for ALTCS continues to be the immediate need for institutional level of care in a nursing home or intermediate care facility for the mentally retarded. The process for revision of the PAS tool for this population included data collection, reliability analysis and development of a scoring algorithm. The details of this process are described in development documents which can be made available upon request.

8. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable

9. The summary of the economic, small business, and consumer impact:

Using the current PAS tool for this population, the Agency has costs associated with misclassified applicants, as there is a potential for approval of young children who do not require an institutional level of care. The average capitation for an ALTCS case is $3682/month.

There are also costs associated with the number of cases requiring physician review to insure that children who require an institutional level of care are approved for ALTCS benefits. Because of improvements in classification using the new tool, it is projected that cases requiring physician review may be reduced by as much as 31%, resulting in a potential annual savings of $31,950.

AHCCCS has spent $ 242,435 for the development of the new PAS tool for children with developmental disabilities who are under age six. The tool was developed using an outside consultant as well as internal and external experts in child development and disability.

With the implementation of the revised PAS tools for this population, the integrity of the PAS eligibility process will be maintained. The increase in the number and quality of developmental questions on the tool, as compared to the current tool, gives a more thorough and accurate evaluation of a child with a developmental disability. Children applying for long-term care benefits using the new PAS tool will receive a medical eligibility determination that corresponds to the current consensus of the medical community and expertise in the field. The State will potentially save money on capitation for children who do not require care at an institutional level. The PAS process will also be easier for families with children requiring care, as the new assessment is easier to understand and easier for staff to administer.

10. A description of the changes between the proposed rules, including supplemental notices, and final rules (if applicable):

No significant changes have been made between the proposed rules and the final rules. The Administration made the rules more clear, concise, and understandable by making grammatical, verb tense, punctuation, and structural changes throughout the rules.

11. A summary of the comments made regarding the rule and the agency response to them:

The Administration received the following comments regarding the rules:

Item #	Rule Cite Line #	Comment From	Comment	Analysis/ Recommendation
1.		Janet Kirwan SW Autism Research Center	Concern with piece addressing Autism, in the past there were no points for autism only for the other three developmental diagnosis that were allowable for application. My concern now is that it is still requiring children with autism meet a further set of criteria and not just the diagnosis as they do for the points in cerebral palsy, mental retardation and for epilepsy, those points are granted based on their diagnosis. There is a further scrutiny for children with autism; my concern is about some of the questions, in particular the autism behavior questions. How were those criteria reached? The fact that we have the drop of the children that fall in the 18 month to 13 month group, the number of children who are eligible using the new PAS tool, you said were going to probably be offset by the number of children who were going to be eligible in the system prior to 12 months. Very few of our children with autism will be on the radar and applying for services under 12 months. Just during that period where our children are most likely to be identified and the parents would be looking for services is the area where there is a drop.	The scoring algorithm for the draft revised tool was developed through a statistical analysis of data collected on 770 children. The purpose of the analysis was to identify the appropriate combination of variables for determining whether a child meets the federal standard of eligibility. The variables coupling Autism Spectrum Disorder with developmental milestones and behaviors were constructed as part of this process. The variables were reviewed for reasonableness by developmental pediatricians before being included in the algorithm. The PAS tool assesses multiple criteria, such as medical, functional, and developmental factors, to determine whether an individual has a non-psychiatric medical condition or a developmental disability, by itself or in combination with other medical conditions, requiring an institutional level of care. Therefore, a combination of factors is evaluated under the PAS instrument, and the outcome is specific to the unique condition of the individual. A specific diagnosis alone does not necessarily correspond with an institutional level of care. The federal standards for receipt of long term care services, including HCBS, are set forth in the Terms and Conditions of AHCCCS Demonstration Project approved under Section 1115 of the SSA. See also A.R.S. 36-2936 Subsection A. While the ALTCS program is not based on a waiver under 42 USC 1396 n(c) or (d), those waivers have the same standard.
2.		Maureen Casey	How are you determining or defining moderate versus severe versus profound mental retardation?	AHCCCS relies on the child's available medical records for the diagnoses.

			The tools are not that precise for children under age six for IQ, in the way you are using specific things for children with autism and behavior, etc. I would suggest that needs to be looked at for kids you are deeming cognitively impaired. It is interesting that cognition is not listed as one of the specific domains, so I am unsure if they are being caught up in the developmental milestones. As for IQ testing the tools are not that precise for children under the age of six, I caution you to look at that. We are clearly concerned about a group of kids that we have historically not captured accurately and we are also aware of another group of kids that are having as much difficulty getting in, children with down syndrome, children with cardio facial syndrome, lots of kids with cognitive impairment are also not getting inside the system under age five. We as a state are deciding that for children under the age of three we are going to make changes about how we are providing those services and how we are paying for those services and we wouldn't want to leave those kids behind. Will there be training for screeners, support coordinators, and the advocates to attend once this is put together so we can have an accurate picture of what folks can expect and respond to parent concerns? I ask that AZEP is a part of this, because some of those kids that we determine as AZEP only and are not accurately moved over to DD stay in AZEP up to age three then pop up in DD at age six. We want to make sure that we capture all the kids that need to be provided services.	When the PAS revision is finalized and implemented, AHCCCS will provide extensive training to its staff including PAS Assessors and physician consultants. In addition, AHCCCS will provide training to designated DES DDD staff, who will then provide direct training to its staff. As in the past, AHCCCS will provide an overview of the ALTCS eligibility criteria including the PAS for external groups upon request and as resources allow.
3.		Kristina Park (would like a response to her comments)	Some of my concerns about the PAS, <u>is the vagueness of some of the questions as it stood in the past.</u> One of the questions asks if a child can take off their shoes and pants. Here in AZ many children wear sandals, flip flops. Developmentally there is a big difference between sneakers versus flip flops. Many of the families going through trying to answer the questions do not think about it in a developmentally form, they try to answer the questions correctly. I have noticed that from going through this and helping other parents that this is an emotionally and rough process since you must think and admit that you cannot control your child or child cannot do many things. You cannot focus on the positives that get you through day to day. In this process you have to be willing to	The draft revised tool contains 101 developmental milestones, versus 50 on the existing tools. The revised and expanded milestones were selected in part for their precision and clarity. Many were based on questions from nationally-recognized and validated instruments. During the pilot study conducted on 770 children, parents/caregivers were able to compare the current and revised tools. All of the parents/caregivers who expressed an opinion preferred the revised tool over the current instrument.

			put everything on the table to a complete stranger since that is how you can get fair assessment of your child. When you are asked can your child take their shoes off, you need to ask what does this mean? Is it a shoe with laces, without, with Velcro? This is a very broad range. Many parents often assume that their child can do this but they can't. So many times we need to understand that the question you are asking is what actually represents what our child is capable of as well as what do you mean by this when you ask this. There is a particular question, "Can a child turn pages?" and further asks "Can a child turn one page?", but it needs to explain if its a paper page or cardboard page. Many of these families have to let their children get worse before they can qualify for services. I am concerned that the part that you are keeping the same also needs to be reviewed. I am concerned whether it really is objective. There are many kids that rely on us and most of the people that this affects do not know about this meeting, or do not have access getting to places like this. It's a big burden. I'm not seeing a lot of families here which concerns me; because every single family I have come in contact with this process has been a major stumbling block. I want you to think about this as part of my information sharing with you. Written comment: PAS Tool review of questions need clarification: Question #8, two or more emotions (non-emotion = not emotion) Question #16, five examples of babble Question #25, when playing with sounds, does your child make grunting, growling or deep-toned sounds? Question #32, cloth, board, paper book – different developmental developments. Question #34, stack blocks (can you model?) Question #42, interest in other children? (don't understand) Question #54, play near other children? Child gets overwhelmed. Question #68, Paper pages? Question #78, Stuffs mouth – as example Question #94, gross versus fine skills, explain lever vs. know doors to be opened Wonderful changes: Question #18, Patta cake! Question #26, coo, laugh, pleasurable sounds! be cautious to indicate that	Extensive training, including refresher training, is provided to all PAS Assessors. Refresher training is based on results of ongoing quality control reviews conducted on completed PAS. Quality control reviews will be increased following implementation of changes to the PAS tool to ensure thorough understanding and proper use of the tool. Assessors are specifically trained to elicit accurate information regarding performance and behaviors, while understanding how difficult this can be for families. The examples provided in the written comment will be considered for use in training.

			it is not when tickled. Question #53, copy activities! Question #62, Sleep less than 8 hours, be cautious to indicate trying to sleep 2-3 hours. Question #85 ! in, on, under.	
4.		Chris Smith SW Research Center (would like a response to comments)	Why is there the additional threshold for individuals with an autism spectrum, to have a diagnosis and then also meet the criteria of specific items from the tool? What is the rationale behind that? In addition to autism, the diagnostic information needs to be enhanced by a score of specific items in the critical. You stated in the presentation that you believed that the effects would be neutral on the targeted population, how do you feel that this will allow more children to be in the system that need to be in the system if the effect is neutral?	The scoring algorithm for the draft revised tool was developed through a statistical analysis of data collected on 770 children. The purpose of the analysis was to identify the appropriate combination of variables for determining whether a child meets the federal standard of eligibility. The variables coupling Autism Spectrum Disorder with developmental milestones and behaviors were constructed as part of this process. The variables were reviewed for reasonableness by developmental pediatricians before being included in the algorithm. An analysis of the projected impact of the revised tool found that it would be neutral at the program level in year 1. The analysis also found variation within specific age cohorts, with a projected increase in eligibility by score for children under 12 months of age and 48 months and older, and a decrease in children 36 – 47 months. Over time, the net result at the program level may be an increase in eligible customers, as larger numbers of young children continue to enter and remain in the program. Please see the response to Item #1. Also, please note that applicants are not required to accrue points from specific

			Written comment received by 5pm 10/12/10: As a result of the public hearing regarding the PAS revisions, please accept the following comments for public record: The federal standard for coverage is an accrual of 40 points on the PAS tool. Cerebral Palsy, Epilepsy, Mental Retardation, and autism spectrum disorders all get baseline point values for meeting criteria for the diagnosis. According to the guidelines of the revised PAS tool to qualify for coverage by AHCCCS an individual who has met criteria for an autism spectrum disorder and accrues 40 points on the PAS tool (meeting the federal standard) must also have accrued points from specific items in the PAS. Why is this additional requirement necessary before becoming eligible for coverage from AHCCCS? These criteria become particularly problematic for the Autism + Behaviors, Children 30 to 35 months category. Children in this category need to exhibit an additional three out of four behaviors and the behaviors are not consistent with current diagnostic criteria for autism. Thus, very impaired children with autism, who will meet the federal standard of 40 points, require institutionalization (either in a facility or a home), who do not exhibit these behaviors will not be eligible for coverage. These items were selected because they were strongly correlated with autism in the pilot study, but correlation does not explain causation (of severity, in this case). The purpose and implications of the selected of correlated items is unclear. We suggest removing the additional item requirements beyond the criteria for the federal standard of 40 points on the PAS tool. Additionally, because the deficits associated with an early identification of autism spectrum disorder can be subtle at first (and then lead to greater impairments) we suggest that PAS assessors have some basic training or education specifically on the presentation of early warning signs for autism. We believe this is imperative because of the reorganization of the items in the PAS tool, it appears and your data show, that it may be more difficult for younger children with an autism spectrum disorder to meet the federal standard for coverage.	items in order to meet the eligibility standard, but only to accrue 40 or more points from any combination of algorithm variables in order to be found eligible by score. In addition, physician review is completed on cases scoring below the threshold as described in rule. Neither the pilot study nor the final PAS tool were designed or intended to establish a correlation between specific behaviors and any particular diagnosis. The pilot study and the PAS tool are designed to establish a correlation between functional abilities and the immediate risk of institutionalization. Information about the different developmental disabilities is covered in PAS assessor training. To clarify, PAS assessors are identifying children who

				require an institutional level of care; they are not assessing for early warning signs of any particular condition, which would not indicate an institutional level of care. (also referred to as immediate risk for institutionalization.)
5.		Leighssa Pearson-Dobrosky Health Group	My concern when we have questions that are yes or no questions that are procedural, and I have a child that can do three out of six or two out of eight, mom or dad might say the child can perform toiletry skills, is the assessor going to come in and say can he do this independently? Can we get these questions more broken down, such as Can he pull up his pants? Can he pull down his pants? Can he do his fasteners? Etc. We have a very long chain of behaviors that are needed to do something that is procedural. A yes or no is not specific enough for something that needs to be broken down. Another concern is the number of words that a child may have. A child may have 150-200 words that are all objects, but they cannot tell you what they are for, color, what to do with them, can't ask for them, and some of the more important phrases missed are "I am hungry", "I am tired", "I am in pain". So if we can break things down more to ensure they have functional communication, such as, can they request things, comment, ask questions, may be more helpful to assess the child.	Please see the response to Item #3. As indicated, the revised tool strives to be precise in its wording and does seek to break tasks into discrete steps. For example, the current PAS asks a single question, "Does s/he remove her/his own shoes and pants?" The revised tool asks, "Does your child pull up clothing with elastic waistbands (for example underwear or sweatpants)?" and "Does your child put shoes on correct feet (does not need to tie laces)?"
			Written Comments	
6.		De Freedman	I respectfully submit my comments to the 2010 proposed PAS Tool revision: As a taxpayer who just spent 8 months volunteering as a member of the AZ DDD Sustainability Workgroup at the request of AZ DES Director Neal Young, I am dismayed at the secretive process used by AHCCCS to create these proposed state rule changes that amend the current PAS Tool. AHCCCS employees Alan Schafer and Theresa Gonzales also were members of the DDD Sustainability Workgroup and were present, if my memory serves correctly, on more than one occasion when amending the current PAS Tool for children with developmental disabilities during a few meetings of the DDD Sustainability Workgroup was discussed. It was the group consensus, based upon prior conversations with AHCCCS employees and the contributions of Alan Schafer and Theresa Gonzales when present, that the only known way to amend the PAS Tool was by legislation which is not politically feasible at this time. For that reason, revision of the PAS Tool was not discussed extensively by the DDD Sustainability Workgroup nor were any recommendations made in our report to Neal Young even though it was	The rulemaking has been conducted consistent with all the notice and publication requirements of state law. AHCCCS notified a list of interested parties and other DD advocacy groups of the proposed regulation by email. In addition the proposed regulation was posted on the agency's internet website to inform the public of the proposed rule. While the standard for eligibility has not changed, the PAS

			the consensus of the DDD Sustainability Workgroup that the current PAS Tool is seriously out of date given what has been learned since 1996 about child development, especially for children zero to three. Never during their time meeting with the DDD Sustainability Workgroup did either Alan Schafer or Theresa Gonzales mention that AHCCCS had been working on revising the PAS Tool since 2009 nor that those revisions would be accomplished by a state rule change. Instead, on September 9, 2010 I received a forwarded email from Mariaelena Ugarte of AHCCCS sent to another member of the DDD Sustainability Workgroup announcing the AHCCCS PAS Tool revision to be accomplished by proposed State rule change. It is my understanding that not only were no DES/DDD employees (nor any other DES employees) involved in the AHCCCS PAS Tool Revision Project, but that they were as surprised as I was to learn that AHCCCS had been working on this project since 2009. I do not understand why no DDD employees, those AZ state employees who best know what should be included in the PAS Tool because they actually are the individuals responsible for overseeing the AZ state services and therapies for children with developmental disabilities, were never consulted. It is my understanding that not even DDD Medical Director Robert Klaehn, MD, was consulted. As the parent of a nine year old child with autism who has qualified for ALTCS since September 1, 2003, I know the inadequacies of the ALTCS qualification process including the current PAS Tool because I experienced the process first hand and I have shared experiences with other parents raising children with developmental disabilities, especially autism. I am dismayed that I nor any other AZ taxpayers with similar experiences were never consulted by AHCCCS regarding its PAS Tool Revision Project. As the Secretary of the AZ Autism Coalition (http://www.azautism.org), I would have informed AHCCCS that Coalition members have been studying a PAS Tool revision for the past several years and in fact have a draft proposal that we would gladly share with AHCCCS. Our membership includes over 150 stakeholders of the AZ Autism Community including parents, services providers, university professors, school personnel, psychologists, developmental pediatricians and representatives of ADE, DDD and DHS/BMH, all of whom are eager to share their experience and expertise with AHCCCS, but were never asked.	tool has been updated to improve accuracy, consistency and ease of administration. The DD sustainability workgroup's purpose was unrelated to the ALTCS eligibility process and therefore it would not be an appropriate forum to present the DD PAS tool. This revision to the PAS tool was conducted in the same manner as previous revisions to the tools used for people who are elderly/ physically disabled and those used for people with developmental disabilities. Our consulting physicians, who also practice in the community, are involved in all PAS tool revisions, along with other experts in the particular field, such as, developmental pediatricians that are known locally and nationally. The Administration engaged the services of an independent consultant, Andrew Cohen from Pacific Health Policy

			Upon learning of the AHCCCS PAS Tool Revision Project, I immediately emailed Mariaelena Ugarte of AHCCCS and requested the "the complete development documents including, but not limited to, the data collection, reliability analysis and development of a scoring algorithm for the 2010 proposed PAS Tool revision, notice of which was posted on 9/10/2010 on the AHCCCS website at http://www.azahcccs.gov/reporting/Downloads/ProposedStateRules/NOPRFinal_PAStool.pdf. " I am disappointed with the documentation I received. I still await the ACTUAL (rather than a prepared summary report and powerpoint presentations) "data collection, reliability analysis and development of a scoring algorithm" before I can address whether the 2010 proposed PAS Tool revision is what it claims to be. According to the materials sent to me by Mariaelena Ugarte, AHCCCS did an internal "mini project" of the proposed PAS Tool revision by analyzing six cases. The standard practice for such a project certainly constitutes the review of many more than six cases. It is my experience that nothing conceived in total darkness can be trusted. Forgive me if I am skeptical of the 2010 proposed PAS Tool revision as I have no idea which other state PASSRs were used as models or the identities, let alone qualifications, of the individuals who did the analysis. While I know David Hirsch, MD, and respect him, it is my understanding that his participation in the development and testing of the 2010 proposed PAS Tool revision was finished in 2009 and very limited. I respectfully request that before AHCCCS proceed any further with the 2010 proposed PAS Tool revision AZ stakeholder's be consulted and that that the 2010 proposed PAS Tool revision actually be tested fully, certainly beyond six cases, to show that it will not adversely affect the ALTCS eligibility of AZ children with developmental disabilities. Contrary to AHCCCS claims, it is my experience that the PAS Tool is a very subjective eligibility tool rather than an objective tool. Those of us who have experienced the determination of ALTCS eligibility for our children with developmental disabilities, especially autism, using the PAS Tool are all too aware of the subjectivity of the PAS Tool. Without proper training for AHCCCS personnel that will not change regardless of whether the 2010 proposed PAS Tool revision is a better tool to determine ALTCS eligibility.	Group, to conduct a redesign of the PAS instrument used for children under six, including a survey and analysis of existing valid and reliable tools for assessing functional impairments and input from developmental experts, with the goal of identifying reliable indicia of when a child is at immediate risk of institutionalization. This is a separate question from how best to provide services to children who have been determined to be at immediate risk of institutionalization. Anecdotal information regarding individual children with a developmental disability does not constitute objective statistically valid assessment criteria with respect to the question of whether the child is at risk of immediate institutionalization. The information requested was sent via email multiple times with a separate final request to confirm receipt of the information. The Administration did not receive any indication that the information sent was not received. The specific information on cases cannot be shared under federal and state privacy laws. In a mini pilot eight assessors looked at six cases each for a total of 48 cases in order to refine questions. In addition, in the full pilot at least 18 assessors completed assessments on approximately 770 cases where both the current and new tool were administered to establish the reliability of the new tool. The questions used in the PAS tool are derived from nationally recognized developmental assessment tools, such as, Ages and Stages, Vineland-II, Inventory for Client and Agency Planning (ICAP), Center for Disease Control (CDC) Guidelines, Modified Checklist for Autism in Toddlers (MCHAT). In the Administration's opinion these are the most objective instruments available.
8.		Andrea Ford	In follow up to the hearing today on the PAS proposed (and current) tool,	The objective of the tool is to measure functional

			here are our concerns: 1/ Does not give uniform assessment for all age groups - medical points are different (attainable per age group three to five yr and zero to five are being discriminated against). 2/ Loss of skills is not given points for zero to five age group when they lose previously attained milestones when older (over 12 year old would or adult). 3/ It discriminates on the basis of disability - MR gets medical points and only a special diet gets medical points (for a three to five year old/zero to five year old). Discriminatory on the basis on type of disability. 4/ Waiver 1115 general requirements STC's require the State to comply with ADA and all federal anti-discrimination laws. 5/ EPSDT is not met if young children are found in State screenings to have a developmental disability (eg:autism) and the condition is not treated because they are denied ALTCS for lack of 40 and above points, or, not being considered in the State's opinion to be at immediate risk of institutionalization. Please give our parent advocacy written notice that these comments have been received and will be considered.	limitations as measured against recognized developmental milestones that are tied to these age groups. Regression is captured in the accumulative design of the developmental questions by age groups. Use of the PAS tool does not constitute violation of any discrimination laws. Federal law requires that as a condition of eligibility for the receipt of certain long-term care and Home Community Based Services (HCBS), the administration limit eligibility for those services to persons at immediate risk of institutionalization. Persons at immediate risk of institutionalization require an institutional level of care. The risk of institutionalization is measured by the degree of disability. Use of the PAS tool does not constitute violation of any discrimination laws. The requirements of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program apply to persons under the age of 21 who are determined eligible for title XIX. That EPSDT requirement has no application to the eligibility determination process itself.
9.		Brian Lensch DES	In reviewing the public document there are several places throughout which make reference to individuals as a <u>"disability" rather than "people first"</u> language (person with a disability). R9-28-301 Page 9 "DD" means developmentally disabled: <u>better to state</u> a person with a developmental disability. R9-28-303 Page 11; A.1. "..for a physically disabled applicant or	Disagree with recommended changes due to the existence of the defined term "DD" throughout Chapter 28, not merely in rules R9-28-301, R9-28-303, and R9-28-305. To revise the meaning in the subject rules would create inconsistency with other rules using the terminology.

			member..": better to state "… for an applicant or member with a physical disability…" Page 11: A.1. "… a physically disabled child…" better to state "…a child with a physical disability…" Page 11: A.3. "…an applicant or member who is DD…" better to state "… an applicant or member who has a DD…" This occurs approximately nine times through out the document. Page 12: G.7 & 8 "…applicant or member is a physically disabled child…" better to state " … applicant or member is a child with a physical disability…" R9-28-305 Page 15: C.1.a "Each response is assigned a scored a number of points…." Should revise to read "Each response is assigned a number of points…."	Agreed, recommended change has been made.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable

13. Incorporations by reference and their location in the rules:

Not applicable

14. Was this rule previously adopted as an emergency rule?

No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 3. PREADMISSION SCREENING (PAS)

Section

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 3. PREADMISSION SCREENING (PAS)

R9-28-301. Definitions

A. Common definitions. In addition to definitions contained in A.R.S. Title 36, Chapter 29, and 9 A.A.C. 28, Article 1, the words and phrases in this Article have the following meanings for an individual who is elderly or physically disabled (EPD) or developmentally disabled (DD) unless the context explicitly requires another meaning:

"Applicant" is defined in A.A.C. R9-22-101.

"Assessor" means a social worker as defined in this subsection or a licensed registered nurse (RN) who:

Is employed by the Administration to conduct PAS assessments,

Completes a minimum of 30 hours of classroom training in both EPD and DD PAS for a total of 60 hours, and

Receives intensive oversight and monitoring by the Administration during the first 30 days of employment and ongoing oversight by the Administration during all periods of employment.

"Current" means belonging to the present time.

"Disruptive behavior" means inappropriate behavior by the applicant or member including urinating or defecating in inappropriate places, sexual behavior inappropriate to time, place, or person or excessive whining, crying, or screaming that interferes with an applicant's or member's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.

"Frequency" means the number of times a specific behavior occurs within a specified interval.

"Functional assessment" means an evaluation of information about an applicant's or member's ability to perform activities related to:

Developmental milestones,

Activities of daily living,

Communication, and

Behavior.

"Immediate risk of institutionalization" means the status of an applicant or member under A.R.S. § 36-2934(A)(5) and as specified in A.R.S. § 36-2936 and in the Administration's Section 1115 Waiver with Centers for Medicare and Medicaid Services (CMS).

"Intervention" means therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.

~~"Limited or occasional" means a small portion of an entire task or assistance for the task if the assistance is required less than daily.~~

"Medical assessment" means an evaluation of an applicant's or member's medical condition and the applicant's or member's need for medical services.

"Medical or nursing services and treatments" or "services and treatments" means specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.

~~"Physical participation" means an applicant's or member's active participation.~~

~~"Physically lift" means actively bearing some part of an applicant's or member's weight during movement or activity and excludes bracing or guiding activity.~~

"Physician consultant" means a physician who contracts with the Administration.

"Social worker" means an individual with two years of case management-related experience or a baccalaureate or master's degree in:

Social work,

Rehabilitation,

Counseling,

Education,

Sociology,

Psychology, or

Other closely related field.

"Special diet" means a diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.

"Toileting" means the process involved in an applicant's or member's managing of the elimination of urine and feces in an appropriate place.

"Vision" means the ability to perceive objects with the eyes.

B. EPD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is EPD:

"Aggression" means physically attacking another, including:

Throwing an object,

Punching,

Biting,

Pushing,

Pinching,

Pulling hair,

Scratching, and

Physically threatening behavior.

"Bathing" means the process of washing, rinsing, and drying all parts of the body, including an applicant's or member's ability to transfer to a tub or shower and to obtain bath water and equipment.

"Continence" means the applicant's or member's ability to control the discharge of body waste from bladder and bowel.

"Dressing" means the physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the applicant's or member's ability to put on artificial limbs, braces, and other appliances that are needed daily.

"Eating" means the process of putting food and fluids by any means into the digestive system.

~~"Elderly" means an applicant or member who is age 65 or older.~~

"Emotional and cognitive functioning" means an applicant's or member's orientation and mental state, as evidenced by aggressive, self-injurious, wandering, disruptive, and resistive behaviors.

"EPD" means an applicant or member who is elderly and physically disabled.

"Grooming" means an applicant's or member's process of tending to appearance. Grooming includes: combing or brushing hair; washing face and hands; shaving; oral hygiene (including denture care); and menstrual care. Grooming does not include aesthetics such as styling hair, skin care, nail care, and applying cosmetics.

"Mobility" means the extent of an applicant's or member's purposeful movement within a residential environment.

"Orientation" means an applicant's or member's awareness of self in relation to person, place, and time.

"Physically disabled" means an applicant or member who is determined <u>to be</u> physically impaired by the Administration through the PAS assessment as allowed under the Administration's Section 1115 Waiver with CMS.

"Resistiveness" means inappropriately obstinate and uncooperative behaviors, including passive or active obstinate behaviors, or refusing to participate in self-care or to take necessary medications. Resistiveness does not include difficulties with auditory processing or reasonable expressions of self-advocacy.

"Self-injurious behavior" means repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body.

"Sensory" means of or relating to the senses.

"Transferring" means an applicant's or member's ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.

"Wandering" means an applicant's or member's moving about with no rational purpose and with a tendency to go beyond the physical parameter of the residential environment.

C. DD. In addition to definitions contained in subsection (A), the following also apply to an applicant or member who is DD:

"Acute" means an active medical condition having a sudden onset, lasting a short time, and requiring immediate medical intervention.

"Aggression" means physically attacking another, including:

Throwing objects,

Punching,

Biting,

Pushing,

Pinching,

Pulling hair, and

Scratching.

"Ambulation" means the ability to walk and includes quality of the walking and the degree of independence in walking.

~~"Associating time with an event and an action" means an applicant's or member's ability to associate a regular event with a specific time frame.~~

"Bathing or showering" means an applicant's or member's ability to complete the bathing process including drawing the bath water, washing, rinsing, and drying all parts of the body, and washing the hair.

~~"Caregiver training" means training received by a direct care staff person or caregiver for special health care procedures that are normally performed or monitored by a licensed professional, such as a registered nurse. These procedures may include ostomy care, positioning for medical necessity, use of an adaptive device, or respiratory services such as suctioning or a small volume nebulizer treatment.~~

~~"Chronic" means a medical condition that is always present, occurs periodically, or is marked by a long duration.~~

"Clarity of communication" means an ability to speak in recognizable language or use a formal symbolic substitution, such as American ~~–~~ Sign Language.

~~"Climbing stairs or a ramp" means an applicant's or member's ability to move up and down stairs or a ramp.~~

"Community mobility" means the applicant's or member's ability to move about a neighborhood or community independently, by any mode of transportation.

"Crawling and standing" means an applicant's or member's ability to crawl and stand with or without support.

"DD" means developmentally disabled.

"Developmental milestone" means a measure of an applicant's or member's functional abilities, including:

Fine ~~and gross~~ motor skills,

Gross motor skills,

~~Expressive and receptive language~~ Communication,

~~Social skills~~ Socialization,

~~Self-help skills~~ Daily living skills, and

~~Emotional or affective development~~ Behaviors.

"Dressing" means the ability to put on and remove an article of clothing. Dressing does not include the ability to put on or remove braces nor does it reflect an applicant's or member's ability to match colors or choose clothing appropriate for the weather.

"Eating or drinking" means the process of putting food and fluid by any means into the digestive system.

"Expressive verbal communication" means an applicant's or member's ability to communicate thoughts with words or sounds.

"Food preparation" means the ability to prepare a simple meal including a sandwich, cereal, or a frozen meal.

"Hand use" means the applicant's or member's ability to use both hands, or one hand if an applicant or member has only one hand or has the use of only one hand.

"History" means a medical condition that occurred in the past, regardless of whether the medical condition required treatment in the past, and is not now active.

"Personal hygiene" means the process of tending to one's appearance. Personal hygiene may include: combing or brushing hair, washing face and hands, shaving, performing routine nail care, oral hygiene including denture care, and menstrual care. This does not include aesthetics such as styling hair, skin care, and applying cosmetics.

~~"Physical interruption" means immediate hands-on interaction to stop a behavior.~~

~~"Remembering an instruction and demonstration" means an applicant's or member's ability to recall an instruction or demonstration on how to complete a specific task.~~

~~"Resistiveness or rebelliousness" means an applicant's or member's inappropriate, stubborn, or uncooperative behavior. Resistiveness or rebelliousness does not include an applicant's or member's difficulty with processing information or reasonable expression of self-advocacy that includes an applicant's or member's expression of wants and needs.~~

"Rolling and sitting" means an applicant's or member's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.

"Running or wandering away" means an applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.

"Self-injurious behavior" means an applicant's or member's repeated behavior that causes injury to the applicant or member.

"Verbal or physical threatening" means any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.

"Wheelchair mobility" means an applicant's or member's mobility using a wheelchair and does not include the ability to transfer to the wheelchair.

R9-28-303. Preadmission Screening (PAS) Process

A. The assessor shall use the PAS instrument to determine whether the following applicants or members are at immediate risk of institutionalization:

1. The assessor shall use the PAS instrument prescribed in R9-28-304 to assess an applicant or member who is EPD except as specified in subsection (A)(2) for an applicant or member who is ~~a~~ physically disabled ~~applicant or member~~ and who is less than six years old. After assessing a child who is physically disabled ~~child~~ and age six years to less than 12 years, the assessor shall refer the child for physician consultant review under ~~R9-28-303~~ subsections (G) through (J).

2. The assessor shall use the age-specific PAS instrument prescribed in R9-28-305 to assess an applicant or member who is physically disabled and less than six years old. After assessing the child, the assessor shall refer the child for physician consultant review under ~~this Section~~ subsections (G) through (J).
3. The assessor shall use the PAS instrument prescribed in R9-28-305 to assess an applicant or member who is DD, except as specified in subsection (A)(4) for an applicant or member who is DD and residing in a NF. After assessing a child who is DD and less than six months of age, the assessor shall refer the child for physician consultant review under subsections (G) through ~~(H)~~ (J).
4. The assessor shall use the PAS instrument prescribed in R9-28-304 for an applicant or a member who is DD and residing in a NF.
5. The assessor shall use the PAS instrument prescribed in R9-28-304 or R9-28-305, whichever is applicable, to assess an applicant or member who is classified as ventilator-dependent, under Section 1902(e)(9) of the Social Security Act.

B. For an initial assessment of an applicant who is in a hospital or other acute care setting:
1. A registered nurse assessor shall complete the PAS assessment, or
2. In the event that a registered nurse assessor is not available, a social worker assessor shall complete the PAS assessment; and
3. The assessor shall conduct the PAS assessment and determine medical eligibility when discharge is scheduled within seven days.

C. An assessor shall conduct a face-to-face PAS assessment with an applicant or member, except as provided in subsection (F). The assessor shall make reasonable efforts to obtain the applicant's or member's available medical records. The assessor may also obtain information for the PAS assessment from face-to-face interviews with the:
1. Applicant or member,
2. Parent,
3. Guardian,
4. Caregiver, or
5. Any person familiar with the applicant's or member's functional or medical condition.

D. Using the information described in subsection (C), an assessor shall complete the PAS assessment based on the assessor's education, experience, professional judgment, and training.

E. After the assessor completes the PAS assessment, the assessor shall calculate a PAS score. The assessor shall compare the PAS score to an established threshold score. The scoring methodology and threshold scores are specified in R9-28-304 and R9-28-305. Except as determined by physician consultant review as provided in subsections (G) through (J), the threshold score is the point at which an applicant or member is determined to be at immediate risk of institutionalization.

F. Upon request~~,~~ from a person acting on behalf of the applicant, the Administration shall conduct a PAS assessment to determine whether a deceased applicant who was residing in a NF or who received services in an

ICF-MR any time during the time period covered by the application would have been eligible to receive ALTCS benefits for those months.

G. In the following circumstances, the Administration shall request that a physician consultant review the PAS assessment, the available medical records, and use professional judgment to make the determination that an applicant or member has a developmental disability or has a nonpsychiatric medical condition that, by itself or in combination with ~~a medical condition~~ other medical conditions, places an applicant or member at immediate risk of institutionalization:

1. The PAS score of an applicant or member who is EPD is less than the threshold specified in R9-28-304, but is at least 56;
2. The PAS score of an applicant or member who is DD is less than the threshold specified in R9-28-305, but is at least 38;
3. An applicant or member scores below the threshold specified in R9-28-304, but the Administration has reasonable cause to believe that the applicant's or member's unique functional abilities or medical condition may place the applicant or member at immediate risk of institutionalization;
4. An applicant or member scores below the threshold specified in R9-28-304 and has a documented diagnosis of autism, autistic-like behavior, or pervasive developmental disorder;
5. An applicant or member who is seriously mentally ill as defined in A.R.S. § 36-550 who scores at or above the threshold specified in R9-28-304, but may not meet the requirements of A.R.S. § 36-2936. When an applicant or member who is seriously mentally ill scores at or above the threshold, the physician consultant shall exercise professional judgment to determine whether the applicant or member meets the requirements of A.R.S. § 36-2936.
6. An applicant is an AHCCCS acute care member and scores at or above the threshold specified in R9-28-304 but the Administration has reasonable cause to believe that the applicant's condition is convalescent and requires less than 90 days of institutional care;
7. An applicant or member is a child who is physically disabled ~~child who is~~ and is at least six but less than 12 years of age;
8. An applicant or member is a child who is physically disabled ~~child~~ and is under six years of age; and
9. An applicant is under six months of age.

H. The physician consultant shall consider the following:

1. Activities of daily living dependence;
2. Delay in development;
3. Continence;
4. Orientation;
5. Behavior;
6. Any medical condition, including stability and prognosis of the condition;
7. Any medical nursing treatment provided to the applicant or member including skilled monitoring, medication, and therapeutic regimens;

8. The degree to which the applicant or member must be supervised;
9. The skill and training required of the applicant or member's caregiver; and
10. Any other factor of significance to the individual case.

I. If the physician consultant is unable to make the determination from the PAS assessment and the available medical records, the physician consultant may conduct a face-to-face review with the applicant or member or contact others familiar with the applicant's or member's needs, including a primary care physician or other caregiver, to make the determination.

J. The physician consultant shall state the reasons for the determination in the physician review comment section of the PAS instrument.

R9-28-305. Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

A. The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of ~~four~~ three PAS instruments specifically designed to assess an applicant or member in the following age groups:

1. 12 years of age and older,
2. ~~6 to~~ Six through 11 years of age, and
3. ~~3 to 5~~ Birth through five years of age~~, and~~.
4. ~~Less than 3 years of age.~~

B. The PAS instruments for an applicant or member who is DD include three major categories:

1. Intake information category. The assessor solicits intake information category information on an applicant's or member's demographic background. The components of this category are not included in the calculated PAS score.
2. Functional assessment category. The functional assessment category differs by age group as indicated in subsections (B)(2)(a) through (B)(2)(e):
    a. For an applicant or member 12 years of age and older, the assessor solicits the functional assessment category information on an applicant's or member's:
        i. Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
        ii. Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and
        iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, and resistive or rebellious behavior.
    b. For an applicant or member ~~6 through 11~~ six through 11 years of age, the assessor solicits the functional assessment category information on an applicant's or member's:

i. Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;

ii. Communication, including expressive verbal communication and clarity of communication; and

iii. Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.

c. For an applicant or member ~~3~~ six months through ~~5~~ five years of age, the assessor solicits the functional assessment category information on an applicant's or member's~~:~~

~~i. Performance~~ performance with respect to a series of developmental milestones that measure an applicant's or member's degree of functional growth~~;~~.

~~ii. Need for assistance with independent living skills, including toileting and dressing, and an applicant's or member's orientation to familiar settings;~~

~~iii. Communication, including clarity of communication; and~~

~~iv. Behavior, including aggression, verbal or physical threatening, and self-injurious behavior.~~

~~d. For an applicant or member 6 months of age through 3 years of age, the assessor solicits the functional assessment category information on age-specific developmental milestones.~~

~~e.~~d. For an applicant or member less than ~~6~~ six months of age, the assessor shall not complete a functional assessment. The assessor shall include a description of the applicant's or member's development in the PAS instrument narrative summary.

3. Medical assessment category. The assessor solicits medical assessment category information on an applicant's or member's:

a. Medical condition;

b. Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;

c. Current medication;

d. Medical stability;

e. Sensory functioning;

f. Physical measurements; and

g. Current ~~placement~~ living arrangement, ventilator dependency and eligibility for DES Division of Developmental Disabilities program services.

C. The assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the assessor's PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.

1. Functional score.

a. The Administration calculates the functional score from responses to scored items in the functional assessment category. Each response is assigned ~~a scored~~ a number of points which is multiplied by a weighted numerical value, resulting in a weighted score for each response.

b. The following items are scored as indicated in subsection (D), under the Functional Assessment matrix:

i. For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections are also scored;

ii. For an applicant or member ~~6 through 11~~ six through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections are scored;

iii. For an applicant or member ~~3~~ six months of age through ~~5~~ five years of age, ~~all~~ items in the developmental milestones section ~~and behavior section are scored. Designated items in the independent living skills~~ are scored based on the age of the applicant~~;~~. ~~and~~

~~iv. For an applicant or member 6 months of age up to 3 years of age, all items regarding age specific milestones are scored~~.

c. The sum of the weighted scores equals the functional score. The range of weighted score per item and maximum functional score for each age group is presented below:

AGE GROUP	RANGE FOR WEIGHTED SCORE PER ITEM	MAXIMUM FUNCTIONAL SCORE ATTAINABLE
12+	0 - 11.2	124.1
6-11	0 - 24	112.5
~~3~~0-5	0 - ~~15.6~~5.0	~~78.2~~106.02
~~0-2~~	~~0 - 1.4~~	~~70~~

d. No minimum functional score is required.

2. Medical score.

a. Items (i) through (iii) are scored as indicated in subsection (D), under the Medical Assessment matrix:

i. The assessor shall score designated items in the medical conditions for an applicant or member 12 years of age and older and ~~6~~ six years of age through 11 years of age.

ii. The assessor shall score designated items in the medical conditions and medical stability sections for an applicant or member ~~3 years~~ six months of age through ~~6~~ five years of age.

~~iii. The assessor shall score designated items in the medical conditions, services and treatments, and medical stability sections for an applicant or member 6 months of age through 3 years of age.~~

~~iv.~~ iii. The assessor shall complete only the medical assessment section of the PAS for an applicant or member less than ~~6~~ six months of age. There is no weighted or calculated score assigned. The assessor shall refer the applicant or member for physician consultant review.

b. The Administration calculates the medical score from information obtained in the medical assessment category. Each response to a scored item is assigned a number of points. The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

AGE GROUP	RANGE OF POINTS PER ITEM	MAXIMUM MEDICAL SCORE ATTAINABLE
12+	0 - 20.6	21.4
6-11	0 - 2.5	5
~~3~~0-5	0 - ~~14.8~~10	~~23~~60
~~0-2~~	~~0 - 7~~	~~44.3~~

c. No minimum medical score is required.

3. Total score.
   a. The sum of an applicant's or member's functional and medical scores equals the total score.
   b. The total score is compared to an established threshold score in R9-28-304. For an applicant or member who is DD, the threshold score is 40. Based upon the PAS instrument an applicant or member with a total score equal to or greater than 40 is at immediate risk of institutionalization.

D. The following matrices represent the number of points available and the weight for each scored item.

1. Functional assessment points. An applicant or member age group zero to five: The value is received for each negative response. An applicant or member age groups six to 11 and 12+: the ~~The~~ lowest value in the range of points available per item in the functional assessment category indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
2. Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, ~~0~~ zero, indicates that the applicant or member:
   a. Does not have a medical condition specified in the following matrices,
   b. Does not need medical or nursing ~~services~~ service as specified in the following matrices, or
   c. Does not receive any medical or nursing ~~services~~ service as specified in the following matrices.

AGE GROUP 12 AND OLDER FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Independent Living Skills Section			
Hand Use, Food Preparation	0-3	3.5	0-10.5

Ambulation, Toileting, Eating, Dressing, Personal Hygiene	0-4	2.8	0-11.2
Communicative Skills and Cognitive Abilities Section			
Associating Time, Remembering Instructions	0-3	0.5	0 - 1.5
Behavior Section			
Aggression, Threatening, Self Injurious	0-4	2.8	0-11.2
Resistive	0-3	3.5	0-10.5

AGE GROUP 12 AND OLDER MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	0.4	0-.4
Moderate, Severe, Profound Mental Retardation	0-1	20.6	0-20.6

AGE GROUP 6-11 FUNCTIONAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Independent Living Skills Section			
Climbing Stairs, Wheelchair Mobility, Bladder Control	0-3	1.875	0-5.625
Ambulation, Dressing, Bathing, Toileting	0-4	1.5	0-6
Crawling or Standing	0-5	1.25	0-6.25
Rolling or Sitting	0-8	0.833	0-6.66
Communication Section			
Clarity	0-4	1.5	0-6
Expressive Communication	0-5	1.25	0-6.25

Behavior Section			
Wandering	0-4	6	0-24
Disruptive	0-3	7.5	0-22.5

AGE GROUP 6 - 11 MEDICAL ASSESSMENT	# of Points Available Per Item (P)	Weight (W)	Range of Possible Weighted Score Per Item (P) x (W)
Medical Conditions Section			
Cerebral Palsy, Epilepsy	0-1	2.50	0-2.5

~~AGE GROUP 3 - 5 FUNCTIONAL ASSESSMENT~~	~~# of Points Available Per Item (P)~~	~~Weight (W)~~	~~Range of Possible Weighted Score Per Item (P) x (W)~~
~~Developmental Milestones Section~~			
~~Factors Measuring an Individual's Degree of Functional Growth~~	~~0 1~~	~~0.70~~	~~0 .7~~
~~Independent Living Skills Section~~			
~~Toileting, Dressing~~	~~0-4~~	~~3.90~~	~~0 15.6~~
~~Behavior Section~~			
~~Aggression, Threatening, Self Injurious~~	~~0 4~~	~~1.00~~	~~0 4~~

~~AGE GROUP 3 - 5 MEDICAL ASSESSMENT~~	~~# of Points Available Per Item (P)~~	~~Weight (W)~~	~~Range of Possible Weighted Score Per Item (P) x (W)~~
~~Medical Conditions Section~~			
~~Moderate, Severe, Profound Mental Retardation~~	~~0 1~~	~~14.80~~	~~0 14.8~~
~~Medical Stability Section~~			

~~Direct Caregiver Required, Special Diet~~	~~0-1~~	~~4.10~~	~~0-4.1~~

~~AGE GROUP 0-2 FUNCTIONAL ASSESSMENT~~	~~# of Points Available Per Item (P)~~	~~Weight (W)~~	~~Range of Possible Weighted Score Per Item (P) x (W)~~
~~Developmental Milestones Section~~			
~~Factors Measuring an Individual's Degree of Functional Growth~~	~~0-1~~	~~1.40~~	~~0-1.4~~

~~AGE GROUP 0-2 MEDICAL ASSESSMENT~~	~~# of Points Available Per Item~~	~~Weight~~	~~Range of Possible Weighted Score Per Item (P) x (W)~~
~~Services and Treatments Section~~			
~~Non-Bladder or Bowel Ostomy, Tube Feeding, Oxygen~~	~~0-1~~	~~6.10~~	~~0-6.1~~
~~Medical Conditions Section~~			
~~Any Mental Retardation, Epilepsy, Cerebral Palsy~~	~~0-1~~	~~7.00~~	~~0-7~~
~~Medical Stability Section~~			
~~Services and Treatments Section~~			
~~Trained Direct Caregiver, Special Diet or a Minimum of Two Hospitalizations~~	~~0-1~~	~~5.00~~	~~0-5~~

AGE GROUP 0 – 5 FUNCTIONAL ASSESSMENT	Weight
6 -9 Months	5.0
9-11 Months	4.1
12-17 Months	2.9
18-23 Months	2.125
24-29 Months	1.75
30-35 Months	1.55
36-47 Months	1.34
48-59 Months	1.14
60 Months+	1.03

-

AGE GROUP 0 - 5 MEDICAL ASSESSMENT	Weight
Cerebral Palsy	5.0
Epilepsy	5.0
Moderate, Severe, or Profound Mental Retardation (36 Months and older only)	15.0
Autism + M-CHAT (18 Months and older only) Fails at least six M-CHAT based questions	7.0
Autism + Behaviors (30-35 Months only) Exhibits at least 3 of 4 specific behaviors	5.0
Autism + Behaviors (36 Months and older only) Exhibits at least 6 of 8 specific behaviors	10.0
Drug Regulation + Administration (6 Months to 35 Months)	1.0
Drug Regulation + Administration (36 Months and older)	1.5
Non-Bowel/Bladder Ostomy Care (6 Months to 35 Months)	7.0
Non-Bowel/Bladder Ostomy Care (36 Months and older)	5.0
Tube Feeding (6 Months to 35 Months)	7.0
Tube Feeding (36 Months and older)	5.0
Physical Therapy or Occupational Therapy (6 Months to 35 Months)	1.0
Physical Therapy or Occupational Therapy (36 Months and older)	1.5
Acute Hospital Admission (One)	1.0
Acute Hospital Admissions (Two or more)	2.0
Direct Care Staff Trained (6 Months to 11 Months)	0.5
Direct Care Staff Trained (12 Months and older)	1.0
Special Diet	2.0