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STATE PLAN UNDER TITLE XIX

OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM

STATE ARKANSAS

HCFA-AT-80-38 (BPP)
MAY 22, 1980

APPROVED BY DHHS/HCFA/OPO
DATE: 8/26/82
TRANSMITTAL NO: 82-13

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: ARKANSAS

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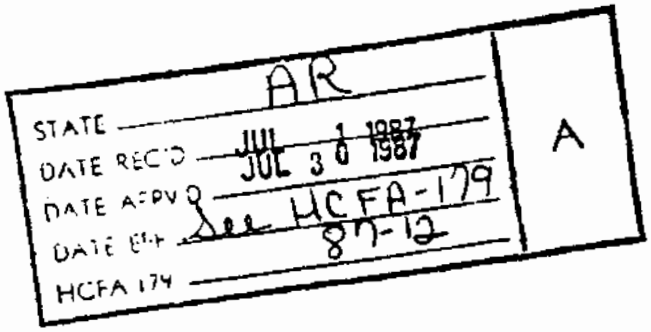
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LIST OF ATTACHMENTS

No.	Title of Attachments
*1.1-A	Attorney General's Certification
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*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
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	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

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*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy
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*Forms Provided

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Revision: HCFA-PM-94-3 (MB)
APRIL 1994
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Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

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Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

__X__ State Public Health Agency

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STATE OF ARKANSAS
THE ATTORNEY GENERAL
LESLIE RUTLEDGE

CERTIFICATION OF THE STATE ATTORNEY GENERAL OF THE STATE OF ARKANSAS ON LEGAL AUTHORITY FOR THE OPERATION OF A MEDICAL PROGRAM UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

This is to certify that:

(1) The Department of Human Services is the State agency authorized to administer the Title XIX (Medicaid) Program in Arkansas.

(2) The State Department of Human Services is authorized to establish and maintain a medical care program for the indigent sick, and the Director of the Department of Human Services is authorized to promulgate rules and regulations to implement the program so as to qualify for assistance under the Social Security Amendments, or other applicable Federal law, under the provisions of Act 821 of 1989, or A.C.A. Section 20-77-107 (Cum. Supp.1991).

Leslie Rutledge
Attorney General

January 26, 2015
DATE

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Revised: September 30, 2003

State/Territory: [Arkansas]

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.
1902(a)(47) and	X	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

Revision: HCFA-PM-87-4 (BERC) **OMB No.: 0938-0193**
MARCH 1987

State: ARKANSAS

Citation	**2.3**	**Residence**
435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)		**Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.**

Revision: HCFA-PM-87-4 (BERC) **OMB No.: 0938-0193**
MARCH 1987

State: ARKANSAS

Citation	**2.4**	**Blindness**
42 CFR 435.530(b) **42 CFR 435.531** **AT-78-90** **AT-79-29**		**All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.6-A.**

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: ARKANSAS

Citation(s)

42 CFR 435.10 and Subparts G & H 1902(a)(10)(A)(i) (III), (IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii) (IX), 1902(a)(10) (A)(ii)(X), 1902 (a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) **OMB No.: 0938-0193**
SEPTEMBER 1986

State/Territory: ARKANSAS

Citation	**2.7**	**Medicaid Furnished Out of State**
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		**Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered

See S14, SPA 2013-015

State: ARKANSAS

Agency*	**Citation(s)**	**Groups Covered**
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
N/A		2. Deemed Recipients of AFDC
	1902(a)(10)(A)(i)(I) of the Act	b. **See S14, SPA 2013-015**
	DCO 420(a)(22)(A) of the Act	c. **See S14, SPA 2013-015**
	DCO 406(h) and 1902(a)(10)(A)(i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act Division of Children and Family Services (DCFS)	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	**Citation(s)**	**Groups Covered**
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued) 3. **See S14, SPA #2013-015** 4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)
DCO	1902(a)(52) and 1925 of the Act	

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered

See S14, SPA #2013-015

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Agency*	**Citation(s)**	**Groups Covered**

See S14, SPA #2013-015

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered

See S14, SPA #2013-015

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered

See S14, SPA #2013-015

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
		10. **See S14, SPA #2013-015**
DCO	1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
DCO	1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
DCO	1902(e)(4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
SOCIAL SECURITY ADMINISTRATION (SSA)	42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance X a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. X Aged X Blind X Disabled

92-18

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* Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

DCO 1634(c) of the Act

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

☑ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

☑ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

DCO 42 CFR 435.122

16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

SSA 42 CFR 435.130

17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

DCO 42 CFR 435.132 19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--

a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

b. Remain institutionalized; and

c. Continue to need institutional care.

DCO 42 CFR 435.133 20. Blind and disabled individuals who--

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

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DATE RECD 3-2-05
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Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

DCO 42 CFR 435.134 21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

☐ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

☐ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

☐ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

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Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

DCO 42 CFR 435.135 22. Individuals who --

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

/X/ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

/_/ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

/_/ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

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STATE Arkansas
DATE RECD 3-2-05
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Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

DCO 1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

[X] Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

[ ] The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

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State/Territory: ARKANSAS

Agency*	Citation(s)	Groups Covered
DCO	1634(d) of the Act	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

___ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

___ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

___ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

___ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual

STATE Arkansas
DATE REC'D 3-2-05
DATE APP'VD 4-5-05
DATE EFF 3-1-05
HCFA 179 05-02

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91-63

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
DCO	1902(a)(10)(E)(i), 1905(p) and **1860D-14(a)(3)(D)** of the Act	25. Qualified Medicare Beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed **three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI)**. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
DCO	1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), and **1905(s)** of the Act	26. Qualified disabled and working individuals-- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
DCO	1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and **1860D-14(a)(3)(D)** of the Act	27. Specified Low-Income Medicare Beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed **three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI)**. (Medical assistance for this group is limited to Medicare Part B premiums under Section 1839 of the Act.)
DCO	1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii), and **1860D-14(a)(3)(D)** of the Act	28. Qualified Individuals-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); c. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level; d. Whose resources do not exceed **three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI**). (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

State: ARKANSAS

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	1634(e) of the Act	**29.** a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611 (e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.
		___ b. The State applies more restrictive eligibility standards than those under SSI. Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611 (e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy
N/A	42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act	☐ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance. ☐ The plan covers all individuals as described above. ☐ The plan covers only the following group or groups of individuals: ___ Aged ___ Blind ___ Disabled **See S14, SPA #2013-015**
DCO	42 CFR 435.211	☐ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

State: [Arkansas]

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508(section 4732)

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

X The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is _ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

TN # 03-11
Supersedes TN # 91-63

Effective Date 8-13-03
Approval Date 12-22-03

Arkansas
DATE REC'D 9-30-03
DATE APPR'D 12-22-03
8-13-03
03-11

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SUPERSEDES TN- 91-63

Revised: September 30, 2003

State: [Arkansas]

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than Medically Needy (continued)

1932(a)(4) of Act

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

___ Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

_X_ No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

___ The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

_X_ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

Arkansas
9-30-03
12-22-03
8-13-03
03-11

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SUPERSEDES TN: 91-63

TN # 03-11
Supersedes TN # 91-63

Effective Date 8-13-03
Approval Date 12-22-03

State/Territory: ARKANSAS

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.217 Division of County Operations (DCO) and Division of Developmental Disabilities (DDS)	☒ 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
	42 CFR 435.217 Division of County Operations (DCO) and Division of Developmental Disabilities (DDS)	☒ **5. PACE participants**

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	**Citation(s)**	**Groups Covered**

See S14, SPA #2013-015

*Agency that determines eligibility for coverage.

State: ARKANSAS

Agency*	Citation(s)	Groups Covered

See S14, SPA #2013-015

State: ARKANSAS

Agency*	Citation(s)	Groups Covered

See S14, SPA #2013-015

Agency*	Citation(s)	Groups Covered

See S14, SPA #2013-015

State: ARKANSAS

Agency*	Citation(s)	Groups Covered

See S14, SPA #2013-015

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

N/A 42 CFR 435.230
435.121
1902(a)(10)
(A)(ii)(XI)
of the Act

☑ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

STATE Arkansas
DATE REC'D FEB 11 1992
DATE APPV'D FEB 20 1992
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Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

DCO 42 CFR 435.231 /X/
1902(a)(10)(A)(ii)(V) of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

/ / The State covers all individuals as described above.

/X/ The State covers only the following group or groups of individuals:

1902(a)(10)(A)(ii) and 1905(a) of the Act

- X Aged
- X Blind
- X Disabled
- ___ Individuals under the age of--
  - ___ 21
  - ___ 20
  - ___ 19
  - ___ 18
- ___ Caretaker relatives
- ___ Pregnant women

91-56

STATE Arkansas
DATE RECD 3-2-05
DATE APPD 4-5-05
DATE EFF 3-1-05
HCFA ID 05-02
A

State: ARKANSAS

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
N/A	1902(e)(3) of the Act	☐	13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
			14. **See S14, SPA #2013-015**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

Agency*	Citation	Groups Covered

See S14, SPA #2013-015

*Agency that determines eligibility for coverage.

State: ARKANSAS

Citation	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1902(e)(12) of the Act	_____ 20. A child under age _____ (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of _____ months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.
	_____ 21. **See S14, SPA #2013-015**

Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A) (ii)(XIII) of the Act	[ ]	23.	BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A
1902(a)(10)(A) (ii)(XV) of the Act	[X]	24	TWWIIA Basic Insurance Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XVI) of the Act	[ ]	25.	TWWIIA Medical Improvement Group Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page12h of Attachment 2.6-A. NOTE: If the State elects to cover this group, it MUST also cover the Basic Insurance Group described in no. 21 above.

STATE ARKANSAS
DATE REC'D 10-31-00
DATE APPV'D 01-25-01
DATE EFF 02-01-01
TN NO 00-14

A

State: ARKANSAS

Citation	**Groups Covered**
	B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(10)(ii)(XVIII) of the Act	☐ 26. Women who: a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix; b. are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act; c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and d. have not attained age 65.
1920B of the Act	☐ 27. Women who are determined by a 'qualified entity' (as defined in 1920B(b) based on preliminary information, to be a woman described in 1902(aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the last day.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR435.301 This plan includes the medically needy.

/ / No.

/X/ Yes. This plan covers:

DCO 1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

DCO 1902(e) of the Act 2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

DCO 1902(a)(10)(C)(ii)(I) of the Act 3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

STATE Arkansas
DATE RECD 3-2-05
DATE APPVD 4-5-05
DATE EFF 3-1-05
HCFA ID 05-02
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91-56

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy (Continued)

4. **See S14, SPA #2013-015**

N/A 42 CFR 435.308

5. ☐ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--

____ 21
____ 20
____ 19
____ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

☒ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

X (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

DCFS X (a) In foster homes (and are under the age of 21).

DCO X (b) In private institutions (and are under the age of 21).

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___ ___).

___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

DCO X (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

93-07

STATE Arkansas
DATE RECD 3-2-05
DATE APPD 7-5-05
DATE EFF 3-1-05
HCFA ID 05-02
A

Agency*	Citation(s)		Groups Covered

C. Optional Coverage of Medically Needy (Continued)

DCO	42 CFR 435.310	/X/	6. Caretaker relatives.
DCO	42 CFR 435.320 and 435.330	/X/	7. Aged individuals.
DCO	42 CFR 435.322 and 435.330	/X/	8. Blind individuals.
DCO	42 CFR 435.324 and 435.330	/X/	9. Disabled individuals.
N/A	42 CFR 435.326	/_/	10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
DCO	435.340		11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

91-56

STATE Arkansas
DATE REC'D 3-2-05
DATE APP'D 4-5-05
DATE EFF 3-1-05
HCFA 179 05-02
A

State: **ARKANSAS**

Agency*	Citation		Groups Covered
Division of County Operations (DCO)		X	13. Unemployed Parents

*Agency that determines eligibility for coverage

STATE Arkansas
DATE REC'D 3-2-05
DATE APP'D 4-5-05
DATE EFF 3-1-05
HCFA 179 05-02
A

STATE Arkansas DATE REC'D 8-26-05 DATE APP'D 11-17-05 DATE EFF 11-1-05 HCFA 179 05-05	A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
DCO	1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act for those individuals who specifically request a state determination. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):*_____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26- 05, and Baltimore, Maryland 21244-1850.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):*_____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26- 05, and Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19 AND 18

See S25, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

Not Applicable.

STATE Arkansas DATE REC'D 10-24-02 DATE APPV'D 12-16-02 DATE EFF 1-1-03 HCFA 179 02-21	A

SUPERSEDES: TN- 91-56

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirements
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) **See S28, SPA #2013-015**.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
	(iii) **See S28, SPA #2013-015.**
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

State: **ARKANSAS**

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905 (p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).

State: Arkansas
Date Received: 23 September, 2013
Date Approved: 3 November, 2015
Effective Date: 1 January, 2014
Transmittal Number: 13-0018 MM6

STATE: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
	4. State has entered into an Interstate Compact on Adoption and Medical Assistance to provide for reciprocal provision of medical assistance for Title IV-E children, pursuant to Public Law 96-272.

STATE AR
DATE REC'D 3-31-86
DATE APPV'D 4-24-86
DATE EFF 3-1-86
HCFA 179 86-4

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Supersedes NRC

State: **ARKANSAS**

Citation	Condition or Requirement

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State: Arkansas
Date Received: 23 September, 2013
Date Approved: 3 November, 2015
Effective Date: 1 January, 2014
Transmittal Number: 13-0018 MM6

State/Territory: ARKANSAS

Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, * ~~intermediate care facilities~~, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ☐ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

*nursing facilities and intermediate care facilities for the mentally retarded,

TN No. 92-11
Supersedes
TN No. 91-57

Approval Date 4/6/92 Effective Date 3/1/92

STATE Arkansas
DATE REC'D 4-1-92
DATE APP'D 4-6-92
DATE EFF 3-1-92
HCFA 179 92-11

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State/Territory: ARKANSAS

Citation	Condition or Requirement
	An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(l)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. /X/ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number), except for aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) of the Social Security Act (section 1137(f)).

TN No. 92-11
Supersedes
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Approval Date 4/6/92

Effective Date 2/1/92

STATE
DATE REC'D 2-1-92
DATE APP'D 4-6-92
DATE EFF 3-1-92
HCFA 179 92-11

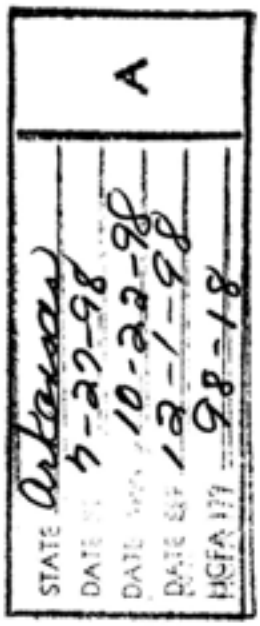
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Citation	Condition or Requirement
	B. Posteligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the posteligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

STATE Arkansas
DATE REC'D 9-22-98
DATE APP'VD 10-22-98
DATE EFF 12-1-97
HCFA 179 98-18

A

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 40.00 Couples $ 80.00 For the following persons with greater need: Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 40.00 Adults $ 40.00 For the following persons with greater need: Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2-A. $ 40.00



Citation	Condition or Requirement

For the following persons with greater need:

Supplement 15 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2. , the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

__X__ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

_____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to maximum maintenance needs standard).

_____ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

STATE Arkansas
DATE RECD 7-22-98
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HCFA 179 98-18
A

Citation	Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

__X__ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or

____ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

__X__ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

____ a greater amounted calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

Reference Attachment 2.6-A, page 5b

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

STATE Arkansas A
DATE REC'D 2-22-98
DATE APP'D 10-22-98
DATE EFF 12-1-98
HCFA 179 98-18

Citation	Condition or Requirement

435.725
435.733
435.832

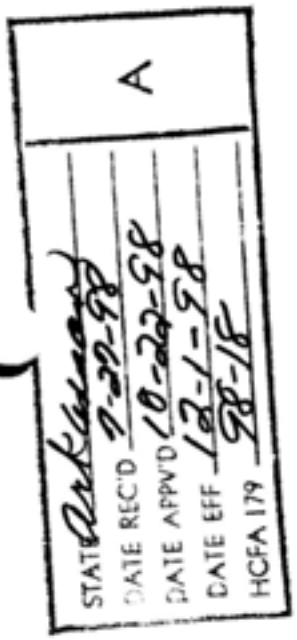
4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:

a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:

o AFDC level; or
o Medically needy level:

(Check one)

-- AFDC levels in Supplement 1
X Medically needy level in Supplement 1
-- Other: $_____



b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:

(I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)

435.725
435.733
435.832

5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

__X__ No.

____ Yes (the applicable amount is shown on page 5a.)

Citation	Condition or Requirement
	____ Amount for maintenance of home is: $_____.
	____ Amount for maintenance of home is the actual maintenance costs not to exceed $_____.
	____ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
	____ Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

STATE Arkansas DATE REC'D 2-27-98 DATE APPV'D 10-22-98 DATE EFF 12-1-97 HCFA 179 98-18	A

CITATION	CONDITION OR REQUIREMENT

Definition of dependency

The definition of dependency below is used to define dependent children, parents and siblings for purposes of deducting allowances under Section 1924:

A dependent family member includes minor (under age 18) or dependent (age 18 or over) children, dependent parents, or dependent siblings (including half-brothers and half-sisters) of the institutionalized spouse or community spouse who live in the home of the community spouse. To qualify as a dependent, an individual must be claimed on the income tax return of the institutionalized spouse or community spouse as a dependent, which must be verified by viewing the tax return.

STATE Arkansas
DATE REC'D 2-27-98
DATE APPV'D 10-22-98
DATE EFF 12-1-98
HCFA 179 98-18

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State: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	**Condition or Requirement**
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. **See S28, SPA #2013-015**

Citation	Condition or Requirement
	X Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
	___ Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
	___ Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	___ Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.
	X Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
	X Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
	X Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.

STATE Arkansas
DATE REC'D 9/25/2002
DATE APPV'D 12/11/2002
DATE EFF 12/1/2002
HCFA 179 02-14

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SUPERSEDES TN 95-27

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income [redacted]
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

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STATE Arkansas
DATE SUBMITTED APR 06 1992
DATE APPROVED MAY 08 1992
DATE OF MAR 01 1992
HCFA ID 92-18
A

TN No. 92-18
Supersedes TN No. 91-56
Approval Date MAY 08 1992
Effective Date MAR 01 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: X The methods of the SSI program only. ___ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

STATE Arkansas
DATE RECD APR 06 1992
DATE APPVD MAY 08 1992
DATE EFF MAR 01 1992
HCFA ID 92-18
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
6	[redacted]
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: X The methods of the SSI program only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

STATE Arkansas
APR 06 1992
MAY 08 1992
MAR 01 1992
92-18
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Citation		Condition or Requirement
		If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g.	(1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act		(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

STATE Arkansas
DATE REC'D MAR 25 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1993
HCFA 179 93-09

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* U.S. G.P.O.:1993-342-239:80032

Citation		Condition or Requirement
1902(a)(10)(A)(ii)(XIII) of the Act	(i)	Working Individuals with Disabilities – BBA

In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:

____ The methodologies of the SSI program.

____ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.

____ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

STATE ARKANSAS	A
DATE REC'D 10-31-00	
DATE APPV'D 01-25-01	
DATE EFF 02-01-01	
HCFA 179 00-14	

State/Territory: ARKANSAS

Citation	Condition or Requirement

1902(a)(10)(A)(ii)(XV) of the Act

(ii) Working Individuals with Disabilities – Basic Insurance Group - TWWIIA

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

X The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

____ The agency applies the following income and/or resource standard(s):

- The individual must have net personal income less than 250% of the poverty level for his/her family size.
- Countable resources are determined by family size:

1 (Individual only)	$4000
2	$6000
3	$6200
4	$6400

Add $200 for each additional member.

State: Arkansas
Date Received: 10-10-13
Date Approved: 1-6-14
Date Effective: 1-1-14
Transmittal Number: 13-09

State/Territory: ARKANSAS

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV) of the Act	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. Regardless of methodology, all earned income is disregarded in determining eligibility under this group. ____ The income methodologies of the SSI program. ____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. ____ The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.

State: Arkansas
Date Received: 10-10-13
Date Approved: 1-6-14
Date Effective: 1-1-14
Transmittal Number: 13-09

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV) of the Act (cont.)	Resource Methodologies In determining whether the individual meets the resource standard described above, the agency uses the following methodologies. Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-.A ____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. ____ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

STATE ARKANSAS
DATE REC'D 10-31-00
DATE APPV'D 01-25-01
DATE EFF 02-01-01
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State/Territory: ARKANSAS

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV) of the Act (cont.)	____ The agency does not disregard funds in retirement accounts.
	____ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
	____ The agency uses the resource methodologies of the SSI program.
	____ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

State: Arkansas
Date Received: 10-10-13
Date Approved: 1-6-14
Date Effective: 1-1-14
Transmittal Number: 13-09

Transmittal Number: 13-09
Approval Date: 6 January, 2014
Date Effective: 1 January, 2014
Supersedes TN# 00-14

State/Territory: ARKANSAS

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV) of the Act	(iii) Working Individuals with Disabilities – Employed Medically Improved Individuals - TWWIIA

In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:

___ The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

____ The agency applies the following income and/or resource standard(s):

State: Arkansas
Date Received: 10-10-13
Date Approved: 1-6-14
Date Effective: 1-1-14
Transmittal Number: 13-09

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XVI) of the Act (cont.)	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. Regardless of methodology, all earned income is disregarded in determining eligibility under this group. ____ The income methodologies of the SSI program. ____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. ____ The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.

STATE ARKANSAS
DATE REC'D 10-31-00
DATE APPV'D 01-25-01
DATE EFF 02-01-01
HCFA 179 0014

A

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XVI) of the Act (cont.)	Resource Methodologies In determining whether the individual meets the resource standard described above, the agency uses the following methodologies. Unless one of the following items is checked the agency, under the authority of section 1902(*r*)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6- A. ____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. ____ The agency disregards funds in retirement accounts in a manner other than those listed above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

STATE ARKANSAS DATE REC'D 10-31-00 DATE APPV'D 01-25-01 DATE EFF 02-01-01 HCFA 179 00-14	A

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XVI) of the Act (cont.)	____ The agency does not disregard funds in retirement accounts. ____ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A. ____ The agency uses the resource methodologies of the SSI program. ____ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

STATE ARKANSAS DATE REC'D 10-31-00 DATE APPV'D 01-25-01 DATE EFF 02-01-01 HCFA 179 00-14	A

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XVI) and 1905(v)(2) of the Act	Definition of Employed - Employed Medically Improved Individuals - TWWIIA ____ The agency uses the statutory definition of "employed", i.e., earning at least the minimum wage, and working at least 40 hours per month. ____ The agency uses an alternative definition of "employed" that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency's threshold criteria are described below:

STATE ARKANSAS
DATE REC'D 10-31-00
DATE APPV'D 01-25-01
DATE EFF 02-01-01
HCFA 179 00-14

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SUPERSEDES: NONE - NEW PAGE

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act	Payment of Premiums or Other Cost Sharing Charges For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A: ____ The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

STATE	ARKANSAS
DATE REC'D	10-31-00
DATE APPV'D	01-25-01
DATE EFF	02-01-01
HCFA 179	00-14
	A

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont.)	For individuals eligible under the Basic Insurance Group described in No. 24 on page 23d of Attachment 2.2-A: NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums. _X_ The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income. The premiums or other cost-sharing charges, and how they are applied, are described on page 12p.

STATE ARKANSAS
DATE REC'D 10-31-00
DATE APPV'D 01-25-01
DATE EFF 02-01-01
HCFA 179 00-14

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Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont.)	Payment of Premiums or Other Cost Sharing Charges

For individuals eligible under the Medical Improvement Group described in No. 25 on page 23d of Attachment 2.2-A:

NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums.

____ The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.

The premiums or other cost-sharing charges, and how they are applied, are described on page 12p.

STATE ARKANSAS DATE RECD 10-31-00 DATE APVD 01-25-01 DATE EFF 02-01-01 HCFA ID 00-14	A

State/Territory: ARKANSAS

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cont.)	Premiums and Other Cost-Sharing Charges For the Basic Insurance Group and/or the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described **in Medicaid Premiums and Cost Sharing pages G1 through G3. In future years, cost share amounts will change with the medical component of the CPI-U.**

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the SSI program. X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	[redacted]

Arkansas
STATE
DATE RECD NOV 05 1992
DATE APPVD DEC 04 1992
DATE EFF OCT 01 1992
HCFA 179 92-40
A

State: ARKANSAS

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.

8

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

___ Same as SSI resource standards.

___ More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

STATE Arkansas
DATE REC'D JUN 14 1993
DATE APP'V'D JUL 01 1993
DATE EFF MAY 01 1993
HCFA 179 93-22

A

Citation	Condition or Requirement
1902(l)(3)(A) and (C) of the Act	e. For children covered under the provisions of section 1902(a)(10)(A)(i)(VII) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. X No. The agency does not apply a resource standard to these individuals.
1902(m)(1)(C) and (m)(2)(B) of the Act	f. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ___ Same as SSI resource standards. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

STATE Arkansas
DATE REC'D 05-24-01
DATE APPV'D 07-16-01
DATE EFF 08-01-01
HCFA 179 AR-01-13

A

State: **ARKANSAS**

Citation	Condition or Requirement

7. Resource standard – Medically Needy

a. Resource standards are based on family size.

1902 (a)(10)(c)(i) of the Act

b. A single standard is employed in determining resource eligibility for all groups.

__ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for—
___ Aged
___ Blind
___ Disabled

STATE Arkansas
DATE REC'D. 12-30-09
DATE APP'D 3-30-10
DATE EFF 1-1-10
HCFA 179 10-02
A

Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.

1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B) and **1860D-14(a)(3)(D)** of the Act

8. Resource Standard – Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and **Qualified Individuals**

For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, **and Qualified Individuals covered under 1902(a)(10)(E)(iv) of the Act,** the resource standard is **three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).**

1902(a)(10)(E)(ii), 1905(s) and **1860D-14(a)(3)(D)** of the Act

9. Resource Standard – Qualified Disabled and Working Individuals

For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

b. Categorically Needy Only

X This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.

STATE Arkansas
DATE REC'D JUN 14 1993
DATE APPV'D JUL 01 1993
DATE EFF MAY 01 1993
HCFA 179 93-22

A

Citation	Condition or Requirement

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

X Aged, blind, disabled.
X AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

X Aged, blind, disabled.
X AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

___ Aged, blind, disabled.
___ AFDC-related.

STATE Arkansas
DATE REC'D AUG 31 1993
DATE APPV'D SEP 08 1993
DATE EFF AUG 01 1993
HCFA 179 93-24

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	[redacted]
1902(e)(8) and 1905(a) of the Act	X b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for-- X 12 months ___ 6 months ___ ___ months (no less than 6 months and no more than 12 months)

9

STATE Arkansas
DATE RECD APR 06 1992
DATE APPVD MAY 08 1992
DATE EFF MAR 01 1992
HCFA ID 92-18

A

TN No. 92-18
Supersedes TN No. 91-56
Approval Date MAY 08 1992
Effective Date MAR 01 1992

ARKANSAS

Citation	Condition or Requirement

1902(a)(18) and 1902(f) of the Act

12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals

The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.

Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.

1917(c)

13. Transfer of Assets - All eligibility groups

The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.

Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.

1917(d)

14. Treatment of Trusts - All eligibility groups

The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.

____ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;

X The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts.

The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

STATE Arkansas
DATE REC'D MAR 27 1995
DATE APP'D APR 12 1995
DATE EFF JAN 01 1995
HCFA I.D. 95-05

A

TN No. 95-05
Supersedes TN No. 91-26
Approval Date APR 12 1995
Effective Date JAN 01 1995

Citation	Condition or Requirement
1924 of the Act	15. ~~13.~~ The agency complies with the provisions of §1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: X the maximum standard permitted by law; ____ the minimum standard permitted by law; or $____ a standard that is an amount between the minimum and the maximum.

STATE Arkansas
DATE REC'D 7-27-98
DATE APP'D 10-22-98
DATE EFF 12-1-97
HCFA 179 98-18

A

1. Redacted sections removed per approved MAGI SPA 13-0015MM.
2. Removed Page 3b per approved MAGI SPA 13-0015MM1.
3. Redacted aree per approved MAGI SPA 13-0015MM.
4. Redacted area per approved MAGI SPA 13-0015MM.
5. Page 11a removed from State Plan per approved MAGI SPA 13-0015MM.
6. Redacted area per approved MAGI SPA 13-0015MM.
7. Redacted area per approved MAGI SPA 13-0015MM.

Pages 19, 19a, and 9b were removed per approved MAGI SPA 13-0015MM.
8. Page 21 was removed from State Plan per approved MAGI SPA 13-0015MM.
9. Redacted section per approved MAGI SPA 13-0015MM.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

S28 has been replaced by SPA 22-0027. Please see the following pages.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS

See S30, SPA #2013-015

*See Supplement 8a to Attachment 2.6-A, Page 2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS (Continued)

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS (Continued)

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals (Aged Individuals Only)

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(4) of the Act are as follows: PM 93-5

Based on 80 percent of the official Federal income poverty line.

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a resultofa title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

STATE Arkansas
DATE RECD 11-1-02
DATE APP'D 12-20-02
DATE EFF 1-1-03
HCFA 179 AR 02-23

A

SUPERSEDES TN- 02-16

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p)(2)(A) of the Act are as follows:

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: /X/ 85 percent /_/ _____ percent (no more than 100)

Eff. Jan. 1, 1990: /X/ 90 percent /_/ _____ percent (no more than 100)

Eff. Jan. 1, 1991: 100 percent

Eff. Jan. 1, 1992: 100 percent

b. Levels:

Family Size	Income Levels
1	$ 567.50
2	$ 765.83

CA. QUALIFIED DISABLED WORKING INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified disabled working individuals under the provisions of section 1905(s) of the Act are as follows:

Family Size	Income Levels
1	$ 1,135.00
2	$ 1,531.66

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

RESOURCE LEVELS

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

- **Must be incurred no earlier than the three-month period preceding the month of application.**
- The non-covered expenses must be prescribed by a Medical professional (e.g., a physician, dentist, optometrist, chiropractor, etc.).
- Payments for cosmetic/elective procedures (e.g., face lifts or liposuction) will not be allowed **except when prescribed by a medical professional**.
- **Amount is the least of the fee recognized by Medicaid, Medicare, or the average cost allowed by a commercial health insurance plan in Arkansas.**
- **Expenses incurred as a result of the imposition of a transfer of assets penalty, are not allowed.**
- **Expenses resulting from the failure to obtain prior approval from applicable private insurance, Medicare, or Medicaid, due to the service being medically unnecessary, are not allowed.**
- **Deduction is not allowed for procedures allowed by Medicaid when prior authorization is denied due to the service being medically unnecessary.**
- **Expenses when a third party (including Medicaid) is liable for the expenses, even if provided by an out-of-network provider, are not allowed.**
- **General health insurance premiums paid by someone other than the recipient (excluding the community spouse) who is not a financially responsible relative and repayment is not expected to be paid back to the third party by the recipient, are not allowed.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902 (r) (2) OF THE ACT*

[ ] Section 1902 (f) State [X] Non-Section 1902 (f) State

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

MORE LIBERAL METHODS OF TREATING INCOME UNDER
SECTION 1902(r)(2) OF THE ACT*

☐ Section 1902(f) ☒ Non-Section 1902(f) State

See S30, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

LESS RESTRICTIVE METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT*

See S55, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902(f) State

☒ Non-Section 1902(f) State

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902 (r) (2) OF THE ACT

[ ] Section 1902 (f) State [X] Non-Section 1902 (f) State

For ARSeniors (Section 1902(m)) **the difference between** $2,000.00 for individuals and $3,000.00 for couples, **and the QMB resource level for individuals and couples, as appropriate, is excluded;** thereby effectively setting the resource limit for **ARSeniors at the appropriate QMB resource level.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

LESS RESTRICTIVE METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

See S55, SPA #2013-015

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arkansas

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2)
1917(b)(1)(C)

The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

Categorically needy individuals in nursing facilities and home & community based waiver programs under the special income level (300%) defined at 1902 (a)(10)(A)(ii)(V)."

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

X The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State's Insurance Department.

STATE Arkansas DATE REC'D 11-30-07 DATE APPV'D 2-21-08 DATE EFF 7-1-08 HCFA 179 07-19	A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arkansas

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
- The policy was issued no earlier than the effective date of this State plan amendment.
- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.
- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.
- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.
- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.
- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.
- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

A
STATE Arkansas
DATE RECT 11-30-07
DATE APP'D 2-21-08
DATE EFF 7-1-08
HCFA 179 07-19

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

TRANSFER OF RESOURCES

1917 of the Act — The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

Section 303(b) of P.L. 100-360

A. The criteria for determining the period of ineligibility are:

1. Effective July 1, 1988 (except for interspousal transfers), no period of ineligibility will be imposed on an individual for uncompensated transfers unless the individual is an inpatient of a medical institution or nursing facility who transferred resources without compensation 30 months prior to institutionalization, if a Medicaid recipient at the beginning of institutionalization, or 30 months prior to application, if not Medicaid eligible at the beginning of institutionalization.

   a. The agency uses a procedure which provides for a period of ineligibility that will be the lesser of:

      i. 30 months, or

      ii. A number of months equal to the uncompensated value of the transferred resources divided by $1500. Any remainder from the division will be disregarded.

   b. No individual is ineligible by reasons of A.1. if:

      i. The resource transferred was a home, and title to the home was transferred to:

         (a) a child of the institutionalized individual who is under age 21 or who is blind or disabled (as determined by SSI or MRT);

STATE Arkansas
DATE REC'D 12-30-93
DATE APP'D 01-19-94
DATE EFF 12-01-93
HCFA 179 93-37

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

(b) a son or daughter of the institutionalized individual who resided in the home for at least two years before the applicant was admitted to the medical institution or nursing facility, and who provided care which enabled the institutionalized individual to remain at home during that period; or

(c) a sibling of the institutionalized individual who had an equity interest in the home for at least one year before the applicant was admitted to the medical institution or nursing facility.

ii. The resources were transferred to (or to another for the sole benefit of) a blind or permanently and totally disabled child (as determined by SSI or MRT).

iii. A satisfactory showing is made that the individual intended to dispose of the resources at FMV or for other valuable consideration, or that the resources were transferred exclusively for a purpose other than to qualify for medical assistance.

iv. It is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

(a) counting uncompensated value would make an individual ineligible;

(b) lack of assistance would deprive the individual of food and shelter;

(c) the individual's combined total of gross income and countable resources (no income disregards allowed) do not exceed the applicable federal benefit rate (NF income limit); and

STATE Arkansas
DATE REC'D 12-30-93
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

(d) The resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft, or other extraordinary circumstances.

P.L. 101-66
8/10/93

2. Effective October 1, 1993, the transfer of asset provisions are in accordance with OBRA of 1993, as follows:

a. The look back period will be 36 months (or 60 months in the case of transfers to trusts);

b. There will be no cap on the period of ineligibility;

c. There will be no overlapping of periods of ineligibility;

d. The period of ineligibility for the uncompensated transfer of assets shall be determined as follows:

- The total value of all resources transferred will be divided by the average monthly cost to a private pay nursing facility resident;

- The total annual income diverted will be multiplied by the life expectancy of the individual and divided by the average monthly cost to a private pay nursing facility resident;

e. No period of ineligibility shall be imposed on an individual for uncompensated transfers if denial of eligibility would work an undue hardship.

The exceptions to the period of ineligibility will be applied, as mandated by OBRA.

STATE Arkansas
DATE RECD 12-30-93
DATE APPVD 01-19-94
DATE EFF 12-01-93
HCFA ID 93-37

Af.

TN No. 93-37
Supersedes
TN No. Supplement 9 to Attachment 2.6-A, Pages 1, 2, 3, 4, 5, 5a, 5b, 6, and 7, Approved 10-18-89 and 9-20-85, TN 89-31 and TN 85-10

Approval Date 01/19/94 Effective Date 12/01/93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which medical assistance is otherwise under the agency plan:

Arkansas
MAR 2 7 1995
APR 1 2 1995
JAN 0 1 1995
95-05

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TN No. 95-05
Supersedes
TN No. SUPERSEDES NONE - NEW PAGE

Approval Date APR 1 2 1995 Effective Date JAN 0 1 1995

State: ARKANSAS

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

X the first day of the month in which the asset was transferred;

___ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the ~~agency~~ state;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

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A

State: ARKANSAS

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

_X_ does not impose a penalty;

___ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

_X_ does not impose a penalty;

___ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:

_X_ totals the value of all assets transferred to produce a single penalty period;

___ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:

_X_ assigns each transfer its own penalty period;

___ uses the method outlined below:

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TN No. 95-05
Supersedes TN No. SUPERSEDES: NONE - NEW PAGE
Approval Date APR 12 1995 Effective Date JAN 01 1995

State: ARKANSAS

TRANSFER OF ASSETS

9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

If a community spouse enters a nursing facility, any remaining penalty period is divided and shared equally by both spouses.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

___ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

___ For transfers of individual income payments, the agency will impose partial month penalty periods.

_X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

___ The agency uses an alternate method to calculate penalty periods, as described below:

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Approval Date APR 12 1995
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State: ARKANSAS

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship--
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

Determine current ownership of the assets. purpose of the transfer, and compensation received.

Notify the individual of penalty period to be imposed for uncompensated transfer unless convincing evidence is provided that purpose of the transfer was for a reason other than establishing eligibility.

If rebuttal is unacceptable to agency, allow an appeal and agency hearing.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Counting uncompensated value would make an individual ineligible.

Lack of assistance would deprive the individual of food. shelter and care determined to be medically necessary.

The individual's total assets are not great enough to pay for nursing facility care for a month; if income is over the federal limit, an income trust must be established.

The transferred assets cannot be recovered due to loss, destruction, theft or other extraordinary circumstances.

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TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006,** the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under a 1915(c) or (d) waiver.

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TN No. 06-15
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

_X_ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

Individuals eligible under Home and Community Based Services waivers under 1915(c).

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

_X_ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

Any services provided to individuals under a Home and Community Based Services waivers under 1915(c) or (d).

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State: **ARKANSAS**

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

  X The State uses the first day of the month in which the assets were transferred

  ___ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

  AND

  which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

TRANSFER OF ASSETS

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care--

Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

TRANSFER OF ASSETS

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

STATE Arkansas
DATE RECD 9-26-06
DATE APPROVED 12-18-06
DATE EFF 10-1-06
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TN No. 06-15
Supersedes
TN No. **None-New**

Approval Date 12-18-06 Effective Date 10-1-06

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed_____ days (may not be greater than 30).

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State: ARKANSAS

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

Refer to Supplement 9(a) to Attachment 2.6-A, Page 5.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $_____.

STATE Arkansas
DATE RECD MAR 2 7 1995
DATE APPD APR 1 2 1995
DATE EFF JAN 0 1 1995
HCFA ID 95-05

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TN No. 95-05
Supersedes TN No. 91-22
Approval Date APR 1 2 1995
Effective Date JAN 0 1 1995

Revised: April 1, 1991

SUPPLEMENT 12 TO ATTACHMENT 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE ARKANSAS

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT ARE MORE LIBERAL THAN THOSE OF THE SSI PROGRAM

For aged, blind and disabled individuals, including Qualified Medicare Beneficiaries, Non-Home Income Producing Property, such as mineral and timber rights, rented farm land, and rented dwellings, will continue to be excluded from resources if it meets the pre-5/1/90 SSI $6000/6% rule, which was terminated by Section 8014 of OBRA, 1989. This rule will not apply to cash assistance recipients, to those individuals deemed to be cash assistance recipients; to qualified disabled working individuals (QDWIs) or to COBRA continuation recipients. (Arkansas has not elected to provide coverage to the COBRA continuation recipients.)

TN No. 91-12 Approval Date 12/5/91 Effective Date 4/1/91

Supersedes TN No. 87-12

STATE Arkansas
5-6-91
12-5-91
4-1-91
91-17

REVISED: April 1, 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

SECTION 1924 PROVISIONS

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility, the State resource standard is the minimum spousal resource standard established at Section 1924(f)(2)(A) of the Social Security Act.

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

Undue hardship exists if each condition below is met:

1. counting uncompensated value would make an individual ineligible.

2. lack of assistance would deprive the individual of food and shelter.

3. the individual's combined total of gross income and countable resources (no income disregards allowed) do not exceed the applicable federal benefit rate (LTC income limit); and

4. the resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft or other extraordinary circumstance.

STATE Ark	A
DATE REC'D 5-6-91	
DATE APPV'D 7-8-91	
DATE EFF 4-1-91	
HCFA 179 91-16	

TN No. 91-16 Approval Date 7/8/91 Effective Date 4/1/91

Supersedes TN No. 90-12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **ARKANSAS**

ELIGIBILITY CONDITIONS AND REQUIREMENTS

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

For TB infected individuals under 1902(z)(1) of the Act, the income and resources eligibility levels are as follows:

The resource standard is the SSI resource limit with more liberal methods as described in Supplement 8b to Attachment 2.6-A.

The income standard is the SSI break-even amount computed by multiplying the SSI Federal Benefit Rate by 2, plus $85. This standard should be compared to the individual's actual gross income with more liberal methods as described in Supplement 8a to Attachment 2.6-A.

STATE Arkansas DATE RE[illegible] 9-25-2002 DATE A[illegible] 12-11-2002 DATE EF[illegible] 12-1-2002 HCFA 179 02-14	A

SUPERSEDES TN. 95-27

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arkansas

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Greater Need - Description (Reference Attachment 2.6-A, Page 4a, item a)

- Up to first $100.00 of earned income is disregarded for recipients in Nursing facilities whose physician's plan of care prescribes a self-employed activity as a therapeutic or rehabilitative measure. The total earned income disregarded and personal needs allowance cannot exceed $140.00.

- In order to foster self worth and to enhance recipients' level of productivity and quality of life, earned income from competitive and sheltered work opportunities, up to the SSI SPA, is disregarded for recipients in ICF/MR facilities. In addition, up to a $40.00 personal needs allowance will be deducted from any other income.

- For individuals receiving a VA pension limited to $90.00 per month under Section 8003 of P.L. 101-508 and Section 601 of P.L. 102-568, the personal needs allowance is the greater of the amount permitted to be paid under Section 8003 (up to $90.00) or amount specified in this section.

STATE Arkansas DATE RECD 4-26-99 DATE APPVD 6-16-99 DATE EFF 7-1-99 HCFA ID 99-01	A

STATE Arkansas
DATE REC'D 9-26-06
DATE APP'VD 12-18-06
DATE EFF 10-1-06
HCFA 179 06-15

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

__X__ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

_____ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

_____ This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

_____ This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Arkansas**

ASSET VERIFICATION SYSTEM

1940(a) 1. The Agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the Agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the Agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the Agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years.

State: Arkansas
Date Received: 9/30/13
Date Approved: 12/12/13
Date Effective: 10/1/13
Transmittal Number: 13-23

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Arkansas**

ASSET VERIFICATION SYSTEM

2. System Development

A. ____ The Agency itself will build and maintain an AVS.

In 3 below, describe how the system will meet the requirements in Section 1.

B. _X__ The Agency will hire the following contractor to build and maintain an AVS.

In 3 below, identify the contractor, if known, and describe how the system will meet the requirements in Section 1.

C. ____ The Agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also identify the contractor, if known, who will build and maintain the consortium's AVS, and how the system will meet the requirements in Section 1.

D. ____ The Agency already has a system in place that meets the requirements for an acceptable AVS:

In 3 below, describe how the system meets the requirements in Section 1.

E. ____ Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach how it will meet the requirements in Section 1.

State: Arkansas
Date Received: 9/30/13
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Arkansas**

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation description and other information requested for the implementation approach checked in Section 2.

Arkansas Department of Human Services intends to implement an AVS system and is currently working with Health Management Systems (HRS) to develop and implement an AVS system.

State: Arkansas
Date Received: 9/30/13
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Date Effective: 10/1/13
Transmittal Number: 13-23

State Plan Under Title XIX of the Social Security Act

State: ARKANSAS

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 03/31/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

State: Arkansas
Date Received: 13 December, 2013
Date Approved: 15 July, 2014
Effective Date: 1 January, 2014
Transmittal Number: 14-01

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	See Attachment A, Column C, Line 1 of the CMS approved MAGI Conversion Plan.	No	No	No	No
Disabled Persons, non-institutionalized	See Attachment A, Column C, Line 2 of the CMS approved MAGI Conversion Plan including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, institutionalized	See Attachment A, Column C, Line 3 of the CMS approved MAGI Conversion Plan including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Children Age 19 or 20	See Attachment A, Column C, Line 4 of the CMS approved MAGI Conversion Plan including any subsequent CMS approved modifications to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Childless Adults	See Attachment A, Column C, Line 5 of the CMS approved MAGI Conversion Plan including any subsequent CMS approved modifications to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
The numbers in this summary chart will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.					

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ■ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   State: Arkansas
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   Date Approved: 15 July, 2014
   Effective Date: 1 January, 2014
   Transmittal Number: 14-01

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ■ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

State: Arkansas
Date Received: 13 December, 2013
Date Approved: 15 July, 2014
Effective Date: 1 January, 2014
Transmittal Number: 14-01

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

- [x] Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

- [ ] The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

State: Arkansas
Date Received: 13 December, 2013
Date Approved: 15 July, 2014
Effective Date: 1 January, 2014
Transmittal Number: 14-01

A. Expansion State Designation

The state:

- [x] Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

- [ ] Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

- [ ] Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

- [ ] Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

State: Arkansas
Date Received: 13 December, 2013
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PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan

ARKANSAS

02/28/2014

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives**			no	new SIPP conversion	SIPP
	Dollar standards by family size					
	1	$108.33	$124			
	2	$216.66	$237			
	3	$275.00	$301			
	4	$333.33	$364			
	5	$383.33	$420			
	6	$441.66	$483			
	7	$500.00	$547			
	8	$558.33	$610			
	9	$616.66	$674			
	10	$675.00	$737			
	add-on	$58.33	$64			
2	**Noninstitutionalized Disabled Persons**			n/a	new SIPP conversion	SIPP
	Dollar standards					
	Single	$108.33	$108			
	Couple	$216.66	$217			
3	**Institutionalized Disabled Persons**	300%	300%	n/a	ABD conversion template	n/a
	SSI FBR%					
4	**Children Age 19-20**	n/a	n/a	n/a	n/a	n/a
5	**Childless Adults**	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable.

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APRIL 1994

State/Territory: ARKANSAS

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provide agreements with the Medicaid agency without regard to whether the nurse-midwife is unde the supervision of, or associated with, a physician or other health care provider.

___ Not applicable. Nurse-midwives are not authorized to practice in this State.

STATE Arkansas
DATE RECD 5-18-94
DATE APPVD 6-7-94
DATE EFF 4-1-94
HCFA 179 94-09

A

TN No. 94-09
Supersedes TN No. 93-39 Approval Date 6/7/94 Effective Date 4/1/94

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ARKANSAS

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

IV (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10), clause (VII) of the matter following (E) of the Act F

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(1)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

TN No. 91-53
Supersedes TN No. 90-61

Approval Date DEC 13 1991

Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA I/9 91-53

A

STATE	ARKANSAS
DATE REC'D	1-28-08
DATE APPV'D	3-28-08
DATE EFF	4-1-08
HCFA 179	07-23

A

Revision: HCFA Region VI (MB)
November 1992
Revised: April 1, 2008

State: Arkansas

Citation		Amount, Duration, and Scope of Services: Categorically Needy (Continued)
1902(a)(10)(D)	(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(e)(7) of the Act	(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved state plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	X (viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act	(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	___ (x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.
1915(j)	**X (xi)**	**Self-Directed Personal Assistance Services, as described and limited in Supplement 4 to Attachment 3.1-A.**

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration, and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy. **PACE and Self-Directed Personal Assistance Services are also included in Attachment 3.1-A.**

SUPERSEDES: TN- 01-44

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: ARKANSAS

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, Subpart B (a)(2) Medically needy.

/X This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act
42 CFR 440.220

(i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

/ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

(42 CFR 440.140 and 440.160)

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

TN No. 92-04
Supersedes TN No. 91-53
Approval Date FEB 20 1992
Effective Date MAR 01 1992
HCFA ID: 7982E

STATE Arkansas
DATE REC'D FEB 11 1992
DATE APPV'D FEB 20 1992
DATE EFF MAR 01 1992
HCFA 179 92-04
A

Revision: HCFA-PM-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: ARKANSAS

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

[X] (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

[ ] Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160, Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act, 1902(a)(10)(C)

[ ] (vii) Services in an institution for mental diseases for individuals over age 65..

[ ] (viii) Services in an intermediate care facility for the mentally retarded.

[X] (ix) Inpatient psychiatric services for individuals under age 21.

TN No. 92-06
Supersedes TN No. 91-[illegible]59 Approval Date 12/16/92 Effective Date 3/1/92

HCFA ID: 7982E

[illegible]
2-24-92
12-16-92
3-1-92
92-06

Revision: HCFA-PM-93- 5 (MB)
May 1993
Revised: April 1, 2008

State: Arkansas

STATE Arkansas
DATE REC'D 1-28-08
DATE APPV'D 3-28-08
DATE EFF 4-1-08
HCFA 179 07-23

A

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act ___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act ___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

1915(j) ___ **Self-Directed Personal Assistance Services, as described and limited in Supplement 1 to Attachment 3.1-B.**

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

SUPERSEDES: TN- 93-22

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: ARKANSAS

Citation	3.1 Amount, Duration, and Scope of Services (continued)	
	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I)1905(p)(3)(A)(ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals - 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

STATE: Arkansas
4/2/98
5/15/98
January 1, 1998
98-03
A

SUPERSEDES: TN. 93-09

TN No. 98-03
Supersedes TN No. 93-09
Approval Date 5/15/98
Effective Date January 1, 1998

Revision: HCFA-PM-97-3 (CMSO)
December 1997
Revised: January 1, 2003
State: ARKANSAS

1925 of the Act

(a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

SUPERSEDES: TN 98-03

STATE Arkansas	A
DATE RECD 31 Mar 2003	
DATE APPVD 6 May 2003	
DATE EFF 1 Jan 2003	
HCFA 179 AR 03-04	

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ARKANSAS

Citation		
	3.1(a)(6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act		(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	X (a)(8)	PRESUMPTIVELY ELIGIBLE PREGNANT WOMEN Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN No. 92-04
Supersedes TN No. 91-52 Approval Date FEB 20 1992 Effective Date MAR 01 1992

HCFA ID: 7982E

STATE Arkansas
DATE REC'D FEB 11 1992
DATE APPV'D FEB 20 1992
DATE EFF MAR 01 1992
HCFA 179 92-04
A

Revision: HCFA-PM-91- 4 AUGUST 1991 (BPD) OMB No.: 0938-

State/Territory: ARKANSAS

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 ☐ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

42 CFR 440.240 and 440.250 (a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), and 1925(b)(4) of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

☒ (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

TN No. 91-53
Supersedes TN No. 90-33
87-21
90-33

Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APP'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-53

A

Revision: HCFA - Region VI
November 1990

State ARKANSAS

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

Section 1905(a)(4)(A) of Act (Sec. 4211(f) of P.L. 100-203).

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☒ Yes, to all

☐ Yes, to individuals age 21 or over; nursing facility services are provided.

☐ Yes, to individuals under age 21; nursing facility services are provide

☐ No; nursing facility services are not provided.

☐ Not applicable; the medically needy are not included under this plan

STATE Arkansas
DATE REC'D DEC 19 1990
DATE APPV'D 4-19-91
DATE EFF OCT - 1 1990
HCFA 179 90-61

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TN # 90-61
Supersedes
TN # 80-07

Approval Date _____ Effective Date OCT - 1 1990

Revision: HCFA-PM-93-8 (BPD)
December 1993

State/Territory: ARKANSAS

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c) (1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c) (2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

STATE Arkansas
DATE REC'D 12-30-93
DATE APPV'D 01-19-94
DATE EFF 12-01-93
HCFA 179 93-36
A

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State - ARKANSAS

Citation
42 CFR 440.260
AT-78-90

3.1(d) Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

TN # 76-29
Supersedes
TN #

Approval Date 2/2/77 Effective Date 8/25/76

Revision: HCFA-PM-87-5 (BERC) OMB No.: 0938-0193
APRIL 1987

State/Territory: ARKANSAS

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/ / Yes.

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/X/ Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

/ / No.

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

STATE AR
RECD JUL 1 1987
APPD JUL 30 1987
See HCFA-179
87-12

A

TN No. 87-12
Supersedes
TN No. 76-29

Approval Date JUL 30 1987 Effective Date See HCFA-179

HCFA ID: 1008P/0011P

* U.S. GOVERNMENT PRINTING OFFICE: 1987—181-270/60174

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987
Revised: January 1, 2002
State/Territory: ARKANSAS

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/ / 30 consecutive days;

/X/ 24 days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/X/ Yes. The requirements of section 1902(e)(9) of the Act are met.

/ / Not applicable. These services are not included in the plan.

STATE Arkansas
DATE RECD 01-07-02
DATE APPVD 01-16-02
DATE EFF 01-01-02
HCFA 179 AR-01-44

A

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: ARKANSAS

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A X Part B

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

STATE Arkansas
DATE REC'D JUN 14 1993
DATE APP'D JUL 01 1993
DATE EFF MAY 01 1993
HCFA 179 93-22

A

TN No. 93-22
Supersedes TN No. 93-09
Approval Date JUL 01 1993
Effective Date MAY 01 1993

Revision: HCFA-PM-97-3 (CMSO)
December 1997
Revised: January 1, 2003
State: ARKANSAS

Citation		
1902(a)(10)(E)(ii) and 1905(s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual-1 (QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.

SUPERSEDES: TN 98-03

STATE Arkansas
DATE REC'D 31 Mar 2003
DATE APP'D 6 May 2003
DATE EFF 1 Jan 2003
HCFA 179 AR 03-04

A

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: ARKANSAS

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) withing a group listed at 42 CFR 431.625(d)(2).

___ Individuals receiving title II or Railroad Retirement benefits.

___ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

X The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

STATE: Arkansas
DATE RECD: 4/2/98
DATE APPVD: 5/15/98
EFF. DT.: January 1, 1998
TN NO: 98-03

A

SUPERSEDES: TN: 93-09

TN No. 98-03
Supersedes TN No. 93-09
Approval Date 5/15/98
Effective Date January 1, 1998

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: ARKANSAS

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

X For the entire range of services available under Medicare Part B.

___ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

STATE Arkansas
DATE REC'D MAR 25 1993
DATE APPV'D MAY 03 1993
DATE EFF JAN 01 1993
HCFA 179 93-09

A

TN No. 93-09
Supersedes TN No. 92-04
Approval Date MAY 03 1993
Effective Date JAN 01 1993

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

TN # 76-29
Supersedes
TN #

Approval Date 2/2/77 Effective Date 8/25/76

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 441.252
AT-78-99

3.4 Special Requirements Applicable to Sterilization Procedures

All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ARKANSAS

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

☒ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.

TN No. 91-53
Supersedes TN No. 90-28
Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-53

A

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ARKANSAS

Citation 3.5 **Families Receiving Extended Medicaid Benefits (Continued)**

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services.
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- ☐ Intermediate care facility services for the mentally retarded.
- ☐ Inpatient psychiatric services for individuals under age 21.
- ☐ Hospice services.
- ☐ Respiratory care services.
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

TN No. 91-53
Supersedes TN No. 91-28 Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
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DATE EFF OCT - 1 1991
HCFA 179 91-53

A

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ARKANSAS

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 mos. ☐ 2nd 6 mos.

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

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Supersedes TN No. 90-28 Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
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DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA ITR 91-33

A

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ARKANSAS

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

TN No. 91-53
Supersedes TN No. 90-28 Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-53
A

Revision: HCFA Region VI
May 1990

State/Territory: ARKANSAS

/_/ Enrollment is in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

/_/ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

STATE Arkansas	A
DATE REC'D 5-29-90	
DATE APPV'D 6-6-90	
DATE EFF 4-1-90	
HCFA 179 9028	

None-New Page

Revision: HCFA - Region VI
DECEMBER 1990

State/Territory: ARKANSAS

Sec 1905(o)(3) of the Act. (Sec 6408(c) of P.L. 10[illegible]-239 and Sec 4705 of P.L. 101-508)

3.8 Additional amounts for Nursing Facility Residents

When hospice care is furnished to an individual residing in a nursing facility, the hospice is paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility equals at least 95 percent of the per diem rate that would have been paid to the nursing facility for that individual in that facility under this State Plan.

TN No 90-64 Approval Date 1/14/91 Effective Date 4/1/90
Supersedes
Tn No New Page

STATE Arkansas
DATE REC'D 12-20-90
DATE APP'VD 3-18-91
DATE EFF 4-1-90
HCFA 179 90-64

A

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: /_/ No limitations /X/ With limitations*

2.a. Outpatient hospital services.

   Provided: /_/ No limitations /X/ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic and covered under the Plan.

   /X/ Provided: /_/ No limitations /X/ With limitations*

   /_/ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: /_/ No limitations /X/ With limitations*

3. Other laboratory and x-ray services.

   Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

STATE Arkansas
DATE REC'D DEC 30 1991
DATE APPV'D JUL 29 1992
DATE EFF JAN 01 1992
HCFA 179 91-64
A

Supersedes TN-91-54

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED **Revised:** **July 1, 2026**

CATEGORICALLY NEEDY

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1. Inpatient Hospital Services

Inpatient admissions to an acute care/general hospital will be allowed up to seven (7) days of service per admission when determined inpatient care is medically necessary. On the eighth day of hospitalization, if the physician determines the patient should not be discharged on the eighth day of hospitalization, the hospital may request an extension of inpatient days.

Inpatient admissions to a rehabilitative hospital will be allowed up to ten (10) days of service per admission when determined inpatient care is medically necessary. Extension of benefits will be available when medically necessary. Medically necessary inpatient days are available to individuals under age 1 without regard to corresponding hospital day limit and extension procedures

1. Inpatient Hospital Services (continued)

Substance Use Disorder Residential Treatment provided in Acute Care Hospitals for Individuals under age 21

For Inpatient Substance Use Disorder Residential Treatment Unit admissions will follow a 100% prior authorization process to determine medical necessity for inpatient admission utilizing the American Society of Addition Medicine (ASAM) criteria. Inpatient Substance Use Disorder Residential Treatment Unit Services are not covered when provided in an Institution for Mental Disease (IMD).

1. Inpatient Hospital Services (continued)

Acute Crisis Unit

Effective for dates of service on or after July 1, 2021, Hospital Acute Crisis Units are covered for eligible Medicaid clients who are experiencing a psychiatry or substance use disorder, or both, crisis that does not meet the need for inpatient hospitalization. These units provide hospital diversion and step-down services in a safe environment with psychiatry and substance use disorder services available on-site, as well as on-call psychiatry available 24 hours per day. They must ensure the following services are available at a minimum:

A. ongoing assessment and observation;
B. crisis intervention;
C. psychiatric, substance, and co-occurring treatment; and
D. initiation of referral mechanisms for independent assessment and care planning.

Services are available for up to 96 hours per encounter. Providers must initiate an extension of benefits request for medical necessity approval prior to providing services beyond 96 hours.

This expenditure is being paid as inpatient hospital because the definition of outpatient limits services to less than a 24-hour period. (42 CFR 440.2)

1. Inpatient Hospital Services

A. Rehabilitative Hospital

1. Augmentative Communication Device (ACD) Evaluation - Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.

STATE Arkansas
DATE RECD 6-28-99
DATE APPVD 9-17-99
DATE EFF 9-1-99
HCFA 179 99-10

A

SUPERSEDES: NONE - NEW PAGE

2.a. Outpatient Hospital Services

(1) For the purpose of determining amount, duration and scope, outpatient hospital services are divided into four types of services:

- Emergency services
- Outpatient surgical procedures
- Non-emergency services
- Therapy/treatment services

Emergency Services

The determination of an emergency medical condition will be in compliance with Section 1867 of the Social Security Act.

A retrospective review will be performed by the Professional Review Organization (PRO) on a sampling of paid claims.

Non-emergency services may be necessary in the outpatient hospital setting when qualified physicians are not available in their offices or walk-in clinics to carry out the necessary treatment.

2.a. Outpatient Hospital Services (Continued)

Outpatient Surgical Procedures

Coverage of outpatient surgical procedures are limited to procedures which the Arkansas Medicaid Program has determined to be safe and effective when performed on an outpatient basis.

Since outpatient surgical procedures are limited to approved **medically necessary** services, no additional benefit limitations are imposed.

Treatment/Therapy Services

The covered outpatient hospital treatment/therapy services include, but are not limited to the following:

- Dialysis
- Radiation therapy
- Chemotherapy administration
- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy
- Factor 8 injections
- Burn therapy

Treatment/therapy services are included in the outpatient hospital services limit of twelve (12) visits per State Fiscal Year.

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure**;** opioid use disorder when the visit is part of a Medication Assisted Treatment Plan**;** and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.a. Outpatient Hospital Services (Continued)

Augmentative Communication Device (ACD) Evaluation

Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.

STATE Arkansas DATE REC'D 6-28-99 DATE APP'D 9-12-99 DATE EFF 9-1-99 HCFA ID 99-10	A

SUPERSEDES: NONE - NEW PAGE

2.b. Rural Health Clinic Services

Rural health clinic services are limited to **sixteen (16) encounters** a year for **clients twenty-one (**21**) years of age** and older. This yearly limit is based on the State Fiscal Year (July I through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, **federally qualified health center encounters, and advanced practice registered nurse services,** or a combination of the seven.

Extensions **of the benefit limit** will be **available** if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients** under age **twenty-one (**2l**)** in the Child Health Services (EPSDT) Program are not benefit limited.

Rural **health clinic** core services are defined as follows:

1. Physicians' services, **advanced practice registered nurse's services**, and physician assistant s**ervices when properly supervised**;

2. Services and supplies furnished as an incident to professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants or **advanced practice registered** nurse**s** are those which are commonly furnished in connection with these professional services, are generally furnished in the **rural health center** office, and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

3. Clinical psychologist services;

4. Clinical social worker services;

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CATEOGORICALLY NEEDY

2.b. Rural Health Clinic Services

5. Services of nurse midwives

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4). Federally qualified health center services are limited to sixteen (16) encounters per client**,** per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

For federally qualified health center core services beyond the benefit limit, extensions will be available if medically necessary. Beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA - Pub. 45-4). (Continued)

Covered FQHC core services are defined as follows:

- physician services;
- services and supplies incident to physician's services (including drugs and biologicals that cannot be self-administered);
- Immunizations provided based on recommendations of the Advisory Committee on Immunization Practices (ACIP) and their administration;
- physician assistant services;
- nurse practitioner services;
- clinical psychologist services;
- clinical social worker services;
- **licensed certified social worker services;**
- **licensed professional counselor services;**
- **licensed mental health counselor services;**
- **licensed marriage and family therapist services;**
- services and supplies incident to clinical psychologis**t,** clinical social worke**r, licensed certified social worker, licensed professional counselor, licensed mental health counselor, and licensed marriage and family therapist** services as would otherwise be covered if furnished by or incident to physician services; and
- part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440.70.

FQHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the FQHC offers such a service, (e.g. dental, etc.). The "other ambulatory services" that are provided by the FQHC will count against the limit established in the plan for that service.

CATEGORICALLY NEEDY

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3. Other Laboratory and X-Ray Services

Other **professional and technical laboratory and radiological services** are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined **under 42 CFR 440.30 in an office or similar facility other than a hospital outpatient department or clinic.**

Diagnostic laboratory **s**ervices benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY**,** July 1 – June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services health benefit limit**s: (**a**)** Malignant neoplasm; **(**b**)** HIV infection; and **(c)** renal failure. The cost of related diagnostic laboratory services, and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limits or the five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD)**,** and the screening is part of a Medication Assisted Treatment **(**MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory services health benefit limit.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per SFY outpatient diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY radiology/other services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their place of residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per **S**FY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

4.a. **Nursing Facility Services (other than services in an institution for mental diseases) for individuals 21 years of age or older.**

A Registered Nurse and a Physician Reviewer assess medical needs and make medical eligibility determinations and patient level of care classifications for applicants referred by a physician for nursing home care.

Nursing facility services include coverage of prescription medications within the State's formulary without limitations.

STATE Arkansas
DATE REC'D DEC 19 1990
DATE APP'VD 4-19-91
DATE EFF OCT - 1 1990
HCFA 179 90-67

A

Supersedes: 89-46

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found.

(1) No limitations on services within the scope of the program (except for consultations, home health services and personal care services) if services are EPSDT related. Extension of the benefit limit for consultations (2 per State Fiscal Year), home health services (50 visits per State Fiscal Year), personal care services (64 hours per calendar month), personal care transportation (50 units per date of service per recipient), physical therapy evaluations (**2** per State Fiscal Year), occupational therapy evaluations (**2** per State Fiscal Year), speech-language therapy evaluations (4 units per State Fiscal Year), and chiropractor X-ray services (2 per State Fiscal Year) will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

Medical Screens are provided based on the recommendations of the American Academy of Pediatrics. Immunizations are provided based on recommendations of the Advisory Committee on Immunization Practices (ACIP).

The State will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan.

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(2) Apnea (Cardiorespiratory) Monitors

Apnea (cardiorespiratory) monitors are provided for eligible recipients in the EPSDT Program. Use of the apnea monitors must be medically necessary and prescribed by a physician. Prior authorization is not required for the initial one-month period. If the apnea monitor is needed longer than the initial month, prior authorization is required.

(3) **Early Intervention Day Treatment (EIDT) Services**

EIDT clinics provide clinic-based evaluation and treatment services for the purpose of early intervention and prevention to eligible recipients in the EPSDT Program. Beneficiaries that have yet to reach school-age may receive EIDT services year-round. School-age beneficiaries can only receive EIDT services during the summer when school is not in session.

A beneficiary must receive an evaluation referral signed and dated by the beneficiary's primary care provider (PCP) to receive EIDT services. For a beneficiary that has yet to reach school-age, the beneficiary's PCP must have completed an approved developmental screen for the beneficiary within the twelve (12) months immediately preceding the date of the evaluation referral. A comprehensive developmental evaluation is a required component of determining EIDT eligibility for beneficiaries who have yet to reach school age. School-age beneficiaries must have a documented qualifying intellectual or developmental disability diagnosis as defined in Ark. Code Ann. § 20-48-101(4) to receive EIDT services during the summer when school is not in session.

A prescription is required for all early intervention and prevention services at an EIDT clinic. If the beneficiary's PCP determines EIDT services are medically necessary based on the results of the beneficiary's evaluations or qualifying medical diagnosis, then the PCP would issue a prescription on a DMS-642 YTP (year-round treatment prescription), or on a DMS-642 STP (summer only treatment prescription) depending on whether the beneficiary had reached school age. The PCP will include the amount and duration of each EIDT service a beneficiary is to receive on the appropriate form. A beneficiary receiving EIDT services is required to receive a new comprehensive developmental evaluation, if applicable, and prescription every twelve (12) months to continue receiving EIDT services.

Since EIDT services are clinic-based services, these services cannot be delivered through telemedicine or at any location other than the licensed EIDT clinic. EIDT providers are considered all-inclusive, meaning a beneficiary attending an EIDT should have all of their habilitative occupational therapy, physical therapy, and speech-language pathology service needs performed by the EIDT program at the EIDT clinic.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 1j

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: April 4, 2008

CATEGORICALLY NEEDY

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(4) RESERVED

(5) Private Duty Nursing **to enhance the effectiveness of ~~ventilator or tracheotomy equipment~~** treatment for ventilator dependent beneficiaries or high technology non-ventilator beneficiaries

Enrolled providers are Private Duty Nursing Agencies licensed by Arkansas Department of Human Services, Division of Health. Services are provided by Registered Nurses or Licensed Practical Nurses licensed by the Arkansas State Board of Nursing.

A. Ventilator Dependent Beneficiaries or
B. High Technology Non-Ventilator Dependent Beneficiaries

Beneficiaries under age 21 to receive PDN Nursing Services must require constant supervision, visual assessment and monitoring of both equipment and patient.

Services are limited to eligible Medicaid beneficiaries in the EPSDT Program. Private duty nursing services for non-ventilator dependent beneficiaries include patients requiring at least two of the following services:

(1) Intravenous Drugs (e.g. chemotherapy, pain relief or prolonged IV antibiotics)
(2) Hyperalimentation - parenteral or enteral
(3) Respiratory - Tracheostomy or Oxygen Supplementation
(4) Total Care Support for ADLs and close patient monitoring

These services require prior authorization. Services may be provided in the beneficiaries' home, a Division of Developmental Disabilities (DDS) community provider facility or a public school. (Home does not include an institution.) Prior authorization is required. Private duty nursing medical supplies are limited to a maximum reimbursement of $80.00 per month, per beneficiary With substantiation, the maximum reimbursement may be extended.

SUPERSEDES: TN- 06-16

STATE Arkansas
DATE REC'D 6-11-08
DATE APP'VD 8-18-08
DATE EFF 4-4-08
HCFA 179 07-21

A

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

6. Cochlear Implants

Coverage of Cochlear implantation is limited to recipients in the EPSDT Program. This procedure requires a prior authorization.

STATE Arkansas
DATE REC'D APR - 4 1991
DATE APP'VD MAY - 9 1991
DATE EFF FEB - 1 1991
HCFA I.D. 91-15
A

Supersedes: 90-16

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(7) Dentures

Dentures are provided to eligible Medicaid recipients in the Child Health Services (EPSDT) Program with prior authorization from the Medical Assistance Section.

(8) Hearing Aid Dealers

Supplies prescribed instrument after medical clearance and upon recommendation of an audiologist to eligible recipients in the Child Health Services (EPSDT) Program. Maintenance of instrument provided with prior approval from the Utilization Review Section.

(9) Audiologist Services

Provision of audiometric testing and hearing aid evaluation to eligible recipients in the Child Health Services (EPSDT) Program.

Arkansas
DEC 30 1991
DEC 14 1992
DEC 01 1991
91-59
A
Supersedes TN 91-28

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(10) Hearing Aids

The provision of hearing aids, accessories and repairs for eligible Medicaid recipients in the Child Health Services (EPSDT) Program with prior authorization from the Utilization Review Section. Hearing aid is limited to two appliances per six month period. With prior authorization, additional services may be provided if medically necessary.

(11) Eye Prostheses

Eye prostheses are provided for eligible Medicaid recipients in the Child Health Services (EPSDT) Program with prior authorization from the Medical Assistance Section.

(12) Desensitization Injections

Limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

ARKANSAS
JUL 01 1991
NOV 14 1991
JUL 01 1991
Supersedes: 91-15; 90-02

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services(42 CFR 440.130(d))

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Outpatient Behavioral Health Services (OBHS)

As part of the Behavioral Health transformation within the state of Arkansas, DMS is creating a more integrated and client-focused behavioral health care system. These changes were developed in coordination with the Division of Behavioral Health Services (DBHS), providers, representatives of the Arkansas System of Care, beneficiaries and other key stakeholders.

A. Scope

Care, treatment and services provided by a certified Behavioral Health Services provider to Medicaid-eligible beneficiaries. These services are available to all eligible Medicaid beneficiaries. Services which require an Independent Assessment are indicated by the statement, "Eligibility for this service is determined by an Independent Assessment and must be prior authorized."

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

B. Services

i.: Individual Behavioral Health Counseling*

DEFINITION: Individual Behavioral Health Counseling, including tobacco cessation counseling, is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

i.: Individual Behavioral Health Counseling(continued)*

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

ii. Group Behavioral Health Counseling*

DEFINITION: Group Behavioral Health Counseling, including tobacco cessation, is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling with Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present (continued)*

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

iv. Marital/Family Behavioral Health Counseling without Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling without Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

v. Group Psychoeducation*

DEFINITION: Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery for the benefit of the beneficiary. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children. Dyadic treatment must be prior authorized.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the Provider must have Arkansas State Infant Mental Health Certification.

vi. Multi-Family Behavioral Health Counseling*

DEFINITION: Multi-Family Behavioral Health Counseling, including tobacco cessation, is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others for the benefit of the beneficiary. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

vii. Mental Health Diagnosis*

DEFINITION: Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

viii. Interpretation of Diagnosis*

DEFINITION: Interpretation of Diagnosis is a direct service provided for the purpose of interpreting and communicating the results of psychiatric or other medical exams, procedures, or accumulated data. Services also include diagnostic activities, as needed, and/or advising the beneficiary and his/ her family of the ramifications of the diagnosis. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

ix. Substance Abuse Assessment*

Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DBHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

ix. Substance Abuse Assessment (continued)*

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician;

x. Psychological Evaluation*

DEFINITION: Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.

Allowable Performing Provider - Licensed Psychologist, Licensed Psychological Examiner and a Licensed Psychological Examiner - Independent

xi: Pharmacologic Management*

DEFINITION: Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

xii: Psychiatric Assessment*

DEFINITION: Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(14) RESERVED

(15) Physical Therapy and Related Services

a. Physical Therapy

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Effective for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(3) Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.

A qualified physical therapist assistant may provide services under the supervision of a licensed physical therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(4) Effective for dates of service on or after July 1, 2017, individual and group therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(15) Physical Therapy and Related Services (Continued)

b. Occupational Therapy

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Services must be prescribed by a physician and provided by or under the supervision of a qualified occupational therapist.

A qualified occupational therapist assistant may provide services under the supervision of a licensed occupational therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(3) Effective for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(4) Effective for dates of service on or after July 1, 2017, individual and group occupational therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

c. Services for individuals with speech, hearing and language disorders (provided by or under the supervision of a speech pathologist or audiologist)

(1) Speech-language pathology services are limited to Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Speech-**language** pathology services must be referred by a physician and provided by or under the supervision of a qualified speech-**language** pathologist.

A qualified speech-**language** therapist assistant may provide services under the supervision of a licensed speech-**language** therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(3) Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(4) Effective for dates of service on or after July 1, 2017, individual and group speech-language pathology services are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(16) Dental Services

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Procedures which may be provided to recipients in the Child Health Services (EPSDT) Program without prior authorization are:

a. Initial radiographs taken in conjunction with preparation of a treatment plan.

b. Periodic oral exam, prophylaxis, topical fluoride **and/or fluoride varnish** for children in the Child Health Services (EPSDT) Program.

c. Emergency treatment. One visit without prior authorization is payable for any emergency. Procedures payable without prior authorization when provided as emergency care include:

1. All necessary radiographs.
2. Extraction of up to three teeth for relief of pain or acute infections.
3. Control of bleeding.
4. Treatment for relief of pain resulting from injuries to the oral cavity or related services.
5. Emergency services provided to patients in hospitals or long term care facilities.

All other procedures require prior authorization from the Medical Assistance Section. A full mouth radiograph is limited to once every five years. Periodic oral exam, prophylaxis, fluoride treatment, **fluoride varnish** and bite-wing X-rays are limited to once per 6 (six) months plus 1 (one) day. Scaling is limited to one per state fiscal year (July 1 through June 30). Periapical X-rays are limited to four (4) per recall visit. Any limits will be exceeded based on medical necessity.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

17. Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Residential Rehabilitation Center Services

- Restorative Therapies
- Behavioral Rehabilitation
- Life Skills Training for Rehabilitation
- Individual and Group Counseling
- Assessment Services
- Nursing Care

Residential Rehabilitation Center Services are available to eligible Medicaid recipients under age 21 in the Child Health Services (EPSDT) Program. There is no established benefit limit other than medical necessity as determined by the Professional Review Organization (PRO). The medical necessity criteria includes need for services in the residential setting. Persons needing rehabilitative services on a less intense basis than provided in the inpatient setting may receive outpatient rehabilitative services through other appropriate service categories included in the state plan, e.g., outpatient hospital, physical therapy, occupational therapy and speech therapy, rehabilitative services for persons with mental illness (RSPMI) and home health.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services

1. School-Based Mental Health Services

a. Services are limited to eligible Medicaid recipients under age 21 in the Child Health Services (EPSDT) Program.

b. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary.

c. Services are provided at the school or in the home when the home is considered to be an educational setting for a child who is enrolled in the public school system. The home is not considered a place of service when the parent elects to home school the child.

d. The State assures that eligible Medicaid recipients will be given free choice of providers within and outside the school setting.

e. Provider Qualifications

The Arkansas Medicaid program has established provider participation requirements for school-based mental health services.

In order to ensure quality and continuity of care, School Districts and/or Education Services Cooperatives that are School-Based Mental Health Service Providers approved to receive Medicaid reimbursement must ensure that contractors and personnel engaged as Licensed School-Based Mental Health Practitioners meet specific Medicaid qualifications. Practitioners licensed as school-based mental health services provider personnel may provide the services according to their scope of practice as identified by the licensure requirements. Services will be provided by the following:

1. School Psychology Specialist (licensed by the Arkansas Department of Education (ADE)
2. Licensed Certified Social Worker (licensed by the Arkansas Social-Work Licensing Board)
3. Licensed Masters Social Worker (licensed by the Arkansas Social-Work Licensing Board)
4. Psychological Examiner (licensed by the Arkansas Board of Examiners in Psychology)
5. Licensed Psychologist (licensed by the Arkansas Board of Examiners in Psychology)
6. Licensed Professional Counselor (licensed by the Arkansas Board of Examiners in Counseling)
7. Licensed Associate Counselor (licensed by the Arkansas Board of Examiners in Counseling)

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CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (42 CFR 440.130(d)) (continued)

1. School-Based Mental Health Services (continued)

f. Covered Services (continued)

1. Individual Behavioral Health Counseling - A face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.

2. Mental Health Diagnosis - A clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

3. Psychological Evaluation - Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (42 CFR 440.130(d)) (continued)

1. School-Based Mental Health Services (continued)

f. Covered Services (continued)

4. Interpretation of Diagnosis - A direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.

5. Marital/Family Behavioral Health Counseling with Beneficiary Present - A face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

6. Crisis Intervention – An unscheduled, immediate, short-term treatment activity provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services, which can include interventions, stabilization activities, coping strategies and other various activities to assist the beneficiary in crisis, are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. The services provided are expected to reduce or eliminate the risk of harm to the person or others in order to stabilize the beneficiary. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (continued)

1. School-Based Mental Health Services (42 CFR 440.130(d)) (continued)

f. Covered Services (continued)

7. Group Behavioral Health Counseling - Face-to-face treatment provided to a group of beneficiaries, including tobacco cessation. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. Rehabilitative Services for Children

ELIGIBILITY FOR SERVICES

The following recipients are eligible for rehabilitative services to children as set forth in this Section:

A. General Eligibility

1. Categorically Needy Medicaid recipients.

B. Specific Eligibility

1. The recipient must be age twenty (20) years or less, and

2. Require rehabilitative mental health services based on recommendation of a physician or other licensed and/or certified practitioner of the healing arts acting within their scope of practice as defined in state law and/or regulations.

DURATION OF SERVICES

Each Title XIX EPSDT recipient is eligible for covered rehabilitative services in accordance with 42 CFR 440.130(d) which are medically necessary. There shall be a determination, made by a child service agency designated by state law and/or regulations, at Title 9, Chapter 30 of the Arkansas Code to make such a determination, that the child continues to be either at risk of abuse or neglect or is abused or neglected. The Division of Medical Services, as the entity authorized to determine medical necessity, reserves the right to request additional information to determine medical necessity.

COVERED SERVICES

A covered service is a specific non-residential or residential rehabilitative service determined to be medically necessary, as defined above, and included in a child's treatment plan prepared by a qualified provider of rehabilitative services to children. These services are designed to ameliorate psychological or emotional problems related to neglect and/or abuse, to restore psychological or emotional functioning which was impaired by the problems related to neglect

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. **Rehabilitative Services for Children (Continued)**

and/or abuse, and to assist the child in improving or maintaining his/her highest functioning level. The following services are covered when provided according to the plan of care and when care is provided by professional state licensed and/or certified psychiatrists, psychologists, counselors, and social workers acting within their scope of practice as defined in state law and/or regulations.

1. **Evaluation, Assessment, and Plan of Care Development - This non-residential service includes the initial assessment of a child's service needs and the development of a Care Plan to address those needs.**

(a) **The evaluation and assessment shall:**

(1) **Be based on informed clinical opinion;**

(2) **Be conducted by a team of professionals trained to utilize appropriate evaluative methods and procedures and acting within their scope of practice or responsibility as defined in State law and/or regulations; and**

(3) **Include an evaluation of the child's cognitive development, social and emotional development and adaptive development.**

(b) **The plan of care shall contain:**

(1) **A written plan using the information derived from the evaluation and assessment;**

(2) **A statement of the child's present level of functioning in the domains examined in the evaluation and assessment;**

(3) **A statement of the specific services and supports necessary to meet the unique needs of the child, the setting in which the services are to be delivered, the frequency and method of delivery, and the anticipated duration of services;**

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. Rehabilitative Services for Children (Continued)

(4) A statement of the persons responsible for implementing the plan of care; and

(5) A statement of the functional outcomes expected to be achieved though the provision of services and supports.

2. Therapeutic Foster Care - This residential service is provided to children whose plan of care indicates a need for a structured and consistent home environment in order to learn to manage their behavior. This twenty-four hour service consists of face-to-face interventions with a child to assist the child in understanding the consequences of inappropriate behaviors and adhering to a behavioral routine which minimizes inappropriate behaviors and their consequences. This service is provided for the purpose of the development, restoration, and/or maintenance of the child's mental or emotional growth and the development, restoration, and/or maintenance of the skills to manage his/her mental or emotional condition.

3. Residential Treatment - This residential service provides twenty-four hour treatment to children whose psychological or emotional problems related to neglect and/or abuse can best be restored by residential treatment in accordance with the child's plan of care. The objective of this service is to assist the child in improving or maintaining his/her highest functioning level through individual and group therapeutic interventions to improve or maintain the skills needed to safely and securely interact with other persons, through symptom management to allow the child to identify and minimize the negative effects of psychiatric or emotional symptoms which interfere with the child's personal development and community integration, and through supportive counseling with a child to develop, restore and/or maintain the child's mental or emotional growth.

PROVIDER QUALIFICATION

Rehabilitative services for children will be provided only through qualified provider agencies. Qualified provider agencies must meet the following rehabilitative services for children criteria:

1. Have full access to all pertinent records concerning the child's needs for services including records of the Arkansas District Courts, local Children's Service Agencies, and State Child and Family Services Agency,

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. **Rehabilitative Services for Children (Continued)**

2. **Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population,**

3. **Have a minimum of one year's experience in providing all core elements of rehabilitative services for children,**

4. **Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements,**

5. **Have a financial management capacity and system that provides documentation of services and costs in, conformity with generally accepted accounting principles,**

6. **Have a capacity to document and maintain individual case records in accordance with State and Federal requirements, and**

7. **Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing, and audits.**

SERVICE SETTINGS

Rehabilitative services for children will be provided in the least restrictive setting appropriate to the child's assessed condition, plan of care, and service needs. Services shall be provided to children in one of the following settings:

1. **Non-residential services provided to children who reside in a family home setting will be provided either in the child's home or in the customary place of business of a qualified provider.**

2. **Residential services provided to children who reside outside of a family home will be provided in an appropriately state licensed and/or certified facility including:**

(a) **Therapeutic foster homes licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services.**

SUPERSEDES: NONE - NEW PAGE

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. **Rehabilitative Services for Children (Continued)**

3. **Services shall not be reimbursed when provided in the following settings:**

(a) **Nursing facilities,**

(b) **Intermediate care facilities for the mentally retarded, and**

(c) **Institutions for the treatment of mental diseases.**

FREEDOM OF CHOICE

The State assures that the provision of rehabilitative services for children will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. **Eligible recipients will have free choice of any qualified provider of rehabilitative services for children, and**

2. **Eligible recipients will have free choice of the providers of other medical care as covered elsewhere under the Plan.**

COMPARABILITY OF SERVICES

The State assures that the provision of rehabilitative services for children will not limit an individual's access to medically necessary services in violation of section 1902(a)(10) of the Act.

1. **Rehabilitative services for children will be made available to all children for whom this service is determined to be medically necessary, and**

2. **All medically necessary health care services described in section 1905(a) will be provided to all EPSDT eligible recipients.**

SUPERSEDES: NONE - NEW PAGE

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. **Rehabilitative Services to Youth**

ELIGIBILITY FOR SERVICES

The following recipients are eligible for rehabilitative services to youth as set forth in this Section:

A. **General Eligibility**

1. **Categorically Needy Medicaid recipients.**

B. **Specific Eligibility**

1. **The recipient must be age twenty (20) years or less, and**

2. **Require rehabilitative mental health services based on recommendation of a physician or other licensed and/or certified practitioner of the healing arts acting within their scope of practice as defined in state law and/or regulations.**

DURATION OF SERVICES

Each Title XIX EPSDT recipient is eligible for covered rehabilitative services in accordance with 42 CFR 440.130(d) which are medically necessary. There shall be a determination, made by a youth services agency designated by state law and/or regulations, at Title 9, Chapter 28 of the Arkansas Code to make such a determination, that the youth continues to be either at risk of delinquency or is delinquent and is in need of those services specified at Title 9, Chapter 28 of the Arkansas Code. The Division of Medical Services, as the entity authorized to determine medical necessity, reserves the right to request additional information to determine medical necessity.

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SUPERSEDES PREVIOUS PAGE

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

COVERED SERVICES

A covered service is a specific in-home or out-of-home non-residential or residential rehabilitative service determined to be medically necessary, as defined above, and included in a youth's treatment plan prepared by a qualified/certified provider of rehabilitative services to youth. These services are designed to ameliorate psychological or emotional problems of youth, which contribute to delinquent behavior and placement or the risks of placement in the youth services system. They are designed to restore psychological or emotional functioning of the youth to assist him/her in achieving or maintaining his/her highest functioning level. The following services are covered when provided in a setting appropriate to the plan of care and when care is provided through a certified provider of rehabilitative services for youth.

1. Diagnosis and Evaluation - This non-residential service provides assessment of the nature and extent of a youth's physical, emotional, educational and behavioral problems and recommendations for treatment strategies to remedy the identified problems. The specific diagnostic services provided and level of sophistication of reports produced are based on the individual needs of the referring agency. Allowable components include:

   (a) Social assessment,

   (b) Psychological evaluation,

   (c) Psychiatric evaluation,

   (d) Consultation with the referring agency, and

   (e) A medical evaluation, if the assessment indicates a physical association with the emotional and/or behavioral problem(s).

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CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

2. Therapy - This non-residential service provides for a therapeutic relationship between the client and a "qualified therapist" for the purpose of accomplishing changes that are identified as goals in the case plan through the use of various counseling techniques. Services to specific individuals include:

(a) Individual therapy,*
(b) Group therapy,*
(c) Family therapy* (youth included), and
(d) Consultation with the referral source.

Qualified therapist is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Therapist" the individual must be in good standing before the board to which he or she is licensed.

3. Emergency Shelter - This residential service provides services for youth whose circumstances or behavioral problems necessitate immediate removal from their homes or for youth released from a youth services facility who need temporary placement in the community until long term residential arrangements can be made. Emergency Shelter services include:

(a) Additional evaluation of the nature and extent of a youth's emotional and behavioral problems, including social assessment psychological evaluation, psychiatric evaluation and consultation with the referring agency, and

(b) Interventions to address the youth's emotional and behavioral problems.

The extent and depth of services provided to a youth in the Emergency Shelter program depends upon the individual needs of the youth and the referral source.

*** Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.**

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

4. Therapeutic Foster Care - This residential service provides intensive therapeutic care for children provided in family homes which operate within a comprehensive residential treatment system or as an adjunct to a mental health treatment program and for which a service fee is paid to specially trained foster families. Care givers who provide this service in their homes, if not specially trained, are specifically qualified to provide the service because they have an educational or a professional background that attests to qualification equal to or greater than that of care givers who have received special training. Children to whom this service is provided have physical, emotional, or behavioral problems which cannot be remedied in their own home, in a routine foster parenting situation, or in a residential program.

5. Therapeutic Group Home - This residential service provides twenty-four hour intensive therapeutic care provided in a small group home setting for youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment, as diagnosed by a qualified professional. The program is offered to prepare a juvenile for less intensive treatment, independent living, or to return to the community.

6. Residential Treatment - This residential service provides twenty-four hour treatment service available for up to one year for each individual, for youth whose emotional and/or behavioral problems, as diagnosed by a qualified professional, cannot be remedied in his or her own home. Residential Treatment services require the formulation and implementation of an individualized treatment plan with time-framed, measurable objectives for each youth.

Qualified professional is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Professional" the individual must be in good standing before the board to which he or she is licensed.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

PROVIDER QUALIFICATION

Rehabilitative services for youth will be provided only through qualified providers and provider agencies. Qualified rehabilitative services for youth provider agencies must meet the following criteria. Care is provided by qualified therapists , other qualified professionals and staff, qualified by experience and/or training, of certified rehabilitative services providers for youth. Rehabilitative services providers for youth must:

1. Be certified by the State Youth Services Agency as having programs and professional staff capable of delivering the rehabilitative services offered under the Plan,

2. Have full access to all pertinent records concerning the youth's needs for services including records of the Arkansas District Courts, local Youth Service Agencies, and State Youth Services Agency,

3. Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population,

4. Have a minimum of one year's experience in providing rehabilitative services for youth,

5. Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements,

6. Have a financial management capacity and system that provides documentation of services and costs in conformity with generally accepted accounting principles,

7. Have a capacity to document and maintain individual case records in accordance with State and Federal requirements, and

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

8. Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.

SERVICE SETTINGS

Rehabilitative services for youth will be provided in the least restrictive setting appropriate to the youth's assessed condition, plan of care and service. Services shall be provided to youth in one or more of the following settings:

1. Non-residential services provided to youth who reside in a family home setting will be provided either in the youth's home or in the customary place of business of a qualified provider.

2. Residential services provided to youth who reside outside of a family home will be provided in an appropriately state licensed and/or certified setting including:

(a) Emergency shelter facilities licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services,

(b) Residential treatment facilities licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services, and

(c) Therapeutic foster and group homes licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

SERVICE SETTINGS(Continued)

3. Services shall not be reimbursed when provided in the following settings:

(a) Nursing facilities,

(b) Intermediate care facilities for the mentally retarded, and

(c) Institutions for the treatment of mental diseases.

FREEDOM OF CHOICE

The State assures that the provision of rehabilitative services for youth will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of any the qualified providers of rehabilitative services for youth, and

2. Eligible recipients will have free choice of the providers of other medical care as covered elsewhere under the Plan.

COMPARABILITY OF SERVICES

The State assures that the provision of rehabilitative services for youth will not limit an individual's access to medically necessary services in violation of section 1902(a)(10) of the Act.

1. Rehabilitative services for youth will be made available to all children for whom this service is determined to be medically necessary, and

2. All medically necessary health care services described in section 1905(a) will be provided to all EPSDT eligible recipients.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners

1. Licensed Certified Social Worker (LCSW)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed certified social worker (LCSW) who has a Master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (CSWE). The LCSW must be State licensed and certified to practice as a Licensed Certified Social Worker (LCSW) in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LCSW services are:
1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

2. Licensed Professional Counselors (LPC)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed professional counselor (LPC) who must possess a Master's degree in mental health counseling from an accredited college or university. The LPC must be licensed as a Licensed Professional Counselor and be in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting medical necessity. Covered outpatient LPC services are:
1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

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* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- CO-06

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

3. Licensed Marriage and Family Therapist (LMFT)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:

1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

23. Developmental Rehabilitation Services

Developmental Rehabilitation Services are early intervention services for eligible Medicaid recipients under three years of age that have been identified as medically necessary and recommended by a licensed physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. This program covers two basic services:

1. Developmental Testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour. (Limited to four (4) one hour units per calendar year.)

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This service provides a diagnostic process necessary for the purpose of determining a child's initial and continuing eligibility, developmental status and need for medically necessary developmental services. This includes:

a. The assessment of motor, language, adaptive and/or cognitive functioning by standardized developmental instruments such as Bayley Scales of Infant Development, Early Learning Accomplishment Profile, Brigance Test of Development, etc. Specific activities include the administration of a minimum of two test instruments, interpretation of test scores with informed clinical opinion, and provision of a written narrative report.

b. Developmental functioning in each of these areas describes the level on which the child is currently functioning as compared to other children of the same chronological age, and the skills to be remediated.

c. Results will be included in the development of the IFSP. Developmental testing does not include medical, speech therapy, occupational therapy, physical therapy, audiological or vision evaluations.

2. Therapeutic Activities; direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes. (Limited to four (4) 15-minute units per week.)

a. This service is provided to the child and the child's parent/family to promote acquisition of skills in developmental areas (cognitive, motor, adaptive, communication). These rehabilitative services include:

1) the planned interaction of personnel, materials, time and space, to provide direct, medically necessary therapeutic intervention to the child;
2) provision of information to the family therapeutic curriculum planning;
3) provision of information to the family related to establishing the skill level and enhancing the development of the child.

SUPERSEDES

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

23. Developmental Rehabilitation Services (continued)

2. Therapeutic Activities (continued)

b. Therapeutic intervention will focus on developmentally appropriate individualized skills training and support to foster, promote and enhance child engagement in daily activities, functional independence and social interaction.

c. Assistance will be provided to family/caregivers in the identification and utilization of opportunities to incorporate therapeutic intervention strategies in daily life activities that are natural and normal for the child and family.

d. Child progress and mastery of functional skills to reduce or overcome limitations resulting from developmental delays will be continuously monitored by the Developmental Therapist.

e. Therapeutic activities may be provided in an individual session only.

3. A provider of Developmental Testing and Therapeutic Activities must be certified through the Arkansas Department of Human Services, Developmental Disabilities Services as a Developmental Therapist or Developmental Therapy Assistant. Certification requirements are:

a. A Developmental Therapist is a qualified professional, licensed by the Arkansas Department of Education, who has completed an additional certification requirement of a 24 hour training course and passed a competency based assessment with a minimum score of 80%. Developmental Testing Services must be provided by a Developmental Therapist.

b. A Developmental Therapy Assistant is a qualified paraprofessional who holds a minimum of a high school diploma and has two years experience working with children with disabilities. The Developmental Therapy Assistant must complete an initial 24 hour training course and pass a competency based assessment with a minimum score of 80%. The Assistant must work under the supervision of the Developmental Therapist and must be supervised 10% of the time spent in direct interaction with the recipient. A Developmental Therapy Assistant may provide only Therapeutic Activities services.

Developmental Rehabilitation Services may be provided in the recipient's home, in the community, or in a clinical setting. These services require prior authorization.

Extension of the benefit limit will be provided if medically necessary.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services

Substance Abuse Treatment Services (SATS) are provided for eligible recipients in the Child Health Services (EPSDT) Program. Services must be medically necessary and require prior authorization.

The SATS program covers the following services:

A. Addiction Assessment
B. Treatment Planning
C. Care Coordination
D. Multi-person (family) Group Counseling
E. Individual Counseling
F. Group Counseling
G. Marital/Family Counseling
H. Medication Management

Please refer to Attachment 3.1-A, Page 1zz.3 for the service descriptions, definitions, established benefit limits and individual qualified provider requirements. Benefit limits may be extended based on medical necessity.

SATS Qualified Provider Requirements

SATS providers must hold certification from the Division of Behavioral Health Services (DBHS) as a Substance Abuse Treatment Services provider in order to enroll as a SATS Medicaid provider.

The following requirements must be met for DBHS/OADAP certification:

A. Providers must be licensed by Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (OADAP).

B. Providers must submit a written request from the organization's Chief Executive Officer (CEO) to DBHS for certification by DBHS as a SATS Provider.

C. The request for certification by DBHS must include a copy of the provider's accreditation, most recent accreditation survey, and correspondence between the provider and the accrediting organization since the most recent accreditation survey.

D. A list of service delivery sites, including each site's address, telephone number, and fax number must be submitted. Each site from which SATS services are delivered must be included under the provider's accreditation. Proof of this accreditation must be submitted with the request for certification of a site.

E. Current CARF, JCAHO, or COA, *that includes accreditation of the pertinent outpatient alcohol and/or other drug abuse treatment component* (OADAP Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs p. 11). Current nationally accredited behavioral health programs without specific alcohol and drug treatment certification will need to obtain accreditation of their substance abuse program prior to receiving certification as a SATS provider of substance abuse treatment.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

F. Provisional, Conditional, Preliminary, Pending, Expedited or Deferred Accreditations are not acceptable.

G. The provider must: notify its accrediting organization in writing of all new or additional SATS services implemented subsequent to the provider's most recent accreditation survey; provide DBHS with a copy of the notification letter; and affirm in writing to DBHS that the new service(s) will be included in the provider's next regularly scheduled accreditation survey, if not surveyed before that time. Provider organization opening new services sites must follow DBHS certification policy and procedures.

H. DBHS must be authorized to receive information directly from the accrediting organization and to provide information directly to the accrediting organization, as it relates to SATS. DBHS will furnish these documents to providers at their request.

I. DBHS retains the right to request information in connection with licensure, accreditation, certification, provision or billing of SATS services; to perform site visits at anytime; and to conduct scheduled or unannounced visits, to insure entities are providing SATS services in accordance with the information that was submitted to DBHS. During a site visit the provider must allow access to all sites, policies and procedures, patient records, financial records, and any other documentation necessary to ascertain that services were/are of a quality which meets professionally recognized standards of health care.

J. Providers must adhere to evidence-based practices as approved by DBHS for specific populations and services provided.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions

The following service definitions were developed by a work group composed of members from the Division of Behavioral Health Services, the Division of Medical Services and providers. The service definitions also contain sections that address the maximum units allowable, and unit definitions.

SERVICES:	ADDICTION ASSESSMENT

DEFINITION:

The Substance Abuse Assessment Service identifies and evaluates the nature and extent of an individual's use/abuse/addiction to alcohol and/or other drugs and identifies but does not diagnose any existing co-morbid conditions. A standardized assessment instrument, approved by DBHS and DMS, must be used to complete the assessment process. The assessment process results in the assignment of a diagnostic impression, patient placement recommendation for treatment regimen appropriate to the condition and situation presented by the recipient, and referral into a service or level of care appropriate to effectively treat the condition(s) identified. A 9 panel test is part of the assessment to assist in the recipient's self-report of the alcohol and drug use and to develop an accurate diagnosis, referral and treatment plan. The 9 Panel Test is a screening test for marijuana, cocaine, benzoylecgonine, PCP, Morphine and its related metabolites derived from opium (opiates), methamphetamines (including Ecstasy), methadone, amphetamines, barbiturates, and benzodiazepines.

Benefit limit/Unit Definition: 1 per episode; 1 assessment per SFY

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

- Board certified or board eligible Psychiatrist
- Other licensed physician in state of Arkansas
- Advanced Practice Nurse (APN) and Physicians Assistant who have a collaborative agreement with a physician licensed in state of Arkansas
- Licensed Alcoholism and Drug Abuse Counselor (LADAC)
- Advanced Certified Alcoholism and Drug Abuse Counselor (ACADC)
- Certified Co-Occurring Disorder Professional – Diplomate Level (CCDP-D)

With the addition of substance abuse credentials (LADAC, ACADC, CCDP-D), the following persons may provide substance abuse clinical services:

- Licensed Certified Social Worker (LCSW) and Licensed Master Social Worker (LMSW). (LMSW must be under approved supervision)
- Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) are independent practice and don't require supervision, and Licensed Associate Counselor (LAC) – must have approved supervision
- Psychologist
- Psychological Examiner (LPE-I) licensed to practice independently
- Psychological Examiner (LPE) under the supervision of a Psychologist

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions (continued)

SERVICES:	TREATMENT PLANNING

DEFINITION:

A developed plan in cooperation with the individual (parent or guardian if the individual is under 18) to deliver specific addiction services to the individual to restore, improve or stabilize the individual's condition. The plan must be based on individualized service needs identified in the completed Addiction Assessment. The plan must include goals for the medically necessary treatment of identified problems, symptoms and addiction issues. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the individual, and time limitations for services.

Benefit Limit/Unit Definition: 1 per episode; 1 per SFY

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

- Board certified or board eligible Psychiatrist
- Other licensed physician in state of Arkansas
- Advanced Practice Nurse (APN) and Physicians Assistant who have a collaborative agreement with a Physician licensed in state of Arkansas
- Licensed Alcoholism and Drug Abuse Counselor (LADAC)
- Advanced Certified Alcoholism and Drug Abuse Counselor (ACADC)
- Certified Co-Occurring Disorder Professional – Diplomate Level (CCDP-D)

With the addition of substance abuse credentials (LADAC, ACADC, CCDP-D) the following persons may provide substance abuse clinical services:

- Licensed Certified Social Worker (LCSW) and Licensed Master Social Worker (LMSW). (LMSW must be under approved supervision)
- Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) are independent practice and don't require supervision, and Licensed Associate Counselor (LAC) – must have approved supervision
- Psychologist
- Psychological Examiner (LPE-I) licensed to practice independently
- Psychological Examiner (LPE) under the supervision of a Psychologist

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions (continued)

SERVICES:	CARE COORDINATION

DEFINITION:

Care Coordination services are services that will assist the client and family in gaining access to needed medical, social, educational, and other services. Care Coordination will be provided using a wrap-around or recovery model and will include the following activities: input into the treatment planning process, coordination of the treatment planning team, referral to services and resources identified in the treatment plan, facilitating linkages between levels of care, and monitoring and follow up activities that are necessary to ensure the goals identified in the treatment plan are met or need to be revised. Care Coordination services ensure communication and collaboration between agencies, providers and other individuals necessary to implement the goals identified in the treatment plan.

Benefit limit/Unit Definition: 12 units per SFY; 15 Minute Unit

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

A care coordinator must have the following credentials:

The following persons may provide substance abuse Care Coordinator Services under Arkansas Medicaid while under the supervision of a Certified Clinical Supervisor (CCS) recognized by the Arkansas Substance Abuse Certification Board or Registered Clinical Supervisor recognized by the Arkansas Board of Examiners of Alcoholism and Drug Abuse Counselors (BEADAC):

- Certified Alcohol and Drug Counselor (CADC)
- Certified Co-Occurring Disorder Professional – Bachelors Level (CCDP-B)
- Certified Co-Occurring Disorder Professional – Associate Level (CCDP-A)
- Licensed Associate Alcoholism and Drug Abuse Counselor (LAADAC)
- Counselor in Training (CIT) as defined by ADAP licensing standards

The staff ratios shall not exceed 30 clients to 1 care coordinator.

The Case Planning Team must include a credential practitioner and a care coordinator. The Credential Practitioner must also hold one or more of the following Credentials: CCDP-D, LADAC, or ACADC.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions (continued)

SERVICES:	MULTI-PERSON (FAMILY) GROUP COUNSELING

DEFINITION:

Multi-Person (Family) Counseling Services is a group therapeutic intervention using face to face verbal interaction between 2 to a maximum of 9 recipients and their family members or significant others. The Multi-Person (Family) Group Counseling Service provided to a group composed of family members of more than one recipient that is designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. The goal being to support the rehabilitation and recovery effort. Multi-Family Group Counseling must be prescribed on the Treatment Plan to address familial problems or needs and to achieve goals or objectives specified on the Treatment Plan.

Benefit limit/Unit Definition: 6 units/day; 48 units per SFY; 15 Minute Unit

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

- Board certified or board eligible Psychiatrist
- Other licensed physician in state of Arkansas
- Advanced Practice Nurse (APN) and Physicians Assistant who have a collaborative agreement with a physician licensed in state of Arkansas
- Licensed Alcoholism and Drug Abuse Counselor (LADAC)
- Advanced Certified Alcoholism and Drug Abuse Counselor (ACADC)
- Certified Co-Occurring Disorder Professional – Diplomate Level (CCDP-D)

With the addition of substance abuse credentials (LADAC, ACADC, CCDP-D) the following persons may provide substance abuse clinical services:

- Licensed Certified Social Worker (LCSW) and Licensed Master Social Worker (LCSW). (LMSW must be under approved supervision)
- Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) are independent practice and don't require supervision, and Licensed Associate Counselor (LAC) – must have approved supervision
- Psychologist
- Psychological Examiner (LPE-I) licensed to practice independently
- Psychological Examiner (LPE) under the supervision of a Psychologist

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions (continued)

SERVICES:	INDIVIDUAL COUNSELING

DEFINITION:

Individual Counseling services includes the face to face counseling services necessary to initiate and support the rehabilitation effort, orient the recipient to the treatment process, develop the ongoing treatment plan, augment the treatment process, intervene in a problem area, contingency management, prevent a relapse situation, continuing care or provide ongoing psychotherapy as dictated by the recipient's needs.

Benefit limit/Unit Definition: 6 units/month; 48 units/SFY; 15 Minute Unit

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

- Board certified or board eligible Psychiatrist
- Other licensed physician in state of Arkansas
- Advanced Practice Nurse (APN) and Physicians Assistant who have a collaborative agreement with a Physician licensed in state of Arkansas
- Licensed Alcoholism and Drug Abuse Counselor (LADAC)
- Advanced Certified Alcoholism and Drug Abuse Counselor (ACADC)
- Certified Co-Occurring Disorder Professional – Diplomate Level (CCDP-D)

With the addition of substance abuse credentials (LADAC, ACADC, CCDP-D) the following persons may provide substance abuse clinical services:

- Licensed Certified Social Worker (LCSW) and Licensed Master Social Worker (LMSW). (LMSW must be under approved supervision)
- Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) are independent practice and don't require supervision, and Licensed Associate Counselor (LAC) – must have approved supervision
- Psychologist
- Psychological Examiner (LPE-I) licensed to practice independently
- Psychological Examiner (LPE) under the supervision of a Psychologist

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions (continued)

SERVICES:	GROUP COUNSELING

DEFINITION:

Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve one's capacity to deal with problems that are a result of and/or contribute to substance abuse. The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan, orient the beneficiary to the treatment process, support the rehabilitation effort, and to minimize relapse. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

Benefit limit/Unit Definition: 6 units/day; 48 units per SFY; 15 Minute Unit

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

- Board certified or board eligible Psychiatrist
- Other licensed physician in state of Arkansas
- Advanced Practice Nurse (APN) and Physicians Assistant who have a collaborative agreement with a Physician licensed in state of Arkansas
- Licensed Alcoholism and Drug Abuse Counselor (LADAC)
- Advanced Certified Alcoholism and Drug Abuse Counselor (ACADC)
- Certified Co-Occurring Disorder Professional – Diplomate Level (CCDP-D)

With the addition of substance abuse credentials (LADAC, ACADC, CCDP-D) the following persons may provide substance abuse clinical services:

- Licensed Certified Social Worker (LCSW) and Licensed Master Social Worker (LMSW). (LMSW must be under approved supervision)
- Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) are independent practice and don't require supervision, and Licensed Associate Counselor (LAC) – must have approved supervision
- Psychologist
- Psychological Examiner (LPE-I) licensed to practice independently
- Psychological Examiner (LPE) under the supervision of a Psychologist

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions (continued)

SERVICES:	MARITAL/FAMILY COUNSELING

DEFINITION:

Face-to-face treatment provided to more than one member of a family simultaneously in the same session, or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the recipient's master treatment plan. The identified recipient must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the recipient and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the recipient, the recipient's condition and the condition's impact on the marital/family relationship.

Benefit limit/Unit Definition: 6 units/day; 48 units per SFY; 15 Minute Unit

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

- Board certified or board eligible Psychiatrist
- Other licensed physician in state of Arkansas
- Advanced Practice Nurse (APN) and Physicians Assistant who have a collaborative agreement with a Physician licensed in state of Arkansas
- Licensed Alcoholism and Drug Abuse Counselor (LADAC)
- Advanced Certified Alcoholism and Drug Abuse Counselor (ACADC)
- Certified Co-Occurring Disorder Professional – Diplomate Level (CCDP-D)

With the addition of substance abuse credentials (LADAC, ACADC, CCDP-D) the following persons may provide substance abuse clinical services:

- Licensed Certified Social Worker (LCSW) and Licensed Master Social Worker (LMSW). (LMSW must be under approved supervision)
- Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT) are independent practice and don't require supervision, and Licensed Associate Counselor (LAC) – must have approved supervision
- Psychologist
- Psychological Examiner (LPE-I) licensed to practice independently
- Psychological Examiner (LPE) under the supervision of a Psychologist

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (Continued)

Substance Abuse Treatment Service Definitions (continued)

SERVICES:	MEDICATION MANAGEMENT

DEFINITION:

This service is a direct service and is provided to the recipient by a Physician or APN with prescriptive authority. It includes pharmacologic management, including medication assessment, prescription, use and review of medication. This service is limited to the prescribing of psychotropic medications and those medications necessary to treat addiction related medical conditions and medication assisted addiction treatment.

Benefit limit/Unit Definition: 2 units/month; 12 units per SFY; 15 Minute Unit

STAFFING REQUIREMENTS: (All staff must have a contractual or salaried employee relationship with the certified SATS Provider.)

- Board certified or board eligible Psychiatrist
- Other licensed physician in state of Arkansas
- Advanced Practice Nurse (APN) and Physicians Assistant who have collaborative agreement with a Physician licensed in state of Arkansas

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (42 CFR 440.130(d)) **(Continued)**

The transition process to eliminate the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the SATS program will begin being transitioned to the Outpatient Behavioral Health Program starting on July 1, 2017. SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any or SATS provider for a service provided after June 30, 2018.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

25. Applied Behavioral Analysis (ABA) Therapy

(1) Applied Behavior Analysis (ABA) therapy is only one component of services to treat Autism Spectrum Disorder (ASD). ABA therapy services are provided in accordance with 42 CFR 440.130(c).

(2) ABA therapy services must be prescribed by the beneficiary's Arkansas Medicaid assigned primary care provider (PCP);

(3) ABA therapy services must be performed by a:

a. Board-certified behavior analyst (BCBA) who must have board-certified behavior analyst (or more advanced) certification in good-standing from the Behavior Analyst Certification Board;

b. Board-certified assistant behavior analyst (BCaBA) who must have board-certified assistant behavior analyst certification in good-standing from the Behavior Analyst Certification Board; or

c. Registered behavior technician (RBT) who must have registered behavior technician certification in good-standing from the Behavior Analyst Certification Board.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

25. Applied Behavioral Analysis (ABA) Therapy (Continued)

4. ABA therapy services include the following components:
   a. Behavior identification assessment services, which include the following components:
      i. Performing required comprehensive evaluations; and
      ii. Developing the initial individualized treatment plan (ITP);
   b. ABA therapy treatment services, which includes delivering ABA therapy treatment services directly to the beneficiary in accordance with the beneficiary's ITP;
   c. Adaptive behavior treatment with protocol modification services, which includes the following components:
      i. Actively training or assisting a BCaBA or RBT with the delivery of services to a beneficiary during an ABA therapy treatment session;
      ii. Conducting clinical observation of and data collection on the beneficiary's progress towards ITP goals and objectives during an ABA therapy treatment session; and
      iii. Adjusting and updating the ITP as required;
   d. Family adaptive behavior treatment services, which are meetings between the beneficiary's parent(s)/guardian(s) or other appropriate caregiver and the supervising BCBA, where the supervising BCBA:
      i. Discusses the beneficiary's progress;
      ii. Provides any necessary technical or instructional assistance to the parent/guardian in connection with service delivery;
      iii. Answers any parent/guardian or beneficiary questions and concerns; and
      iv. Discusses any necessary changes to the beneficiary's individualized treatment plan.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ☒ No limitations ☐ With limitations*
PA*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ☐ No limitations ☒ With limitations*

4.d. Tobacco cessation counseling services for pregnant women

Provided: ☐ No limitations ☒ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ☐ No limitations ☒ With limitations*

5.b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ☐ No limitations ☒ With limitations*

6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law.

6.a. Podiatrists' services.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

4.c. Family Planning Services

(1) Comprehensive family planning services are limited to an original examination and up to three follow-up visits annually. This limit is based on the state fiscal year - July 1 through June 30.

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

*describe if there are any limits on who can provide these counseling services

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: **[X]** No limitations **[ ]** With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations:

5. a. Physicians' services, whether furnished in the office, the **client's** home, a hospital, a skilled nursing facility, or elsewhere

(1) **For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, a nursing home, or elsewhere are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).**

(a) Benefit Limit Details

The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic, federally qualified health center, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and advanced practice registered nurse or a combination of the seven. Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

(b) Extension of Benefits

For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, **advanced practice registered nurse**, or rural health clinic core services beyond the benefit limit, extensions will be **available** if medically necessary.

(i) The following diagnoses are considered categorically medically necessary and are exempt from benefit extension requirements: Malignant neoplasm; HIV infection and renal failure.

(ii) Additionally, physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(c) Special Exceptions

(i) Each attending physician/dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

(**ii**) Surgical procedures **which** are generally considered to be elective require a **p**rior **a**uthorization from the Utilization Review Section.

(iii) Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

– **(iv)** Organ transplants are covered as described in Attachment 3.1-E.

5. a. Physicians' Services (Continued)

(6) Consultations, including interactive consultations (telemedicine), are limited to two (2) per recipient per year in a physician's office, patient's home, hospital or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be provided if medically necessary for recipients.

(7) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act).

Medical services furnished by a dentist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age 21 and older.

The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, rural health clinic services, office medical services furnished by an optometrist and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for medical services furnished by a dentist, physicians' services, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services or **advanced practice nurse or registered nurse practitioner services or a combination of the six**. For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Surgical services furnished by a dentist are not benefit limited.

CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

Services are limited to two (2) visits per State Fiscal Year (July 1 through June 30). The benefit limit for State Fiscal Year 1992 will be calculated beginning with services provided on or after December 1, 1991. **Beneficiaries** in the Child Health Services (EPSDT) Program are not benefit limited.

b. Optometrists' Services

Examination of eyes and provision of glasses and/or contact lens and other diagnostic screening, preventive and rehabilitative services and treatment of conditions found for eligible persons. The following limits are imposed:

(1) One eye exam every **twelve (12)** months for eligible **beneficiaries** 21 years of age and older.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible **client** under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be **available** if medically necessary for **clients** in the Child Health Services (EPSDT) Program.

(3) Office medical services provided by an optometrist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for **clients twenty-one (**21**) years or older**.

The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, **Federally Qualified Health Center services**, certified nurse midwife services, and advanced practice **registered** nurse**s**, or a combination of the **seven**. For services beyond the **benefit** limit, extensions will be **available** if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit.

c. Chiropractors' Services

(1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.

(2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid **clients** twenty-one (21) years or older. Services provided to **clients** under age **twenty-one (**21**)** in the Child Health Services (EPSDT) Program are not benefit limited.

(4) **Effective for dates of service on or after January 1, 2018, c**hiropractic services **do not** require a referral by the **client's** primary care **provider** (PCP).

d. Advanced **Practice Registered** Nurses **(APRN)**

For clients twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

The benefit limit will be in conjunction with the benefit limit established for physicians' services, **r**ural **h**ealth **c**linic, medical services furnished by a dentist, **office medical services furnished by an optometrist**, certified nurse midwife services and **federally qualified health center**, or a combination of the **seven**. For services beyond the **established benefit** limit, extensions will be **available** if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit. **Clients** in the Child Health Services (EPSDT) Program are not benefit limited.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Chiropractors' services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

d. Other practitioners' services.

/X/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

STATE AR
DATE REC'D NOV 22 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
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AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

8. Private duty nursing services.

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided. PA*

*Description provided on attachment.

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice and defined by State law. (Continued)

6.d. Other Practitioners' Services

(1) Hearing Aid Dealers

Refer to Attachment 3.1-A, Item 4.b. (8).

(2) Audiologists

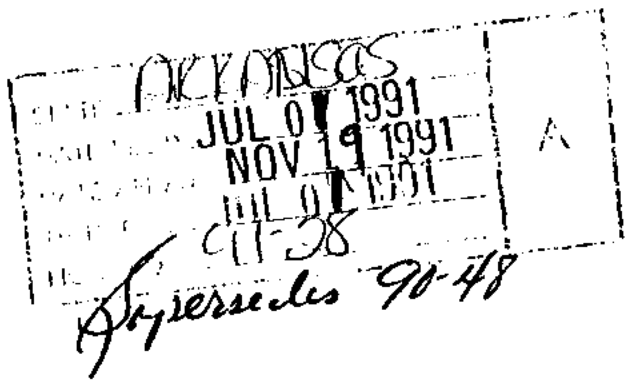
Refer to Attachment 3.1-A, Item 4.b. (9).

(3) Optical Labs

Provides eyeglasses and eyeglass repair to eligible recipients.

(4) Nurse Anesthetists

Services limited to licensed nurse anesthetists.



6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

(5) Psychologists

Refer to Attachment 3.1-A, Item 4.b. (13).

(6) Obstetric - Gynecologic and Gerontological Nurse Practitioner

Refer to Attachment 3.1-A, Item 24 for coverage limitations.

(7) Pharmacists

(8) Licensed Registered Nurse Sexual Assault Nurse Examiner-Pediatric/Adolescent (SANE-P) certified by the International Association of Forensic Nurses working under the supervision of a licensed Advanced Practice Registered Nurse (APRN).

6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

(11) Emergency Medical Technicians who are licensed to provide advanced life support and basic life support services.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: April 1, 2002

CATEGORICALLY NEEDY

7.a. Home Health Services

7.b. Based on a physician's prescription as to medical necessity provided to eligible recipients at their place of residence not to include institutions required to provide these services. For services above 50 visits per recipient per State Fiscal Year, the provider must request an extension. Extension of the benefit limit will be provided for all recipients, including EPSDT, if determined medically necessary.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

(1) Medical supplies are covered for eligible Medicaid recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home (Home does not include a long term care facility.) Supplies are limited to a maximum reimbursement of $250.00 per month, per recipient. As medical supplies are provided to recipients through the Home Health Program and the Prosthetics Program, the maximum reimbursement of $250.00 per month may be provided through either program or a combination of the two. However, a recipient may not receive more than $250.00 in supplies whether received through either of the two programs or a combination of the two unless an extension has been granted. Extensions will be considered for recipients under age 21 in the Child Health Services (EPSDT) Program if documentation verifies medical necessity. The provider must request an extension of the established benefit limit.

(2) Durable Medical Equipment (DME) - Services are covered in the recipient's home if prescribed by the recipient's physician as medically necessary. Some DME requires prior authorization. DME is limited to specific items. Specific DME is listed in Section III of the Prosthetics Provider Manual.

(3) Augmentative Communication Device

Services for recipients under age 21 are covered as a result of a Child Health Services (EPSDT) screening/referral. Services for recipients over age 21 are covered if prescribed by the recipient's physician as medically necessary. Prior authorization is required.

(4) Specialized Wheelchairs

Specialized Wheelchairs are provided for eligible recipients of all ages if prescribed by the recipient's physician as medically necessary. Prior authorization is required for some items. These items are listed in Section III of the Prosthetics Provider Manual.

7. Home Health Services (Continued)

7.c. **In accordance with 42 CFR 440.70(b)(3) medical supplies, equipment and appliances are suitable for use in any setting in which normal life activities take place.** (Continued)

(5) Diapers/Underpads

Diapers/underpads are limited to $130.00 per month, per beneficiary. The $130.00 benefit limit is a combined limit for diapers/underpads provided through the Prosthetics Program and Home Health Program. The benefit limit may be extended with proper documentation. Only patients with a medical diagnosis other than infancy which results in incontinence of the bladder and/or bowel may receive diapers. This coverage does not apply to infants who would otherwise be in diapers regardless of their medical condition. Providers cannot bill for underpads/diapers if a beneficiary is under the age of three years.

(6) DME/Continuous Glucose Monitors.

A. Continuous Glucose Monitors (CGM) will be covered for Arkansas Medicaid clients.
B. A prior authorization (PA) will be required and the service will be provided for those clients who meet medical necessity.

7.d. Physical therapy, occupational therapy, or speech-language pathology and audiology services provided by a home health agency or medical rehabilitative facility.

Physical therapists must meet the requirements outlined in 42 CFR 440.110(a).

Services under this item are limited to physical therapy when provided by a home health agency and prescribed by a physician. Effective for dates of service on or after July 1, 2017, individual and group physical therapy are limited to six (6) units per week. Effective for dates on or after January 1, 2021, physical therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limits will be provided if medically necessary for eligible Medicaid recipients.

8. Private Duty Nursing to enhance the effectiveness of treatment for ventilator-dependent beneficiaries or non-ventilator dependent tracheotomy beneficiaries

Enrolled providers are Private Duty Nursing Agencies licensed by Arkansas Department of Health. Services are provided by Registered Nurses or Licensed Practical Nurses licensed by the Arkansas State Board of Nursing.

Services are covered for Medicaid-eligible beneficiaries age 21 and over when determined medically necessary and prescribed by a physician.

Beneficiaries 21 and over to receive PDN Nursing Services must require constant supervision, visual assessment and monitoring of both equipment and patient. In addition, the beneficiary must be:

A. Ventilator dependent (invasive) or
B. Have a functioning trach
   1. requiring suctioning and
   2. oxygen supplementation and
   3. receiving Nebulizer treatments or require Cough Assist / inexsufflator devices.

8. Private Duty Nursing Services (Continued)

In addition, at least one **(1)** from each of the following conditions must be met:

1. Medications:
   - Receiving medication via gastrostomy tube (G-tube)
   - Have a Peripherally Inserted Central Catheter (PICC) line or central port

2. Feeding:
   - Nutrition via a permanent access such as G-tube, **Low-Profile** Button, **or** Gastrojejunostomy tube (G-J tube**). Feedings** are either bolus or continuous.
   - Parenteral nutrition (total parenteral nutrition)

Services are provided in the beneficiary's home, a Division of Developmental Disabilities (DDS) community provider facility, or a public school. (Home does not include an institution.) Prior authorization is required. Private duty nursing medical supplies are limited to a maximum reimbursement of $80.00 per month, per beneficiary. With substantiation, the maximum reimbursement may be extended.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. **Clinic services.**

/X/ **Provided:** / / **No limitations** /X/ **With limitations***

/ / **Not provided.**

10. **Dental services.**

/X/ **Provided:** / / **No limitations** /X/ **With limitations***

/ / **Not provided.** PA*

11. **Physical therapy and related services.**

a. **Physical therapy.**

/X/ **Provided:** / / **No limitations** /X/ **With limitations***

/ / **Not provided.**

b. **Occupational therapy.**

/X/ **Provided:** / / **No limitations** /X/ **With limitations***

/ / **Not provided.**

c. **Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).**

/X/ **Provided:** / / **No limitations** /X/ **With limitations***

/ / **Not provided.**

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*Description provided on attachment.

9. Clinic Services

(1) Adult Developmental Day Treatment (ADDT) Services

Limited to comprehensive day treatment centers offering the following **core** services to beneficiaries age 18 and above:

a. **Assessment and Treatment Plan Development**, **2** unit**s** per year

b. Adult Day Habilitation Services, 5 units per day, 1 hour each

c. Provision of noon meal

Optional Services available through ADDT in conjunction with core services are as follows:

a. Physical therapy - Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.

b. Speech**-language** therapy - Services must be referred by a physician and provided by or under the supervision of a qualified speech pathologist.

c. Occupational therapy - Services must be prescribed by a physician and provided by or under the supervision of a qualified occupational therapist.

Occupational, Physical, and Speech**-Language** Therapy Services are provided in accordance with Items 3.1-A.4b(15), 3.1-A.11, 3.1-B.4b(15), and 3.1-B(11).

Extensions of the benefit limit for all ADDT services will be provided if medically necessary.

9. Clinic Services (Continued)

(2) Family Planning Clinic Services

Services limited to family planning, reproductive health services and supplies.

(3) Maternity Clinic Services

Limited to antepartum and postpartum services.

(4) Ambulatory Surgical Center Services

Ambulatory surgical center facility services are limited to those services furnished in connection with or directly related to a surgical procedure covered by the Medicaid agency.

(5) End-Stage Renal Disease (ESRD) Facility Services

Covered services include:

a) Outpatient hemodialysis and peritoneal dialysis treatment in a Title XVIII certified ESRD facility.

b) Training for individuals who have been selected by their physician to participate in the peritoneal self-dialysis program.

Beneficiaries aged 21 and older are limited to 3 hemodialysis treatments per week. Beneficiaries under the age of 21 in the Child Health Services (EPSDT) Program are not benefit limited.

10. Dental Services

Refer to Attachment 3.1-A, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.

Dental services are available for Medicaid beneficiaries age 21 and over but most are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.

There is an annual benefit limit of $500 for dental services for adults. Extractions **and fees paid to the dental lab for the manufacture of dentures** are excluded from the annual limit.

All dentures, whether full or partial, must be provided by the one dental lab under contract with the Arkansas Medicaid Program to manufacture dentures. For adults, there is lifetime limit of one set of dentures. This policy applies to both:

- **Medicaid eligible beneficiaries age 21 and over and**
- **Medicaid eligible beneficiaries under 21 whose eligibility is based on a "pregnant woman aid category" AND whose Medicaid ID number ends in the 100 series (100 through 199).**

11. Physical Therapy and Related Services

Speech-Language Pathology services and qualified Speech-Language Pathologists meet the requirements set forth in 42 CFR 440.110. Speech-Language Pathology Assistants work under the supervision of the Speech-Language Pathologist in accordance with the State's licensing and supervisory requirements.

Physical Therapy services and qualified Physical Therapists meet the requirements set forth in 42 CFR 440.110. Physical Therapy assistants work under the supervision of the Physical Therapist in accordance with the State's licensing and supervisory requirements.

Occupational Therapy services and qualified Occupational Therapists meet the requirements set forth in 42 CFR 440.110. Occupational Therapy assistants work under the supervision of the Occupational Therapist in accordance with the State's licensing and supervisory requirements.

Audiology services and qualified Audiologists meet the requirements set forth in 42 CFR 440.110.

A. Occupational, Physical and Speech-**Language** Therapy

1. Refer to Attachment 3.1-A, Item 4.b. (15) for therapy services for recipients under age 21.

2. For recipients over age 21, effective for dates of services on or after July 1, 2017, individual and group therapy are limited to six (6) units per week per discipline. **For recipients over age 21, Speech-language therapy e**valuations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

3 For recipients over age 21, effective for dates on or after January 1, 2021, physical therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). For recipients over age 21, effective for dates on or after January 1, 2021, occupational therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit for the evaluation will be provided if medically necessary.

B. Speech-**Language** Therapy

Speech Generating Device (**SGD**) Evaluation - Effective for dates of service on or after September 1, 1999, **Speech Generating** Device (**SGD**) evaluation is covered for eligible Medicaid recipients of all ages. One **SGD** evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.

ARKANSAS

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided. PA*

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided. PA*

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided. PA*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

APPROVED BY DHHS/HCFA/DPO
DATE: NOV 7 1985
TRANSMITTAL NO: 85-21

*Description provided on attachment.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation**,** prescription drugs for opioid **or alcohol** use disorder as part of a Medication Assisted Treatment plan, EPSDT, high blood pressure**, hypercholesterolemia,** blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the Arkansas Medicaid Pharmacy Vendor's Website, are covered:

a. select agents when used for weight gain

b. select agents when used for the symptomatic relief of cough and colds

c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride

d. select nonprescription drugs

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a seventy-two (72) hour supply of drugs in emergency situations.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

a. Prescribed Drugs (continued)

(4) The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of Federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data.

The state will be negotiating supplemental rebates in the Medicaid program in addition to the Federal rebates provided for in Title XIX. Rebate agreements between the state and pharmaceutical manufacturer(s) will be separate from the Federal rebates.

Effective May 1, 2022, CMS has authorized the state of Arkansas to enter into a multi-state supplemental rebate pool, using a Preferred Drug List (PDL) to maximize state supplemental rebates. The state will continue to select products participating in the federal rebate program that will be in its Preferred Drug List Program and will only receive state supplemental rebates for manufacturer's supplemental covered products included on the PDL.

A rebate agreement between the state and a participating drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on May 24, 2016, and entitled, State of Arkansas Supplemental Rebate Agreement, has been authorized by CMS. Any additional versions of rebate agreements negotiated between the state and manufacturer(s) after May 24, 2016, will be submitted to CMS for authorization.

The state supplemental rebate agreements would apply to the drug benefit, both fee-for-service and those paid by contracted Medicaid managed care organizations (MCOs), under prescribed conditions in Attachment C of the State of Arkansas Supplemental Rebate Agreement. State supplemental rebate agreements would apply to beneficiaries, including those made eligible under the Affordable Care Act receiving fee-for-service benefits and those that are enrolled under a Medicaid managed care organization agreement.

Supplemental rebates received by the State in excess of those required under the National Drug Rebate Agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provisions of the national drug rebate agreement.

The supplemental rebate program does not establish a drug formulary within the meaning of 1927(d)(4) of the Social Security Act.

Effective May 1, 2022, CMS has authorized the state of Arkansas to enter into value/outcomes-based contracts with manufacturers on a voluntary basis. The conditions of the value/outcomes-based contract would be agreed upon by both the state and manufacturer.

The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927(b)(3)(D) of the Social Security Act.

(5) Pursuant to 42 U.S.C. Section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided within a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

a. Prescribed Drugs (continued)

Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

When a pharmacist receives a prescription for a brand or trade name drug, and dispenses an innovator multisource drug that is subject to the Federal Upper Limits (FULs), the innovator multisource drug must be priced at or below the FUL or the prescription hand annotated by the prescriber "Brand Medically Necessary". Only innovator multisource drugs that are subject to the Federal Upper Limit at 42 CFR 447.332(a) and dispensed on or after July 1, 1991, are subject to the provisions of Section 1903(i)(10)(B) of the Social Security Act.

For drugs listed on the Arkansas Medicaid Generic Upper Limit List, the upper limit price will not apply if the prescribing physician certifies in writing that a brand name drug is medically necessary.

The Arkansas Medicaid Generic Upper Limit List is comprised of State generic upper limits on specific multisource drug products and CMS identified generic upper limits on multisource drug products.

The Medicaid agency will provide coverage of prescription and over-the-counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence – 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

b. Dentures

Refer to Attachment 3.1-A, Item 4.b (7) for coverage of dentures for Child Health Services (EPSDT) recipients.

Dentures are available for eligible Medicaid beneficiaries age 21 and over, but are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.

Dentures are excluded from the annual limit but are limited to one set per lifetime.

c. Prosthetic Devices

(1) Eye Prostheses - Refer to Attachment 3.1-A, item 4.b.(11).

(2) Hearing Aids, Accessories and Repairs - Refer to Attachment 3.1-A, Item 4.b.(10).

(3) Pacemakers and internal surgical prostheses when supported by invoice.

(4) a. Parenteral hyperalimentation services, including fluids, supplies and equipment, when provided in the recipient's home. Home does include a nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR). Service requires prior authorization.

b. Enteral nutrition services, including fluids, supplies and equipment, when provided in the recipient's home. Home does not include a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) because this service is included and reimbursed as an NF and ICF-MR benefit as described in Attachment 3.1-A, Item 4.a. Service requires prior authorization.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(5) Orthotic Appliances

Services for recipients under age 21 are not benefit limited.

Services for recipients age 21 and over are limited to $3,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for an orthotic appliance is $500 or more, prior authorization is required. Specific covered orthotic appliances are listed in Section III of the Prosthetics Provider Manual.

(6) Prosthetic Devices

Services for recipients under age 21 are not benefit limited.

Services for recipients age 21 and over are limited to $20,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for a prosthetic device is $1,000 or more, prior authorization is required. Specific covered prosthetic devices are listed in Section III of the Prosthetics Provider Manual.

STATE Arkansas DATE REC'D 03-18-02 DATE APPV'D 04-15-02 DATE EFF 04-01-02 HCFA 179 AR 02-09	A

SUPERSEDES: TN- AR 99-26 (pg. 5cc)

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

For the provision of glasses and/or contact lens for eligible **beneficiaries,** the following limits are imposed:

(1) One pair of glasses every **twelve (12)** months for eligible **beneficiaries** 21 years of age and over. **Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries 21 years of age and over. Replacement of glasses is covered for post cataract patients with prior authorization.**

(2) One pair of glasses every twelve (12) months for eligible **beneficiaries** under 21 years of age in the Child Health Services (EPSDT) Program. **One replacement pair of glasses every twelve (12) months for eligible beneficiaries under 21 years of age in the Child Health Services (EPSDT) Program. Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries under 21 years of age.** Under special circumstances, additional glasses may be authorized.

(3) Contact **lenses** are covered for **beneficiaries** of all ages if either of the following conditions are exhibited by the patient:

a. Medical necessity
b. Cataract patients

Prior authorization is required by the Medical Assistance Section. Lens replacement for all **beneficiaries** is allowed as medically necessary.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services - Not provided.

STATE Arkansas
DATE REC'D 2-26-90
DATE APPV'D 3-13-90
DATE EFF 3-1-90
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Supersedes - None - New Page

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November 1990
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**AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY SERVICES PROVIDED**

b. Screening Services

___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

c. Preventive services

_X_ Provided ___No Limitations _X_ With Limitations* _ _ Not Provided

d. Rehabilitative services

_X_ Provided ___No Limitations _X_ With Limitations* ___ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases

a. Inpatient hospital services

___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

b. Nursing facility services

c. ___ Provided ___No Limitations ___ With Limitations* _X_ Not Provided

*Description provided on attachment

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: March 1, 2026

CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - Provided, with limitation.

Vaccines:

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Certified Community-based Doulas:

A Certified Community-based Doula is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Certified Community-based Doula services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Certified community-based doulas shall provide only the following services:

1. Childbirth education;
2. Assistance with navigating the healthcare system;
3. Client advocacy before, during, and after the birth of a child;
4. Connection with community resources; and
5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

Services shall include support during a hospital delivery and during the prenatal and postpartum periods as defined through rules established by the Arkansas Department of Human Services.

To be eligible to provide services, Doulas must be:

(1) Certified by the Department of Health in accordance with state law; and (2) At least eighteen (18) years of age and have an NPI number.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Breastfeeding and Lactation Consultants:

A breastfeeding and lactation consultant is a trained professional specializing in providing medically appropriate care to aid in milk expression or infant nutrition. Breastfeeding and Lactation Consultant services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Breastfeeding and lactation consultant services are medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the extended postpartum period to aid in milk expression or infant nutrition. Components of Breastfeeding and Lactation Consultant services include individual outpatient consultation and group classes.

To be eligible to provide services, Breastfeeding and Lactation Consultants must:

- Be at least eighteen (18) years of age and have an NPI number; and
- Have one of the following certifications:
    1. An International Board-Certified Lactation Consultant; or
    2. A Certified Lactation Counselor;
        - Certified Lactation Counselors must be certified by either the (1) International Breastfeeding Institute or (2) Academy of Lactation Policy and Practice;
        - Certified Lactation Counselors are required to be supervised by a Medicaid enrolled healthcare provider to receive reimbursement. Supervision is defined as being employed by one of the following:
            A. An agency led by an International Board-Certified Lactation Consultant;
            B. A physician, advanced practice nurse, or physician assistant
            C. A local health unit or
            D. A hospital

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.

Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- SERVICE: Mental Health Evaluation/Diagnosis
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

formulation for the purpose of developing a plan of care. This service is required prior to provision of all other mental health services with the exception of crisis interventions. Services are to be congruent with the age, strengths, necessary, accommodations for disability, and cultural framework of the beneficiary and his/her family.

Setting information could be summarized in the description if the State would like to include this information.

This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- SERVICE: Psychological Evaluation
DEFINITION: A Psychological Evaluation employs standardized psychological tests conducted and documented for evaluation, diagnostic, or therapeutic purposes. The evaluation must be medically necessary, culturally relevant; with reasonable accommodations for any disability, provide information relevant to the beneficiary's continuation in treatment, and assist in treatment planning. All psychometric instruments must be administered, scored, and interpreted by the qualified professional.

  This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- SERVICE: Psychiatric Diagnostic Assessment
DEFINITION: A direct face-to-face service contact occurring between the physician **or Advanced Practice Nurse** and the beneficiary for the purpose of evaluation. Psychiatric Diagnostic Assessment includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for additional requirements.)

  *This service must be performed by a physician **or Advanced Practice Nurse** and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.*

  Please refer to Provider Qualifications on page 6a18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

An APN performing the Psychiatric Diagnostic Assessment MUST meet the following:

1. ***Licensed by the Arkansas State Board of Nursing***
2. ***Practicing with licensure through the American Nurses Credentialing Center***
3. ***Practicing under the supervision of an Arkansas-licensed psychiatrist who has an affiliation with the RSPMI program and with whom the Advanced Practice Nurse has a collaborative agreement. Prior to the initiation of the treatment plan, the findings of the Psychiatric Diagnostic Assessment conducted by the Advanced Practice Nurse must be discussed with the supervising psychiatrist. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may do it to.***
4. ***Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act***
5. ***Practicing within an Advanced Practice Nurse's experience and competency level***

- SERVICE: Master Treatment Plan
  DEFINITION: A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. The plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, time limitations for services, and documentation of medical necessity by the supervising physician.

  This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary and is necessary for developing an array of rehabilitative treatment services according to goals and objectives for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- SERVICE: Periodic Review of Master Treatment Plan
  DEFINITION: The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided; and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities, and necessary accommodations that will be provided to the beneficiary, time limitations for services, and the medical necessity of continued

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

services. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary to ensure that the array of rehabilitative treatment services is producing the desired outcome according to goals and objectives and to determine if the maximum reduction of a mental disability restoration of the beneficiary to his or her best possible functional level is progressing.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Interpretation of Diagnosis**
  DEFINITION: A face-to face therapeutic intervention provided to a beneficiary in which the results/implications/diagnoses from a mental health diagnosis evaluation or a psychological evaluation are explained by the professional who administered the evaluation. Services are to be congruent with the age, strengths, necessary accommodations, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician or licensed mental health professional to assist the beneficiary and his or her primary support persons in understanding what is necessary for developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Individual Psychotherapy**
  DEFINITION: Face-to-face treatment provided by a licensed mental health professional on an individual basis. Services consist of structured sessions that work toward achieving mutually defined goals as documented in the master treatment plan. Services are to be congruent with the age, strengths, needed accommodations necessary for any disability, and cultural framework of the beneficiary and his/her family. The treatment service must reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is not present**
  DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary is not present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. These services identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.

  When all three conditions are taken together, it would be necessary to address marital/family dynamics and improve/strengthen the marital/family interactions and functioning in order o focus on the Medicaid eligible beneficiary's condition and how it can be improved.

  The reason for providing this service is to improve the integrity of the patient's support system and documentation must reflect how the therapy accomplishes that rather than becoming therapy for the caregiver in and of itself.

  The service may only be provided by a mental health professional practicing within the scope of their licensure.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is present**
  DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist**
  Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant**
  Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist assistant and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **Group Outpatient – Speech Therapy, Speech Language Pathologist**
  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
  Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant

  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Group Outpatient – Group Psychotherapy**
  DEFINITION: Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Therapeutic Day/Acute Day Treatment**
  DEFINITION: This service includes the administration of individual, family/marital and group therapies, face to face interventions and supportive services and is designed to be more intensive in nature than rehabilitative day services.

  The providers are a combination of licensed professionals (psychologist, LCSW, LPC, LPE, RN, and paraprofessionals. Licensed professionals must supervise the milieu and a physician must provide oversight. Paraprofessionals must be supervised by a licensed professional.

  Short-term daily array of continuous, highly structured, intensive outpatient services provided by a mental health professional. These services are for beneficiaries experiencing acute psychiatric symptoms that may result in the beneficiary being in imminent danger of psychiatric hospitalization and are designed to stabilize the acute symptoms. These direct therapy and medical services are intended to be an alternative to inpatient psychiatric care and are expected to reasonably improve or maintain the beneficiary's condition and functional level to prevent hospitalization and assist with assimilation to his/her community after an inpatient psychiatric stay of any length. These services are to be provided by a team consisting of mental health clinicians, paraprofessionals and nurses, with physician oversight and availability. The team composition may vary depending on clinical and programmatic needs but must at a minimum include a licensed mental health clinician and physician who provide services and oversight. Services are to be congruent with the age,

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

These services must include constant staff supervision of beneficiaries and physician oversight.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Crisis Intervention**
  DEFINITION: Unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Physical Examination – Psychiatrist or Physician**
  Physical Examination – Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

DEFINITION: A general multisystem examination based on age and risk factors to determine the state of health of an enrolled RSPMI beneficiary.

This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Pharmacologic Management by Physician (formerly Medication Maintenance by a physician)**
  Pharmacologic Management by Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner
  DEFINITION: Provision of service tailored to reduce, stabilize or eliminate psychiatric symptoms by addressing individual goals in the master treatment plan. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Medication Administration by a Licensed Nurse**
  DEFINITION: Administration of a physician-prescribed medication to a beneficiary. This includes preparing the beneficiary and medication; actual administration of oral, intramuscular and/or subcutaneous medication; observation of the beneficiary after administration and any possible adverse reactions; and returning the medication to its previous storage.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Group Outpatient – Pharmacologic Management by a Physician**
  DEFINITION: Therapeutic intervention provided to a group of beneficiaries by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting. This includes evaluating medication prescription, administration, monitoring, and supervision; and informing beneficiaries regarding medication(s) and its potential effects and side effects. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Routine Venipuncture for Collection of Specimen**
  DEFINITION: The process of drawing a blood sample through venipuncture (i.e., inserting a needle into a vein to draw the specimen with a syringe or vacutainer) or collecting a urine sample by catheterization as ordered by a physician or psychiatrist.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Collateral Intervention, Mental Health Professional**
  DEFINITION: A face-to-face contact by a mental health professional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan , and/or rehabilitation. The identified beneficiary does not have to be present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Collateral Intervention, Mental Health Paraprofessional**
  DEFINITION: A face-to-face contact by a mental health paraprofessional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan, and/or rehabilitation. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. The identified beneficiary does not have to be present for this service.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Professional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Paraprofessional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Intervention, Mental Health Professional (formerly On-Site and Off-Site Interventions, MHP)**
  DEFINITION: Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes. These activities may be either scheduled or unscheduled as the goal warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Intervention, Mental Health Paraprofessional (formerly On-Site and Off-Site Intervention, Mental Health Paraprofessional)**
  DEFINITION: Face-to-face, medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions prescribed on the master treatment plan, which are expected to accomplish a specific goal or objective listed on the master

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

treatment plan. These activities may be either scheduled or unscheduled as the goal or objective warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **SERVICE: Rehabilitative Day Service for Persons under Age 18**
  DEFINITION: An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms of youth diagnosed with childhood disorders, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, age-appropriate, recovery based, culturally competent, must reasonably accommodate disability, and must have measurable outcomes. These activities are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of these services is to enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as positive peer interactions, appropriate social/family interactions, and managing overt expression of symptoms like impulsivity and anger; daily living and self-care skills, such as personal care and hygiene, and daily structure/use of time; cognitive skills, such as problem solving, developing a positive self-esteem, and reframing, money management, community integration, understanding illness, symptoms and the proper use of medications; and any similar skills required to implement a beneficiary's master treatment plan.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

- **Rehabilitative Day Service for Persons Ages 18-20**
  Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below).
  Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20.

- **SERVICE: Adult Rehabilitative Day Service**
  DEFINITION: Adult Rehabilitative day services provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, and supervision to individuals who are mentally ill and who, due to the severity of their impairment, are in need of face to face interventions provided in a structured group program. This service is designed for long-term recovery and self-sufficiency.

  Adult Rehabilitative day services provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary in a facility-based program providing specialized rehabilitation.

  Services may include:

  A. Goal compliance,

  B. Problem solving,

  C. Patient Safety

  D. Task completion

  E. Pharmaceutical supervision and/or

  G. Health monitoring.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, recovery based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms, and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan .

This service also includes the administration of individual intervention services, individual therapy, group therapy and supportive services, but are designed to assist with beneficiary functioning on a day to day basis within the community.

The providers are licensed mental health professionals and paraprofessionals under their supervision.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 6a18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

B. Provider Qualifications

Rehabilitative Services for Persons with Mental Illness (RSPMI) are limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. The provider must be certified as an RSPMI provider by the Division of Behavioral Health Services. Providers not certified by the Division of Behavioral Health Services may not provide these services.

Providers for each specific RSPMI service, as detailed in the scope of the program section, must practice within the scope of their Arkansas licensure. Individuals providing RSPMI services must be:

1. Licensed in the State of Arkansas as a mental health professional as defined in the RSPMI provider manual;

2. Medical records librarian as defined in the RSPMI provider manual;

3. Licensed in the State of Arkansas as a Psychiatrist - The psychiatrist may provide oversight, medical care, or both. If the psychiatrist does not provide all medically necessary RSPMI medical care, then a medical doctor may provide medical care in addition to a psychiatrist;

4. Licensed Psychologist or Licensed Psychological Examiner

5. Licensed Physician or

6. Certified Mental Health Paraprofessional, under the direct supervision of a Licensed Mental Health Professional

See Section 213.000 of the RSPMI provider manual for additional provider qualifications.

Qualified professionals must be present to furnish all medically necessary RSPMI services, including all services in each patient's care plan.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)(continued)

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) and Licensed Mental Health Practitioner (LMHP) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI and LMHP programs will begin being transitioned to the Outpatient Behavioral Health Program starting on July 1, 2017. RSPMI and LMHP will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI or LMHP provider for a service provided after June 30, 2018.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

2. Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Extended Rehabilitative Hospital Services

Extended Rehabilitative Hospital Services are services for the rehabilitation of patients with various neurological, musculo-skeletal, orthopedic and other medical conditions following stabilization of their acute medical conditions. Extended Rehabilitative Hospital Services are a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation.

The following services are included in the global coverage of an Extended Rehabilitative Hospital:

1) Restorative Therapies
2) Behavioral Rehabilitation
3) Life Skills Training
4) Individual and Group Counseling
5) Assessment Services
6) Nursing Care

Persons eligible for admission must have at least one of the following neurological conditions: Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

An Extended Rehabilitative Hospital must be licensed by the Division of Health as a Rehabilitative Hospital. An Extended Rehabilitative Hospital must also be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. Extended Rehabilitative Hospital services are provided by a licensed practitioner who is directly related to the beneficiary's rehabilitative adjustment.

Extended Rehabilitative Hospital services provided are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. No extensions will be considered. However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

Service delivery is delivery is the same as inpatient hospital services described in Attachment 3.1-A, Page 1a, Item 1, minus the room and board component.

Extended Rehabilitative Hospital Services are available to eligible Medicaid recipients of all ages when medically necessary as determined by the PRO. Services are limited to 30 days per State Fiscal Year for beneficiaries age 21 and older. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

3. Outpatient Behavioral Health Services (OBHS)

As part of the Behavioral Health transformation within the state of Arkansas, DMS is creating a more integrated and client-focused behavioral health care system. These changes were developed in coordination with the Division of Behavioral Health Services (DBHS), providers, representatives of the Arkansas System of Care, beneficiaries and other key stakeholders.

A. Scope

Care, treatment and services provided by a certified Behavioral Health Services provider to Medicaid-eligible beneficiaries. These services are available to all eligible Medicaid beneficiaries. Services which require an Independent Assessment are indicated by the statement, "Eligibility for this service is determined by an Independent Assessment and must be prior authorized."

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

B. Services

i.: Individual Behavioral Health Counseling*

DEFINITION: Individual Behavioral Health Counseling, including tobacco cessation, is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

B. Services

ii. Group Behavioral Health Counseling*

DEFINITION: Group Behavioral Health Counseling, including tobacco cessation, is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling with Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children. Dyadic treatment must be prior authorized.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present (continued)*

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

iv. Marital/Family Behavioral Health Counseling without Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling without Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

v. Group Psychoeducation*

DEFINITION: Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery for the benefit of the beneficiary. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

v. Group Psychoeducation (continued)*

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children. Dyadic treatment must be prior authorized.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the Provider must have Arkansas State Infant Mental Health Certification.

vi. Multi-Family Behavioral Health Counseling*

DEFINITION: Multi-Family Behavioral Health Counseling, including tobacco cessation, is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

vii. Mental Health Diagnosis*

DEFINITION: Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

vii. Mental Health Diagnosis (continued)*

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

viii. Interpretation of Diagnosis*

DEFINITION: Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

viii. Interpretation of Diagnosis (continued)*

For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

ix. Substance Abuse Assessment*

Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DBHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician;

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

x. Psychological Evaluation*

DEFINITION: Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.

Allowable Performing Provider - Licensed Psychologist, Licensed Psychological Examiner and a Licensed Psychological Examiner - Independent

xi: Pharmacologic Management*

DEFINITION: Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

xii: Psychiatric Assessment*

DEFINITION: Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xiii. Treatment Plan*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

xiv. Crisis Stabilization Intervention*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Crisis Stabilization Intervention are scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. Services can include interventions, stabilization activities, coping strategies and other various activities to assist the beneficiary in crisis. The services provided are expected to reduce or eliminate the risk of harm to the person or others in order to stabilize the beneficiary. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the beneficiary and his/her family.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelor's; and Qualified Behavioral Health Provider – Non-Degreed

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xv: Partial Hospitalization*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.

Allowable Performing Provider – Must be certified by the Department of Human Services as a Partial Hospitalization provider.

xvi: Behavioral Assistance*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Behavioral Assistance is a specific outcome oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xvii. Family Support Partners*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Family Support Partners is a service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children or youth with behavioral health care needs for the benefit of the beneficiary. Family Support Partners come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency of the beneficiary. FSPs are required to be trained and certified by the State as a FSP to provide this service.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xviii: Peer Support*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Peer Support is a consumer centered service provided by individuals who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Peer Support is a person-centered service with a recovery focus which allows beneficiaries the opportunity to direct their own recovery and advocacy process. This service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.

Allowable Performing Provider - Certified Peer Support Specialist; and a Certified Youth Support Specialist

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xix. Individual Pharmacologic Counseling*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: A specific, time limited one-to-one intervention by a nurse with a beneficiary and/or caregivers, related to their psychopharmological treatment. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required.

Allowable Performing Provider -Registered Nurse

xx: Group Pharmacologic Counseling*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: A specific, time limited intervention provided to a group of beneficiaries and/or caregivers by a nurse, related to their psychopharmological treatment. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required.

Allowable Performing Provider - Registered Nurse

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxi. Intensive Outpatient Substance Abuse Treatment*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Intensive Outpatient services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Services are goal oriented interactions with the individual or in group/family settings. This community based service allows the individual to apply skills in "real world" environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Intensive outpatient programs provide 9 or more hours per week of skilled treatment, 3 – 5 times per week in groups of no fewer than three and no more than 12 clients.

Allowable Performing Provider – Behavioral Health Agency that is certified by the Department of Human Services as an Intensive Outpatient Substance Abuse Treatment provider The Intensive Outpatient Substance Abuse Treatment provider shall have practitioners appropriately licensed and certified to deliver Intensive Outpatient Substance Abuse Treatment.

xxii: Individual Life Skills Restoration*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Individual Life Skills Restoration is a service that provides support and training for beneficiaries on a one-on-one basis. This service includes behavioral modeling to restore a beneficiary's skills needed to support an independent lifestyle and restore a strong sense of self-worth. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. In addition, it aims to restore the ability of youth in setting and achieving goals, and restoring independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxiii. Group Life Skills Restoration*

Group Life Skills Restoration is a service that provides support and training for beneficiaries in a group setting of up to six (6) beneficiaries with one staff member or up to ten (10) beneficiaries with two staff members. This service includes behavioral modeling to restore a beneficiary's skills needed to support an independent lifestyle and restore a strong sense of self-worth. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. In addition, it aims to restore the ability of youth in setting and achieving goals, and restoring independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: group

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xxiv: Child and Youth Support Services*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Child and Youth Support Services are clinical, time-limited services for principal caregivers for the benefit of the beneficiary designed to restore a child's positive behaviors and compliance with parents at home; and restore a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff for the benefit of the beneficiary. This service is intended to assist the parent in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools for the benefit of the beneficiary.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxv. Psychosocial Rehabilitation Services – Working Environment*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Psychosocial Rehabilitation Services – Working Environment is designed to assist beneficiaries restore skills needed to promote and sustain independence and stability in their working environment. The service actively facilitates the restoration of skills needed to acquire a job.

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xxvi: Psychosocial Rehabilitation Services – Living Environment *

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Psychosocial Rehabilitation Services – Living Environment is designed to assist beneficiaries restore skills needed to promote and sustain independence and stability in their living environment. An emphasis is placed on the development and strengthening of natural supports in the community.

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxvii. Adult Life Skills Development

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Adult Life Skills Development services are designed to assist beneficiaries in restoring skills needed to support an independent lifestyle and promote an improved sense of self-worth. Adult Life skills Development is designed to restore the beneficiary's ability to set and achieve goals, restore independent living skills, restore the ability to demonstrate accountability, and restore the ability to make goal-directed decisions related to independent living.

Allowable Performing Provider -Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xxviii: Therapeutic Communities

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Therapeutic Communities are highly structured residential environments in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified through a person-centered and directed planning process. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process.

Example services include, but are not limited to, a combination of Individual Behavioral Health Counseling, Group Behavioral Health Counseling, Psychoeducation, Marital-Family Behavioral Health Counseling, Multi-Family Behavioral Health Counseling, Crisis Stabilization Intervention, Peer Support, Individual Pharmacologic Counseling, Group Pharmacologic Counseling, Adult Life Skills Development and Psychosocial Rehabilitative Services.

This service will not be paid for within an Institution for Mental Disease (IMD)

This service does not include payment for room and board of the beneficiary.

Therapeutic Community shall be certified by the Department of Human Services as a Therapeutic Communities provider.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxix. Crisis Care - De-escalation*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Crisis Care – De-escalation provides temporary direct care for a beneficiary in the beneficiary's community that is not facility-based. Crisis Care – De-escalation services de-escalate stressful situations and provide a therapeutic outlet. Crisis Care includes behavioral interventions that keep beneficiaries in their current situation and reduces the need for acute hospitalization or other higher levels of care. Crisis Care shall be indicated in the treatment plan.

This service will not be paid for within an Institution for Mental Disease (IMD).

This service does not include payment for room and board of the beneficiary.

Crisis Care – De-escalation provider must be certified by the Department of Human Services as a Crisis Care – De-escalation provider.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelor's; and Qualified Behavioral Health Provider – Non-Degreed.

xxx. Acute Crisis Units*

Definition: Acute Crisis Units provide brief 96 hours or less) crisis treatment services to persons over the age of 17 who are experiencing a psychiatry and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.

This service will not be paid for within an Institution for Mental Disease (IMD).

This service does not include payment for room and board of the beneficiary.

Acute Crisis Unit must be certified by Department of Human Services as an Acute Crisis Unit.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

An Extension of Benefit for medical necessity is required for admissions exceeding ninety-six (96) hours.

*All medically necessary 1905(a) services, that correct or ameliorate physical and mental illnesses and conditions, are covered for EPSDT eligible beneficiaries, ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)

xxxi. Crisis Intervention*

DEFINITION: Crisis Intervention is an unscheduled, immediate, short-term treatment activity provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and **their** family. These services, which can include interventions, stabilization activities, evaluation, coping strategies, and other various activities to assist the beneficiary in crisis, are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. The services provided are expected to reduce or eliminate the risk of harm to the person or others in order to stabilize the beneficiary.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician

xxxii. Substance Abuse Detoxification*

Definition: Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term**,** may be provided in a crisis unit, residential, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing treatment.

This service will not be paid for within an Institution for Mental Disease (IMD).

This service does not include payment for room and board of the beneficiary.

Substance Abuse Detoxification Unit must be certified by the Department of Human Services as a Substance Abuse Detoxification provider.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelor's; and Qualified Behavioral Health Provider – Non-Degreed.

Six encounters are allowed per State Fiscal Year (July 1 through June 30). Extension of Benefits for Medically Necessary Encounters beyond the first six (6) is required.

*All medically necessary 1905(a) services, that correct or ameliorate physical and mental illnesses and conditions**,** are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxxiii: Residential Community Reintegration Services*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Residential Community Reintegration Services are designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and Outpatient Behavioral Health Services. Twenty-four hour per day intensive therapeutic care is provided in a small group home setting for individuals under 21 years of age with emotional and/or behavior problems which cannot be remedied by less intensive treatment to prevent acute or sub-acute hospitalization. The program is also offered as a step-down or transitional level of care to prepare a beneficiary for less intensive treatment. Services include all medically necessary Outpatient Behavioral Health Services (OBHS) to address the beneficiary's behavioral health needs.

Example services include, but are not limited to, a combination of Individual Behavioral Health Counseling, Group Behavioral Health Counseling, Psychoeducation, Marital-Family Behavioral Health Counseling, Multi-Family Behavioral Health Counseling, Crisis Stabilization Intervention, Peer Support, Individual Pharmacologic Counseling, Group Pharmacologic Counseling, Adult Life Skills Development and Psychosocial Rehabilitative Services.

This service will not be paid for within an Institution for Mental Disease (IMD).

This service does not include payment for room and board of the beneficiary.

Residential Community Reintegration sites shall be certified by the Department of Human Services as a Residential Community Reintegration provider.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)

C. Provider Agency Qualifications

Outpatient Behavioral Health Services (OBHS) may be provided by appropriately certified providers who offer core behavioral health services for treatment and rehabilitation of behavioral health issues. The provider must be certified as an OBHS provider by the Department of Human Services (DHS). Providers not certified by DHS are not qualified to provide these services.

D. Performing Provider Qualifications

Outpatient Behavioral Health Services (OBHS) are limited to certified providers who offer core behavioral health services for treatment and rehabilitation of behavioral health issues. The provider must be certified as an OBHS provider by the Department of Human Services (DHS). Providers not certified by DHS are not qualified to provide these services.

Providers for each specific OBHS service are certified by DHS. Any provider licensed by the State must practice within their scope of Arkansas licensure. Individuals providing OBHS services must be one of the following:

1. Licensed in the State of Arkansas as a Clinician:

- **a. Licensed Clinical Social Worker (LCSW)**
- **b. Licensed Marital and Family Therapist (LMFT)**
- **c. Licensed Psychologist (LP)**
- **d. Licensed Psychological Examiner – Independent (LPEI)**
- **e. Licensed Professional Counselor (LPC)**
- **f. Licensed Master Social Worker (LMSW)**
- **g. Licensed Associate Counselor (LAC)**
- **h. Licensed Psychological Examiner (LPE)**
- **i. Provisionally Licensed Psychologist (PLP)**

2. Licensed Physician

3. Licensed Advanced Nurse Practitioner (limited to Adult Psychiatric Mental health Clinical Nurse Specialists, Child Psychiatric Mental Health Clinical Nurse Specialist, Adult Psychiatric Mental Health APN and Family Psychiatric Mental Health APN)

4. Licensed Registered Nurse

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)

5. Certified Qualified Behavioral Health Providers (includes Certified Peer Support Specialist, Certified Youth Support Specialist, and Certified Family Support Partner), under direct supervision of an individual licensed in the State of Arkansas as a Clinician that is an allowable performing provider of a service as indicated in D., 1.,a – e.

a. Certified Peer Support Specialists, Certified Youth Support Specialists, and Certified Family Support Partners are certified by DHS and must adhere to the mandated training requirements to become certified. The requirements to become and maintain certification are as follows:

i. Must complete 40 hours of QBHP training

ii. Must complete annual ongoing training approved by Arkansas DHS

iii. Must have lived experience

iv. Must ensure and document that all Certified Peer Support Specialists, Certified Youth Support Specialists, and Certified Family Support Partners are under supervision of a mental health professional as defined in Section 13., d., 3., c., 1 above.

b. Qualified Behavioral Health Providers are certified by the Behavioral Health Agency that they work for. In order to become certified as a Qualified Behavioral Health Provider, the Agency must provide and document that each Qualified Behavioral Health Provider has completed the required training and the Agency must issue a certificate to the Qualified Behavioral Health Provider. The requirements to become and maintain certification are as follows:

i. Must complete 40 hours of QBHP training, which includes, but is not limited to, topics such as behavior management, group interaction, listening techniques, and knowledge of behavioral health illnesses.

ii. Must complete, at a minimum, 8 hours of annual in-service training

CATEGORICALLY NEEDY

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14. Services for Individuals Age 65 or Older in Institutions for Mental Diseases

a. Inpatient Hospital Services

Not provided.

b. Nursing Facility Services

Not provided.

STATE Arkansas
DATE REC'D JAN 12 1995
DATE APP'D FEB 22 1995
DATE EFF FEB 15 1995
HCFA 179 93-01
A

3.1-A, Page 6c

SUPERSEDES: TN - 94-06

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. Services in an intermediate care facility for the mentally retarded, as defined in Section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not provided. PA*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided. PA*

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided. ☒ **Provided in accordance with section 2302 of the Affordable Care Act**

*Description provided on attachment.

15. **Services in an intermediate care facility for the mentally retarded, as defined in Section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.**

A Registered Nurse and a Physician Reviewer assess medical needs and make medical eligibility determinations and patient level of care classifications for applicants referred by a physician for nursing home care.

ICF/MR services include coverage of prescription medications within the State's formulary without limitations.

STATE Arkansas
DATE REC'D DEC 19 1990
DATE APPV'D 4-19-91
DATE EFF OCT - 1 1990
HCFA 179 90-69

A

Supersedes: 89-46

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

Inpatient Psychiatric Providers which are inpatient psychiatric hospitals must be:

- licensed as a psychiatric hospital by the State agency which licenses psychiatric hospitals and
- certified by the Medicare Certification Team as meeting the conditions of participation as a psychiatric hospital in the Title XVIII (Medicare) Program.

OR

Inpatient Psychiatric Providers which are inpatient psychiatric residential treatment facilities must be:

- **accredited as meeting the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations and**
- licensed by the Arkansas Department of Human Services, Division of Children and Family Services as a psychiatric residential treatment facility. (Applicable only to Inpatient Psychiatric Providers located in Arkansas.)

OR

Inpatient Psychiatric Providers which are inpatient psychiatric programs in a psychiatric facility must be:

- **accredited as meeting the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations.**

OR

Inpatient Psychiatric Providers which are inpatient psychiatric programs in a psychiatric hospital must:

- be in a psychiatric hospital licensed as a psychiatric hospital by the State agency which licenses psychiatric hospitals;
- be in a psychiatric hospital certified by the Medicare Certification Team as meeting the conditions of participation as a psychiatric hospital in the Title XVIII (Medicare) Program and
- **have an inpatient psychiatric program which is accredited as meeting the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations.**

STATE Approved
MAR 05 1993
HCFA REC'D MAR 22 1993
HCFA APP'VD MAR 01 1993
93-08
Superseded by 87-31

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age (Continued)

Inpatient psychiatric services reimbursable under the Arkansas Medicaid Program must be provided:

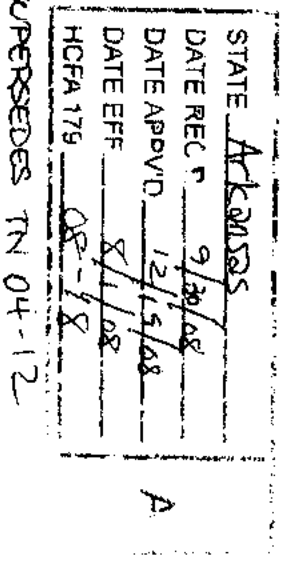
- by an Inpatient Psychiatric Provider selected by the recipient;
- by an Inpatient Psychiatric Provider enrolled in the Arkansas Medicaid Program;
- to an eligible Arkansas Medicaid recipient before the recipient reaches age 21 or, if the recipient was receiving inpatient psychiatric services at the time they reached 21 years of age, services may continue until the recipient no longer requires the services or the recipient becomes 22 years of age, whichever comes first.
- with certification from the independent or facility based team (whichever is appropriate in accordance with 42 CFR 441.153) that the recipient meets the criteria for inpatient psychiatric services;
- with prior authorization from the Medicaid Agency Review Team and
- under the direction of a physician (contracted physicians are acceptable).

STATE Arkansas
DATE REC'D 9-23-91
DATE APP'D 10-21-91
DATE EFF 10-1-91
HCFA ID 91-45
A
Supersedes: 88-04

17. Nurse-Midwife Services

Any person possessing the qualifications for a registered nurse in the State of Arkansas who is also certified as a nurse-midwife by the American College of Nurse-Midwives, upon application and payment of the requisite fees to the Arkansas State Board of Nursing, be qualified for licensure as a certified nurse-midwife. A certified nurse-midwife meeting the requirements of Arkansas Act 409 of 1995 is authorized to practice nurse-midwifery.

Services provided by a certified nurse midwife are limited to twelve (12) visits a year for **beneficiaries** age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, office medical services furnished by an optometrist **and advanced practice nurse or registered nurse practitioner or a combination of the six.** For services beyond the twelve visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. **Beneficiaries** under age 21 in the Child Health Services (EPSDT) program are not benefit limited.



18. Hospice Care

- The hospice patient must be terminally ill which is defined as having a medical prognosis with a life expectancy of six months or less. The terminal illness must be certified by the patient's attending physician and hospice services prescribed.

- Patients must voluntarily elect to receive hospice services and choose the hospice provider. Hospice election is by "election periods". Election periods in the Arkansas Medicaid Hospice Program correspond to the election periods established for Medicare. The initial hospice election period is of 90 days duration and is followed by a second 90-day election period. The patient is then eligible for an unlimited number of 60-day election periods.

- Election of the hospice benefit results in a waiver of the **beneficiary's** rights to payment for only those services which are related to the treatment of the terminal illness or related conditions and common to both Title XVIII and Title XIX. The **beneficiary** does not waive rights to payment for services related to the terminal illness that are unique to Title XIX.

- Hospice services must be provided primarily in a patient's residence.

  A patient may elect to receive hospice services in a nursing facility **or an intermediate care facility for the mentally retarded (ICF/MR)** if the hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the patient's hospice care, and the facility agrees to provide room and board to the patient.

- Hospice services must be provided consistent with a written plan of care.

- Dually eligible (Medicare and Medicaid) **beneficiaries** must elect hospice care in the Medicare and Medicaid hospice programs simultaneously to be eligible for Medicaid hospice services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

STATE	Arkansas
DATE REC'D	9-12-94
DATE APPV'D	9-15-94
DATE EFF	9-1-94
HCFA 179	94-22

A

TN No. 94-22
Supersedes TN No. 94-12 Approval Date 9/15/94 Effective Date 9/1/94

State/Territory: ARKANSAS

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

☐ Provided: ☐ No limitations ☒ With limitations*

☒ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☒ **Provided:** ☐ No limitations ☒ With limitations*** with Prior Authorization**

☐ Not provided.

23. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

19. Case Management Services

Refer to Supplement 1 to Attachment 3.1-A.

20. Extended Services for Pregnant Women

a. Pregnancy-related and postpartum services for a 60 day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

Services provided will only be pregnancy-related services, postpartum services and family planning. Sixty (60) days of postpartum care is covered if the individual is Medicaid eligible at delivery.

b. Services for any other medical conditions that may complicate pregnancy.

(1) Risk Assessment

A medical, nutritional, and psychosocial assessment by the physician or registered nurse to designate patients as high or low risk.

(a) Medical assessment using the Hollister Maternal/Newborn Record System to include:

- medical history
- menstrual history
- pregnancy history

(b) Nutritional assessment to include:

- 24 hour diet recall
- Screening for anemia
- weight history

(c) Psychosocial assessment to include criteria for an identification of psychosocial problems which may adversely affect the patient's health status.

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(1) Risk Assessment (Continued)

Pregnant women who are assessed as high risk, by definition, have medical conditions or circumstances which complicate the pregnancy. These patients need more medical services and attention in an effort to ensure a healthy birth outcome. Some conditions which complicate the pregnancy, and are therefore considered high risk, are:

Teenage pregnancies
Diabetes
Toxemia

MAXIMUM: 2 per pregnancy

(2) Case Management Services

Refer to Item 19 and Supplement 1 to Attachment 3.1-A.

Case Management services are reimbursed using a monthly rate. A minimum of 2 contacts per month must be provided. Case management is triggered by risk assessment and care plan development. A case management contact may be with the patient, other professionals, family, and/or other caregivers.

STATE Arkansas
DATE REC'D 11-29-91
DATE APPV'D 8-22-91
DATE EFF 7-1-91
HCFA 179 91-30
A

Supersedes 87-12

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(3) Perinatal Education

Educational classes provided by a health professional (Public Health Nurse, Nutritionist, or Health Educator) to include:

- pregnancy
- labor and delivery
- reproductive health
- postpartum care
- nutrition in pregnancy

These educational classes are designed to prevent the development of conditions which may complicate the pregnancy or to provide information to the pregnant woman in caring for herself during a pregnancy which may already have complicating factors.

MAXIMUM: 6 classes (units) per pregnancy

STATE AR
DATE RECD JUL 1 1987
DATE APPVD JUL 30 1987
DATE EFF See HCFA-179
HCFA ID 87-12

A

Supersedes 86-26

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(4) Nutritional Consultation - Individual

Services provided for high risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration to include at least one of the following:

- an evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
- nutritional care plan follow-up and reassessment as indicated

By definition, this service is covered only for women with high risk pregnancies. This service is appropriate for women whose complications require nutritional education for treatment of the complication (such as diabetics).

MAXIMUM: 9 units per pregnancy (1 unit equals 1 client visit)

STATE AR
DATE REC'D JUL 1 1987
DATE APPV'D JUL 30 1987
DATE EFF See HCFA-179
HCFA 179 87-12
A
New page

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(5) Social Work Consultation

Services provided for high risk pregnant women by a licensed social work to include at least one of the following:

- an evaluation to determine health risks due to psychosocial factors with development of a social work care plan
- social work plan follow-up, appropriate intervention and referrals

By definition, this service is only covered for women with high risk pregnancies. This service is appropriate for women whose complications require social work consultation as an essential element of treatment in dealing with the complication (such as a teenager with no place to live).

MAXIMUM: 6 units per pregnancy (1 unit equals 1 client visit)

STATE AR
DATE RECD JUL 1 1987
DATE APP'D JUL 30 1987
DATE EFF See HCFA-179
HCFA 179 87-12
A
New page

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(6) Early Discharge Home Visit

If a physician chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours), the physician or registered nurse employee may provide a home visit to the mother and baby within 72 hours of the hospital discharge; or the physician may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by physician order (includes hospital discharge order).

A physician may order a home visit for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

These services are preventive in nature to try to avoid post-partum complications.

(7) Pregnancy-Related Substance Abuse Treatment Services (SATS)

Pregnancy-Related Substance Abuse Treatment Services (SATS) are provided for Medicaid eligible pregnant women through the last day of the month in which the 60th post partum day falls. Services are provided based on medical necessity and require prior authorization.

The SATS program covers the following services:

A. Addiction Assessment
B. Treatment Planning
C. Care Coordination
D. Multi-person (family) Group Counseling
E. Individual Counseling
F. Group Counseling
G. Marital/Family Counseling
H. Medication Management

Please refer to Attachment 3.1-A, Page 1zz.3 for the service descriptions, definitions, benefit limits and individual qualified provider requirements. Benefit limits may be extended based on medical necessity.

SATS Qualified Provider

SATS providers must hold certification from the Division of Behavioral Health Services (DBHS) as a SATS provider in order to enroll as a Substance Abuse Treatment Services Medicaid provider.

The following requirements must be met for DBHS/OADAP certification:

A. Providers must be licensed by Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (OADAP).

B. Providers must submit a written request from the organization's Chief Executive Officer (CEO) to DBHS for certification by DBHS as a SATS Provider.

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(7) Pregnancy-Related Substance Abuse Treatment Services (SATS) (Continued)

C. The request for certification by DBHS must include a copy of the provider's accreditation, most recent accreditation survey, and correspondence between the provider and the accrediting organization since the most recent accreditation survey.

D. A list of service delivery sites, including each site's address, telephone number, and fax number must be submitted. Each site from which SATS services are delivered must be included under the provider's accreditation. Proof of this accreditation must be submitted with the request for certification of a site.

E. Current CARF, JCAHO, or COA, *that includes accreditation of the pertinent outpatient alcohol and/or other drug abuse treatment component* (OADAP Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs p. 11). Current nationally accredited behavioral health programs without specific alcohol and drug treatment certification will need to obtain accreditation of their substance abuse program prior to receiving certification as a SATS provider of substance abuse treatment.

F. Provisional, Conditional, Preliminary, Pending, Expedited or Deferred Accreditations are not acceptable.

G. The provider must: notify its accrediting organization in writing of all new or additional SATS services implemented subsequent to the provider's most recent accreditation survey; provide DBHS with a copy of the notification letter; and affirm in writing to DBHS that the new service(s) will be included in the provider's next regularly scheduled accreditation survey, if not surveyed before that time. Provider organization opening new services sites must follow DBHS certification policy and procedures.

H. DBHS must be authorized to receive information directly from the accrediting organization and to provide information directly to the accrediting organization, as it relates to SATS. DBHS will furnish these documents to providers at their request.

I. DBHS retains the right to request information in connection with licensure, accreditation, certification, provision or billing of SATS services; to perform site visits at anytime; and to conduct scheduled or unannounced visits, to insure entities are providing SATS services in accordance with the information that was submitted to DBHS. During a site visit the provider must allow access to all sites, policies and procedures, patient records, financial records, and any other documentation necessary to ascertain that services were/are of a quality which meets professionally recognized standards of health care.

J. Providers must adhere to evidence-based practices as approved by DBHS for specific populations and services provided.

21. RESERVED

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).

Respiratory care for ventilator-dependent individuals means services that are not otherwise available under the State's Medicaid plan, provided on a part-time basis in the recipient's home by a respiratory therapist or other health care professional trained in respiratory therapy to an individual who---

a. Is medically dependent on a ventilator for life support at least 6 hours per day;
b. Has been so dependent for at least a number of consecutive days (number is based on maximum number of days authorized under the State plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;
c. Except for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the State plan;
d. Has adequate social support services to be cared for at home;
e. Wishes to be cared for at home; and
f. Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual.

1. Ventilator Equipment (i.e., ventilator, suction pump, oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, ventilator supplies and hospital bed) including 24-hour availability of respiratory therapy and equipment maintenance, with prior authorization.

2. Respiratory therapy/treatment services for ventilator-dependent recipients under age 21, with prior authorization.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Services of Christian Science nurses.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

e. Emergency hospital services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

/_/ Not provided. SEE ITEM 26.

*Description provided on attachment.

STATE Arkansas
DATE REC'D 5/14/97
DATE A... 8/12/97
DATE E... 9/1/97
HCFA I.D. 97-03

A

SUPERSEDES: TN. 91-43

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

(1) A. Ground Ambulance Services

Payment will be made for ambulance services, provided the conditions below are met and the services are provided in accordance with laws, regulations and guidelines governing ambulance services under Part B of Medicare. These services are equally available to all beneficiaries. The use of medical transportation must be for health-related purposes and reimbursement will not be made directly to Title XIX beneficiaries.

I. For transportation of **beneficiaries** when medically necessary as certified by a physician to a hospital, to a nursing home from the hospital or **beneficiary's** home, to the **beneficiary's** home from the hospital or nursing home, from a hospital (after receiving emergency outpatient treatment) to a nursing home if a **beneficiary** is bedridden, and from a nursing home to another nursing home if determined necessary by the Office of Long Term Care. Emergency service is covered only through licensed emergency ambulance companies. Services not allowed by Title XVIII but covered under Medicaid will be **reimbursed** for Medicare/Medicaid **beneficiaries**.

II. For services provided at an alternative location or destination to which an ambulance is dispatched, and the ambulance service treatment is initiated from a 911 call that is documented in the records of the ambulance service. Alternative destination means a lower-acuity facility that provides medical services.

Alternative location is the location to which an ambulance is dispatched, and the ambulance service treatment is initiated from a 911 call that is documented in the records of the ambulance service. Alternative destination means a lower-acuity facility that provides medical services, including:

- **A federally qualified health center;**
- **An urgent care center;**
- **A physician's office or medical clinic, as chosen by the beneficiary;**
- **A behavioral or mental healthcare facility**

Excluded alternative destinations are facilities that provide a higher-acuity medical service or medical services for a routine chronic condition, such that they would be considered as destinations for which transportation under (1) above would occur:

- **Emergency Room;**
- **Critical Access Hospital;**
- **Rural Emergency Hospital;**
- **Dialysis center;**
- **Hospital;**
- **Private residence;**
- **Skilled nursing facility**

B. Air Ambulance Services

Air ambulance services are provided to Arkansas Medicaid beneficiaries only in emergencies.

Air ambulance providers must be licensed by the Arkansas Ambulance Boards and enrolled as a Title XVIII, Medicare Provider.

(2) Early Intervention Day Treatment (EIDT) and Adult Developmental Day Treatment (ADDT) Transportation

EIDT and ADDT providers may provide transportation to and from their facility. The Medicaid transportation broker must provide transportation to and from the nearest qualified medical provider for the purpose of obtaining medical treatment.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

STATE Arkansas	A
DATE REC'D 10-20-05	
DATE APPV'D 11-17-05	
DATE EFF 1-1-06	
HCFA 179 05-10	

a. Transportation (Continued)

(3) Non-Emergency

(a) Public Transportation

Effective for dates of service on or after December 1, 2001, public transportation services are available when provided by an enrolled Medicaid public transportation provider to an eligible Medicaid **beneficiary** being transported to or from a medical facility to receive medical care services covered by the Arkansas Medicaid Program. Transportation will be covered from the point of pick-up to the medical facility or from the medical facility to the point of delivery. The following benefit limits are established. One unit of service = 1 mile. The benefit limits do not apply to EPSDT **beneficiaries.**

Effective for dates of service on or after January 1, 2006, public transportation services are available when provided by an enrolled Medicaid public transportation provider to a full benefit dual eligible being transported to or from a pharmacy to receive prescriptions covered under the Medicare Prescription Drug Benefit- Part D.

- Public Transportation, Taxi, Intra-City, One Way - may be billed once per day, per **beneficiary** for a maximum of 15 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.

- Public Transportation, Taxi, Intra-City, Round Trip - may be billed once per day, per **beneficiary** for a maximum of 30 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.

- Public Transportation, City-to-City - may be billed once per day, per **beneficiary** for a maximum of 50 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.

- Public Transportation, ADA Accessible Van, Intra-City, One Way - may be billed once per day, per **beneficiary** for a maximum of 15 units. The provider may request an extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

STATE Arkansas
DATE REC'D 10-20-05
DATE APPV'D 11-17-05
DATE EFF 1-1-06
HCFA 179 05-10

A

a. Transportation (Continued)

(3) Non-Emergency (Continued)

(a) Public Transportation (Continued)

- Public Transportation, ADA Accessible Van, Intra-City, Round Trip - may be billed once per day, per **beneficiary** for a maximum of 30 units. The provider may request an extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.

- Public Transportation, ADA Accessible Van, Intrastate Authority - may be billed once per day, per **beneficiary** for a maximum of 50 units. The provider may request an extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.

(b) Non-Public Transportation

Effective for dates of service on or after December 1, 2001, non-public transportation services are available when provided by an enrolled Medicaid transportation provider to an eligible Medicaid **beneficiary** transported to or from a medical provider to receive medical services covered by the Arkansas Medicaid Program. Transportation will be covered from the point of pick-up to the medical service delivery site and from the medical service delivery site to the **beneficiary's** return destination.

Effective for dates of service on or after January 1, 2006, non-public transportation services are available when provided by an enrolled Medicaid non-public transportation provider to a full benefit dual eligible being transported to or from a pharmacy to receive prescriptions covered under the Medicare Prescription Drug Benefit- Part D.

The following benefit limits are established. The benefit limits do not apply to EPSDT **beneficiaries**.

This service may be billed once per day, per **beneficiary** for a maximum of 300 miles per date of service.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Volunteer Transportation

Volunteer carriers are reimbursed for providing transportation to recipients to medical services provided the carriers are registered by the Arkansas Department of Human Services and Medical Services and the medical services are part of the case plan. A General Relief check is issued by local Human Services staff for payment of Medicaid transportation if a licensed carrier is not available.

These services may be billed once per day, per recipient for a maximum of 300 miles per day. The benefit limit does not apply to EPSDT recipients.

b. Services of Christian Science Nurses - Not Provided.

c. Care and services provided in Christian Science sanitoria - Not Provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

d. Nursing facility services for patients under 21 years of age.

A Registered Nurse and a Physician Reviewer assess medical needs and make medical eligibility determinations and patient level of care classifications for applicants referred by a physician for nursing home care.

Nursing facility services include coverage of prescription medications within the State's formulary without limitations.

e. Emergency Hospital Services

Limited to immediate treatment and removal of patient to a qualifying hospital as soon as patient's condition warrants.

f. Critical Access Hospital (CAH)

Services that are furnished by an instate provider that meets the requirements for participation in Medicaid as a CAH and are of a type that would be covered by Medicaid if furnished by a Medicaid enrolled instate hospital to a Medicaid recipient. Services that are not permitted under CAH licensure requirements are not covered by Medicaid.

Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

CAH services are subject to the same benefit limits as inpatient and outpatient hospital services as described in Attachment 3.1-A, Items 1 and 2a.

24. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89).

Services are limited to 12 nurse practitioner visits per State Fiscal Year, July 1 through June 30. This yearly limit does not apply to recipients in the Child Health Services (EPSDT) program.

Refer to Attachment 3.1-A, Item 6.d.(6) for obstetric-gynecologic and **gerontological** nurse practitioner services.

STATE: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided ___X___ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

__X__ Provided: __**X**__ State Approved (Not Physician) Service Plan Allowed
__X__ Services Outside the Home Also Allowed
__X__ Limitations Described on Attachment

_____ Not Provided.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: April 1, 2008

CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Not provided.

STATE Arkansas
DATE REC'D 6-30-08
DATE APP'V'D 9-23-08
DATE EFF 4-1-08
HCFA 179 08-13
A

SUPERSEDES: TN- 04-17

CATEGORICALLY NEEDY

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1. Personal Care

A. Personal care services are provided by a personal care aide to assist with a client's physical dependency needs. The personal care aide must have at least 24 hours classroom training and a minimum of supervised practical training of 16 hours provided by or under the supervision of a registered nurse for a total of no less than 40 hours.

B. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or institution for mental disease that are –

1. Authorized for the individual in accordance with a service plan approved by the State;
2. Provided by an individual who is qualified to provide such services; and
3. Furnished in a home, and at the State's option, in another location, including licensed residential care facilities and licensed assisted living facilities.

C. The State defines "a member of the individual's family" as:

1. A spouse,
2. A minor's parent, stepparent, foster parent or anyone acting as a minor's parent,
3. A minor's "guardian of the person" or anyone acting as a minor's "guardian of the person" or
4. An adult's "guardian of the person" or anyone acting as an adult's "guardian of the person".

D. Under no circumstances may Medicaid reimbursement be made for personal care services rendered by the client's:
1. Legal guardian; or
2. Attorney-in-fact granted authority to direct the client's care.

E. Personal care services are covered for categorically needy individuals only.

F. Personal care services are medically necessary, prescribed services to assist clients with their physical dependency needs.

1. Personal care services involve "hands-on" assistance, by a personal care aide, with a client's physical dependency needs (as opposed to purely housekeeping services**). Personal care services also include employment-related personal care associated with transportation.**
2. The tasks the aide performs are similar to those that a nurse's aide would normally perform if the client were in a hospital or nursing facility.

G. Prior authorization is required for personal care pursuant to the Independent Assessment for all beneficiaries. **Personal care services for adults 21 years of age or older are limited to a maximum of 64 hours per calendar month.**

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

1905(a)(26) and 1934

__X__ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits-for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

STATE Arkansas
DATE REC'D 6 Jan 04
DATE APP'VD 26 Mar 04
DATE EFF 1 Jul 04
HCFA 179 04-01

A

27. Program of All-Inclusive Care for the Elderly (PACE)

Refer to Supplement 3 to Attachment 3.1-A.

STATE Arkansas
DATE REC'D 1-28-08
DATE APPV'D 3-28-08
DATE EFF 4-1-08
HCFA 179 07-23

A

SUPERSEDES: NONE - NEW PAGE

28. **Self-Directed Personal Assistance Services**

__X__ **Self-Directed Personal Assistance Services, as described in Supplement 4 to Attachment 3.1-A.**

__X__ **Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.**

____ **No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.**

SUPERSEDES: NONE - NEW PAGE

STATE Arkansas	A
DATE REC'D 1-28-08	
DATE APPV'D 3-28-08	
DATE EFF 4-1-08	
HCFA 179 07-23	

28. Self-Directed Personal Assistance Services

Refer to Supplement 4 to Attachment 3.1-A.

SUPERSEDES: NONE - NEW PAGE

STATE ARKANSAS
DATE REC'D 1-28-08
DATE APPV'D 3-28-08
DATE EFF 4-1-08
HCFA 179 07-23

A

29. Telemedicine Services

Telemedicine is the use of electronic information and communication healthcare technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring.

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: No limitations With limitations X None licensed or approved

Please describe any limitations:

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: No limitations With limitations (please describe below)

X Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

(a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

(b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

(c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

State/Territory: Arkansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: _01/01/2022

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X __ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_ X__A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X _A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1-A Amount, Duration, and Scope of Services

[Please check the box below to indicate if this benefit is provided for the categorically needy (3.1-A) or medically needy only (3.1-B)]

☒ 1905(a)(29) MAT as described and limited in __Supplement 5 __ to Attachment 3.1-A.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT SERVICES

A. Target Group:

Pregnant Women

B. Areas of State in which services will be provided:

(XX) Entire State.

( ) Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

STATE AR
DATE RECD JUL 1 1987
DATE APPVD
DATE EFF See HCFA-179
HCFA ID 87-12

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C. Comparability of Services

( ) Services are provided in accordance with section 1902(a)(10)(B) of the Act.

(XX) Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case Management Services are services by a physician, a licensed social worker, or registered nurse which will assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational, & other services. (Ex.: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver newborn, follow-up to verify appointment, reschedule appt.)

E. Qualification of Providers:

Physician or clinic that provides perinatal services and employs specified staff.

State/Territory: ARKANSAS

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE AR DATE RFC'D JUL 1 1987 DATE APPV'D JUL 30 1987 DATE EFF See HCFA-179 HCFA 179 87-12	A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Targeted Populations:

TCM services, when prescribed by a physician or other medical professional designated by the Division of Medical Services, are available to beneficiaries age 60 and older **as well as beneficiaries age 21 and older with a physical disability or aged 65 and older who participate in the ARChoices in Homecare (ARChoices)** 1915(c) waiver program who:

- have limited functional capabilities in two or more ADLs or IADLs, resulting in a need for coordination of multiple services and/or other resources; OR
- are in a situation or condition which poses imminent risk of death or serious bodily harm and one who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

___ Case-management services will be made available for up to ____ consecutive days of a covered stay in a medical institution for individuals age 21 and over transitioning from an institution to a community setting. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_x_ Entire State
___ Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_x_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

  Assessments/Reassessments are required, at least, annually.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

Care Plans must be renewed, at least, annually.

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:

  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

    1. services are being furnished in accordance with the individual's care plan;
    2. services in the care plan are adequate; and
    3. changes in the needs or status of the individual are reflected in the care plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers, according to established program guidelines.

Monitoring visits may be as frequent as necessary, within established Medicaid maximum allowable limitations.

Monitoring is allowed through regular contacts with service providers at least every other month to verify that appropriate services are provided in a manner that is in accordance with the service plan and assuring through contacts with the beneficiary, at least **every other month**, that the beneficiary continues to participate in the service plan and is satisfied with services.

Face to face monitoring contacts must be completed as often as deemed necessary, based on the professional judgment of the TCM, but no less frequent than established in Medicaid TCM program policy.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case management providers must be certified by the Division of Provider Services and Quality Assurance on an annual basis, unless approved otherwise by the Division of Medical Services, based on performance evaluations or other approved data.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

In order to be certified by the Division of **Provider Services and Quality Assurance**, the provider must meet the following qualifications:

A. Be located in the state of Arkansas

B. Be licensed as a Class A or Class B Home Health Agency or Private Care Agency by the Arkansas Department of Health or a unit of state government or be a private or public incorporated agency whose stated purpose is to provide case management to the elderly or adults with physical disabilities.

C. Is able to demonstrate one year of experience in performing case management services (experience must be within the past 3 years);

D. Be able to demonstrate one year of experience in working specifically with individuals in the targeted group (experience must be within the past 3 years);

E. Have an administrative capacity to insure quality of services in accordance with state and federal requirements;

F. Have the financial management capacity and system that provides documentation of services and costs;

G. Have the capacity to document and maintain individual case records in accordance with state and federal requirements;

H. Be able to demonstrate that the provider has current liability coverage, and

I. Employ qualified case managers who **reside in or near the area of responsibility and who meet at least one of the following qualifications:**

1. **Licensed in the state of Arkansas as a social worker (Licensed Master Social Worker or Licensed Certified Social Worker), a registered nurse, or a licensed practical nurse;**
2. **Have a bachelor's degree from an accredited institution in a health and human services or related field; or**
3. **Have two years' experience in the delivery of human services, including without limitation having performed satisfactorily as a case manager for a period of two years (experience must be within the past three years).**

A copy of the current certification must accompany the provider application and Medicaid contract.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.

2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

N/A Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):

At a minimum, providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

In addition, TCM services are limited to a maximum of 50 hours (200 15-minute units) per SFY.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

A. Target Group:

Medicaid recipients age twenty-two and older who are diagnosed as having a developmental disability of mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act) is invoked to provide services less than Statewide.

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are defined as referral for services or treatment. It is an activity under which responsibility for locating, coordinating and monitoring necessary and appropriate services for an individual rests with a specific person. Case management services will assist Medicaid recipients in gaining access to needed medical, social, educational and other services. These medical, social, educational and other services include services provided under the Arkansas Medicaid State Plan as well as those services not provided under the Arkansas Medicaid State Plan.

Arkansas
JUN 09 1994
JUL 06 1994
AUG 01 1994
94-11
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
Medicaid recipients age twenty-two and older who are diagnosed as having a developmental disability of mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

D. Definition of Services (Continued):

Targeted Case Management Services are limited to **104** hours per SFY.

The following are targeted case management service descriptions:

- Assessment/**Service Plan Development**: Face to face contact with the **beneficiary** and contact with other professionals, caregivers, or other parties on behalf of the **beneficiary**. Assessment is performed for the purpose of collecting information about the **beneficiary's** situation and **to determine** functioning and **to determine** and **identify** the **beneficiary's** problems and needs. **Service Plan Development** includes **ensuring the active participation of the Medicaid-eligible beneficiary. The goals and actions in the care plan must address medical, social, education and other services needed by the Medicaid-eligible beneficiary. The maximum units allowed for this service may not exceed twelve (12) units per assessment/service plan visit with beneficiaries age 22 and over.**

- Service Management/**Referral and Linkage**: **Activities and contacts that link Medicaid-eligible beneficiaries with medical, social, education providers and/or other programs and services that are capable of providing needed services.** Functions and processes **that** include contacting service providers selected by the **beneficiary** and **negotiation** for the delivery of services identified in the service plan. Contacts with the **beneficiary** and/or other professionals, caregivers, or other parties on behalf of the **beneficiary** may be a part of service management.

- Service Monitoring/**Service Plan Updating**: **Activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid-eligible beneficiary.** Verifying through regular contacts with service providers **at least every other month** that appropriate services are provided in a manner **that** is in accordance with the service plan and assuring through contacts with the **beneficiary, at least monthly,** that the **beneficiary** continues to participate in the service plan and is satisfied with services. **The maximum units for this service may not exceed four (4) units per monitoring visit when providers are dealing with beneficiaries age 22 and over.**

SUPERSEDES: TN- 94-11

STATE Arkansas
DATE RECD 5-2-07
DATE APPVD 12-11-07
DATE EFF 7-1-07
HCFA 179 07-08

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid recipients age twenty-two and older who are diagnosed as having a developmental disability of mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

D. Definition of Services (Continued):

Refer to Attachment 4.19-B, Page 7**a, C**. for the definition of a unit of service.

STATE Arkansas
DATE RECD 5-9-07
DATE APPVD 12-11-07
DATE EFF 7-1-07
HCFA 179 07-08

A

SUPERSEDES: TN- 91-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid recipients age twenty-two and older who are diagnosed as having a developmental disability of mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

E. Qualification of Providers:

Providers of targeted case management services for recipients as described above must be a Division of Developmental Disabilities Services **Certified Case Manager who must maintain the following information**

(1) Documentation of a high school diploma or GED.
(2) Documentation of the successful completion of the DDS Certified Case Management Training.
(3) Documentation of two years of experience of working with individuals with disabilities.
(4) Documentation of a successful completion of a criminal background check and adult and child maltreatment registry checks.
(5) In addition, the individual must provide two letters of reverence and sign a Code of Ethics agreement.

SUPERSEDES: TN- 94-11

STATE Arkansas
DATE RECD 5-2-07
DATE APPV'D 12-11-07
DATE EFF 7-1-07
HCFA 179 07-03

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid recipients age twenty-two and older who are diagnosed as having a developmental disability of mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

(1)Eligible recipients will have free choice of the providers of case management services.
(2)Eligible recipients will have free choice of the providers of other medical care under the plan.

G. **Targeted** case management services under the plan **are not integral to the administration of another non-medical program and** do not duplicate **other services** made to public agencies or private entities under other program authorities for this same purpose.

SUPERSEDES: TN- 94-11

STATE Arkansas
DATE RECD 5-2-07
DATE APPVD 12-11-07
DATE EFF 7-1-08
HCFA 179 07-08

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

A. Target Group:

Medicaid recipients age twenty-one and younger who experience developmental delays; have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay; are determined to be at risk of having substantial developmental delay if early intervention services are not provided; are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act) is invoked to provide services less than Statewide:

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management services are defined as referral for services or treatment. It is an activity under which responsibility for locating, coordinating and monitoring necessary and appropriate services for an individual rests with a specific person. Case management services will assist Medicaid recipients in gaining access to needed medical, social, educational and other services. These medical, social, educational and other services include services provided under the Arkansas Medicaid State Plan as well as those services not provided under the Arkansas Medicaid State Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid recipients age twenty-one and younger who experience developmental delays; have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay; are determined to be at risk of having substantial developmental delay if early intervention services are not provided; are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

D. Definition of Services (Continued):

The following are targeted case management service descriptions. **Effective for dates of service on or after December 1, 1997, prior authorization is required.**

- Assessment/Updating: Face to face contact with the recipient and contact with other professionals, caregivers, or other parties on behalf of the recipient. Assessment is performed for the purpose of collecting information about the recipient's situation and functioning and determining and identifying the recipient's problems and needs. Updating includes reexamining the recipient's needs and identifying changes which have occurred since the previous assessment. Updating includes measuring the recipient's progress toward service plan goals.

- Service Management: Functions and processes which include initial development of a service plan identifying the type of services to be pursued, which must be related to the recipient's needs identified in the assessment, contacting service providers selected by the recipient and negotiating for the delivery of services identified in the service plan and altering the service plan as the recipient's needs change. Contacts with the recipient and/or other professionals, caregivers, or other parties on behalf of the recipient may be a part of service management.

STATE Arkansas
DATE RECD September 26, 1997
DATE APPR. October 30, 1997
DATE EFF. December 1, 1997
HCFA ID. 94-13

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SUPERSEDES: TN. 94-11

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid recipients age twenty-one and younger who experience developmental delays; have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay; are determined to be at risk of having substantial developmental delay if early intervention services are not provided; are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

D. Definition of Services (Continued):

- Service Monitoring: Verifying through regular contacts with service providers that appropriate services are provided in a manner which is in accordance with the service plan and assuring through regular contact with the recipient that the recipient continues to participate in the service plan and is satisfied with services.

Refer to Attachment 4.19-B, Page 7, B. for the definition of a unit of service.

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TN No. 94-11 Approval Date JUL 06 1994 Effective Date AUG 01 1994

Supersedes TN No. 94-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid recipients age twenty-one and younger who experience developmental delays; have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay; are determined to be at risk of having substantial developmental delay if early intervention services are not provided; are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

E. Qualification of Providers:

Providers of targeted case management services for recipients as described above must:

- be certified by the Division of Developmental Disabilities Services as having successfully completed a Case Management Training Program, or
- be certified as an individual recognized and funded by the Arkansas Department of Education as an Early Childhood Coordinator who is responsible for implementing special education services under PL 99-457.

STATE Arkansas
JUN 09 1994
JUL 06 1994
AUG 01 1994
94-11

TN No. 94-11 Approval Date JUL 06 1994 Effective Date AUG 01 1994

Supersedes TN No. 94-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

Medicaid recipients age twenty-one and younger who experience developmental delays; have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay; are determined to be at risk of having substantial developmental delay if early intervention services are not provided; are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

(1) Eligible recipients will have free choice of the providers of case management services.
(2) Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Arkansas
JUN 09 1994
JUL 06 1994
AUG 01 1994
94-11
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TN No. 94-11 Approval Date JUL 06 1994 Effective Date AUG 01 1994

Supersedes TN No. 94-02

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

A. Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are at risk of deliquency as evidenced by being in the care or custody of the Department of Human Services, Division of Youth Services (DYS) or under the care of a designated provider (specified by DYS) for assessment, supervision or treatment.

B. Areas of State in which services will be provided:

[x] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act) is invoked to provide services less than Statewide.

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[x] Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

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D. Definition of Services:

Targeted case management services are those that assist an individual in the target group in accessing needed medical, social, educational, and other services appropriate to the needs of the individual. Case management assistance includes the following activities:

1. Client Intake through identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.

2. Assessment of the recipients family/community circumstances and service needs in order to coordinate the identification, accessing and the delivery of services.

3. Case Planning with the recipient, care giver and other parties, as appropriate to identify the care, services and resources required to meet the recipient's needs and how they might be most appropriately delivered.

AMENDED 1/14/98 EFFECTIVE 1/21/98 APPROVED 3/1/98 98-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are at risk of delinquency as evidenced by being in the care or custody of the Department of Human Services, Division of Youth Services (DYS) or under the care of a designated provider (specified by DYS) for assessment, supervision or treatment.

D. Definition of Services: (Continued)

4. Service Coordination and Monitoring through linkage, referral, coordination, facilitation, documentation and recipient specific advocacy to ensure the recipients access to the care, services and resources identified in the case plan. This is accomplished by personal, written or electronic contacts with the recipient, his/her family or care giver, service providers and other interested parties:

5. Case Plan Reassessment will be periodically conducted to determine and document whether or not medical, social, educational or other services continue to be adequate to meet the goals identified in the case plan. Activities include assisting recipients to access different medical, social, educational or other needed care and services beyond those already identified and provided.

E. Qualification of Providers:

Case management services will be provided only through qualified provider agencies. Qualified case management services provider agencies must meet the following criteria:

- Have full access to all pertinent records concerning the child's needs for services including records of the Arkansas District Judicial Courts, Central Arkansas Observation and Assessment Center and the County and State Youth Services Agency,
- Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population,
- Have a minimum of one year's experience in providing all core elements of case management services to the target populations,
- Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements,

ARKANSAS
DATE RECD 1/14/98
DATE EFF 4/1/98
HCFA 179 31/98
98-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are at risk of delinquency as evidenced by being in the care or custody of the Department of Human Services, Division of Youth Services (DYS) or under the care of a designated provider (specified by DYS) for assessment, supervision or treatment.

E. Qualification of Providers: (Continued)

- Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles,
- Have a capacity to document and maintain individual case records in accordance with State and Federal requirements, and
- Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.

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98-01
HCFA 179
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F. Freedom of Choice:

The State assures that the provision of case management services to children in the care or custody of the Division of Youth Services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the qualified providers of case management service, and
- Eligible recipients will have free choice of the providers of other medical care as covered elsewhere under the Plan.

G. Non-Duplication of Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are at risk of delinquency as evidenced by being in the care or custody of the Department of Human Services, Division of Youth Services (DYS) or under the care of a designated provider (specified by DYS) for assessment, supervision or treatment.

G. Non-Duplication of Payment (Continued):

To the extent any eligible recipients in the identified target population are receiving targeted case management services from another agency as a result of being members of other covered target groups, the provider agency will ensure that case management activities are coordinated to avoid unnecessary duplication of services and the State assures that it will not seek Federal matching for the case management services that are duplicative.

STATE Arkansas
DATE REC'D 4/14/98
DATE APPV'D 5/21/98
DATE EFF 3/1/98
HCFA ID 98-01

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SUPERSEDES: TN. 97-20

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

RESERVED

STATE	Arkansas
DATE RECD	11/18/97
DATE APPVD	12/9/97
DATE EFF	11/1/97
HCFA ID	97-20

A

SUPERSEDES: TN · 92-39

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

RESERVED

STATE	OKLAHOMA
DATE RECD	11/18/97
DATE APPVD	12/9/97
DATE EFF	11/1/97
HCFA ID	97-20

A

SUPERSEDES: TN - 92-39

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

RESERVED

STATE Arkansas	A
DATE RECD 11/18/94	
DATE APPVD 12/9/94	
DATE EFF 11/1/94	
HCFA ID 94-2D	

SUPERSEDES: TN - 92-39

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

RESERVED

STATE	Arkansas
DATE RECD	11/18/97
DATE APP	12/9/97
DATE EFF	11/1/97
HCFA ID:	97-20

A

SUPERSEDES: TN - 92-39

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

A. Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or are abused or neglected children and are in the care or custody of the Department of Human Services, Division of Children and Family Services (DCFS).

B. Areas of State in which services will be provided:

[x] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act) is invoked to provide services less than Statewide.

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[x] Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted case management services are those that assist an individual in the target group in accessing needed medical, social, educational, and other services appropriate to the needs of the individual. Case management assistance includes the following activities:

1. Client Intake through identifying programs appropriate for the individual's needs, and providing assistance to the individual in accessing those programs.

2. Assessment of the recipients family/community circumstances and service needs in order to coordinate the identification, accessing and the delivery of services.

3. Case Planning with the recipient, caregiver and other parties, as appropriate to identify the care, services and resources required to meet the recipient's needs and how they might be most appropriately delivered.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or are abused or neglected children and or in the care or custody of the Department of Human Services, Division of Children and Family Services (DCFS).

D. Definition of Services (Continued):

4. **Service Coordination and Monitoring through linkage, referral, coordination, facilitation, documentation and recipient specific advocacy to ensure the recipients access to the care, services and resources identified in the case plan. This is accomplished by personal, written or electronic contacts with the recipient, his/her family or caregiver, service providers and other interested parties.**

5. **Case Plan Reassessment will be periodically conducted to determine and document whether or not medical, social, educational or other services continue to be adequate to meet the goals identified in the case plan. Activities include assisting recipients to access different medical, social, educational or other needed care and services beyond those already identified and provided.**

E. Qualification of Providers:

Case management services will be provided only through qualified provider agencies. Qualified case management services provider agencies must meet the following criteria:

- **Have full access to all pertinent records concerning the child's needs for services including records of the Arkansas Family Courts and the State Child Welfare and Protection Agency,**
- **Must ensure 24-hour availability of case management services and continuity of those services,**
- **Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population,**
- **Have a minimum of five years experience in provide all core elements of case management services to the target populations,**
- **Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements,**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or abused or neglected children and are in the care or custody of the Department of Human Services, Division of Children and Family Services (DCFS).

E. **Qualification of Providers (Continued):**

- **Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles,**
- **Have a capacity to document and maintain individual case records in accordance with State and Federal requirements, and**
- **Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.**

Individual case managers working for provider agencies must meet the following minimum qualifications:

- **have a minimum of a bachelor's degree in social work, sociology, psychology or a related field, and**
- **function under a supervisor who, at minimum possesses the formal education equivalent of a bachelor's degree in social work, sociology, or a related field; plus four years experience in child welfare or human services.**

F. Freedom of Choice:

The State assures that the provision of case management services to children in the care or custody of the Division of Children and Family Services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- ***Eligible recipients will have free choice of the qualified providers of case management services.***

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or are abused or neglected children and are in the care or custody of the Department of Human Services, Division of Children and Family Services (DCFS).

F. **Freedom of Choice (Continued):**

- **Eligible recipients will have free choice of the providers of other medical care as covered elsewhere under the Plan.**

G. **Non-Duplication of Payment:**

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. To the extent any eligible recipients in the identified target population are receiving targeted case management services from another provider agency as a result of being members of other covered target groups, the provider agency will ensure that case management activities are coordinated to avoid unnecessary duplication of services and the State assures that it will not seek Federal matching for the case management services that are duplicative.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

A. Target Group:
By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

B. Areas of State in which services will be provided:

[X] Entire State.

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act) is invoked to provide services less than Statewide:

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

D. Definition of Services:
Case management is a service instrument by which service agencies assist an individual in accessing needed medical, social, educational, and other support services. Consistent with the requirements of Section 1902(a)(23) of the Act, the providers will monitor client treatment to assure that clients receive services to which they are referred. One case management unit is the sum of case management activities that occur within a day. These activities include:

o A written comprehensive assessment of the child's needs, including analysis of recommendations (e.g. medical records) regarding client's service needs; this does not include the performance of medical/psychological evaluations - it only includes the review of the records of those evaluations in order to assess the child's needs.

o Arranging for the delivery of the needed services as identified in the assessment;

o Assisting the recipient in accessing needed services;

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

D. Definition of Services (Continued):

o Monitoring the child's progress by making referrals to service providers through telephone, written or personal contacts, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing needs (including reviews of child's medical records);

o Preparing and maintaining case records; documenting contacts, services needed, reports, the child's progress, etc.;

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

D. Definition of Services (Continued):

o Special Restrictions -

- Medicaid reimbursement shall not be sought for clients who are in institutional placement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

E. Qualifications of Providers:

Providers must be certified as a Medicaid provider meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management
   - o assessment
   - o care/services plan development
   - o linking/coordination of services
   - o reassessment/followup

2. Appropriate staff for case management include: registered nurses, licensed social workers, pediatricians, registered dieticians, parent aides and clerical support staff who are credentialed as explained in section E.3 on Pages 30 and 31 or who are under the direct supervision of an appropriately credentialed case manager.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

E. Qualifications of Providers (Continued):

3. Qualifications of Credentialed Case Manager:

- Registered Nurse - must be licensed as a registered nurse by the Arkansas Board of Nursing and have satisfactorily completed a one month CMS case management orientation.

- Social Worker - must be a licensed social worker in the State of Arkansas or be qualified through education, training or experience to work in a social work roll and have satisfactorily completed a one month CMS case management orientation.

- Pediatrician - must be a licensed M. D. in the State of Arkansas and have satisfactorily completed a one month CMS case management orientation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
By invoking the exception to comparability allowed by 1915 (g)(I) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

E. Qualifications of Providers (Continued):

3. Qualifications of Credentialed Case Manager (Continued):

- Employed parent of a child with special health care needs. Employed by CMS for the purpose of assisting families to access services and who complete the one month orientation with CMS. A parent cannot be case manager for his or her own child.

- Clerical Support Staff who have two years of experience with a program for children with special health care needs in assisting families to obtain needed medical, social and educational services and have demonstrated the ability to assist families appropriately to access needed services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CASE MANAGEMENT

Target Group:
By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of case management services.
- Eligible recipients will have free choice of the providers of other medical care under the plan.
- Service plan will be developed with family and primary care physician (PCP). PCP prescription and referral requirements will be waived.

G. The State assures that an agreement will be entered into between the Title V agency, Children's Medical Services, and the Medicaid agency, which will fully comply with the provision of 42 CFR 431.615 to avoid duplication of Title V and Medicaid services.

H. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE Arkansas
DATE REC'D 01-22-01
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State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

__**X**_ Entire State

___ Only in the following geographic areas:

C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_**X**__ Services are not comparable in amount duration and scope (§1915(g)(1)).

D. Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management may be delivered through home visits and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual's needs and completing related documentation; and
   - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
   - Assessments/Reassessments are required at least annually.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definitions of Services (continued)

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible individual;
   - Care plans must be updated/renewed at least annually.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
   - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

4. Monitoring and follow-up activities:
   - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's care plan;
     - Services in the care plan are adequate; and
     - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definition of Services (continued)

Case managers will continue to monitor and follow-up on the care plan while conducting case management activities, including assessments, referrals and linkages to service providers, during visits. The visits may be as frequent as needed by the client but must be at least every 30 days, which will allow regular assessment of the plan implementation. The case manager will assess the services or community resources received and adequacy of the services. The case manager also will identify the beneficiaries' action steps, determine whether they require additional support or adjustments of services or activities and document relevant activities/changes. At least annually the care plan must be fully reviewed with beneficiaries to ensure the activities are relevant, appropriate and are being followed and update the plan as necessary. Beneficiary interviews may occur through a home visit, face-to face office visit, or other contact method that allows gathering the information needed.

_X__Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Hospital providers licensed as general hospitals with an obstetrics unit with a model recognized by the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HOMEVEE) program to be effective in improving maternal and child health that have applied and been approved to become Maternal Life360 providers. The hospital may use its own staff or subcontract for case management. Case managers employed by the hospital will have no direct relationship with the inpatient department, and case management services will not be provided by the inpatient or acute unit of the hospital. Case managers will be focused on the person-centered care delivered for the beneficiaries in the community and will not duplicate coordination provided through other hospital-delivered services. Case managers delivering this benefit must be able to provide all components of targeted case management within their scope of practice. Case managers must also meet the following criteria:

- A minimum or a high school diploma or GED and experience with early childhood education, childhood development, or social work, family support, maternity, or case management services, or demonstrated comparable experience or competency through educational or other professional activities to provide the required TCM services for the population.

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

H. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

I. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

J. Monitoring

Providers must meet established standards that measure services under this program/state plan service to eligible beneficiaries. The State will monitor performance on these standards through monthly expenditure reporting and quarterly progress reporting. Providers will use the MMIS to enroll individuals and enter visits provided in order to monitor individual enrollment and services rendered. The state will also review quality metrics for individual provider- and system-level goals.

The state will ensure that providers meet acceptable performance, including the process and health outcomes and case documentation/program reporting, and will address any identified non-compliance for these services. Audits will ensure case records are maintained as required.

K. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Eligible juveniles as defined in §1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution **following adjudication,** and for at least 30 days following release.

Post Release TCM Period beyond 30 day post release minimum requirement:
☒ State will provide TCM beyond the 30-day post release requirement. **[explain]:**

TCM services will be allowable beyond the 30-day post-release period as determined medically necessary.

Areas of State in which services will be provided (§1915(g)(1) of the Act):
☒ Entire state

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
☒ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management (TCM) services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

The periodic reassessment is conducted every (check all that apply):

☒ 1 month
☐ 3 months
☐ 6 months
☐ 12 months
☐ Other frequency **[explain]:** Click or tap here to enter text.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities are:
  activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

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State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Frequency of additional monitoring:
Specify the type and frequency of monitoring (check all that apply)
☒ Telephonic. Frequency: Monthly
☒ In-person. Frequency: Monthly
☐ Other **[explain]:** Click or tap here to enter text.

☒ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. For instance, a case manager might also work with state children and youth agencies for children who are involved with the foster care system.
(42 CFR 440.169(e))

☒ If another case manager is involved upon release or for case management after the 30-day post release mandatory service period, states should ensure a warm hand off to transition case management and support continuity of care of needed services that are documented in the person-centered care plan. A warm handoff should include a meeting between the eligible juvenile, and both the pre-release and post-release case manager. It also should include a review of the person-centered care plan and next steps to ensure continuity of case management and follow-up as the eligible juvenile transitions into the community.

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State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[**Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]**

Targeted case management services are provided only through qualified providers. Qualified case management providers must meet the following criteria:

A. The provider must be enrolled with Arkansas Medicaid.
B. The provider must have a minimum of one year's experience in providing all core elements of case management services to the target populations.
C. The provider must have the financial management capacity and system that provides documentation of services and costs in conformity with generally accepted accounting principles.
D. The provider must have a capacity to document and maintain individual case records in accordance with state and federal requirements.

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State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Freedom of choice (42 CFR 441.18(a)(1)):

☒ The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services below.]

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State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

☒ The state assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plans.
- Delivery of TCM and the policies, procedures, and processes developed to support implementation of these provisions are built in consideration of the individuals release and will not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Payment (42 CFR 441.18(a)(4)):

☒ The state assures payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):

☒ The state assures providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

☒ The state assures that case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 15 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

☐ State has additional limitations **[Specify any additional limitations.]**
Click or tap here to enter text.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1905(a)(13)(B) - Attestation for Vaccines and Vaccine Administration

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration.

Arkansas maintains a method of monitoring ACIP notifications of changes to recommendations to ensure that coverage and billing codes are updated to comply with those revisions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.
A.__X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

A special income level equal to 300% of the SSI Federal Benefit (FBR) (42 CFR 435.**236**)

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

Spousal impoverishment rules will be used in determining eligibility for the 435.236 group.

B._____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C.__X__ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1.__X__ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726.
Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A.) Individual (check one)
   1.__X__ The following standard included under the State plan (check one):
      (a) _____ SSI
      (b)_____ Medically Needy
      (c)__X__ The special income level for the institutionalized
      (d)_____ Percent of the Federal Poverty Level: _____%
      (e)_____ Other (specify):_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

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2. N/A The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3. N/A The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ The amount is determined using the following formula:
_____
7. X Not applicable (N/A)

(C.) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7. X Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

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SUPERSEDES: NONE - NEW PAGE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Regular Post Eligibility

2. N/A 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.___The following standard included under the State plan (check one):

(a) _____SSI

(b) _____Medically Needy

(c) _____The special income level for the institutionalized

(d) _____Percent of the Federal Poverty Level: _____%

(e) _____Other (specify):_____

2.___The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

3.___The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1._____The following standard under 42 CFR 435.121:

_____

2._____The Medically needy income standard

_____

3._____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

4._____The following percentage of the following standard that is not greater than the standards above:

_____% of _____ standard.

5._____The amount is determined using the following formula:

_____

_____

6._____Not applicable (N/A)

SUPERSEDES: NONE - NEW PAGE

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

(C.) Family (check one):

1.____AFDC need standard
2.____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A). X The following standard included under the State plan (check one):

1. _____SSI
2. _____Medically Needy
3. X The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

SUPERSEDES: NONE - NEW PAGE

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

(B). **N/A** The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) **N/A** The following formula is used to determine the needs allowance:

_____
_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be less than the cost to the agency of providing State plan approved services to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the amount the state would have otherwise paid for a comparable population.

1. ___ Rates are set at a percent of the amount that would have otherwise been paid for a comparable population.
2. ___ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3. ___ Adjusted Community Rate (please describe)
4. **X** Other (please describe)
See Page 37A for description of the rate setting methodology for Program of All-Inclusive Care for the Elderly (PACE).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Program of All-Inclusive Care for the Elderly (PACE)

The Arkansas PACE amount that would otherwise have been paid (AWOP) for a PACE-comparable population and capitation rate amounts are developed for Medicaid Only and Dual Eligible populations and may be further stratified by additional factors as appropriate. The state uses the most recent available Medicaid - claims and eligibility data for a comparable population. The data used in the AWOP and PACE rate calculations is limited to recipients 55 or older who are eligible for nursing facility level of care or ARChoices Waiver level of care, and who are eligible for PACE but not enrolled in the program.

The base year data used in the AWOP and rate development is no more than three years prior to the rate year and is trended forward using the historical claims and eligibility information extracted for the PACE-comparable population. The claims data includes all services included in the state plan. Only claims that were actually paid are included in the analysis to create a historical per-member-per-month rate.

Base data, including Medicaid claims and eligibility data, are summarized by rate cell and category of service. Adjustments are then applied to project the base period data to the rating period and to reflect expected future costs. These adjustments include, but are not limited to, completion factors for incurred but not reported claims, removal of pharmacy rebates, fee schedule changes, and trend assumptions to account for changes in utilization, service mix, and unit costs. An adjustment is also applied to reflect state administrative expenses.

The projected AWOP reflects the expected costs of the comparable population for the rating period and is developed on a per member per month basis for each rate cell.

Rates are developed for the appropriate rate categories. All appropriate adjustments are considered in the development of the rates.

In setting the PACE capitation rates, a managed care adjustment is applied to reduce the AWOP amounts by a percentage established by the state which reflects anticipated reductions in health care service costs resulting from the reduction in nursing facility services and increase in non-institutional care for PACE enrollees relative to the population underlying the AWOP development.

The percentage is determined by evaluating per member per month (PMPM) cost using the base data adjusted for the actual mix of PACE participants residing in the community, and dampening based on expected acuity for PACE vs. non-PACE home and community-based services. Historical financial performance for the PACE organizations is reviewed to validate the reasonableness of the final capitation rates.

The AWOPs and capitation rates will be rebased/recalculated every two years and the rebasing calculations will be completed for two calendar years (Jan-Dec). Separate AWOPs will be submitted for each year of the proposed two-year rating period. The rebasing/recalculations will be completed in accordance with the methodology described above and consistent with CMS rate-setting guidance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

II. Rates and Payments (continued)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner.

C. The State will submit all capitated rates to CMS for prior approval, and will include the name, organizational affiliate of any actuary used, and attestation/description of the capitation rates.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. __X__ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __X__ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. __X__ Services included in the following Section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

ARChoices Attendant Care

iii. Payment Methodology

A. ____ The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) as that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

iii. Payment Methodology (Continued)

C. __X__ The State will use a different reimbursement methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached.

iv. Use of Cash

A. __X__ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. _____ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

When the participant voluntarily elects to discontinue participation in IndependentChoices, **DHS professional staff** will discuss with the individual the reason for disenrollment and assist the individual in resolving any barriers or problems that may exist in preventing continuation. If the participant wishes to continue with the option to disenroll, **DHS professional staff** will assist by informing the participant of traditional agency personal care providers in the participant's area. **DHS professional staff** will assist with the coordination of agency services to the degree requested by the participant.

IndependentChoices can continue until agency services are established or the participant may elect to use informal supports until agency services are established.

The timeframes discussed under involuntary disenrollment do not apply to voluntary disenrollment. The request of the participant will be honored whether they ask to be disenrolled immediately or at anytime in the future. **DHS professional staff** will coordinate the participant's wishes to the degree requested by the participant. This may include self-advocation by the participant and asking **DHS professional staff** to coordinate agency services with the participant's preferred provider. In some instances the participant may wish to forego agency personal assistance services and choose to rely on family or friends. If the participant requests that **DHS professional staff** coordinate the agency services, **DHS staff** will ascertain when services can be started. **DHS staff** will then close the IndependentChoices case the day before agency services begin. Regardless of the situation, the State will assure that there will not be an interruption in delivering necessary services unless it is the preference of the participant to depend on informal supports.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to traditional service delivery model are noted below.

Participants may be disenrolled for the following reasons:

1. Health and Welfare: Any time **DPSQA** feels the health and welfare of the participant is compromised by continued participation in the IndependentChoices Program, the participant may be returned to the traditional personal care program. Prior to this point **counseling entity's support coordinator** has worked with the participant offering suggestions, identifying or changing representatives or employees to better meet the needs of the consumer, making in-home visits as needed by APS or HCBS RNs, and working to resolve these concerns. If no resolution is available, meeting the participant's health and well-being needs is of most importance; including referral back to the traditional model.

2. Change in Condition: Should the participant's cognitive ability to direct his/her own care diminish to a point where the participant can no longer self-direct and there is no responsible representative available to direct the care the **counseling entity's support coordinator** will seek out sources of support. If no resources are available, the IndependentChoices case will be closed. The participant will be informed of the pending closure by letter. The letter will include a list of traditional personal care agencies serving the participant's area. If the participant is also a 1915(c) waiver recipient, an e-mail will be auto generated to the HCBS RN or targeted case manager. The e-mail to the HCBS RN or targeted case manager is auto generated and populated with the appropriate names once a closure date is entered in the database. The e-mail will inform the HCBS RN or targeted case manager of the pending closure of the IndependentChoices case necessitating a change in the HCBS service plan. Within five days of sending the letter the **counseling entity's support coordinator** will follow up with the participant to determine which agency the participant may wish to choose. The **counseling entity's support coordinator** will coordinate the referral with the agency provider. However, if the participant declines agency services, the **counseling entity's support coordinator** will respect the choice made by the participant. The participant may choose to have their needs met by informal caregivers.

3. Misuse of Allowance: A notice will be issued should the participant or the representative who manages their cash allowance: 1) fail to pay related state and federal payroll taxes; 2) use the allowance to purchase items unrelated to personal care needs; 3) fail to pay the salary of a personal assistant; or 4) misrepresent payment of a personal assistant's salary. The **counseling entity's support coordinator** will discuss the violations with the participant and allow the participant to take corrective action including restitution if applicable. The participant will be permitted to remain in the program, but will be assigned to the fiscal intermediary, who will provide maximum bookkeeping support and services. The participant or representative will be notified that further failure to follow the expenditure plan will result in disenrollment and a report filed with Office of Medicaid Inspector General when applicable.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment (Continued)

Should an unapproved expenditure or oversight occur a second time, the participant/ representative will be notified that their IndependentChoices case is being closed and the participant is being returned to traditional personal care. Office of Medicaid Inspector General is informed of situations as required. The State will assure interruption of services will not occur while the participant is transitioning from IndependentChoices to traditional services.

4. Underutilization of Allowance: The fiscal intermediary is responsible for monitoring the use of Medicaid funds received on behalf of the participant. If the participant is underutilizing the allowance and not using the allowance according to their cash expenditure plan, the fiscal intermediary will inform the counseling entities through quarterly reports and monthly reports upon request. The **counseling entity's support coordinator** will discuss problems that are occurring with the participant and their support network. Together the parties will resolve the underutilization. The **counseling entity's support coordinator** will continue to monitor the participant's use of their allowance through both reviewing of reports and personal contact with the participant. If a pattern of underutilization continues to occur, future discussions will focus on what is in the best interest of the participant in meeting their ADLs even if the best solution is a return to agency services. Unused funds are returned to the Arkansas Medicaid program within 45 days upon disenrollment. Funds accrued in the absence of a savings plan will be returned to the Arkansas Medicaid program within a twelve month filing deadline. Exceptions to involuntary disenrollment may be considered if the participant has been hospitalized for an extended period of time or has had a brief visit out of state with approval by the participant's physician. Person-centered planning allows the flexibility of decision making based on individual needs that best meet the needs of the participant.

5. Failure to Assume Employer Authority: Failure to Assume Employer Authority occurs when a participant fails to fulfill the role of employer and does not respond to counseling support. Participants who fail in their employer responsibilities but do not have a representative will be given the opportunity to select a representative who can assume employer responsibilities on behalf of the participant. Disenrollment will not occur without guidance and counseling by the **counseling entity's support coordinator** or by the fiscal intermediary. When this occurs, the **counseling entity's support coordinator** will coordinate agency personal care services to the degree requested by the participant. The participant may wish to self-advocate from a list provided by the **counseling entity's support coordinator**, ask the **counseling entity's support coordinator** to coordinate, or may simply wish to receive personal assistance services informally. The participant's wishes will be respected.

B. The State will provide the following safeguards to ensure continuity of services and assure participant health, safety and welfare during the period of transition between self-directed and traditional service delivery models.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

vi. Involuntary Disenrollment (Continued)

When a participant is involuntarily disenrolled, a notice of intent to close the IndependentChoices case will be mailed to the participant. The notice will allow a minimum of 10 days but no more than 30 days before IndependentChoices enrollment will be discontinued, depending on the situation. During the transition period, the **counseling entity's support coordinator** will work with the participant/representative to assure services are provided to help the individual transition to the most appropriate personal care services available.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

There are no additional restrictions on living arrangements.

viii. Geographic Limitations and Comparability

A. __X__ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. ____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. __X__ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Age 18 and older.

E. ____ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. __X__ The State elects to provide self-directed personal assistance services to 7500 participants, at any given time.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Not applicable. The state will not allow entities who provide other Medicaid State Plan services to be responsible for developing the self-directed service plan.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

i. The system performance measures, outcome measures and satisfaction measures that the State will monitor and evaluate.

Many activities evaluate the overall performance of the IndependentChoices program such as:

- The IndependentChoices program uses a database to track a wide array of data, and uses all of the data it stores. Data entry drives end user functionality through form and e-mail generation, field calculation, data cross-referencing, and notices and reports. The reporting capabilities can help to monitor every element of operations such as: case particulars, work reports and management and operational tools. Use of the database supports discovery, remediation, and quality improvements.
- Using a **DHS-**approved assessment tool to determine the resources in time required to provide care in the home.
- Reports received from Financial Management Services provider received on a quarterly basis used by **DHS Independent Choices QA staff** to determine why underutilization of the Cash Expenditure Plan occurs and how underutilization can be resolved.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

All individual facets of the program work in a continuum to identify, remediate and improve the quality of services and the satisfaction of program participants while improving the overall performance of the program. Each phase of the program is described, detailing how assurances are met through the Arkansas Quality Assurance and Improvement Plan described below.

Monitoring and Oversight

The Division of Medical Services (DMS) retains responsibility for the administration and oversight of all Medicaid programs. The Division of **Provider Services and Quality Assurance (DPSQA)** is the operating agency for the IndependentChoices program and responsible for the day-to-day operations. Both Divisions are part of the Arkansas Department of Human Services. **DPSQA** will be responsible for executing the Quality Assurance and Improvement Plan with monitoring and oversight by DMS.

DPSQA will provide DMS with a monthly report comparing status of current data to previous year data. Examples included in the report may include but are not limited to the following:

- Enrollment activities
- Status of pending applications
- Status of active case load
- Participants who also receive home and community based services (HCBS)
- Medicaid Cost for IndependentChoices including participant-directed cost for HCBS services
- Detailed information for cost data for the most current month including cost of participant's budget and support services.
- Year in Progress, count of participants, contact notes, home visits, new enrollments for the current month, year to date and accumulative prior year experiences.

Lines of communication between the two Divisions are established and utilized to discuss additional needs and concerns that either Division may have.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

The IndependentChoices database is designed in such a way that discovery and remediation go hand in hand; not only for the **DHS Independent Choices QA staff**, nurses and contractors, but also for management staff. By design, the efficiency of the database enhances the **DHS Independent Choices QA staff's** ability to **monitor the program without being** overly burdened **by** paperwork. Examples on the following pages may include but are not limited to:

The database quantifies:

- referrals received during the month,
- persons disenrolling,

The database identifies:

- reasons for disenrolling from the program,
- IndependentChoices participants who also receive HCBS waiver services,
- the HCBS RN assigned to the participant,
- the participant's physician,
- physician's fax number,
- date of next reassessment due.

The database tracks and creates exception reports when standards are not met and quantifies results. Some examples of the reports are:

- time between the date of referral, the nurse's home visit, and receipt of the assessment from the **DHS Independent Assessment Contractor**,
- time between the referral and the actual enrollment
- number of home visits made by HCBS RN's within a timeframe.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Each active and pending record contained within the database only includes data fields that are used in reporting. Each participant record may include the following:

- representative information, if applicable,
- participant's employee,
- participant's back-up worker,
- directions to the participant's home,
- nurse tracking,
- **Independent Choices QA** tracking,
- contact notes,
- HCBS ARChoices service plan for persons receiving both ARChoices and IndependentChoices.

These data elements will assist the **DHS Independent Choices QA staff** and nurses in performing their duties by allowing timely management and monitoring of each participant's case. The database allows nurses, **DHS Independent Choices QA staff** or contractors to set health risk indicators identifying program participants who may require more frequent monitoring.

The data allow**s** nurses and **DHS Independent Choices QA staff** to run reports from their case load. Automated highlights on specific data elements draw the nurse or **DHS Independent Choices QA staff** attention to areas that require special attention. Highlighted data fields represent the following:

- assessment performed by the **DHS Independent Assessment Contractor** but not received by **DPSQA**,
- date enrollment forms sent to a potential enrollee but not returned.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Reports are available to management to monitor quality of services provided to program participants and performance of staff. The reports identify program strengths and weaknesses or individual areas of concern. Reports compare data elements over periods of time to measure progress of corrective actions. As issues are identified they are addressed with appropriate staff to determine a new course of action through issuing new policy, enacting new procedures, clarifying an existing policy or procedure, or developing additional training. Identified issues continue to be monitored to determine if the corrective action is resolving the concern and is achieving the expected outcomes.

These reports allow flexibility to generate data based on any specified period of time, by a nurse, **DHS Independent Choices QA staff**, contractor or by management. Reporting frequencies range from daily, monthly, or annually. Policy dictates a maximum period of time for completion of specific tasks with the focus on completing necessary tasks that allow the program participant to direct and meet their own health care needs.

Reporting is used to identify and remediate problems, improve program operation and to evaluate staff performance.

The database stores contact notes documenting IndependentChoices **QA** staff and contractors' communication with program participants. Policy requires each contact note to be entered into the participant's record to enhance the ability of management to address concerns expressed by the participant, a legislator, the Governor's Office, etc., with a quick review of the contact notes.

Examples of data elements found in the nurse tracking database portion may include, but is not limited to these data elements describing some of the following characteristics:

- **Level of care tier** category
- principal diagnosis,
- secondary diagnoses,
- participant well cared for,
- strong informal supports,
- no concerns noted,
- need for frequent **counseling entity's support coordinator** contact.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Contact notes may include the following:

- person initiating the call,
- person receiving the call,
- date and time of call,
- subject of contact
- description of communication,
- complaint indicator
- whom complaint is directed toward
- date of complaint resolution

Nurses are supported by the Nurse Case Load Report that quantifies the active and pending caseload for each nurse by describing the following:

- by county, the number of active and pending clients with or without home and community-based services,
- data is also displayed in the aggregate by nurse per assigned counties.

The DHS Independent Assessment Contractor uses a **DHS-**approved assessment tool to define the participant's medical needs relative to the amount of resources required to care for the person in the home. The **DHS-**approved assessment tool is similar to the MDS assessment performed in nursing homes but is specifically designed for the community environment. The assessment results in a **level of care tier** defining the degree of functional impairment. These results help define the population served in addition to using a scientifically scaled and validated assessment instrument. The use of this assessment helps to more clearly describe the medical complexities of program participants as they strive to remain in the community and avoid institutionalization.

Monitoring occurs in various other ways such as:

- Underutilization of the allowance could be the first indication that a participant may be experiencing difficulty directing their own care. It could indicate the beginning of a decline in cognitive function, impairing the participant's ability to direct their care, a need for a representative or decision making partner; a loss of worker; or it may be nothing more than not submitting the timesheets in a timely manner. Each **counseling entity's support coordinator** works with his or her participants to determine the cause of the underutilization. The **counseling entity's support coordinator** and participant work together to resolve the problem with the **counseling entity's support coordinator** providing further assistance, as needed, or by the participant meeting his or her responsibilities as an employer. The **counseling entity's support coordinator** follows-up with additional calls to the participant and monitors future underutilization reports for reoccurrences.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

- Site visits to the contractors are made at a minimum bi-annually and more often if needed. The purpose of the site visit may be to provide an in-service, address concerns, or to evaluate performance. If during an evaluation deficiencies are noted, **DPSQA** may provide additional in-services, require an acceptable corrective action plan, monitor the corrective action plan, withhold payment or terminate the contract.

Participant Feedback

The **DPSQA** and its counseling and fiscal contractors support and encourage participant communication by provision of a toll-free number. Participants may pose questions and voice concerns using the toll-free number. Incoming calls from participants and outgoing calls from **counseling entity's support coordinators** or contractors are entered into the participant's individual electronic record. If the communication is an expressed complaint the **counseling entity's support coordinator** follows **DPSQA** required reporting procedures for documenting and resolving the complaint. Resolutions may include policy or procedural changes. Monitoring will continue to determine if the change has any impact or if the problem needs additional review.

A DHS appeal process is available for decisions made concerning Medicaid eligibility. An internal appeal process is available for participants when they are in disagreement with the number of hours recommended by the HCBS RN, involuntary disenrollment or if they have disagreements with their **counseling entity's support coordinator** or fiscal agent. The purpose of the internal appeal is to allow the participant a voice in the decision and a way to mediate any misunderstandings between the participant and the IndependentChoices program. Additional supporting information may be shared during this time. **DPSQA** will issue a letter to the participant within five days from the date the internal appeal is conducted. Most disagreements are resolved prior to a participant initiating a request for a fair hearing and appeal. A formal Medicaid Fair Hearing is available when services are reduced, suspended, eliminated, or upon loss of Medicaid eligibility.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Information and Assistance

Brochures are available for marketing purposes and are provided to any of the 75 county offices upon request.

Each participant receives a program handbook to convey program guidelines and expectations. Examples of information provided may include any of the following and is subject to additions and deletions as needs arise:

- Overview of the IndependentChoices program
- Overview of support services
- Use of a representative (Decision-Making Partner)
- Eligibility
- Participant rights
- Participant responsibilities
- Personal assistance services
- Other Medicaid services
- Medicaid waiver services
- Expectations from **counseling entity's support coordinator**, nurse, bookkeeper
- Participant's enrollment duties
- Confidentiality
- When participant-direction begins
- Case Expenditure Plan
- Record Keeping
- Payroll
- Timesheets
- Hiring, training, conflict resolution, and termination of personal assistant
- Adult protective services
- Support services monitoring
- Reassessments
- Appeal rights

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Participants may also receive in-home visits, newsletters, questionnaires, and contact by phone to support participants wishing to direct their own care.

Participants can speak with their **counseling entity's support coordinator** or the fiscal intermediary from 8:00 a.m. until 4:30 p.m., Monday through Friday, except for legal holidays or during inclement weather. After hours the participant may leave a message; the **counseling entity's support coordinator** will return the call within one working day. Complaints are entered by the receiving party whether that is the **counseling entity's support coordinator** or the fiscal intermediary.

A packet of communication forms is provided to each participant to report a change, to revoke and/or change disclosure of information and to appeal adverse decisions. The **counseling entity's support coordinator** may also verbally take information related to changes in address or phone number.

Health and Welfare

Each participant must have an individual back-up plan to handle situations when the participant's primary employee is unavailable. The participant identifies a person who is willing to assume the tasks of the primary employee. The participant determines the risk involved and how the risk is mitigated based on their own individual needs. Inquiry of the use of the back-up plan occurs during phone communication with the participant. Reports from the IndependentChoices database can identify any program participant without a back-up personal attendant and if there is a conflict regarding a representative serving as a paid back-up personal attendant. The **counseling entity's support coordinator** initiates communications with the participant to begin remediation.

The counseling **entity's support coordinator** and fiscal entities will work closely together to provide information necessary for each entity to perform their duties. Frequent and thorough communication facilitates this good working relationship.

The database assists in addressing health and welfare concerns by allowing monitoring and management of each individual file by:

- identifying a participants representative, employee, physician, back-up worker, directions to the home, results of the **Independent Assessment**, and updates by the **counseling entity's support coordinator** assisting the participant in the IndependentChoices program, and;
- documenting all communications with the program participants.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Financial Accountability

DPSQA assures that payments are made to Medicaid eligible participants by:

- accessing Medicaid eligibility data prior to enrolling a person into IndependentChoices to assure eligibility for Medicaid and the IndependentChoices program;
- IndependentChoices program logic implemented by the Arkansas Medicaid fiscal intermediary, interfaces with the Medicaid Management Information System (MMIS) to edit against creation of an allowance for any participant who is no longer Medicaid eligible or is institutionalized;
- **DPSQA** maintains the MMIS eligibility file for IndependentChoices. The Arkansas fiscal intermediary reads the MMIS eligibility file to create claims for the IndependentChoices program. **DPSQA** queries on a weekly basis the Medicaid data warehouse to identify persons who are deceased, entered a nursing home, or have lost Medicaid eligibility. Once identified, the IndependentChoices eligibility segment is closed by **DHS** Independent Choices **QA staff** on a weekly basis. Through contact with the participant or participant's family or representative this information is obtained prior to the update of the MMIS;
- **DPSQA** also queries the Medicaid data warehouse to identify IndependentChoices participants who have had an acute hospitalization. Once identified, **DPSQA** informs the program participant, FMS provider and the counseling entity by letter that the participant's allowance paid prospectively during the hospitalization must be returned to the Medicaid program. The day of admission and day of discharge are allowable days;
- preventing duplication of agency and consumer-directed services by informing agency provider by fax seven days in advance the date the participant will begin directing their own personal care services.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Qualified Providers

IndependentChoices counseling and fiscal providers assist program participants in all phases of program participation. Some of the examples of the work by these providers may include but is not limited to any of the work activities below:

- enrollment of new participants;
- develop and implement participant-directed budget;
- coordinate with FMS provider and **DPSQA**;
- orientation to IndependentChoices and the philosophy of participant direction;
- offer skills training to the degree desired by the participant on how to recruit, interview, hire, evaluate, manage or dismiss assistants;
- participant-directed counseling support services;
- monitoring IndependentChoices participants/representatives;
- monitor over and under expenditures of Cash Expenditure Plan;
- provide quarterly reports to **DPSQA**;
- manage the individual budget on behalf of the participant;
- process payroll and support payment for other qualified services and supports;
- report and pay state and federal income taxes, FICA, Medicare, and state and federal unemployment taxes;
- verify citizenship status of workers;
- serve as the fiscal agent of the participant per IRS rules;
- issues reports to **DPSQA**;
- communicate with **counseling entity's support coordinator** on budget changes;
- inform participants of their individual budget balance.

OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xi. Quality Assurance and Improvement Plan (Continued)

Qualified Providers (continued)

DPSQA is responsible for the following activities:

- monitor the counseling and fiscal providers to ensure compliance with the spirit of participant-direction and that appropriate counseling, fiscal and programmatic procedures are maintained;
- serve as the liaison between counseling agency, fiscal provider, Medicaid Management Information System (MMIS), and the Arkansas Medicaid fiscal intermediary;
- monitor the process to reimburse the counseling agency and fiscal provider for services provided to program participants.

Quality assurance measures previously discussed, assist **DPSQA** in discovery and remediation to assure high standards in the offering and management of the participant-directed personal care program. The IndependentChoices program establishes, as its foundation, a person-centered approach that guides not only **DPSQA**, but counseling and fiscal providers as well.

xii Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below:

The HCBS RN or the **counseling entity's support coordinator** is the catalyst for identifying potential risks. In-home visits by either party help to identify risks involved in the current home environment as well as potential risks involved with self-direction. The **counseling entity's support coordinator** or the HCBS RN can identify risks that may be environmental in nature such as throw rugs, uneven floors, etc. or the **DHS-**approved assessment tool may identify potential risks such as not receiving a flu vaccine, etc. Based on the HCBS RN's observation and the **DHS-**approved assessment tool, the HCBS RN after receiving notification from the **counseling entity's support coordinator** will discuss the potential risks identified with the individual. If the HCBS RN determines that a representative is needed, the RN will inform the **counseling entity's support coordinator**.

When the HCBS RN determines that a person is in need of a representative, the nurse will inform the **counseling entity's support coordinator** and the **counseling entity's support coordinator** will work with the participant to determine if there is someone who knows the participant's likes, dislikes, and preferences and is willing to accept the responsibilities to represent the participant in the IndependentChoices program.

OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

The **counseling entity's support coordinator** is responsible for working with the participant to determine who can serve as the representative. The **counseling entity's support coordinator** will then work with the representative to teach, educate and work with the proposed representative so that the representative is fully aware of the responsibilities they are accepting in representing a person in a participant-directed program.

If the HCBS RN arrives and the participant is experiencing cognitive impairment and no informal supports are present, the participant will be discouraged from enrolling unless an informal support system can be identified, including someone to act as a representative decision maker. Participation in IndependentChoices requires the participant or their representative to be assertive in their role as employer and accept the risks, rights and responsibilities of directing their own care. If a representative is unavailable and the potential enrollee is incapable of performing these tasks without health and safety risks the person will not be enrolled. Blatant health and welfare concerns will not be compromised if solutions cannot be identified and enacted.

In addition to the HCBS RN's involvement there is communication with other agency providers providing home and community based services, with all parties having a vested interest in the health and welfare of the participant. This communication assists the operating agency to respond to any voiced concern with self-directed care.

The Participant Responsibilities and Agreement Form, which details all the requirements of self-direction, identifies areas where the individual may not be able to meet their responsibilities.

B. The tools or instruments used to mitigate identified risks are described below.

Every opportunity is afforded a participant to direct their own care, but the participant must accept and assume employer responsibility. Counseling support is available to help the participant, but ultimately it is the determination of the participant to succeed that determines whether participant direction will be a successful program for them. The IndependentChoices program requires a participant to make good decisions in order to assure that their personal assistance needs are met.

OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

When a participant needs a representative, the program allows for appointment of a Decision-Making Partner (DMP) who is willing to act and assume the employer role for the participant. The **counseling entity's support coordinator** is the person responsible for working with the participant or the participant's family in the appointment of a **Representative or** decision-making partner. Each time a **Representative or** DMP is appointed the enrollment of the DMP is similar to a new participant enrollment. The **Representative or** DMP must be at least 18 years of age and able and willing to meet the following requirements:

- Possess knowledge of the participant's preferences
- Be willing to meet and uphold all program requirements
- Be willing to sign tax form and verify timesheets,
- Show a strong personal commitment to the participant
- Visit the participant at least weekly
- Uphold all duties without influence by the personal assistant or paid back-up worker
- Obtain approval from the participant and a consensus from other family members of the participant to serve as the DMP
- Be willing to submit to a criminal background check
- Be available to discuss the program hours

Once the participant has appointed a Representative or DMP, there are specific forms that must be completed.

If at any time **DPSQA** learns that the participant's personal attendant is not providing the care agreed upon, the counselor will contact the participant/representative to ascertain the ability of the participant/representative to fulfill the role of employer. This discussion is to seek what types of assistance or support the participant or representative may need. A review of recurring instances of noncompliance could be reason for involuntary disenrollment.

When persons affiliated with the IndependentChoices program suspect abuse or neglect causing potential for health and safety risk to the participant by the representative, family members, personal attendant, or others, the participant will be referred to Adult Protective Services.

OMB Approved 0938-1024

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xii. Risk Management (Continued)

C. The State's process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

The service plan is a result of the **Independent Assessment and a form designated by DHS** and will list **the** risks identified in the assessment. The service plan will **also require the nurse to list** any other risks identified through observation that **were** not identified through the **Independent Assessment or form designated by DHS,** or risks identified by the participant, representative or interested parties through a participant-centered approach. The **service plan will identify the plan** or actions needed to mitigate the risks and who is responsible for each action. The service plan requires the signature of the participant/representative, **agreeing to the service plan and what the participant/representative is willing to do to mitigate risk**.

D. The State's process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant's representative, if any, and others from whom the participant may seek guidance, is described below.

IndependentChoices nurses and counseling entity's support coordinator are trained to apply a participant-centered approach in developing all plans with the participant. Participants are always encouraged to invite friends and family members who have a personal commitment to the participant to be present in all meetings between the participant and nurse or **counseling entity's support coordinator**. Identified risks will be discussed with the participant/representative and interested parties to determine a plan to mitigate the risk. The **nurse and counseling entity's support coordinator are there to facilitate and guide** the discussion and identify concerns with any discussed approaches to mitigation of risk.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xiii. Qualifications of Providers of Personal Assistance

A. ____ The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

B. __X__ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of Representative

A. __X__ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. __X__ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

If the participant has been diagnosed with a mental or cognitive impairment such as mental retardation, dementia, Alzheimer;s Disease, etc., the participant or family members close to the participant will be required to choose a representative in order to participate or continue to participate in IndependentChoices. **If the participant has not been diagnosed with a mental condition, but the DPSQA RN and counseling staff determines through the Self-Assessment instrument, discussions with the participant, and sometimes a trial period of self-direction with enhanced counseling, that the individual's cognitive abilities are not sufficient to self-direct, the participant will be required to choose a representative. The counseling staff will work with the participant to establish a representative, using all avenues to find one if necessary. If the participant refuses to select a representative or the participant cannot find anyone who can act in that capacity after all avenues have been exhausted, the counseling entity's support coordinator will coordinate with the participant to transition the participant to the traditional personal care provider of choice**.

B. ____ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

a. __X__ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

b. ____ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1915(j) Self-Directed Personal Assistance Services (Continued)

xvi. Financial Management Services

A. __X__ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ____ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with Section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. __X__ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth in Federal regulations 45 CFR Section 74.40 – Section 74.48.)

iii. ____ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. _____ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

General Assurances
[Select all three checkboxes below.]

☒ MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020.

☒ The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

☒ The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

Service Package
The state covers the following counseling services and behavioral health therapies as part of MAT: [**Please describe in the text fields as indicated below.]**

Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

Individual Behavioral Health Counseling, Group Behavioral Health Counseling, Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants, and Nurse Practitioners may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT), This group's role is to provide the behavioral and substance use disorder counseling required

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Licensed in Arkansas. Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute. Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Utilization Controls
[Select all applicable checkboxes below.]

☒ The state has drug utilization controls in place. (Check each of the following that apply)

- ☐ Generic first policy
- ☒ Preferred drug lists
- ☐ Clinical criteria
- ☒ Quantity limits

☐ The state does not have drug utilization controls in place.

Limitations
[Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.]

Quantity limits for MAT drugs are set per label. The oral drugs have a therapeutic duplication edit to prevent multiple buprenorphine oral dosage forms. There are no hard limitations for counseling and behavioral therapies related to MAT because authorizations of medically necessary services are available.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State/Territory: ARKANSAS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

The following ambulatory services are provided.

Outpatient Hospital Services

Rural Health Clinic Services

Federally Qualified Health Center Services

Laboratory and X-Ray Services

Early and Periodic Screening, Diagnosis and Treatment

Family Planning Services

Physician Services

Private Duty Nursing Services

Optometrists' Services

Chiropractors' Services**

Other Practitioners' Services ** hearing aid dealers, audiologists

Home Health Services

Clinic Services

Dental Services**

Physical Therapy and Related Services**

Prescribed Drugs

Dentures**

Prosthetic Devices ** hearing aids, eye prostheses

Eyeglasses

Nurse Midwife Services

Targeted Case Management

Transportation

Nurse Practitioner Services

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*Description provided on attachment. ** These services limited to EPSDT.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.

[X] Provided: [ ] No limitations [X] With limitations*

2.a. Outpatient hospital services.

[X] Provided: [ ] No limitations [X] With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic and covered under the Plan.

[X] Provided: [ ] No limitations [X] With limitations*

c. Federally qualified health center (FQHC) servies and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

[X] Provided: [ ] No limitations [X] With limitations*

3. Other laboratory and X-ray services.

[X] Provided: [ ] No limitations [X] With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

[ ] Provided: [ ] No limitations [ ] With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

[X] Provided [ ] Not provided

c. Family planning services and supplies for individuals of childbearing age.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

TN No. 92-06
Supersedes TN No. 91-24

Approval Date 12/16/92

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State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):

4.d. Tobacco cessation counseling services for pregnant women

☒ Provided: ☐ No limitations ☒ with limitations*

e. Medication-Assisted Treatment for opioid use disorders when provided as part of a Medication Assisted Treatment plan

☒ Provided: ☐ No limitations ☒ with limitations*

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

☒ Provided: ☐ No limitations ☒ with limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

☒ Provided: ☐ No limitations ☒ with limitations*

*Description provided on attachment.

1. Inpatient Hospital Services

Inpatient admissions to an acute care/general hospital will be allowed up to seven (7) days of service per admission when determined inpatient care is medically necessary. On the eighth day of hospitalization, if the physician determines the patient should not be discharged on the eighth day of hospitalization, the hospital may and request an extension of inpatient days.

Inpatient admissions to a rehabilitative hospital will be allowed up to ten (10) days of service per admission when determined inpatient care is medically necessary. Extension of benefits will be available when medically necessary. Medically necessary inpatient days are available to individuals under age 1 without regard to the corresponding hospital day limit and extension procedures.

1. Inpatient Hospital Services (continued)

Substance Use Disorder Residential Treatment provided in Acute Care Hospitals for Individuals under age 21

For Inpatient Substance Use Disorder Residential Treatment Unit admissions will follow a 100% prior authorization process to determine medical necessity for inpatient admission utilizing the American Society of Addition Medicine (ASAM) criteria. Inpatient Substance Use Disorder Residential Treatment Unit Services are not covered when provided in an Institution for Mental Disease (IMD).

1. Inpatient Hospital Services (continued)

Acute Crisis Unit

Effective for dates of service on or after July 1, 2021, Hospital Acute Crisis Units are covered for eligible Medicaid clients who are experiencing a psychiatry or substance use disorder, or both, crisis that does not meet the need for inpatient hospitalization. These units provide hospital diversion and step-down services in a safe environment with psychiatry and substance use disorder services available on-site, as well as on-call psychiatry available 24 hours per day. They must ensure the following services are available at a minimum:

A. ongoing assessment and observation;
B. crisis intervention;
C. psychiatric, substance, and co-occurring treatment; and
D. initiation of referral mechanisms for independent assessment and care planning.

Services are available for up to 96 hours per encounter. Providers must initiate an extension of benefits request for medical necessity approval prior to providing services beyond 96 hours.

This expenditure is being paid as inpatient hospital because the definition of outpatient limits services to less than a 24-hour period. (42 CFR 440.2)

1. Inpatient Hospital Services

A. Rehabilitative Hospital

1. Augmentative Communication Device (ACD) Evaluation - Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.

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SUPERSEDES: NONE - (NEW PAGE)

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: August 1, 2003

MEDICALLY NEEDY

2.a. Outpatient Hospital Services

(1) For the purpose of determining amount, duration and scope, outpatient hospital services are divided into four types of services:

- Emergency services
- Outpatient surgical procedures
- Non-emergency services
- Therapy/treatment services

Emergency Services

The determination of an emergency medical condition will be in compliance with Section 1867 of the Social Security Act.

A retrospective review will be performed by the Professional Review Organization (PRO) on a sampling of paid claims.

Non-emergency services may be necessary in the outpatient hospital setting when qualified physicians are not available in their offices or walk-in clinics to carry out the necessary treatment.

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2.a. Outpatient Hospital Services (Continued)

Outpatient Surgical Procedures

Coverage of outpatient surgical procedures are limited to procedures which the Arkansas Medicaid Program has determined to be safe and effective when performed on an outpatient basis.

Since outpatient surgical procedures are limited to approved **medically necessary** services, no additional benefit limitations are imposed.

Treatment/Therapy Services

The covered outpatient hospital treatment/therapy services include, but are not limited to the following:

- Dialysis
- Radiation therapy
- Chemotherapy administration
- Physical therapy
- Occupational therapy
- Speech therapy
- Respiratory therapy
- Factor 8 injections
- Burn therapy

Treatment/therapy services are included in the outpatient hospital services limit of twelve (12) visits per State Fiscal Year.

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; opioid use disorder when the visit is part of a Medication Assisted Treatment plan, and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.a. Outpatient Hospital Services (Continued)

Augmentative Communication Device (ACD) Evaluation

Effective for dates of service on or after September 1, 1999, Augmentative Communication Device (ACD) evaluation is covered for eligible Medicaid recipients of all ages. One ACD evaluation may be performed every three years based on medical necessity. The benefit limit may be extended for individuals under age 21.

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SUPERSEDES: NONE NEW PAGE

2.b. Rural Health Clinic Services

Rural health clinic services are limited to **sixteen (16)** visits a year for **clients twenty-one** (21) **years or** older. This yearly limit is based on the State Fiscal Year (July I through June 30). **R**ural **h**ealth **c**linic **encounters will** be considered in conjunction with the benefit limit established for physician services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, **federally qualified health center encounters, and advanced practice registered nurse services, or a combination of the seven. Benefit limit** extensions will be **available** if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the service limit. Clients** under age **twenty-one (**2l**)** in the Child Health Services (EPSDT) Program are not benefit limited.

Rural **health clinic** core services are defined as follows:

1. Physicians' services, **advanced practice registered nurses' services**, and **services of** physician assistants **when provided under proper supervision;**

2. Services and supplies furnished as an incident to professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants, or **advanced practice registered** nurse**s**, are those which are commonly furnished in connection with these professional services, are generally furnished in the **rural health clinic** office, and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.

3. Clinical psychologist services;
4. Clinical social worker services;

.

2.b. Rural Health Clinic Services

5. Services of nurse midwives; and

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) NCFA – Pub. 45-4).

Federally qualified health center services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

Benefit extensions will be available if medically necessary. Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA - Pub. 45-4). (Continued)

Covered FQHC core services are defined as follows:

- physician services;
- services and supplies incident to physician's services (including drugs and biologicals that cannot be self-administered);
- pneumococcal vaccine and its administration and influenza vaccine and its administration;
- physician assistant services;
- nurse practitioner services;
- clinical psychologist services;
- clinical social worker services;
- **licensed certified social worker services;**
- **licensed professional counselor services;**
- **licensed mental health counselor services;**
- **licensed marriage and family therapist services;**
- services and supplies incident to clinical psychologist, clinical social worker service**s, licensed certified social worker, licensed professional counselor, licensed mental health counselor and licensed marriage and family therapist services** as would otherwise be covered if furnished by or incident to physician services; and
- part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area in which the Secretary has determined there is a shortage of home health agencies.

FQHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the FQHC offers such a service, (e.g. dental, etc.). The "other ambulatory services" that are provided by the FQHC will count against the limit established in the plan for that service.

3. Other Laboratory and X-Ray Services

Other professional and technical laboratory and radiological services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined under 42 CFR 440.30 in an office or similar facility other than a hospital outpatient department or clinic.

Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services health benefit limits: (a) Malignant neoplasm; (b) HIV infection; and (c) renal failure. The cost of related diagnostic laboratory services and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD), and the screening is part of a Medication Assisted Treatment (MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory or radiology/other services health benefit limits.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **S**FY outpatient diagnostic laboratory services benefit limit or five hundred dollars ($500) per SFY radiology/other services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY X-ray services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per SFY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found.

(1) No limitation on services within the scope of the program, except for consultations, home health services if services are EPSDT related. Extension of the benefit limit for consultations **(**2 per State Fiscal Year), home health services **(**50 visits per State Fiscal Year), physical therapy evaluations (**2** per State Fiscal Year)**,** occupational therapy evaluations (**2** per State Fiscal Year), speech**-language** therapy evaluations (4 units per State Fiscal Year), and chiropractor X-ray services (2 per State Fiscal Year) will be provided if medically necessary for recipients in the Child Health Services (EPSDT) Program.

Medical Screens are provided based on the recommendations of the American Academy of Pediatrics. Childhood immunizations are provided based on the Advisory Committee on Immunization Practices (ACIP).

The State will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, even when such health care is not otherwise covered under the State Plan.

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(2) Apnea (Cardiorespiratory) Monitors

Apnea (cardiorespiratory) monitors are provided for eligible recipients in the EPSDT Program. Use of the apnea monitors must be medically necessary and prescribed by a physician. Prior authorization is not required for the initial one month period. If the apnea monitor is needed longer than the initial month, prior authorization is required.

(3) **Early Childhood Intervention Day Treatment (EIDT) Services**

EIDT services provide diagnosis and evaluation for the purpose of early intervention and prevention for eligible recipients in the EPSDT Program. Services are provided, if identified by an Independent Assessment in accordance with the Independent Assessment Manual, in multi-disciplinary clinic based setting as defined in 42 CFR § 440.90.

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(4) RESERVED

(5) Private Duty Nursing to enhance the effectiveness of treatment for ventilator-dependent beneficiaries or high technology non-ventilator beneficiaries

Enrolled providers are Private Duty Nursing Agencies licensed by Arkansas Department of Human Services, Division of Health. Services are provided by Registered Nurses or Licensed Practical Nurses licensed by the Arkansas State Board of Nursing.

Beneficiaries under age 21 to receive PDN Nursing Services must require constant supervision, visual assessment and monitoring of both equipment and patient. PDN services may be covered for Medicaid beneficiaries under 21 who meet the following requirements:

A. Medicaid-eligible ventilator-dependent (invasive) beneficiaries when determined medically necessary and prescribed by a physician or

B. Medicaid-eligible beneficiaries under age 21 who are:

1. In the Child Health Services (EPSDT) Program, and

2. High technology non-ventilator dependent beneficiary requiring at least two (2) of the following services:

(1) Intravenous Drugs (e.g. chemotherapy, pain relief or prolonged IV antibiotics)
(2) Hyperalimentation - parenteral or enteral
(3) Respiratory - Tracheostomy or Oxygen Supplementation
(4) Total Care Support for ADLs and close patient monitoring

These services require prior authorization. Services may be provided in the beneficiaries' home, a Division of Developmental Disabilities (DDS) community provider facility or a public school. (Home does not include an institution.) Prior authorization is required. Private duty nursing medical supplies are limited to a maximum reimbursement of $80.00 per month, per beneficiary. With substantiation, the maximum reimbursement may be extended.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

6. Cochlear Implants

Coverage of Cochlear implantation is limited to recipients in the EPSDT Program. This procedure requires a prior authorization.

STATE Arkansas
DATE RECD APR - 4 1991
DATE APPV'D MAY - 9 1991
DATE EFF FEB - 1 1991
HCFA ID 91-15
A

Supersedes: 90-16

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(7) Dentures

Dentures are provided to eligible Medicaid recipients in the Child Health Services (EPSDT) Program with prior authorization from the Medical Assistance Section.

(8) Hearing Aid Dealers

Supplies prescribed instrument after medical clearance and upon recommendation of an audiologist to eligible recipients in the Child Health Services (EPSDT) Program. Maintenance of instrument provided with prior approval from the Utilization Review Section.

(9) Audiologist Services

Provision of audiometric testing and hearing aid evaluation to eligible recipients in the Child Health Services (EPSDT) Program.

Arkansas
DEC 30 1991
DEC 14 1992
DEC 01 1991
91-59
A
Supersedes TN 91-28

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(10) Hearing Aids

The provision of hearing aids, accessories and repairs for eligible Medicaid recipients in the Child Health Services (EPSDT) Program with prior authorization from the Utilization Review Section. Hearing aid is limited to two appliances per six month period. With prior authorization, additional services may be provided if medically necessary.

(11) Eye Prostheses

Eye prostheses are provided for eligible Medicaid recipients in the Child Health Services (EPSDT) Program with prior authorization from the Medical Assistance Section.

(12) Desensitization Injections

Limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

ARKANSAS
JUL 01 1991
NOV 19 1991
JUL 01 1991
91-28
A
Supersedes: 91-15; 90-48

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d))

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Outpatient Behavioral Health Services (OBHS)

As part of the Behavioral Health transformation within the state of Arkansas, DMS is creating a more integrated and client-focused behavioral health care system. These changes were developed in coordination with the Division of Behavioral Health Services (DBHS), providers, representatives of the Arkansas System of Care, beneficiaries and other key stakeholders.

A. Scope

Care, treatment and services provided by a certified Behavioral Health Services provider to Medicaid-eligible beneficiaries. These services are available to all eligible Medicaid beneficiaries. Services which require an Independent Assessment are indicated by the statement, "Eligibility for this service is determined by an Independent Assessment and must be prior authorized."

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

B. Services

i.: Individual Behavioral Health Counseling*

DEFINITION: Individual Behavioral Health Counseling, including tobacco cessation, is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

i.: Individual Behavioral Health Counseling(continued)*

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

ii. Group Behavioral Health Counseling*

DEFINITION: Group Behavioral Health Counseling, including tobacco cessation, is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling with Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present(continued)*

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children. Dyadic treatment must be prior authorized. .

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

iv. Marital/Family Behavioral Health Counseling without Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling without Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

v. Group Psychoeducation*

DEFINITION: Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery for the benefit of the beneficiary. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children. Dyadic treatment must be prior authorized.**

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the Provider must have Arkansas State Infant Mental Health Certification.

vi. Multi-Family Behavioral Health Counseling*

DEFINITION: Multi-Family Behavioral Health Counseling, including tobacco cessation, is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

vii. Mental Health Diagnosis*

DEFINITION: Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

viii. Interpretation of Diagnosis*

DEFINITION: Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

ix. Substance Abuse Assessment*

Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DBHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

ix. Substance Abuse Assessment (continued)*

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician;

x. Psychological Evaluation*

DEFINITION: Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.

Allowable Performing Provider -Licensed Psychologist, Licensed Psychological Examiner and a Licensed Psychological Examiner - Independent

xi: Pharmacologic Management*

DEFINITION: Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services (42 CFR 440.130(d)) **(continued)**

(2) Outpatient Behavioral Health Services (OBHS)(continued)

xii: Psychiatric Assessment*

DEFINITION: Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(14) RESERVED

(15) Physical Therapy and Related Services

a. Physical Therapy

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) **Effective f**or dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(3) Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.

A qualified physical therapist assistant may provide services under the supervision of a licensed physical therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(4) Effective for dates of service on or after July 1, 2017, individual and group therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(15) Physical Therapy and Related Services (Continued)

b. Occupational Therapy

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Services must be prescribed by a physician and provided by or under the supervision of a qualified occupational therapist.

A qualified occupational therapist assistant may provide services under the supervision of a licensed occupational therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(3) Effective for dates on or after **January 1, 2021**, evaluations are limited to **two (2)** units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

(4) Effective for dates of service on or after July 1, 2017, individual and group occupational therapy are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

c. Services for individuals with speech, hearing and language disorders (provided by or under the supervision of a speech**-language** pathologist or audiologist)

(1) Speech-language pathology services are limited to Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Speech**-language** pathology services must be referred by a physician and provided by or under the supervision of a qualified speech**-language** pathologist.

A qualified speech**-language** therapist assistant may provide services under the supervision of a licensed speech**-language** therapist.

All therapies' service definitions and providers must meet the requirements of 42 C.F.R. § 440.110.

(3) Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit for the evaluation will be provided if medically necessary.

(4) Effective for dates of service on or after July 1, 2017, individual and group speech-language pathology services are limited to six (6) units per week. Extensions of the benefit limit will be provided if medically necessary.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(16) Dental Services

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Procedures which may be provided to recipients in the Child Health Services (EPSDT) Program without prior authorization are:

a. Initial radiographs taken in conjunction with preparation of a treatment plan.

b. Periodic oral exam, prophylaxis, topical fluoride **and/or fluoride varnish** for children in the Child Health Services (EPSDT) Program.

c. Emergency treatment. One visit without prior authorization is payable for any emergency. Procedures payable without prior authorization when provided as emergency care include:

1. All necessary radiographs.
2. Extraction of up to three teeth for relief of pain or acute infections.
3. Control of bleeding.
4. Treatment for relief of pain resulting from injuries to the oral cavity or related services.
5. Emergency services provided to patients in hospitals or long term care facilities.

All other procedures require prior authorization from the Medical Assistance Section. A full mouth radiograph is limited to once every five years. Periodic oral exam, prophylaxis, fluoride treatment, **fluoride varnish** and bite-wing X-rays are limited to once per 6 (six) months plus 1 (one) day. Scaling is limited to one per state fiscal year (July 1 through June 30). Periapical X-rays are limited to four (4) per recall visit. Any limits will be exceeded based on medical necessity.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

17. Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Residential Rehabilitation Center Services

- Restorative Therapies
- Behavioral Rehabilitation
- Life Skills Training for Rehabilitation
- Individual and Group Counseling
- Assessment Services
- Nursing Care

Residential Rehabilitation Center Services are available to eligible Medicaid recipients under age 21 in the Child Health Services (EPSDT) Program. There is no established benefit limit other than medical necessity as determined by the Professional Review Organization (PRO). The medical necessity criteria includes need for services in the residential setting. Persons needing rehabilitative services on a less intense basis than provided in the inpatient setting may receive outpatient rehabilitative services through other appropriate service categories included in the state plan, e.g., outpatient hospital, physical therapy, occupational therapy and speech therapy, rehabilitative services for persons with mental illness (RSPMI) and home health.

STATE Arkansas DATE RECD 5-18-98 DATE APPD 10-29-99 DATE EFF 7-1-98 HCFA ID 98-09	A

SUPERSEDES TN. 97-04

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services

1. School-Based Mental Health Services

a. Services are limited to eligible Medicaid recipients under age 21 in the Child Health Services (EPSDT) Program.

b. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary.

c. Services are provided at the school or in the home when the home is considered to be an educational setting for a child who is enrolled in the public school system. The home is not considered a place of service when the parent elects to home school the child.

d. The State assures that eligible Medicaid recipients will be given free choice of providers within and outside the school setting.

e. Provider Qualifications

The Arkansas Medicaid program has established provider participation requirements for school-based mental health services.

In order to ensure quality and continuity of care, School Districts and/or Education Services Cooperatives that are School-Based Mental Health Service Providers approved to receive Medicaid reimbursement must ensure that contractors and personnel engaged as Licensed School-Based Mental Health Practitioners meet specific Medicaid qualifications. Practitioners licensed as school-based mental health services provider personnel may provide the services according to their scope of practice as identified by the licensure requirements. Services will be provided by the following:

1. School Psychology Specialist (licensed by the Arkansas Department of Education (ADE)
2. Licensed Certified Social Worker (licensed by the Arkansas Social-Work Licensing Board)
3. Licensed Masters Social Worker (licensed by the Arkansas Social-Work Licensing Board)
4. Psychological Examiner (licensed by the Arkansas Board of Examiners in Psychology)
5. Licensed Psychologist (licensed by the Arkansas Board of Examiners in Psychology)
6. Licensed Professional Counselor (licensed by the Arkansas Board of Examiners in Counseling)
7. Licensed Associate Counselor (licensed by the Arkansas Board of Examiners in Counseling)

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STATE Arkansas
DATE RECD Jan 24 2001
DATE APP'VD Mar 26 2001
DATE EFF Feb 01 2001
HCFA 179 00-13

MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (42 CFR 440.130(d)) (continued)

1. School-Based Mental Health Services (continued)

f. Covered Services (continued)

1. Individual Behavioral Health Counseling - A face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.

2. Mental Health Diagnosis - A clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

3. Psychological Evaluation - Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.

MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (42 CFR 440.130(d)) (continued)

1. School-Based Mental Health Services (continued)

f. Covered Services (continued)

4. Interpretation of Diagnosis - A direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.

5. Marital/Family Behavioral Health Counseling with Beneficiary Present - A face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary, including tobacco cessation. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

6. Crisis Intervention –An unscheduled, immediate, short-term treatment activity provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services, which can include interventions, stabilization activities, evaluation, coping strategies and other various activities to assist the beneficiary in crisis, are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. The services provided are expected to reduce or eliminate the risk of harm to the person or others in order to stabilize the beneficiary.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician

MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (42 CFR 440.130(d)) (continued)

1. School-Based Mental Health Services (continued)

f. Covered Services (continued)

7. Group Behavioral Health Counseling - Face-to-face treatment provided to a group of beneficiaries, including tobacco cessation. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. **Rehabilitative Services for Children**

ELIGIBILITY FOR SERVICES

The following recipients are eligible for rehabilitative services to children as set forth in this Section:

A. General Eligibility

1. Medically Needy Medicaid recipients.

B. Specific Eligibility

1. The recipient must be age twenty (20) years or less, and

2. Require rehabilitative mental health services based on recommendation of a physician or other licensed and/or certified practitioner of the healing arts acting within their scope of practice as defined in state law and/or regulations.

DURATION OF SERVICES

Each Title XIX EPSDT recipient is eligible for covered rehabilitative services in accordance with 42 CFR 440.130(d) which are medically necessary. There shall be a determination, made by a child service agency designated by state law and/or regulations, at Title 9, Chapter 30 of the Arkansas Code to make such a determination, that the child continues to be either at risk of abuse or neglect or is abused or neglected. The Division of Medical Services, as the entity authorized to determine medical necessity, reserves the right to request additional information to determine medical necessity.

COVERED SERVICES

A covered service is a specific non-residential or residential rehabilitative service determined to be medically necessary, as defined above, and included in a child's treatment plan prepared by a qualified provider of rehabilitative services to children. These services are designed to ameliorate psychological or emotional problems related to neglect and/or abuse, to restore psychological or emotional functioning which was impaired by the problems related to neglect

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. **Rehabilitative Services for Children (Continued)**

and/or abuse, and to assist the child in improving or maintaining his/her highest functioning level. The following services are covered when provided according to the plan of care and when care is provided by professional state licensed and/or certified psychiatrists, psychologists, counselors, and social workers acting within their scope of practice as defined in state law and/or regulations.

1. **Evaluation, Assessment, and Plan of Care Development - This non-residential service includes the initial assessment of a child's service needs and the development of a Care Plan to address those needs.**

   (a) **The evaluation and assessment shall:**

      (1) **Be based on informed clinical opinion;**

      (2) **Be conducted by a team of professionals trained to utilize appropriate evaluative methods and procedures and acting within their scope of practice or responsibility as defined in State law and/or regulations; and**

      (3) **Include an evaluation of the child's cognitive development, social and emotional development and adaptive development.**

   (b) **The plan of care shall contain:**

      (1) **A written plan using the information derived from the evaluation and assessment;**

      (2) **A statement of the child's present level of functioning in the domains examined in the evaluation and assessment;**

      (3) **A statement of the specific services and supports necessary to meet the unique needs of the child, the setting in which the services are to be delivered, the frequency and method of delivery, and the anticipated duration of services;**

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. Rehabilitative Services for Children (Continued)

(4) A statement of the persons responsible for implementing the plan of care; and

(5) A statement of the functional outcomes expected to be achieved though the provision of services and supports.

2. Therapeutic Foster Care - This residential service is provided to children whose plan of care indicates a need for a structured and consistent home environment in order to learn to manage their behavior. This twenty-four hour service consists of face-to-face interventions with a child to assist the child in understanding the consequences of inappropriate behaviors and adhering to a behavioral routine which minimizes inappropriate behaviors and their consequences. This service is provided for the purpose of the development, restoration, and/or maintenance of the child's mental or emotional growth and the development, restoration, and/or maintenance of the skills to manage his/her mental or emotional condition.

3. Residential Treatment - This residential service provides twenty-four hour treatment to children whose psychological or emotional problems related to neglect and/or abuse can best be restored by residential treatment in accordance with the child's plan of care. The objective of this service is to assist the child in improving or maintaining his/her highest functioning level through individual and group therapeutic interventions to improve or maintain the skills needed to safely and securely interact with other persons, through symptom management to allow the child to identify and minimize the negative effects of psychiatric or emotional symptoms which interfere with the child's personal development and community integration, and through supportive counseling with a child to develop, restore and/or maintain the child's mental or emotional growth.

PROVIDER QUALIFICATION

Rehabilitative services for children will be provided only through qualified provider agencies. Qualified provider agencies must meet the following rehabilitative services for children criteria:

1. Have full access to all pertinent records concerning the child's needs for services including records of the Arkansas District Courts, local Children's Service Agencies, and State Child and Family Services Agency,

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. **Rehabilitative Services for Children (Continued)**

2. **Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population,**

3. **Have a minimum of one year's experience in providing all core elements of rehabilitative services for children,**

4. **Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements,**

5. **Have a financial management capacity and system that provides documentation of services and costs in, conformity with generally accepted accounting principles,**

6. **Have a capacity to document and maintain individual case records in accordance with State and Federal requirements, and**

7. **Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing, and audits.**

SERVICE SETTINGS

Rehabilitative services for children will be provided in the least restrictive setting appropriate to the child's assessed condition, plan of care, and service needs. Services shall be provided to children in one of the following settings:

1. **Non-residential services provided to children who reside in a family home setting will be provided either in the child's home or in the customary place of business of a qualified provider.**

2. **Residential services provided to children who reside outside of a family home will be provided in an appropriately state licensed and/or certified facility including:**

(a) **Therapeutic foster homes licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services.**

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. Rehabilitative Services for Children (Continued)

3. Services shall not be reimbursed when provided in the following settings:

(a) Nursing facilities,

(b) Intermediate care facilities for the mentally retarded, and

(c) Institutions for the treatment of mental diseases.

FREEDOM OF CHOICE

The State assures that the provision of rehabilitative services for children will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of any qualified provider of rehabilitative services for children, and

2. Eligible recipients will have free choice of the providers of other medical care as covered elsewhere under the Plan.

COMPARABILITY OF SERVICES

The State assures that the provision of rehabilitative services for children will not limit an individual's access to medically necessary services in violation of section 1902(a)(10) of the Act.

1. Rehabilitative services for children will be made available to all children for whom this service is determined to be medically necessary, and

2. All medically necessary health care services described in section 1905(a) will be provided to all EPSDT eligible recipients.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. **Rehabilitative Services to Youth**

ELIGIBILITY FOR SERVICES

The following recipients are eligible for rehabilitative services to youth as set forth in this Section:

A. General Eligibility

1. Medically Needy Medicaid recipients.

B. Specific Eligibility

1. The recipient must be age twenty (20) years or less, and

2. Require rehabilitative mental health services based on recommendation of a physician or other licensed and/or certified practitioner of the healing arts acting within their scope of practice as defined in state law and/or regulations.

DURATION OF SERVICES

Each Title XIX EPSDT recipient is eligible for covered rehabilitative services in accordance with 42 CFR 440.130(d) which are medically necessary. There shall be a determination, made by a youth services agency designated by state law and/or regulations, at Title 9, Chapter 28 of the Arkansas Code to make such a determination, that the youth continues to be either at risk of delinquency or is delinquent and is in need of those services specified at Title 9, Chapter 28 of the Arkansas Code. The Division of Medical Services, as the entity authorized to determine medical necessity, reserves the right to request additional information to determine medical necessity.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

COVERED SERVICES

A covered service is a specific in-home or out-of-home non-residential or residential rehabilitative service determined to be medically necessary, as defined above, and included in a youth's treatment plan prepared by a qualified/certified provider of rehabilitative services to youth. These services are designed to ameliorate psychological or emotional problems of youth, which contribute to delinquent behavior and placement or the risks of placement in the youth services system. They are designed to restore psychological or emotional functioning of the youth to assist him/her in achieving or maintaining his/her highest functioning level. The following services are covered when provided in a setting appropriate to the plan of care and when care is provided through a certified provider of rehabilitative services for youth.

1. Diagnosis and Evaluation - This non-residential service provides assessment of the nature and extent of a youth's physical, emotional, educational and behavioral problems and recommendations for treatment strategies to remedy the identified problems. The specific diagnostic services provided and level of sophistication of reports produced are based on the individual needs of the referring agency. Allowable components include:

   (a) Social assessment,

   (b) Psychological evaluation,

   (c) Psychiatric evaluation,

   (d) Consultation with the referring agency, and

   (e) A medical evaluation, if the assessment indicates a physical association with the emotional and/or behavioral problem(s).

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MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

2. Therapy* - This non-residential service provides for a therapeutic relationship between the client and a "qualified therapist" for the purpose of accomplishing changes that are identified as goals in the case plan through the use of various counseling techniques. Services to specific individuals include:

(a) Individual therapy,*
(b) Group therapy,*
(c) Family therapy* (youth included), and
(d) Consultation with the referral source.

Qualified therapist is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Therapist" the individual must be in good standing before the board to which he or she is licensed.

3. Emergency Shelter - This residential service provides services for youth whose circumstances or behavioral problems necessitate immediate removal from their homes or for youth released from a youth services facility who need temporary placement in the community until long term residential arrangements can be made. Emergency Shelter services include:

(a) Additional evaluation of the nature and extent of a youth's emotional and behavioral problems, including social assessment psychological evaluation, psychiatric evaluation and consultation with the referring agency, and

(b) Interventions to address the youth's emotional and behavioral problems.

The extent and depth of services provided to a youth in the Emergency Shelter program depends upon the individual needs of the youth and the referral source.

*** Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.**

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

4. Therapeutic Foster Care - This residential service provides intensive therapeutic care for children provided in family homes which operate within a comprehensive residential treatment system or as an adjunct to a mental health treatment program and for which a service fee is paid to specially trained foster families. Care givers who provide this service in their homes, if not specially trained, are specifically qualified to provide the service because they have an educational or a professional background that attests to qualification equal to or greater than that of care givers who have received special training. Children to whom this service is provided have physical, emotional, or behavioral problems which cannot be remedied in their own home, in a routine foster parenting situation, or in a residential program.

5. Therapeutic Group Home - This residential service provides twenty-four hour intensive therapeutic care provided in a small group home setting for youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment, as diagnosed by a qualified professional. The program is offered to prepare a juvenile for less intensive treatment, independent living, or to return to the community.

6. Residential Treatment - This residential service provides twenty-four hour treatment service available for up to one year for each individual, for youth whose emotional and/or behavioral problems, as diagnosed by a qualified professional, cannot be remedied in his or her own home. Residential Treatment services require the formulation and implementation of an individualized treatment plan with time-framed, measurable objectives for each youth.

Qualified professional is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Professional" the individual must be in good standing before the board to which he or she is licensed.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

PROVIDER QUALIFICATION

Rehabilitative services for youth will be provided only through qualified providers and provider agencies. Qualified rehabilitative services for youth provider agencies must meet the following criteria. Care is provided by qualified therapists, other qualified professionals and staff, qualified by experience and/or training, of certified rehabilitative services providers for youth. Rehabilitative services providers for youth must:

1. Be certified by the State Youth Services Agency as having programs and professional staff capable of delivering the rehabilitative services offered under the Plan,

2. Have full access to all pertinent records concerning the youth's needs for services including records of the Arkansas District Courts, local Youth Service Agencies, and State Youth Services Agency,

3. Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population,

4. Have a minimum of one year's experience in providing rehabilitative services for youth,

5. Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements,

6. Have a financial management capacity and system that provides documentation of services and costs in conformity with generally accepted accounting principles,

7. Have a capacity to document and maintain individual case records in accordance with State and Federal requirements, and

8. Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

SERVICE SETTINGS

Rehabilitative services for youth will be provided in the least restrictive setting appropriate to the youth's assessed condition, plan of care and service. Services shall be provided to youth in one or more of the following settings:

1. **Non-residential services provided to youth who reside in a family home setting will be provided either in the youth's home or in the customary place of business of a qualified provider.**

2. **Residential services provided to youth who reside outside of a family home will be provided in an appropriately state licensed and/or certified setting including:**

   (a) **Emergency shelter facilities licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services,**

   (b) **Residential treatment facilities licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services, and**

   (c) **Therapeutic foster and group homes licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services.**

3. **Services shall not be reimbursed when provided in the following settings:**

   (a) **Nursing facilities,**

   (b) **Intermediate care facilities for the mentally retarded, and**

   (c) **Institutions for the treatment of mental diseases.**

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

FREEDOM OF CHOICE

The State assures that the provision of rehabilitative services for youth will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of any the qualified providers of rehabilitative services for youth, and

2. Eligible recipients will have free choice of the providers of other medical care as covered elsewhere under the Plan.

COMPARABILITY OF SERVICES

The State assures that the provision of rehabilitative services for youth will not limit an individual's access to medically necessary services in violation of section 1902(a)(10) of the Act.

1. Rehabilitative services for youth will be made available to all children for whom this service is determined to be medically necessary, and

2. All medically necessary health care services described in section 1905(a) will be provided to all EPSDT eligible recipients.

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21. Other Licensed Practitioners

1. Licensed Certified Social Worker (LCSW)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed certified social worker (LCSW) who has a Master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (CSWE). The LCSW must be State licensed and certified to practice as a Licensed Certified Social Worker (LCSW) in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LCSW services are:
   1. Diagnosis
   2. Interpretation of Diagnosis
   3. Crisis Management Visit
   4. Individual Outpatient - Therapy Session*
   5. Marital/Family Therapy*
   6. Individual Outpatient - Collateral Services*
   7. Group Outpatient - Group Therapy*

2. Licensed Professional Counselors (LPC)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed professional counselor (LPC) who must possess a Master's degree in mental health counseling from an accredited college or university. The LPC must be licensed as a Licensed Professional Counselor and be in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting medical necessity. Covered outpatient LPC services are:
   1. Diagnosis
   2. Interpretation of Diagnosis
   3. Crisis Management Visit
   4. Individual Outpatient - Therapy Session*
   5. Marital/Family Therapy*
   6. Individual Outpatient - Collateral Services*
   7. Group Outpatient - Group Therapy*

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* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

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MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

3. Licensed Marriage and Family Therapist (LMFT)

a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.

b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.

c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:

1. Diagnosis
2. Interpretation of Diagnosis
3. Crisis Management Visit
4. Individual Outpatient - Therapy Session*
5. Marital/Family Therapy*
6. Individual Outpatient - Collateral Services*
7. Group Outpatient - Group Therapy*

* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

23. Developmental Rehabilitation Services

Developmental Rehabilitation Services are early intervention services for eligible Medicaid recipients under three years of age that have been identified as medically necessary and recommended by a licensed physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. This program covers two basic services:

1. Developmental Testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, eg, Bayley Scales of Infant Development) with interpretation and report, per hour. (Limited to four (4) one hour units per calendar year.)

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This service provides a diagnostic process necessary for the purpose of determining a child's initial and continuing eligibility, developmental status and need for medically necessary developmental services. This includes:

a. The assessment of motor, language, adaptive and/or cognitive functioning by standardized developmental instruments such as Bayley Scales of Infant Development, Early Learning Accomplishment Profile, Brigance Test of Development, etc. Specific activities include the administration of a minimum of two test instruments, interpretation of test scores with informed clinical opinion, and provision of a written narrative report.

b. Developmental functioning in each of these areas describes the level on which the child is currently functioning as compared to other children of the same chronological age, and the skills to be remediated.

c. Results will be included in the development of the IFSP. Developmental testing does not include medical, speech therapy, occupational therapy, physical therapy, audiological or vision evaluations.

2. Therapeutic Activities; direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes. (Limited to four (4) 15-minute units per week.)

a. This service is provided to the child and the child's parent/family to promote acquisition of skills in developmental areas (cognitive, motor, adaptive, communication). These rehabilitative services include:

1) the planned interaction of personnel, materials, time and space, to provide direct, medically necessary therapeutic intervention to the child;
2) provision of information to the family therapeutic curriculum planning;
3) provision of information to the family related to establishing the skill level and enhancing the development of the child.

MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

23. Developmental Rehabilitation Services (continued)

23. Developmental Rehabilitation Services (continued)

2. Therapeutic Activities (continued)

b. Therapeutic intervention will focus on developmentally appropriate individualized skills training and support to foster, promote and enhance child engagement in daily activities, functional independence and social interaction.

c. Assistance will be provided to family/caregivers in the identification and utilization of opportunities to incorporate therapeutic intervention strategies in daily life activities that are natural and normal for the child and family.

d. Child progress and mastery of functional skills to reduce or overcome limitations resulting from developmental delays will be continuously monitored by the Developmental Therapist.

e. Therapeutic activities may be provided in an individual session only.

3. A provider of Developmental Testing and Therapeutic Activities must be certified through the Arkansas Department of Human Services, Developmental Disabilities Services as a Developmental Therapist or Developmental Therapy Assistant. Certification requirements are:

a. A Developmental Therapist is a qualified professional, licensed by the Arkansas Department of Education, who has completed an additional certification requirement of a 24 hour training course and passed a competency based assessment with a minimum score of 80%. Developmental Testing Services must be provided by a Developmental Therapist.

b. A Developmental Therapy Assistant is a qualified paraprofessional who holds a minimum of a high school diploma and has two years experience working with children with disabilities. The Developmental Therapy Assistant must complete an initial 24 hour training course and pass a competency based assessment with a minimum score of 80%. The Assistant must work under the supervision of the Developmental Therapist and must be supervised 10% of the time spent in direct interaction with the recipient. A Developmental Therapy Assistant may provide only Therapeutic Activities services.

Developmental Rehabilitation Services may be provided in the recipient's home, in the community, or in a clinical setting. These services require prior authorization.

Extension of the benefit limit will be provided if medically necessary.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services

Substance Abuse Treatment Services (SATS) are provided for eligible recipients in the Child Health Services (EPSDT) Program. Services must be medically necessary and require prior authorization.

The SATS program covers the following services:

A. Addiction Assessment
B. Treatment Planning
C. Care Coordination
D. Multi-person (family) Group Counseling
E. Individual Counseling
F. Group Counseling
G. Marital/Family Counseling
H. Medication Management

Please refer to Attachment 3.1-A, Page 1zz.3 for the service descriptions, definitions, established benefit limits and individual qualified provider requirements. Benefit limits may be extended based on medical necessity.

SATS Qualified Provider Requirements

SATS providers must hold certification from the Division of Behavioral Health Services (DBHS) as a Substance Abuse Treatment Services provider in order to enroll as a SATS Medicaid provider.

The following requirements must be met for DBHS/OADAP certification:

A. Providers must be licensed by Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (OADAP).

B. Providers must submit a written request from the organization's Chief Executive Officer (CEO) to DBHS for certification by DBHS as a SATS Provider.

C. The request for certification by DBHS must include a copy of the provider's accreditation, most recent accreditation survey, and correspondence between the provider and the accrediting organization since the most recent accreditation survey.

D. A list of service delivery sites, including each site's address, telephone number, and fax number must be submitted. Each site from which SATS services are delivered must be included under the provider's accreditation. Proof of this accreditation must be submitted with the request for certification of a site.

E. Current CARF, JCAHO, or COA, *that includes accreditation of the pertinent outpatient alcohol and/or other drug abuse treatment component* (OADAP Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs p. 11). Current nationally accredited behavioral health programs without specific alcohol and drug treatment certification will need to obtain accreditation of their substance abuse program prior to receiving certification as a SATS provider of substance abuse treatment.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (continued)

F. Provisional, Conditional, Preliminary, Pending, Expedited or Deferred Accreditations are not acceptable.

G. The provider must: notify its accrediting organization in writing of all new or additional SATS services implemented subsequent to the provider's most recent accreditation survey; provide DBHS with a copy of the notification letter; and affirm in writing to DBHS that the new service(s) will be included in the provider's next regularly scheduled accreditation survey, if not surveyed before that time. Provider organization opening new services sites must follow DBHS certification policy and procedures.

H. DBHS must be authorized to receive information directly from the accrediting organization and to provide information directly to the accrediting organization, as it relates to SATS. DBHS will furnish these documents to providers at their request.

I. DBHS retains the right to request information in connection with licensure, accreditation, certification, provision or billing of SATS services; to perform site visits at anytime; and to conduct scheduled or unannounced visits, to insure entities are providing SATS services in accordance with the information that was submitted to DBHS. During a site visit the provider must allow access to all sites, policies and procedures, patient records, financial records, and any other documentation necessary to ascertain that services were/are of a quality which meets professionally recognized standards of health care.

J. Providers must adhere to evidence-based practices as approved by DBHS for specific populations and services provided.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

24. Substance Abuse Treatment Services (42 CFR 440.130(d)) **(Continued)**

The transition process to eliminate the Substance Abuse Treatment Services (SATS) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the SATS program will begin being transitioned to the Outpatient Behavioral Health Program starting on July 1, 2017. SATS will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any or SATS provider for a service provided after June 30, 2018.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

25. Applied Behavioral Analysis (ABA) Therapy

(1) Applied Behavior Analysis (ABA) therapy is only one component of services to treat Autism Spectrum Disorder (ASD). ABA therapy services are provided in accordance with 42 CFR 440.130(c).

(2) ABA therapy services must be prescribed by the beneficiary's Arkansas Medicaid assigned primary care provider (PCP);

(3) ABA therapy services must be performed by a:

a. Board-certified behavior analyst (BCBA) who must have board-certified behavior analyst (or more advanced) certification in good-standing from the Behavior Analyst Certification Board;

b. Board-certified assistant behavior analyst (BCaBA) who must have board-certified assistant behavior analyst certification in good-standing from the Behavior Analyst Certification Board; or

c. Registered behavior technician (RBT) who must have registered behavior technician certification in good-standing from the Behavior Analyst Certification Board.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

25. Applied Behavioral Analysis (ABA) Therapy (Continued)

4. ABA therapy services include the following components:
   a. Behavior identification assessment services, which include the following components:
      i. Performing required comprehensive evaluations; and
      ii. Developing the initial individualized treatment plan (ITP);
   b. ABA therapy treatment services, which includes delivering ABA therapy treatment services directly to the beneficiary in accordance with the beneficiary's ITP;
   c. Adaptive behavior treatment with protocol modification services, which includes the following components:
      i. Actively training or assisting a BCaBA or RBT with the delivery of services to a beneficiary during an ABA therapy treatment session;
      ii. Conducting clinical observation of and data collection on the beneficiary's progress towards ITP goals and objectives during an ABA therapy treatment session; and
      iii. Adjusting and updating the ITP as required;
   d. Family adaptive behavior treatment services, which are meetings between the beneficiary's parent(s)/guardian(s) or other appropriate caregiver and the supervising BCBA, where the supervising BCBA:
      i. Discusses the beneficiary's progress;
      ii. Provides any necessary technical or instructional assistance to the parent/guardian in connection with service delivery;
      iii. Answers any parent/guardian or beneficiary questions and concerns; and
      iv. Discusses any necessary changes to the beneficiary's individualized treatment plan.

4.c. Family Planning Services

(1) Comprehensive family planning services are limited to an original examination and up to three (3) follow-up visits annually. This limit is based on the state fiscal year (July 1 through June 30).

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

***D**escribe if there are any limits on who can provide these counseling services

Arkansas Medicaid does not limit who can provide these counseling services at this time so long as they meet (ii) and (iii).

****Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.**

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: **[**x] No limitations [] With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

4.e. Prescription drugs for treatment of opioid use disorder

a. **P**referred prescription drugs (preferred on the PDL) used for treatment of opioid **or alcohol** use disorder require no prior authorization and do not count against the monthly prescription limits when prescribed as part of a Medication Assisted Treatment plan.

5. a. Physicians' Services

For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, or nursing home or elsewhere are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurse services, rural health clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, and federally qualified health center, or a combination of the seven.

For services beyond the established visit limit, extensions will be available if medically necessary. Clients in the Child Health Services (EPSDT) Program are not benefit limited.

(1) The following diagnoses are considered categorically medically necessary and are exempt from benefit extension requirements: Malignant neoplasm; HIV infection and renal failure.

(2) Physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(3) Each attending physician **or** dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

(4) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

(5) Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

(6) Organ transplants are covered as described in Attachment 3.1-E.

(7) Consultations**, including interactive consultations (telemedicine),** are limited to two (2) per recipient per year in a physician's office, **advanced practice registered nurse's office**, patient's home, hospital, or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be **available** if medically necessary.

(8) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act).

Medical services furnished by a dentist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for **clients twenty-one (21) years or** older.

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act). (continued)

The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services **and services provided by an advanced practice nurse or registered nurse practitioner or a combination of the six**. For services beyond the 12 visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Surgical services furnished by a dentist are not benefit limited.

STATE Arkansas
DATE REC'D 9/30/08
DATE APPVD 12/19/08
DATE EFF 8/1/08
HCFA 179 08-18

SUPERSEDES TN 04-12

Revised: July 1, 1991

State/Territory: ARKANSAS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: / / No limitations /X/ With limitations*

c. Chiropractors' Services

/X/ Provided: / / No limitations /X/ With limitations*

d. Other Practitioners' Services

/X/ Provided: / / No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: / / No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

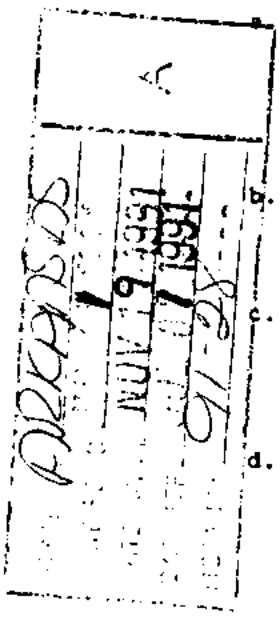
/X/ Provided: / / No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: / / No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: / / No limitations /X/ With limitations*



*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: September 27, 2006

MEDICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

Services are limited to two (2) visits per State Fiscal Year (July 1 through June 30). The benefit limit for State Fiscal Year 1992 will be calculated beginning with services provided on or after December 1, 1991. **Beneficiaries** in the Child Health Services (EPSDT) Program are not benefit limited.

b. Optometrists' Services

Examination of eyes and provision of glasses and/or contact lens and other diagnostic screening, preventive and rehabilitative services and treatment of conditions found for eligible persons. The following limits are imposed:

(1) One eye exam every **twelve (12)** months for eligible **beneficiaries** 21 years of age and older.

SUPERSEDES: TN- 02-02

STATE Arkansas
DATE REC'D 9-21-06
DATE APPV'D 2-7-07
DATE EFF 9-27-06
HCFA 179 06-14

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' Services (Continued)

(2) One eye exam every twelve (12) months for eligible **clients** under **twenty-one (21)** years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be **available** if medically necessary for **clients** in the Child Health Services (EPSDT) Program.

(3) Office medical services provided by an optometrist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for **clients twenty-one (21) years or** over. The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, **federally qualified health center**, certified nurse midwife, and services provided by an advanced practice **registered** nurse, or a combination of the **seven**. For services beyond the twelve (12) visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the ~~**twelve (12)**~~ **sixteen (16)** visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

c. Chiropractors' Services

(1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.

(2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.

(3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid recipients age 21 and older. Services provided to recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

(4) **Effective for dates of service on or after January 1, 2018, c**hiropractic services **do not** require a referral by the **beneficiary's** primary care physician (PCP).

d. Advanced Practice Registered Nurses

For clients twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

The benefit limit will be in conjunction with the benefit limit established for physicians' services, rural health clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, and federally qualified health center or a combination of the seven. For services beyond the established limit, extensions will be available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients in the Child Health Services (EPSDT) Program are not benefit limited.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice and defined by State law. (Continued)

6.d. Other Practitioners' Services

(1) Hearing Aid Dealers

Refer to Attachment 3.1-B, Item 4.b.(8).

(2) Audiologists

Refer to Attachment 3.1-B, Item 4.b. (9).

(3) Optical Labs

Provides eyeglasses and eyeglass repair to eligible recipients.

(4) Nurse Anesthetists

Services limited to licensed nurse anesthetists.

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Supersedes: 90-48

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

(5) Psychologists

Refer to Attachment 3.1-A, Item 4.b.(13).

(6) Obstetric - Gynecologic and Gerontological Nurse Practitioner

Refer to Attachment 3.1-B, Item 21 for coverage limitations.

(7) Pharmacists

(8) Licensed Registered Nurse Sexual Assault Nurse Examiner- Pediatric/Adolescent (SANE-P) certified by the International Association of Forensic Nurses working under the supervision of a licensed Advanced Practice Registered Nurse (APRN).

MEDICALLY NEEDY

6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

(11) Emergency Medical Technicians who are licensed to provide advanced life support and basic life support services.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: April 1, 2002

MEDICALLY NEEDY

7.a. Home Health Services

7.b. Based on a physician's prescription as to medical necessity provided to eligible recipients at their place of residence not to include institutions required to provide these services. For services above 50 visits per recipient per State Fiscal Year, the provider must request an extension. Extension of the benefit limit will be provided for all recipients, including EPSDT, if determined medically necessary.

7.c. Medical supplies, equipment, and appliances suitable for use in the home.

(1) Medical supplies are covered for eligible Medicaid recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home (Home does not include a long term care facility.) Supplies are limited to a maximum reimbursement of $250.00 per month, per recipient. As medical supplies are provided to recipients through the Home Health Program and the Prosthetics Program, the maximum reimbursement of $250.00 per month may be provided through either program or a combination of the two. However, a recipient may not receive more than $250.00 in supplies whether received through either of the two programs or a combination of the two unless an extension has been granted. Extensions will be considered for recipients under age 21 in the Child Health Services (EPSDT) Program if documentation verifies medical necessity. The provider must request an extension of the established benefit limit.

(2) Durable Medical Equipment (DME) - Services are covered in the recipient's home if prescribed by the recipient's physician as medically necessary. Some DME requires prior authorization. DME is limited to specific items. Specific DME is listed in Section III of the Prosthetics Provider Manual.

(3) Augmentative Communication Device

Services for recipients under age 21 are covered as a result of a Child Health Services (EPSDT) screening/referral. Services for recipients over age 21 are covered if prescribed by the recipient's physician as medically necessary. Prior authorization is required.

(4) Specialized Wheelchairs

Specialized Wheelchairs are provided for eligible recipients of all ages if prescribed by the recipient's physician as medically necessary. Prior authorization is required for some items. These items are listed in Section III of the Prosthetics Provider Manual.

7. Home Health Services (Continued)

7.c. **In accordance with 42 CFR 440.70(b)(3) medical supplies, equipment and appliances are suitable for use in any setting in which normal life activities take place. (Continued)**

(5) Diapers/Underpads

Diapers/underpads are limited to $130.00 per month, per recipient. The $130.00 benefit limit is a combined limit for diapers/underpads provided through the Prosthetics Program and Home Health Program. The benefit limit may be extended with proper documentation. Only patients with a medical diagnosis other than infancy which results in incontinence of the bladder and/or bowel may receive diapers. This coverage does not apply to infants who would otherwise be in diapers regardless of their medical condition. Providers cannot bill for underpads/diapers if a recipient is under the age of three years.

(6) DME/Continuous Glucose Monitors.

A. Continuous Glucose Monitors (CGM) will be covered for Arkansas Medicaid clients.

B. A prior authorization (PA) will be required and the service will be provided for those clients who meet medical necessity.

7.d. Physical therapy, occupational therapy, or speech-language pathology and audiology services provided by a home health agency or medical rehabilitative facility.

Services under this item are limited to physical therapy when provided by a home health agency and prescribed by a physician. Effective for dates of service on or after July 1, 2017, individual and group physical therapy are limited to six (6) units per week. Effective for dates of service on or after January 1, 2021, physical therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary for eligible Medicaid recipients.

State/Territory: ARKANSAS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

8. Private duty nursing services.

/X/ Provided: / / No limitations /X/ With limitations*
PA*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*
PA*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*
PA*

*Description provided on attachment.

STATE Arkansas
DATE RECD JUN 10 1991
DATE APP'VD JUL - 2 1991
DATE EFF JUL - 1 1991
HCFA I/9 91-23
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8. Private Duty Nursing to enhance the effectiveness of treatment for ventilator-dependent beneficiaries or non-ventilator dependent tracheotomy beneficiaries.

Enrolled providers are Private Duty Nursing Agencies licensed by **the** Arkansas **Department** of Health. Services are provided by Registered Nurses or Licensed Practical Nurses licensed by the Arkansas State Board of Nursing.

Services are covered for Medicaid-eligible beneficiaries age **twenty-one** (21) and over when determined medically necessary and prescribed by a physician.

Beneficiaries **twenty-one (**21**)** and over to receive PDN Nursing Services must require constant supervision, visual assessment, and monitoring of both equipment and patient. In addition, the beneficiary must be:

A. Ventilator dependent (invasive) or
B. Have a functioning trach requiring:
    1. suctioning;
    2. oxygen supplementation; and
    3. receiving Nebulizer treatments or require Cough Assist / in-exsufflator devices.

In addition, at least one **(1)** from each of the following conditions must be met:

1. Medications:
    - Receiving medication via gastrostomy tube (G-tube)
    - Have a Peripherally Inserted Central Catheter (PICC) line or central port
2. Feeding:
    - Nutrition via a permanent access such as G-tube, **Low-Profile** Button, **or** Gastrojejunostomy tube (G-J tube). **Feedings** are either bolus or continuous.
    - Parenteral nutrition (total parenteral nutrition)

Services are provided in the beneficiary's home, a Division of Developmental Disabilities (DDS) community provider facility, or a public school. (Home does not include an institution.) Prior authorization is required. Private duty nursing medical supplies are limited to a maximum reimbursement of $80.00 per month, per beneficiary. With substantiation, the maximum reimbursement may be extended.

9. Clinic Services

(1) Adult Developmental Day Treatment (ADDT) Services

Limited to adult day treatment centers offering the following **core** services to beneficiaries age eighteen **(**18**)** and above:

a. Assessment **and Treatment Plan Development**, **two (2)** units per year

b. Adult Day Habilitation Services, five (5) units per day, one (1) hour each day

c. Provision of noon meal

Optional Services available through Adult Developmental Day Treatment (ADDT**)** in conjunction with core services are as follows:

a. Physical therapy—Services must be prescribed by a physician and provided by or under the supervision of a qualified physical therapist.

b. Speech**-language** therapy—Services must be prescribed by a physician and provided by or under the supervision of a qualified Speech Pathologist.

c. Occupational therapy—Services must be prescribed by a physician and provided by or under the supervision of a qualified Occupational therapist.

Occupational, Physical, and Speech**-Language** Therapy Services are provided in accordance with Items 3.1-A.4b(15), 3.1-A.11, 3.1-B.4b(15), and 3.1-B(11).

Extensions of the benefit limit for all ADDT services will be provided if medically necessary.

9. Clinic Services (Continued)

(2) Family Planning Clinic Services

Services limited to family planning, reproductive health services and supplies.

(3) Maternity Clinic Services

Limited to antepartum and postpartum services.

(4) Ambulatory Surgical Center Services

Ambulatory surgical center facility services are limited to those services furnished in connection with or directly related to a surgical procedure covered by the Medicaid agency.

(5) End-Stage Renal Disease (ESRD) Facility Services

Covered services include:

a) Outpatient hemodialysis and peritoneal dialysis treatment in a Title XVIII certified ESRD facility.

b) Training for individuals who have been selected by their physician to participate in the peritoneal self-dialysis program.

Beneficiaries aged 21 and older are limited to 3 hemodialysis treatments per week. Beneficiaries under the age of 21 in the Child Health Services (ESPDT) Program are not benefit limited.

STATE Arkansas
DATE RECD 7-13-04
DATE APPVD 9-23-04
DATE EFF 10-1-04
HCFA 179 04-11

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10. Dental Services

Dental services are available for Medicaid beneficiaries age 21 and over but most are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.

There is an annual benefit limit of $500 for dental services for adults. Extractions **and fees paid to the dental lab for the manufacture of dentures** are excluded from the annual limit.

All dentures, whether full or partial, must be provided by the one dental lab under contract with the Arkansas Medicaid Program to manufacture dentures. For adults, there is lifetime limit of one set of dentures. This policy applies to both:

- **Medicaid eligible beneficiaries age 21 and over and**
- **Medicaid eligible beneficiaries under 21 whose eligibility is based on a "pregnant woman aid category" AND whose Medicaid ID number ends in the 100 series (100 through 199).**

Refer to Attachment 3.1-B, Item 4.b. (16) for information regarding dental services for EPSDT eligible children under age 21.

11. Physical Therapy and Related Services

Speech-Language Pathology services and qualified Speech-Language Pathologists meet the requirements set forth in 42 CFR 440.110. Speech-Language Pathology Assistants work under the supervision of the Speech-Language Pathologist in accordance with the State's licensing and supervisory requirements.

Physical Therapy services and qualified Physical Therapists meet the requirements set forth in 42 CFR 440.110. Physical Therapy assistants work under the supervision of the Physical Therapist in accordance with the State's licensing and supervisory requirements.

Occupational Therapy services and qualified Occupational Therapists meet the requirements set forth in 42 CFR 440.110. Occupational Therapy assistants work under the supervision of the Occupational Therapist in accordance with the State's licensing and supervisory requirements.

Audiology services and qualified Audiologists meet the requirements set forth in 42 CFR 440.110.

A. Occupational, Physical and Speech-**Language** Therapy

1. Refer to Attachment 3.1-A, Item 4.b. (15) for therapy services for recipients under age 21.

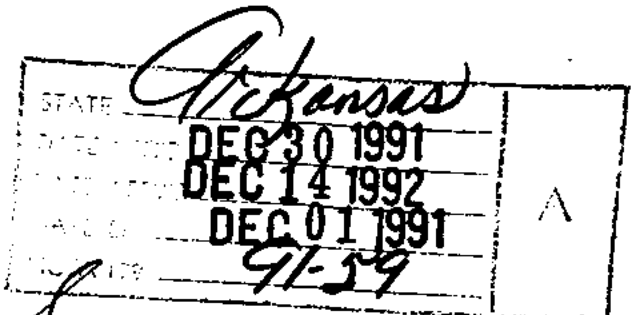
2. For recipients over age 21, effective for dates of services on or after July 1, 2017, individual and group therapy are limited to six (6) units per week per discipline. **For recipients over age 21, speech-language therapy e**valuations are limited to four (4) units per State Fiscal Year (July 1 through June 30). Extensions of the benefit limit will be provided if medically necessary.

3 For recipients over age 21, effective for dates on or after January 1, 2021, physical therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30). For recipients over age 21, effective for dates on or after January 1, 2021, Occupational therapy evaluations are limited to two (2) units per State Fiscal Year (July 1 through June 30).

A. Speech-**Language** Therapy

Speech Generating Device (**SGD**) Evaluation - Effective for dates of service on or after September 1, 1999, **Speech Generating** Device (**SGD**) evaluation is covered for eligible Medicaid recipients of all ages. One **SGD** evaluation may be performed every three **(3)** years based on medical necessity. The benefit limit may be extended for individuals under age 21.

(RESERVED)



Supersedes - None - New Page

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation**,** prescription drugs for opioid **or alcohol** use disorder when part of a Medication Assisted Treatment plan, EPSDT, high blood pressure, h**ypercholesterolemia,** blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the **Arkansas Medicaid Pharmacy Vendor's Website**, are covered:

a. select agents when used for weight gain:

b. select agents when used for the symptomatic relief of cough and colds:

c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:

d. select nonprescription drugs:

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991, will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72-hour supply of drugs in emergency situations.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

a. Prescribed Drugs (continued)

(4) The state is in compliance with section 1927 of the Social Security Act. The state will cover drugs of Federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data.

The state will be negotiating supplemental rebates in the Medicaid program in addition to the Federal rebates provided for in Title XIX. Rebate agreements between the state and pharmaceutical manufacturer(s) will be separate from the Federal rebates.

Effective May 1, 2022, CMS has authorized the state of Arkansas to enter into a multi-state supplemental rebate pool, using a Preferred Drug List (PDL) to maximize state supplemental rebates. The state will continue to select products participating in the federal rebate program that will be in its Preferred Drug List Program and will only receive state supplemental rebates for manufacturer's supplemental covered products included on the PDL.

A rebate agreement between the state and a participating drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on May 24, 2016, and entitled, State of Arkansas Supplemental Rebate Agreement, has been authorized by CMS. Any additional versions of rebate agreements negotiated between the state and manufacturer(s) after May 24, 2016, will be submitted to CMS for authorization.

The state supplemental rebate agreements would apply to the drug benefit, both fee-for-service and those paid by contracted Medicaid managed care organizations (MCOs), under prescribed conditions in Attachment C of the State of Arkansas Supplemental Rebate Agreement. State supplemental rebate agreements would apply to beneficiaries, including those made eligible under the Affordable Care Act receiving fee-for-service benefits and those that are enrolled under a Medicaid managed care organization agreement.

Supplemental rebates received by the State in excess of those required under the National Drug Rebate Agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provisions of the national drug rebate agreement.

The supplemental rebate program does not establish a drug formulary within the meaning of 1927(d)(4) of the Social Security Act.

Effective May 1, 2022, CMS has authorized the state of Arkansas to enter into value/outcomes-based contracts with manufacturers on a voluntary basis. The conditions of the value/outcomes-based contract would be agreed upon by both the state and manufacturer.

The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927(b)(3)(D) of the Social Security Act.

(5) Pursuant to 42 U.S.C. Section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided within a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

a. Prescribed Drugs (continued)

Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

When a pharmacist receives a prescription for a brand or trade name drug, and dispenses an innovator multisource drug that is subject to the Federal Upper Limits (FULs), the innovator multisource drug must be priced at or below the FUL or the prescription hand annotated by the prescriber "Brand Medically Necessary". Only innovator multisource drugs that are subject to the Federal Upper Limit at 42 CFR 447.332(a) and dispensed on or after July 1, 1991, are subject to the provisions of Section 1903(i)(10)(B) of the Social Security Act.

For drugs listed on the Arkansas Medicaid Generic Upper Limit List, the upper limit price will not apply if the prescribing physician certifies in writing that a brand name drug is medically necessary.

The Arkansas Medicaid Generic Upper Limit List is comprised of State generic upper limits on specific multisource drug products and CMS identified generic upper limits on multisource drug products.

The Medicaid agency will provide coverage of prescription and over-the-counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence – 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

b. Dentures

Refer to Attachment 3.1-B Item 4.b(7) for coverage of dentures for Child Health Services (EPSDT) recipients.

Dentures are available for eligible Medicaid beneficiaries age 21 and over, but are benefit limited. Specific benefit limits and prior authorization requirements for beneficiaries age 21 and over are detailed in the Dental Provider Manual.

Dentures are excluded from the annual limit but are limited to one set per lifetime.

State/Territory: ARKANSAS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

c. Prosthetics devices.

☒ Provided: ☐ No limitations ☒ With limitations*

PA*

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*

PA*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Screening services.

☐ Provided: ☐ No limitations ☐ With limitations*

c. Preventive services.

☐ Provided: ☐ No limitations ☐ With limitations*

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient Hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

b. Nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations*

*Description provided on attachment.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices

(1) Eye Prostheses - Refer to Attachment 3.1-B, Item 4.b. (11).

(2) Hearing Aids, Accessories and Repairs - Refer to Attachment 3.1-B, Item 4.b. (10).

(3) Pacemakers and internal surgical prostheses when supported by invoice.

(4) a. Parenteral hyperalimentation services, including fluids, supplies and equipment, when provided in the recipient's home. Home does include a nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR). Service requires prior authorization.

b. Enteral nutrition services, including fluids, supplies and equipment, when provided in the recipient's home. Home does not include a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR) because this service is included and reimbursed as an NF and ICF-MR benefit as described in Attachment 3.1-B, Item 4.a.. Service requires prior authorization.

Arkansas
DEC 28 1992
JAN 21 1993
JAN 01 1993
92-14
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Supersedes: TN 91-28

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(5) Orthotic Appliances

Services for recipients under age 21 are not benefit limited.

Services for recipients age 21 and over are limited to $3,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for an orthotic appliance is $500 or more, prior authorization is required. Specific covered orthotic appliances are listed in Section III of the Prosthetics Provider Manual.

(6) Prosthetic Devices

Services for recipients under age 21 are not benefit limited.

Services for recipients age 21 and over are limited to $20,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for a prosthetic device is $1,000 or more, prior authorization is required. Specific covered prosthetic devices are listed in Section III of the Prosthetics Provider Manual.

SUPERSEDES: TN- AR 99-26 (pg. 5bb)

STATE Arkansas
DATE REC'D 03-18-02
DATE APP'V'D 04-15-02
DATE EFF 04-01-02
HCFA 179 AR 02-09

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12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

For the provision of glasses and/or contact lens for eligible **beneficiaries,** the following limits are imposed:

(1) One pair of glasses every **twelve (12)** months for eligible **beneficiaries** 21 years of age and over. **Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries 21 years of age and over. Replacement of glasses is covered for post cataract patients with prior authorization.**

(2) One pair of glasses every twelve (12) months for eligible **beneficiaries** under 21 years of age in the Child Health Services (EPSDT) Program. **One replacement pair of glasses every twelve (12) months for eligible beneficiaries under 21 years of age in the Child Health Services (EPSDT) Program. Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries under 21 years of age.** Under special circumstances, additional glasses may be authorized.

(3) Contact **lenses** are covered for **beneficiaries** of all ages if either of the following conditions are exhibited by the patient:

a. Medical necessity
b. Cataract patients

Prior authorization is required by the Medical Assistance Section. Lens replacement for all **beneficiaries** is allowed as medically necessary.

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic services – Not Provided.
b. Screening services - Not Provided.
c. Preventive services - Provided, with limitation

Vaccines:

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Certified Community-based Doulas:

A Certified Community-based Doula is a trained professional who provides emotional, physical, and informational support during the prenatal, labor, delivery, and postpartum periods. Certified Community-based Doula services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.

Certified community-based doulas shall provide only the following services:

1. Childbirth education;
2. Assistance with navigating the healthcare system;
3. Client advocacy before, during, and after the birth of a child;
4. Connection with community resources; and
5. Continuous emotional and physical support throughout labor and birth and intermittently during the prenatal and postpartum periods.

Services shall include support during a hospital delivery and during the prenatal and postpartum periods as defined through rules established by the Arkansas Department of Human Services.

To be eligible to provide services, Doulas must be**:**

(1) Certified by the Department of Health as provided in accordance with state law;
(2) At least eighteen (18) years of age and have an NPI number.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

c. Preventive Services—Provided with Limitation (continued)

Breastfeeding and Lactation Consultants:

A breastfeeding and lactation consultant is a trained professional specializing in providing medically appropriate care to aid in milk expression or infant nutrition. Breastfeeding and Lactation Consultant services must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.
Breastfeeding and lactation consultant services are medically appropriate outpatient services or hospital services, or both, provided by a breastfeeding and lactation consultant during pregnancy and through the extended postpartum period to aid in milk expression or infant nutrition. Components of Breastfeeding and Lactation Consultant services include individual outpatient consultation and group classes.

To be eligible to provide services, Breastfeeding and Lactation Consultants must**:**

- Be at least eighteen (18) years of age and have an NPI number and
- Have one of the following certifications:
  1. An International Board-Certified Lactation Consultant; or
  2. A Certified Lactation Counselor;
     - Certified Lactation Counselors must be certified by the (1) International Breastfeeding Institute or (2) Academy of Lactation Policy and Practice.
     - Certified Lactation Counselors are required to be supervised by a Medicaid enrolled healthcare provider to receive reimbursement. Supervision is defined as being employed by one of the following:
       A. An agency led by an International Board-Certified Lactation Consultant;
       B. A physician, advanced practice nurse, or physician assistant
       C. A local health unit or
       D. A hospital

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

A comprehensive system of care for behavioral health services has been developed for use by RSPMI providers. The changes to the program were developed in coordination with providers, representatives of the Arkansas System of Care and other key stakeholders.

DMS is seeking first to revise service definitions and methods within this program to meet the needs of persons whose illnesses meet the definitions outlined in the American Psychiatric Association Diagnostic and Statistical Manual.

Covered mental health services do not include services provided to individuals aged 21 to 65 who reside in facilities that meet the Federal definition of an institution for mental disease. Coverage of RSPMI services within the rehabilitation section of Arkansas' state plan that are provided in IMD's will be discontinued as of September 1, 2011.

A. Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified RSPMI provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

Services:

- SERVICE: Mental Health Evaluation/Diagnosis
  DEFINITION: The cultural, developmental, age and disability -relevant clinical evaluation and determination of a beneficiary's mental status; functioning in various life domains; and an axis five DSM diagnostic

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

formulation for the purpose of developing a plan of care. This service is required prior to provision of all other mental health services with the exception of crisis interventions. Services are to be congruent with the age, strengths, necessary, accommodations for disability, and cultural framework of the beneficiary and his/her family.

Setting information could be summarized in the description if the State would like to include this information.

This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- SERVICE: Psychological Evaluation
DEFINITION: A Psychological Evaluation employs standardized psychological tests conducted and documented for evaluation, diagnostic, or therapeutic purposes. The evaluation must be medically necessary, culturally relevant; with reasonable accommodations for any disability, provide information relevant to the beneficiary's continuation in treatment, and assist in treatment planning. All psychometric instruments must be administered, scored, and interpreted by the qualified professional.

  This service must be performed by a physician or mental health professional and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- SERVICE: Psychiatric Diagnostic Assessment
DEFINITION: A direct face-to-face service contact occurring between the physician **or Advanced Practice Nurse** and the beneficiary for the purpose of evaluation. Psychiatric Diagnostic Assessment includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. (See Section 224.000 for additional requirements.)

  *This service must be performed by a physician **or Advanced Practice Nurse** and is necessary to determine how best to proceed in developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.*

  Please refer to Provider Qualifications on page 5d18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

An APN performing the Psychiatric Diagnostic Assessment MUST meet the following:

1. ***Licensed by the Arkansas State Board of Nursing***
2. ***Practicing with licensure through the American Nurses Credentialing Center***
3. ***Practicing under the supervision of an Arkansas-licensed psychiatrist who has an affiliation with the RSPMI program and with whom the Advanced Practice Nurse has a collaborative agreement. Prior to the initiation of the treatment plan, the findings of the Psychiatric Diagnostic Assessment conducted by the Advanced Practice Nurse must be discussed with the supervising psychiatrist. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may do it to.***
4. ***Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act***
5. ***Practicing within an Advanced Practice Nurse's experience and competency level***

- SERVICE: Master Treatment Plan
  DEFINITION: A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. The plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, time limitations for services, and documentation of medical necessity by the supervising physician.

  This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary and is necessary for developing an array of rehabilitative treatment services according to goals and objectives for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- SERVICE: Periodic Review of Master Treatment Plan
  DEFINITION: The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided; and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities, and necessary accommodations that will be provided to the beneficiary, time limitations for services, and the medical necessity of continued

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

services. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a physician and licensed mental health professionals in conjunction with the beneficiary to ensure that the array of rehabilitative treatment services is producing the desired outcome according to goals and objectives and to determine if the maximum reduction of a mental disability restoration of the beneficiary to his or her best possible functional level is progressing.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Interpretation of Diagnosis**
  DEFINITION: A face-to face therapeutic intervention provided to a beneficiary in which the results/implications/diagnoses from a mental health diagnosis evaluation or a psychological evaluation are explained by the professional who administered the evaluation. Services are to be congruent with the age, strengths, necessary accommodations, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician or licensed mental health professional to assist the beneficiary and his or her primary support persons in understanding what is necessary for developing an array of rehabilitative treatment services for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Individual Psychotherapy**
  DEFINITION: Face-to-face treatment provided by a licensed mental health professional on an individual basis. Services consist of structured sessions that work toward achieving mutually defined goals as documented in the master treatment plan. Services are to be congruent with the age, strengths, needed accommodations necessary for any disability, and cultural framework of the beneficiary and his/her family. The treatment service must reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is not present**
  DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary is not present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family. These services identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.

  When all three conditions are taken together, it would be necessary to address marital/family dynamics and improve/strengthen the marital/family interactions and functioning in order o focus on the Medicaid eligible beneficiary's condition and how it can be improved.

  The reason for providing this service is to improve the integrity of the patient's support system and documentation must reflect how the therapy accomplishes that rather than becoming therapy for the caregiver in and of itself.

  The service may only be provided by a mental health professional practicing within the scope of their licensure.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Marital/Family Psychotherapy – Beneficiary is present**
  DEFINITION: Face-to-face treatment provided to more than one member of a family simultaneously in the same session or treatment with an individual family member (i.e. Spouse or Single Parent) that is specifically related to achieving goals identified on the beneficiary's master treatment plan. The identified beneficiary must be present for this service. Services are to be congruent with the age, strengths, needed accommodations for disability, and cultural framework of the beneficiary and his/her family. These services are to be utilized to identify and address marital/family dynamics and improve/strengthen marital/family interactions and functioning in relationship to the beneficiary, the beneficiary's condition and the condition's impact on the marital/family relationship.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist**
  Scheduled individual outpatient care provided by a licensed speech pathologist supervised by a physician to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **Individual Outpatient – Speech Therapy, Speech Language Pathologist Assistant**
  Scheduled individual outpatient care provided by a licensed speech pathologist assistant supervised by a qualified speech language pathologist to a Medicaid-eligible beneficiary for the purpose of treatment and remediation of a communicative disorder deemed medically necessary. See the Occupational, Physical and Speech Therapy Program Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist assistant and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **Group Outpatient – Speech Therapy, Speech Language Pathologist**
  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.
  Group Outpatient – Speech Therapy, Speech Language Pathologist Assistant

  Contact between a group of Medicaid-eligible beneficiaries and a speech pathologist assistant for the purpose of speech therapy and remediation. See the Occupational, Physical and Speech Therapy Provider Manual for specifics of the speech therapy services.

  This service must be performed by licensed speech language pathologist and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Group Outpatient – Group Psychotherapy**
  DEFINITION: Face-to-face interventions provided to a group of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

The professional uses the emotional interactions of the group's members to assist them in implementing each beneficiary's master treatment plan. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Therapeutic Day/Acute Day Treatment**
  DEFINITION: This service includes the administration of individual, family/marital and group therapies, face to face interventions and supportive services and is designed to be more intensive in nature than rehabilitative day services.

  The providers are a combination of licensed professionals (psychologist, LCSW, LPC, LPE, RN, and paraprofessionals. Licensed professionals must supervise the milieu and a physician must provide oversight. Paraprofessionals must be supervised by a licensed professional.

  Short-term daily array of continuous, highly structured, intensive outpatient services provided by a mental health professional. These services are for beneficiaries experiencing acute psychiatric symptoms that may result in the beneficiary being in imminent danger of psychiatric hospitalization and are designed to stabilize the acute symptoms. These direct therapy and medical services are intended to be an alternative to inpatient psychiatric care and are expected to reasonably improve or maintain the beneficiary's condition and functional level to prevent hospitalization and assist with assimilation to his/her community after an inpatient psychiatric stay of any length. These services are to be provided by a team consisting of mental health clinicians, paraprofessionals and nurses, with physician oversight and availability. The team composition may vary depending on clinical and programmatic needs but must at a minimum include a licensed mental health clinician and physician who provide services and oversight. Services are to be congruent with the age,

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

These services must include constant staff supervision of beneficiaries and physician oversight.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Crisis Intervention**
  DEFINITION: Unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Physical Examination – Psychiatrist or Physician**
  Physical Examination – Psychiatric Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

DEFINITION: A general multisystem examination based on age and risk factors to determine the state of health of an enrolled RSPMI beneficiary.

This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Pharmacologic Management by Physician (formerly Medication Maintenance by a physician)**
  Pharmacologic Management by Mental Health Clinical Nurse Specialist or Psychiatric Mental Health Advanced Nurse Practitioner
  DEFINITION: Provision of service tailored to reduce, stabilize or eliminate psychiatric symptoms by addressing individual goals in the master treatment plan. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a psychiatrist, physician, psychiatric mental health clinical nurse specialist or psychiatric mental health advanced nurse practitioner and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Medication Administration by a Licensed Nurse**
  DEFINITION: Administration of a physician-prescribed medication to a beneficiary. This includes preparing the beneficiary and medication; actual administration of oral, intramuscular and/or subcutaneous medication; observation of the beneficiary after administration and any possible adverse reactions; and returning the medication to its previous storage.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Group Outpatient – Pharmacologic Management by a Physician**
  DEFINITION: Therapeutic intervention provided to a group of beneficiaries by a licensed physician involving evaluation and maintenance of the Medicaid-eligible beneficiary on a medication regimen with simultaneous supportive psychotherapy in a group setting. This includes evaluating medication prescription, administration, monitoring, and supervision; and informing beneficiaries regarding medication(s) and its potential effects and side effects. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a physician and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

- **SERVICE: Routine Venipuncture for Collection of Specimen**
  DEFINITION: The process of drawing a blood sample through venipuncture (i.e., inserting a needle into a vein to draw the specimen with a syringe or vacutainer) or collecting a urine sample by catheterization as ordered by a physician or psychiatrist.

  This service must be performed by a qualified, licensed health care professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Collateral Intervention, Mental Health Professional**
  DEFINITION: A face-to-face contact by a mental health professional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information necessary to the enrolled beneficiary's assessment, master treatment plan , and/or rehabilitation. The identified beneficiary does not have to be present for this service. Services are to be congruent with the age, strengths, needed accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Collateral Intervention, Mental Health Paraprofessional**
  DEFINITION: A face-to-face contact by a mental health paraprofessional with caregivers, family members, other community-based service providers or other Participants on behalf of and with the expressed written consent of an identified beneficiary in order to obtain or share relevant information

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

necessary to the enrolled beneficiary's assessment, master treatment plan, and/or rehabilitation. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. The identified beneficiary does not have to be present for this service.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Professional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.
  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Crisis Stabilization Intervention, Mental Health Paraprofessional**
  DEFINITION: Scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration, and serve as an alternative to 24-hour inpatient care. Services are to be

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Intervention, Mental Health Professional (formerly On-Site and Off-Site Interventions, MHP)**
  DEFINITION: Face-to-face medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions as prescribed on the master treatment plan to re-direct a beneficiary from a psychiatric or behavioral regression or to improve the beneficiary's progress toward specific goal(s) and outcomes. These activities may be either scheduled or unscheduled as the goal warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

  This service must be performed by a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

  Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Intervention, Mental Health Paraprofessional (formerly On-Site and Off-Site Intervention, Mental Health Paraprofessional)**
  DEFINITION: Face-to-face, medically necessary treatment activities provided to a beneficiary consisting of specific therapeutic interventions prescribed on the master treatment plan, which are expected to accomplish a specific goal or objective listed on the master

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

treatment plan. These activities may be either scheduled or unscheduled as the goal or objective warrants. Services are to be congruent with the age, strengths, necessary accommodations for any disability, and cultural framework of the beneficiary and his/her family.

This service must be performed by a mental health paraprofessional under the supervision of a licensed mental health professional and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **SERVICE: Rehabilitative Day Service for Persons under Age 18**
  DEFINITION: An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms of youth diagnosed with childhood disorders, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, age-appropriate, recovery based, culturally competent, must reasonably accommodate disability, and must have measurable outcomes. These activities are designed to assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their mental illness. The intent of these services is to enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as positive peer interactions, appropriate social/family interactions, and managing overt expression of symptoms like impulsivity and anger; daily living and self-care skills, such as personal care and hygiene, and daily structure/use of time; cognitive skills, such as problem solving, developing a positive self-esteem, and reframing, money management, community integration, understanding illness, symptoms and the proper use of medications; and any similar skills required to implement a beneficiary's master treatment plan.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

- **Rehabilitative Day Service for Persons Ages 18-20**
  Apply the above definition and requirements (except Staff to Client Ratios, which are outlined below).
  Additional information: Use code H2017 with no modifier to claim for services provided to beneficiaries for ages 18-20.

- **SERVICE: Adult Rehabilitative Day Service**
  DEFINITION: Adult Rehabilitative day services provide a continuing, organized program of rehabilitative, therapeutic and supportive health services, and supervision to individuals who are mentally ill and who, due to the severity of their impairment, are in need of face to face interventions provided in a structured group program. This service is designed for long-term recovery and self-sufficiency.

  Adult Rehabilitative day services provide rehabilitative and health services directed toward meeting the health restoration and maintenance needs of the beneficiary in a facility-based program providing specialized rehabilitation.

  Services may include:

  A. Goal compliance,

  B. Problem solving,

  C. Patient Safety

  D. Task completion

  E. Pharmaceutical supervision and/or

  G. Health monitoring.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

An array of face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These interventions are person- and family-centered, recovery based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety, or anger; behavioral skills, such as proper use of medications, appropriate social interactions, and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms, and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan .

This service also includes the administration of individual intervention services, individual therapy, group therapy and supportive services, but are designed to assist with beneficiary functioning on a day to day basis within the community.

The providers are licensed mental health professionals and paraprofessionals under their supervision.

This service must be performed and overseen by a multidisciplinary team of physician, licensed mental health professional and mental health paraprofessional staff and is necessary as part of an array of other rehabilitative treatment services used together when clinically indicated according to a master treatment plan for maximum reduction of a mental disability and to restore the beneficiary to his or her best possible functional level.

Please refer to Provider Qualifications on page 5d18.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

B. Provider Qualifications

Rehabilitative Services for Persons with Mental Illness (RSPMI) are limited to certified providers who offer core mental health services for the treatment and prevention of mental disorders. **The provider must be certified as an RSPMI provider by the Division of Behavioral Health Services. Providers not certified by the Division of Behavioral Health Services may not provide these services.**

Providers for each specific RSPMI service are licensed by the State and must practice within the scope of Arkansas licensure. Individuals providing RSPMI services must be:

1. Licensed in the State of Arkansas as a mental health professional.;

2. Medical records librarian;

3. Licensed in the State of Arkansas as a Psychiatrist - The psychiatrist may provide oversight, medical care, or both. If the psychiatrist does not provide all medically necessary RSPMI medical care, then a medical doctor may provide medical care in addition to a psychiatrist;

4. Licensed Psychologist or Licensed Psychological Examiner

5. Licensed Physician or

6. Certified Mental Health Paraprofessional, under the direct supervision of a Licensed Mental Health Professional

Qualified professionals must be present to furnish all medically necessary RSPMI services, including all services in each patient's care plan

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)(continued)

The transition process to eliminate the Rehabilitative Services for Persons with Mental Illness (RSPMI) and Licensed Mental Health Practitioner (LMHP) Program is contingent upon the approval of the implementation of the Outpatient Behavioral Health Services Program. Clients currently served by the RSPMI and LMHP programs will begin being transitioned to the Outpatient Behavioral Health Program starting on July 1, 2017. RSPMI and LMHP will cease to exist on June 30, 2018 and no Arkansas Medicaid payments will occur to any RSPMI or LMHP provider for a service provided after June 30, 2018.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

2. Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Extended Rehabilitative Hospital Services

Extended Rehabilitative Hospital Services are services for the rehabilitation of patients with various neurological, musculo-skeletal, orthopedic and other medical conditions following stabilization of their acute medical conditions. Extended Rehabilitative Hospital Services are a global service, covering all rehabilitative, psychological and/or social services required of the admitting facility for licensure, certification and/or accreditation.

The following services are included in the global coverage of an Extended Rehabilitative Hospital:

1) Restorative Therapies
2) Behavioral Rehabilitation
3) Life Skills Training
4) Individual and Group Counseling
5) Assessment Services
6) Nursing Care

Persons eligible for admission must have at least one of the following neurological conditions: Post acute traumatic or acquired brain injury. This includes and is limited to viral encephalitis, meningitis, aneurysms, cerebral vascular accident/stroke, post-operative tumors, anoxia, hypoxias, toxic encephalopathies, refractory seizure disorders and congenital neurological brain disorders. These conditions can be with or without moderate to severe behavioral disorders secondary to a brain injury.

An Extended Rehabilitative Hospital must be licensed by the Division of Health as a Rehabilitative Hospital. An Extended Rehabilitative Hospital must also be certified as a Title XVIII (Medicare) Rehabilitative Hospital provider. Extended Rehabilitative Hospital services are provided by a licensed practitioner who is directly related to the beneficiary's rehabilitative adjustment.

Extended Rehabilitative Hospital services provided are limited to thirty (30) days per state fiscal year, July 1 through June 30, for ages 21 and older. No extensions will be considered. However, beneficiaries who are under the age of 21 years and in the Child Health Services (EPSDT) Program are not limited to the thirty (30) day annual benefit limit. The thirty (30) day annual benefit limit only applies to services provided in an RSPD facility and does not include days counted toward any other Medicaid Program benefit limit, e.g., hospital, nursing home, etc.

Service delivery is delivery is the same as inpatient hospital services described in Attachment 3.1-A, Page 1a, Item 1, minus the room and board component.

Extended Rehabilitative Hospital Services are available to eligible Medicaid recipients of all ages when medically necessary as determined by the PRO. Services are limited to 30 days per State Fiscal Year for beneficiaries age 21 and older. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)

As part of the Behavioral Health transformation within the state of Arkansas, DMS is creating a more integrated and client-focused behavioral health care system. These changes were developed in coordination with the Division of Behavioral Health Services (DBHS), providers, representatives of the Arkansas System of Care, beneficiaries and other key stakeholders.

A. Scope

Care, treatment and services provided by a certified Behavioral Health Services provider to Medicaid-eligible beneficiaries. These services are available to all eligible Medicaid beneficiaries. Services which require an Independent Assessment are indicated by the statement, "Eligibility for this service is determined by an Independent Assessment and must be prior authorized."

DMS has set forth in policy the settings in which each individual service may be provided. Each service shown below includes the place of service allowable for that procedure.

B. Services

i.: Individual Behavioral Health Counseling*

DEFINITION: Individual Behavioral Health Counseling, including tobacco cessation, is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

B. Services

ii. Group Behavioral Health Counseling*

DEFINITION: Group Behavioral Health Counseling, including tobacco cessation, is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling with Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members in the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children. Dyadic treatment must be prior authorized.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

iii. Marital/Family Behavioral Health Counseling with Beneficiary Present (continued)*

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

iv. Marital/Family Behavioral Health Counseling without Beneficiary Present*

DEFINITION: Marital/Family Behavioral Health Counseling without Beneficiary Present, including tobacco cessation, is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary for the benefit of the beneficiary. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

v. Group Psychoeducation*

DEFINITION: Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery for the benefit of the beneficiary. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

v. Group Psychoeducation (continued)*

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children. Dyadic treatment must be prior authorized.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the Provider must have Arkansas State Infant Mental Health Certification.

vi. Multi-Family Behavioral Health Counseling*

DEFINITION: Multi-Family Behavioral Health Counseling, including tobacco cessation, is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

vii. Mental Health Diagnosis*

DEFINITION: Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the DSM-IV or subsequent revisions. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

vii. Mental Health Diagnosis (continued)*

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

viii. Interpretation of Diagnosis*

DEFINITION: Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

viii. Interpretation of Diagnosis (continued)*

For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.

-Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; and For Beneficiaries Under the Age of 4 the provider must have Arkansas State Infant Mental Health Certification.

ix. Substance Abuse Assessment*

Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DBHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician;

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS) (continued)

x. Psychological Evaluation*

DEFINITION: Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.

Allowable Performing Provider - Licensed Psychologist, Licensed Psychological Examiner and a Licensed Psychological Examiner - Independent

xi: Pharmacologic Management*

DEFINITION: Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

xii: Psychiatric Assessment*

DEFINITION: Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder.

Allowable Performing Provider - Advanced Practice Nurse or a Physician

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xiii. Treatment Plan*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; and Physician

xiv. Crisis Stabilization Intervention*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Crisis Stabilization Intervention is a scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. Services can include interventions, stabilization activities, coping strategies and other various activities to assist the beneficiary in crisis. The services provided are expected to reduce or eliminate the risk of harm to the person or others in order to stabilize the beneficiary. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the beneficiary and his/her family.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelor's; and Qualified Behavioral Health Provider – Non-Degreed

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xv: Partial Hospitalization*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.

Allowable Performing Provider – Must be certified by the Department of Human Services as a Partial Hospitalization provider.

xvi: Behavioral Assistance*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Behavioral Assistance is a specific outcome oriented intervention provided individually or in a group setting with the child/youth and/or his/her caregiver(s) that will provide the necessary support to attain the goals of the treatment plan. Services involve applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The intervention should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.

Allowable Performing Provider -Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xvii. Family Support Partners*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Family Support Partners is a service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children or youth with behavioral health care needs for the benefit of the beneficiary. Family Support Partners come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency of the beneficiary. FSPs are required to be trained and certified by the State as a FSP to provide this service.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xviii: Peer Support*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Peer Support is a consumer centered service provided by individuals who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Peer Support is a person-centered service with a recovery focus which allows beneficiaries the opportunity to direct their own recovery and advocacy process. This service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.

Allowable Performing Provider - Certified Peer Support Specialist; and a Certified Youth Support Specialist

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xix. Individual Pharmacologic Counseling*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: A specific, time limited one-to-one intervention by a nurse with a beneficiary and/or caregivers, related to their psychopharmological treatment. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required.

Allowable Performing Provider -Registered Nurse

xx: Group Pharmacologic Counseling*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: A specific, time limited intervention provided to a group of beneficiaries and/or caregivers by a nurse, related to their psychopharmological treatment. The service should encompass all the parameters to make the beneficiary and/or family understand the diagnosis prompting the need for the medication and any life style modification required.

Allowable Performing Provider - Registered Nurse

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxi. Intensive Outpatient Substance Abuse Treatment*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Intensive Outpatient services provide group based, non-residential, intensive, structured interventions consisting primarily of counseling and education to improve symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Services are goal oriented interactions with the individual or in group/family settings. This community based service allows the individual to apply skills in "real world" environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Intensive outpatient programs provide 9 or more hours per week of skilled treatment, 3 – 5 times per week in groups of no fewer than three and no more than 12 clients.
Allowable Performing Provider – Behavioral Health Agency that is certified by the Department of Human Services as an Intensive Outpatient Substance Abuse Treatment provider The Intensive Outpatient Substance Abuse Treatment provider shall have practitioners who are able to and appropriate to deliver Intensive Outpatient Substance Abuse Treatment.

xxii: Individual Life Skills Restoration*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Individual Life Skills Restoration is a service that provides support and training for beneficiaries on a one-on-one basis. This service includes behavioral modeling to restore a beneficiary's skills needed to support an independent lifestyle and restore a strong sense of self-worth. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. In addition, it aims to restore the ability of youth in setting and achieving goals, and restoring independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Allowable Performing Provider -Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxiii. Group Life Skills Restoration*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Group Life Skills Restoration is a service that provides support and training for beneficiaries in a group setting of up to six (6) beneficiaries with one staff member or up to ten (10) beneficiaries with two staff members. This service includes behavioral modeling to restore a beneficiary's skills needed to support an independent lifestyle and restore a strong sense of self-worth. This service should be a strength-based, culturally appropriate process that integrates the youth into their community as they develop their recovery plan. In addition, it aims to restore the ability of youth in setting and achieving goals, and restoring independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living.

Allowable Performing Provider -Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xxiv: Child and Youth Support Services*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Child and Youth Support Services are clinical, time-limited services for principal caregivers for the benefit of the beneficiary designed to restore a child's positive behaviors and compliance with parents at home; and restore a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff for the benefit of the beneficiary. This service is intended to assist the parent in managing their child's symptoms of their illness and training the parents in effective interventions and techniques for working with the schools for the benefit of the beneficiary.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxv. Psychosocial Rehabilitation Services – Working Environment*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Psychosocial Rehabilitation Services – Working Environment is designed to assist beneficiaries restore skills needed to promote and sustain independence and stability in their working environment. The service actively facilitates the restoration of skills needed to acquire a job.

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.

Allowable Performing Provider -Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xxvi: Psychosocial Rehabilitation Services – Living Environment *

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Psychosocial Rehabilitation Services – Living Environment is designed to assist beneficiaries restore skills needed to promote and sustain independence and stability in their living environment. An emphasis is placed on the development and strengthening of natural supports in the community.

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.

Allowable Performing Provider -Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxvii. Adult Life Skills Development

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Adult Life Skills Development services are designed to assist beneficiaries in restoring skills needed to support an independent lifestyle and promote an improved sense of self-worth. Adult Life skills Development is designed to restore the beneficiary's ability to set and achieve goals, restore independent living skills, restore the ability to demonstrate accountability, and restore the ability to make goal-directed decisions related to independent living.

Allowable Performing Provider - Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

xxviii: Therapeutic Communities

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process.

Example services include, but are not limited to, a combination of Individual Behavioral Health Counseling, Group Behavioral Health Counseling, Psychoeducation, Marital-Family Behavioral Health Counseling, Multi-Family Behavioral Health Counseling, Crisis Stabilization Intervention, Peer Support, Individual Pharmacologic Counseling, Group Pharmacologic Counseling, Adult Life Skills Development and Psychosocial Rehabilitative Services.

This service will not be paid for within an Institution for Mental Disease (IMD)

This service does not include payment for room and board of the beneficiary.

Therapeutic Community shall be certified by the Division of Behavioral Health Services as a Therapeutic Communities provider.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive**,** and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxix. Crisis Care - De-escalation*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Crisis Care – De-escalation provides temporary direct care for a beneficiary in the beneficiary's community that is not facility-based. Crisis Care – De-escalation services de-escalate stressful situations and provide a therapeutic outlet. Crisis Care includes behavioral interventions that keep beneficiaries in their current situation and reduces the need for acute hospitalization or other higher levels of care. Crisis Care shall be indicated in the treatment plan.

This service will not be paid for within an Institution for Mental Disease (IMD)**.**

This service does not include payment for room and board of the beneficiary.

Crisis Care – De-escalation provider must be certified by the Department of Human Services as a Crisis Care – De-escalation provider.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelor's; and Qualified Behavioral Health Provider – Non-Degreed.

xxx. Acute Crisis Units*

Definition: Acute Crisis Units provide brief**,** 96 hours or less**,** crisis treatment services to persons over the age of 17 who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.

This service will not be paid for within an Institution for Mental Disease (IMD)**.**

This service does not include payment for room and board of the beneficiary.

Acute Crisis Unit must be certified by Department of Human Services as an Acute Crisis Unit.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelor's; and Qualified Behavioral Health Provider – Non-Degreed.

An Extension of Benefit for medical necessity is required for admissions exceeding ninety-six (96) hours.

*All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)

xxxi. Crisis Intervention*

DEFINITION: Crisis Intervention is an unscheduled, immediate, short-term treatment activity provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services, which can include interventions, stabilization activities, evaluation, coping strategies and other various activities to assist the beneficiary in crisis, are designed to stabilize the person in crisis, prevent further deterioration, and provide immediate indicated treatment in the least restrictive setting. The services provided are expected to reduce or eliminate the risk of harm to the person or others, in order to stabilize the beneficiary.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician

xxxii. Substance Abuse Detoxification*

Definition: Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term and may be provided in a crisis unit, residential, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing treatment.

Substance Abuse Detoxification Unit must be certified by the Department of Human Services as a Substance Abuse Detoxification provider.

This service will not be paid for within an Institution for Mental Disease (IMD).

This service does not include payment for room and board of the beneficiary.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinician – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelor's; and Qualified Behavioral Health Provider – Non-Degreed.

Six (6) encounters are allowed per State Fiscal Year (July 1 through June 30). Extension of Benefits for Medically Necessary Encounters beyond the first six (6) is required.

*All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)(continued)

xxxiii: Residential Community Reintegration Program*

Eligibility for this service is determined by an Independent Assessment and must be prior authorized.

DEFINITION: Residential Community Reintegration Services are designed to serve as an intermediate level of care between Inpatient Psychiatric Facilities and Outpatient Behavioral Health Services. Twenty-four hour per day intensive therapeutic care is provided in a small group home setting for individuals under 21 years of age with emotional and/or behavior problems which cannot be remedied by less intensive treatment to prevent acute or sub-acute hospitalization. The program is also offered as a step-down or transitional level of care to prepare a beneficiary for less intensive treatment. Services include all medically necessary Outpatient Behavioral Health Services (OBHS) to address the beneficiary's behavioral health needs.

Example services include, but are not limited to, a combination of Individual Behavioral Health Counseling, Group Behavioral Health Counseling, Psychoeducation, Marital-Family Behavioral Health Counseling, Multi-Family Behavioral Health Counseling, Crisis Stabilization Intervention, Peer Support, Individual Pharmacologic Counseling, Group Pharmacologic Counseling, Adult Life Skills Development and Psychosocial Rehabilitative Services.

This service will not be paid for within an Institution for Mental Disease (IMD).

This service does not include payment for room and board of the beneficiary.

Residential Community Reintegration Programs shall be certified by the Department of Human Services as a Residential Community Reintegration provider.

Allowable Performing Provider - Independently Licensed Clinician – Master's/Doctoral; Non-Independently Licensed Clinicians – Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider – Bachelors; and Qualified Behavioral Health Provider – Non-Degreed.

***All medically necessary 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT eligible beneficiaries ages birth to twenty-one, in accordance with 1905(r) of the Social Security Act.**

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)

C. Provider Agency Qualifications

Outpatient Behavioral Health Services (OBHS) may be provided by appropriately certified providers who offer core behavioral health services for treatment and rehabilitation of behavioral health issues. The provider must be certified as an OBHS provider by the Department of Human Services (DHS). Providers not certified by DHS are not qualified to provide these services.

D. Performing Provider Qualifications

Outpatient Behavioral Health Services (OBHS) are limited to certified providers who offer core behavioral health services for treatment and rehabilitation of behavioral health issues. The provider must be certified as an OBHS provider by the Department of Human Services (DHS). Providers not certified by DHS are not qualified to provide these services.

Providers for each specific OBHS service are certified by DHS. Any provider licensed by the State must practice within their scope of Arkansas licensure. Individuals providing OBHS services must be one of the following:

1. Licensed in the State of Arkansas as a Clinician:

d. Licensed Clinical Social Worker (LCSW)

e. Licensed Marital and Family Therapist (LMFT)

f. Licensed Psychologist (LP)

g. Licensed Psychological Examiner – Independent (LPEI)

h. Licensed Professional Counselor (LPC)

i. Licensed Master Social Worker (LMSW)

j. Licensed Associate Counselor (LAC)

k. Licensed Psychological Examiner (LPE)

l. Provisionally Licensed Psychologist (PLP)

2. Licensed Physician

3. Licensed Advanced Nurse Practitioner (limited to Adult Psychiatric Mental health Clinical Nurse Specialists, Child Psychiatric Mental Health Clinical Nurse Specialist, Adult Psychiatric Mental Health APN and Family Psychiatric Mental Health APN)

4. Licensed Registered Nurse

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (continued)

3. Outpatient Behavioral Health Services (OBHS)

5. Certified Qualified Behavioral Health Providers (includes Certified Peer Support Specialist, Certified Youth Support Specialist, and Certified Family Support Partner), under direct supervision of an individual licensed in the State of Arkansas as a Clinician that is an allowable performing provider of a service as indicated in D., 1.,a – e.

c. Certified Peer Support Specialists, Certified Youth Support Specialists, and Certified Family Support Partners are certified by DHS and must adhere to the mandated training requirements to become certified. The requirements to become and maintain certification are as follows:

i. Must complete 40 hours of QBHP training

ii. Must complete annual ongoing training approved by Arkansas DHS

iii. Must have lived experience

iv. Must ensure and document that all Certified Peer Support Specialists, Certified Youth Support Specialists, and Certified Family Support Partners are under supervision of a mental health professional as defined in Section 13., d., 3., c., 1 above.

d. Qualified Behavioral Health Providers are certified by the Behavioral Health Agency that they work for. In order to become certified as a Qualified Behavioral Health Provider, the Agency must provide and document that each Qualified Behavioral Health Provider has completed the required training and the Agency must issue a certificate to the Qualified Behavioral Health Provider. The requirements to become and maintain certification are as follows:

i. Must complete 40 hours of QBHP training, which includes, but is not limited to, topics such as behavior management, group interaction, listening techniques, and knowledge of behavioral health illnesses.

ii. Must complete, at a minimum, 8 hours of annual in-service training

MEDICALLY NEEDY

14. Services for Individuals Age 65 or Older in Institutions for Mental Diseases

a. Inpatient Hospital Services

Not provided.

b. Nursing Facility Services

Not provided.

STATE Arkansas
DATE RE: JAN 12 1995
DATE A: FEB 22 1995
DATE E: FEB 15 1995
HCFA ID: 93-01
A

3.1-B, Page 5f

SUPERSEDES: TN - 93-01

State/Territory: ARKANSAS

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

15. Services in an intermediate care facility for the mentally retarded, as defined in Section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

☐ Provided: ☐ No limitations ☐ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

PA*

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

☒ **Provided in accordance with section 2302 of the Affordable Care Act**

*Description provided on attachment.

15. **Services in an intermediate care facility for the mentally retarded, as defined in Section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.**

Not Provided

STATE Arkansas
DATE REC'D DEC 19 1990
DATE APP'VD 4-19-91
DATE EFF OCT - 1 1990
HCFA 179 9061

A

Supersedes: 86-26

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

Inpatient Psychiatric Providers which are inpatient psychiatric hospitals must be:

- licensed as a psychiatric hospital by the State agency which licenses psychiatric hospitals and
- certified by the Medicare Certification Team as meeting the conditions of participation as a psychiatric hospital in the Title XVIII (Medicare) Program.

OR

Inpatient Psychiatric Providers which are inpatient psychiatric residential treatment facilities must be:

- **accredited as meeting the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations and**
- licensed by the Arkansas Department of Human Services, Division of Children and Family Services as a psychiatric residential treatment facility. (Applicable only to Inpatient Psychiatric Providers located in Arkansas.)

OR

Inpatient Psychiatric Providers which are inpatient psychiatric programs in a psychiatric facility must be:

- **accredited as meeting the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations.**

OR

Inpatient Psychiatric Providers which are inpatient psychiatric programs in a psychiatric hospital must:

- be in a psychiatric hospital licensed as a psychiatric hospital by the State agency which licenses psychiatric hospitals;
- be in a psychiatric hospital certified by the Medicare Certification Team as meeting the conditions of participation as a psychiatric hospital in the Title XVIII (Medicare) Program and
- **have an inpatient psychiatric program which is accredited as meeting the child and adolescent standards of the Joint Commission on Accreditation of Healthcare Organizations.**

STATE AR Kansas
DATE RECD MAR 05 1993
DATE APPVD MAR 22 1993
DATE EFF MAR 01 1993
HCFA 179 93-08
A

16. Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age (Continued)

Inpatient psychiatric services reimbursable under the Arkansas Medicaid Program must be provided:

- by an Inpatient Psychiatric Provider selected by the recipient;
- by an Inpatient Psychiatric Provider enrolled in the Arkansas Medicaid Program;
- to an eligible Arkansas Medicaid recipient before the recipient reaches age 21 or, if the recipient was receiving inpatient psychiatric services at the time they reached 21 years of age, services may continue until the recipient no longer requires the services or the recipient becomes 22 years of age, whichever comes first.
- with certification from the independent or facility based team (whichever is appropriate in accordance with 42 CFR 441.153) that the recipient meets the criteria for inpatient psychiatric services;
- with prior authorization from the Medicaid Agency Review Team and
- under the direction of a physician (contracted physicians are acceptable).

STATE Arkansas
DATE REC'D 9-23-91
DATE APP'D 10-21-91
DATE EFF 10-1-91
HCFA ID 91-45
Supersedes: 88-04

A

17. Nurse-Midwife Services

Any person possessing the qualifications for a registered nurse in the State of Arkansas who is also certified as a nurse-midwife by the American College of Nurse-Midwives, upon application and payment of the requisite fees to the Arkansas State Board of Nursing, be qualified for licensure as a certified nurse-midwife. A certified nurse-midwife meeting the requirements of Arkansas Act 409 of 1995 is authorized to practice nurse-midwifery.

Services provided by a certified nurse midwife are limited to twelve (12) visits a year for **beneficiaries** age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, office medical services furnished by an optometrist **and services provided by an advanced practice nurse or registered nurse practitioner or a combination of the six**. For services beyond the twelve visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. **Beneficiaries** under age 21 in the Child Health Services (EPSDT) program are not benefit limited.

STATE Arkansas
DATE REC'D 9/30/08
DATE APPV'D 12/19/08
DATE EFF 8/1/08
HCFA 179 08-18

SUPERSEDES TN 04-12

18. Hospice Care

- The hospice patient must be terminally ill which is defined as having a medical prognosis with a life expectancy of six months or less. The terminal illness must be certified by the patient's attending physician and hospice services prescribed.

- Patients must voluntarily elect to receive hospice services and choose the hospice provider. Hospice election is by "election periods". Election periods in the Arkansas Medicaid Hospice Program correspond to the election periods established for Medicare. The initial hospice election period is of 90 days duration and is followed by a second 90-day election period. The patient is then eligible for an unlimited number of 60-day election periods.

- Election of the hospice benefit results in a waiver of the **beneficiary's** rights to payment for only those services which are related to the treatment of the terminal illness or related conditions and common to both Title XVIII and Title XIX. The **beneficiary** does not waive rights to payment for services related to the terminal illness that are unique to Title XIX.

- Hospice services must be provided primarily in a patient's residence.

  A patient may elect to receive hospice services in a nursing facility **or an intermediate care facility for the mentally retarded (ICF/MR)** if the hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the patient's hospice care, and the facility agrees to provide room and board to the patient.

- Hospice services must be provided consistent with a written plan of care.

- Dually eligible (Medicare and Medicaid) **beneficiaries** must elect hospice care in the Medicare and Medicaid hospice program simultaneously to be eligible for Medicaid hospice services.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations*

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

X Provided: ___ Additional coverage++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided: X Additional coverage++ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: No limitations X With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

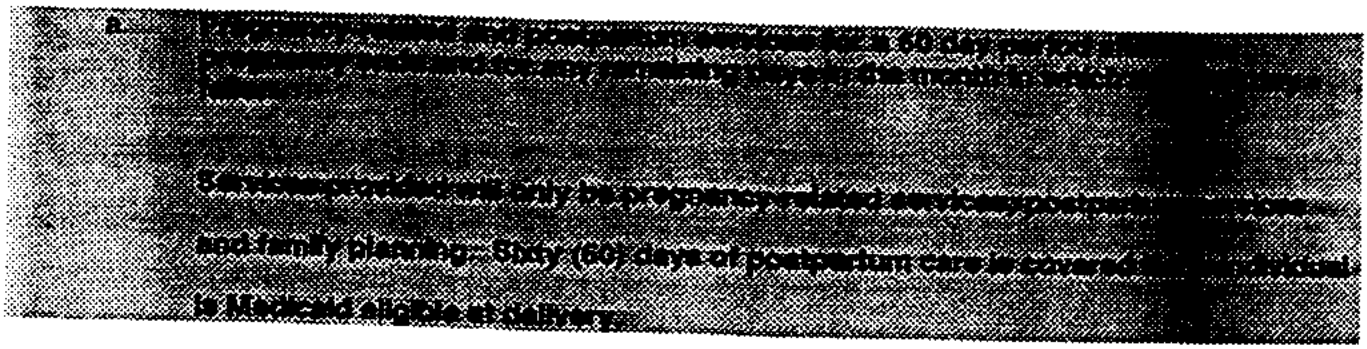
STATE Arkansas
DATE REC'D 9-12-94
DATE APPV'D 9-15-94
EFFECTIVE DATE 9-1-94
HCFA ID: A

TN No. 94-22
Supersedes TN No. 94-12
Approval Date 9/15/94
Effective Date 94-22

19. Case Management Services

Refer to Supplement 1 to Attachment 3.1-A.

20. Extended Services for Pregnant Women



b. Services for any other medical conditions that may complicate pregnancy.

(1) Risk Assessment

A medical, nutritional, and psychosocial assessment by the physician or registered nurse to designate patients as high or low risk.

(a) Medical assessment using the Hollister Maternal/Newborn Record System to include:
- medical history
- menstrual history
- pregnancy history

(b) Nutritional assessment to include:
- 24 hour diet recall
- screening for anemia
- weight history

(c) Psychosocial assessment to include criteria for an identification of psychosocial problems which may adversely affect the patient's health status.

STATE Arkansas
DATE REC'D SEP 12 1991
DATE APPV'D OCT 16 1991
DATE EFF OCT - 1 1991
HCFA I.D. 91-43
A

Supersedes: 90-04

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(1) Risk Assessment (Continued)

Pregnant women who are assessed as high risk, by definition, have medical conditions or circumstances which complicate the pregnancy. These patients need more medical services and attention in an effort to ensure a healthy birth outcome. Some conditions which complicate the pregnancy, and are therefore considered high risk, are:

Teenage pregnancies
Diabetes
Toxemia

MAXIMUM: 2 per pregnancy

(2) Case Management Services

Refer to Item 19 and Supplement 1 to Attachment 3.1-A.

Case Management services are reimbursed using a monthly rate. A minimum of 2 contacts per month must be provided. Case management is triggered by risk assessment and care plan development. A case management contact may be with the patient, other professionals, family and/or other caregivers.

STATE Arkansas
DATE REC'D 7-29-91
DATE APPV'D 8-22-91
DATE EFF 7-1-91
HCFA 179 91-30

A

Arkansas-0...-87-12

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(3) Perinatal Education

Educational classes provided by a health professional (Public Health Nurse, Nutritionist, or Health Educator) to include:

- pregnancy
- labor and delivery
- reproductive health
- postpartum care
- nutrition in pregnancy

These educational classes are designed to prevent the development of conditions which may complicate the pregnancy or to provide information to the pregnant woman in caring for herself during a pregnancy which may already have complicating factors.

MAXIMUM: 6 classes (units) per pregnancy

STATE AR
DATE RCV'D JUL 1 1987
DATE APPV'D JUL 30 1987
DATE EFF See HCFA-179
HCFA 179 87-12

A.

Supersedes 86-26

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(4) Nutritional Consultation - Individual

Services provided for high risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration to include at least one of the following:

- an evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
- nutritional care plan follow-up and reassessment as indicated

By definition, this service is covered only for women with high risk pregnancies. This service is appropriate for women whose complications require nutritional education for treatment of the complication (such as diabetics).

MAXIMUM: 9 units per pregnancy (1 unit equals 1 client visit)

STATE AR
DATE REC'D JUL 1 1987
DATE APPV'D JUL 20 1987
DATE EFF See HCFA-179
HCFA 179 87-12
A
New Page

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(5) Social Work Consultation

Services provided for high risk pregnant women by a licensed social work to include at least one of the following:

- an evaluation to determine health risks due to psychosocial factors with development of a social work care plan
- social work plan follow-up, appropriate intervention and referrals

By definition, this service is only covered for women with high risk pregnancies. This service is appropriate for women whose complications require social work consultation as an essential element of treatment in dealing with the complication (such as a teenager with no place to live).

MAXIMUM: 6 units per pregnancy (1 unit equals 1 client visit)

STATE AR	
DATE RECD JUL 1 1987	
DATE APPVD JUL 30 1987	A
DATE EFF See HCFA-179	
HCFA ID 87-12	

new page

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(6) Early Discharge Home Visit

If a physician chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours), the physician or registered nurse employee may provide a home visit to the mother and baby within 72 hours of the hospital discharge; or the physician may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by physician order (includes hospital discharge order).

A physician may order a home visit for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

These services are preventive in nature to try to avoid post-partum complications.

(7) Pregnancy-Related Substance Abuse Treatment Services (SATS)

Pregnancy-Related Substance Abuse Treatment Services (SATS) are provided for Medicaid eligible pregnant women through the last day of the month in which the 60th post partum day falls. Services are provided based on medical necessity and require prior authorization.

The SATS program covers the following services:

A. Addiction Assessment
B. Treatment Planning
C. Care Coordination
D. Multi-person (family) Group Counseling
E. Individual Counseling
F. Group Counseling
G. Marital/Family Counseling
H. Medication Management

Please refer to Attachment 3.1-A, Page 1zz.3 for the service descriptions, definitions, benefit limits and individual qualified provider requirements. Benefit limits may be extended based on medical necessity.

SATS Qualified Provider

SATS providers must hold certification from the Division of Behavioral Health Services (DBHS) as a SATS provider in order to enroll as a Substance Abuse Treatment Services Medicaid provider.

The following requirements must be met for DBHS/OADAP certification:

A. Providers must be licensed by Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (OADAP).

B. Providers must submit a written request from the organization's Chief Executive Officer (CEO) to DBHS for certification by DBHS as a SATS Provider.

20. Extended Services for Pregnant Women (Continued)

b. Services for any other medical conditions that may complicate pregnancy. (Continued)

(7) Pregnancy-Related Substance Abuse Treatment Services (SATS) (Continued)

C. The request for certification by DBHS must include a copy of the provider's accreditation, most recent accreditation survey, and correspondence between the provider and the accrediting organization since the most recent accreditation survey.

D. A list of service delivery sites, including each site's address, telephone number, and fax number must be submitted. Each site from which SATS services are delivered must be included under the provider's accreditation. Proof of this accreditation must be submitted with the request for certification of a site.

E. Current CARF, JCAHO, or COA, *that includes accreditation of the pertinent outpatient alcohol and/or other drug abuse treatment component* (OADAP Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs p. 11). Current nationally accredited behavioral health programs without specific alcohol and drug treatment certification will need to obtain accreditation of their substance abuse program prior to receiving certification as a SATS provider of substance abuse treatment.

F. Provisional, Conditional, Preliminary, Pending, Expedited or Deferred Accreditations are not acceptable.

G. The provider must: notify its accrediting organization in writing of all new or additional SATS services implemented subsequent to the provider's most recent accreditation survey; provide DBHS with a copy of the notification letter; and affirm in writing to DBHS that the new service(s) will be included in the provider's next regularly scheduled accreditation survey, if not surveyed before that time. Provider organization opening new services sites must follow DBHS certification policy and procedures.

H. DBHS must be authorized to receive information directly from the accrediting organization and to provide information directly to the accrediting organization, as it relates to SATS. DBHS will furnish these documents to providers at their request.

I. DBHS retains the right to request information in connection with licensure, accreditation, certification, provision or billing of SATS services; to perform site visits at anytime; and to conduct scheduled or unannounced visits, to insure entities are providing SATS services in accordance with the information that was submitted to DBHS. During a site visit the provider must allow access to all sites, policies and procedures, patient records, financial records, and any other documentation necessary to ascertain that services were/are of a quality which meets professionally recognized standards of health care.

J. Providers must adhere to evidence-based practices as approved by DBHS for specific populations and services provided.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

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22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☒ **Provided:** ☐ No limitations ☒ With limitations*** with Prior Authorization**

☐ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ with limitations*

☒ Not provided.

c. Care and services provided in Christian Science sanitoria.

☐ Provided: ☐ No limitations ☐ with limitations*

☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

f. Critical Access Hospital (CAH).

☒ Provided: ☐ No limitations ☒ with limitations*

☐ Not provided.

*Description provided on attachment.

21. Pediatric or family nurse practitioners' services as defined in Section 1905(a)(21) of the Act (added by Section 6405 of OBRA '89).

Services are limited to 12 nurse practitioner visits per State Fiscal Year, July 1 through June 30. This yearly limit does not apply to recipients in the Child Health Services (EPSDT) program.

Refer to Attachment 3.1-B, Item 6.d.(6) for obstetric-gynecologic and gerontological nurse practitioner services.

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).

Respiratory care for ventilator-dependent individuals means services that are not otherwise available under the State's Medicaid plan, provided on a part-time basis in the recipient's home by a respiratory therapist or other health care professional trained in respiratory therapy to an individual who---

a. Is medically dependent on a ventilator for life support at least 6 hours per day;
b. Has been so dependent for at least a number of consecutive days (number is based on maximum number of days authorized under the State plan, whichever is less) as an inpatient in one or more hospitals, NFs, or ICFs/MR;
c. Except for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, NF, or ICF/MR and would be eligible to have payment made for inpatient care under the State plan;
d. Has adequate social support services to be cared for at home;
e. Wishes to be cared for at home; and
f. Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support, and who has medically determined that in-home care is safe and feasible for the individual.

1. Ventilator Equipment (i.e., ventilator, suction pump, oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, ventilator supplies and hospital bed) including 24-hour availability of respiratory therapy and equipment maintenance, with prior authorization.

2. **Respiratory therapy/treatment services for ventilator-dependent recipients under age 21, with prior authorization.**

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

(1) A. Ground Ambulance Services

Payment will be made for ambulance services, provided the conditions below are met and the services are provided in accordance with laws, regulations and guidelines governing ambulance services under Part B of Medicare. These services are equally available to all beneficiaries. The use of medical transportation must be for health-related purposes and reimbursement will not be made directly to Title XIX beneficiaries.

I. For transportation of **beneficiaries** when medically necessary as certified by a physician to a hospital, to a nursing home from the hospital or **beneficiary's** home, to the **beneficiary's** home from the hospital or nursing home, from a hospital (after receiving emergency outpatient treatment) to a nursing home if a **beneficiary** is bedridden and from a nursing home to another nursing home if determined necessary by the Office of Long Term Care. Emergency service is covered only through licensed emergency ambulance companies. Services not allowed by Title XVIII but covered under Medicaid will be **reimbursed** for Medicare/Medicaid **beneficiaries**.

II. For services provided at an alternative location or destination to which an ambulance is dispatched, and the ambulance service treatment is initiated from a 911 call that is documented in the records of the ambulance service. Alternative destination means a lower-acuity facility that provides medical services.

Alternative location is the location to which an ambulance is dispatched, and the ambulance service treatment is initiated from a 911 call that is documented in the records of the ambulance service. Alternative destination means a lower-acuity facility that provides medical services, including:

- **A federally qualified health center;**
- **An urgent care center;**
- **A physician's office or medical clinic, as chosen by the beneficiary;**
- **A behavioral or mental healthcare facility**

Excluded alternative destinations are facilities that provide a higher-acuity medical service or medical services for a routine chronic condition, such that they would be considered as destinations for which transportation under (1) above would occur:

- **Emergency Room;**
- **Critical Access Hospital;**
- **Rural Emergency Hospital;**
- **Dialysis center;**
- **Hospital;**
- **Private residence;**
- **Skilled nursing facility**

B. Air Ambulance Services

Air ambulance services are provided to Arkansas Medicaid beneficiaries only in emergencies.

Air ambulance providers must be licensed by the Arkansas Ambulance Boards and enrolled as a Title XVIII, Medicare Provider.

(2) Early Intervention Day Treatment (EIDT) and Adult Developmental Day Treatment (ADDT) Transportation

EIDT and ADDT providers may provide transportation to and from their facility. The Medicaid transportation broker must provide transportation to and from the nearest qualified medical provider for the purpose of obtaining medical treatment.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

STATE Arkansas
DATE REC'D 10-20-05
DATE APPV'D 11-17-05
DATE EFF 1-1-06
HCFA 179 05-10
A

a. Transportation (Continued)

(3) Non-Emergency

(a) Public Transportation

Effective for dates of service on or after December 1, 2001, public transportation services are available when provided by an enrolled Medicaid public transportation provider to an eligible Medicaid **beneficiary** being transported to or from a medical facility to receive medical care services covered by the Arkansas Medicaid Program. Transportation will be covered from the point of pick-up to the medical facility or from the medical facility to the point of delivery. The following benefit limits are established. One unit of service = 1 mile. The benefit limits do not apply to EPSDT **beneficiaries**.

Effective for dates of service on or after January 1, 2006, public transportation services are available when provided by an enrolled Medicaid public transportation provider to a full benefit dual eligible being transported to or from a pharmacy to receive prescriptions covered under the Medicare Prescription Drug Benefit- Part D.

- Public Transportation, Taxi, Intra-City, One Way - may be billed once per day, per **beneficiary** for a maximum of 15 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.

- Public Transportation, Taxi, Intra-City, Round Trip - may be billed once per day, per **beneficiary** for a maximum of 30 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.

- Public Transportation, City-to-City - may be billed once per day, per **beneficiary** for a maximum of 50 units. Extensions of the established benefit limits will be considered if medically necessary. The provider must request an extension.

- Public Transportation, ADA Accessible Van, Intra-City, One Way - may be billed once per day, per **beneficiary** for a maximum of 15 units. The provider may request an Extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

STATE Arkansas
DATE REC'D 10-20-05
DATE APPV'D 11-17-05
DATE EFF 1-1-06
HCFA 179 05-10
A

(3) Non-Emergency (Continued)

(a) Public Transportation (Continued)

- Public Transportation, ADA Accessible Van, Intra-City, Round Trip - may be billed once per day, per **beneficiary** for a maximum of 30 units. The provider may request an Extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.

- Public Transportation, ADA Accessible Van, Intrastate Authority - may be billed once per day, per **beneficiary** for a maximum of 50 units. The provider may request an extension of the benefit limit if medically necessary by submitting documentation including the purpose of the trip and the provider's name and address.

(b) Non-Public Transportation

Effective for dates of service on or after December 1, 2001, non-public transportation services are available when provided by an enrolled Medicaid transportation provider to an eligible Medicaid **beneficiary** transported to or from a medical provider to receive medical services covered by the Arkansas Medicaid Program. Transportation will be covered from the point of pick-up to the medical service delivery site and from the medical service delivery site to the recipient's return destination.

Effective for dates of service on or after January 1, 2006, non-public transportation services are available when provided by an enrolled Medicaid non-public transportation provider to a full benefit dual eligible being transported to or from a pharmacy to receive prescriptions covered under the Medicare Prescription Drug Benefit- Part D.

The following benefit limits are established. The benefit limits do not apply to EPSDT **beneficiaries**.

This service may be billed once per day, per **beneficiary** for a maximum of 300 miles per date of service.

SUPERSEDES TN 01-22

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Volunteer Transportation

Volunteer carriers are reimbursed for providing transportation to recipients to medical services provided the carriers are registered by the Arkansas Department of Human Services and Medical Services and the medical services are part of the case plan. A General Relief check is issued by local Human Services staff for payment of Medicaid transportation if a licensed carrier is not available.

These services may be billed once per day, per recipient for a maximum of 300 miles per day. The benefit limit does not apply to EPSDT recipients.

b. Services of Christian Science Nurses - Not Provided.

c. Care and services provided in Christian Science sanitoria - Not Provided.

d. Nursing facility services provided for patients under 21 years of age - Not Provided.

e. Emergency Hospital Services

Limited to immediate treatment and removal of patient to a qualifying hospital as soon as patient's condition warrants.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

f. Critical Access Hospital (CAH)

Services that are furnished by an instate provider that meets the requirements for participation in Medicaid as a CAH and are of a type that would be covered by Medicaid if furnished by a Medicaid enrolled instate hospital to a Medicaid recipient. Services that are not permitted under CAH licensure requirements are not covered by Medicaid.

Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

CAH services are subject to the same benefit limits as inpatient and outpatient hospital services as described in Attachment 3.1-B, Items 1 and 2a.

STATE Arkansas
DATE RECD 05-30-01
DATE APPV'D 08-03-01
DATE EFF 08-01-01
HCFA I.D. AR-01-14

A

24. **RESERVED**

STATE Arkansas
DATE REC'D 9/28/06
DATE APPVD 12/19/06
DATE EFF 8/1/06
HCFA 179 08-15
SUPERSEDES TN 92-32

A

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ with limitations*

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ with limitations*

c. Care and services provided in Christian Science sanitoria.

☐ Provided: ☐ No limitations ☐ with limitations*

d. Nursing facility services for patients under 21 years of age.

☐ Provided: ☐ No limitations ☐ with limitations*

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ with limitations*

f. Personal care services in recipient's home prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ with limitations*

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

Arkansas
DEC 07 1992
DEC 23 1992
OCT 01 1992
92-41
A

TN No. 92-41
Supersedes TN No. New Page Approval Date DEC 23 1992 Effective Date OCT 01 1992

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

Not Provided

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

_____ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

__X__ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

1905(a)(26) and 1934

_____ Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

27. Program of All-Inclusive Care for the Elderly (PACE)

Not Provided

STATE Arkansas
DATE REC'D 1-28-08
DATE APPV'D 3-28-08
DATE EFF 1-1-08
HCFA 179 07-23

A

SUPERSEDES: NONE - NEW PAGE

28. Self-Directed Personal Assistance Services

___ Self-Directed Personal Assistance Services, as described in Supplement ___ to Attachment 3.1-B.

____ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

__X__ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option for Medically Needy.

STATE ARKANSAS
DATE REC'D 1-28-08
DATE APP'D 3-28-08
DATE EFF 4-1-08
HCFA 179 07-23

A

SUPERSEDES: NONE - NEW PAGE

28. Self-Directed Personal Assistance Services

Not Provided

SUPERSEDES: NONE - NEW PAGE

STATE ARKANSAS
DATE RECD 1-28-08
DATE APPV'D 3-28-08
DATE EFF 4-1-08
HCFA 179 07-23
A

29. Telemedicine Services

Telemedicine is the use of electronic information and communication healthcare technology to deliver healthcare services including without limitation, the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. Telemedicine includes store-and-forward technology and remote patient monitoring.

State/Territory:
Arkansas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: ___X

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

_X__Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

_X__A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

_X__A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1-B Amount, Duration, and Scope of Services

[Please check the box below to indicate if this benefit is provided for the categorically needy (3.1-A) or medically needy only (3.1-B)]

☒ 1905(a)(29) MAT as described and limited in __Supplement 1 __ to Attachment 3.1-B.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

General Assurances
[Select all three checkboxes below.]

☒ MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020.

☒ The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

☒ The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

Service Package
The state covers the following counseling services and behavioral health therapies as part of MAT: [**Please describe in the text fields as indicated below.]**

Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

Individual Behavioral Health Counseling, Group Behavioral Health Counseling, Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants, and Nurse Practitioners may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT), This group's role is to provide the behavioral and substance use disorder counseling required

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Licensed in Arkansas. Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute. Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

Section 1905(a)(29) Medication Assisted Treatment (MAT)

Utilization Controls
[Select all applicable checkboxes below.]

☒ The state has drug utilization controls in place. (Check each of the following that apply)

- ☐ Generic first policy
- ☒ Preferred drug lists
- ☐ Clinical criteria
- ☒ Quantity limits

☐ The state does not have drug utilization controls in place.

Limitations
[Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.]

Quantity limits for MAT drugs are set per label. The oral drugs have a therapeutic duplication edit to prevent multiple buprenorphine oral dosage forms. There are no hard limitations for counseling and behavioral therapies related to MAT because authorizations of medically necessary services are available.

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section §1905(a)(29) of the Social Security Act. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #68). Public burden for all of the collection of information requirements under this control number is estimated to take about 25 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

1905(a)(13)(B) - Attestation for Vaccines and Vaccine Administration

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration.

Arkansas maintains a method of monitoring ACIP notifications of changes to recommendations to ensure that coverage and billing codes are updated to comply with those revisions.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

__**X**_ Entire State

___ Only in the following geographic areas:

C. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

_**X**__ Services are not comparable in amount duration and scope (§1915(g)(1)).

D. Definition of services (42 CFR 440.169):

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management may be delivered through home visits and includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual's needs and completing related documentation; and
   - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
   - Assessments/Reassessments are required at least annually.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definitions of Services (continued)

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible individual;
   - Care plans must be updated/renewed at least annually.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
   - Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

4. Monitoring and follow-up activities:
   - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's care plan;
     - Services in the care plan are adequate; and
     - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

D. Definition of Services (continued)

Case managers will continue to monitor and follow-up on the care plan while conducting case management activities, including assessments, referrals and linkages to service providers, during visits. The visits may be as frequent as needed by the client but must be at least every 30 days, which will allow regular assessment of the plan implementation. The case manager will assess the services or community resources received and adequacy of the services. The case manager also will identify the beneficiaries' action steps, determine whether they require additional support or adjustments of services or activities and document relevant activities/changes. At least annually the care plan must be fully reviewed with beneficiaries to ensure the activities are relevant, appropriate and are being followed and update the plan as necessary. Beneficiary interviews may occur through a home visit, face-to face office visit, or other contact method that allows gathering the information needed.

_X__Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Hospital providers licensed as general hospitals with an obstetrics unit with a model recognized by the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HOMEVEE) program to be effective in improving maternal and child health that have applied and been approved to become Maternal Life360 providers. The hospital may use its own staff or subcontract for case management. Case managers employed by the hospital will have no direct relationship with the inpatient department, and case management services will not be provided by the inpatient or acute unit of the hospital. Case managers will be focused on the person-centered care delivered for the beneficiaries in the community and will not duplicate coordination provided through other hospital-delivered services. Case managers delivering this benefit must be able to provide all components of targeted case management within their scope of practice. Case managers must also meet the following criteria:

- A minimum or a high school diploma or GED and experience with early childhood education, childhood development, or social work, family support, maternity, or case management services, or demonstrated comparable experience or competency through educational or other professional activities to provide the required TCM services for the population.

F. Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

H. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

I. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

J. Monitoring

Providers must meet established standards that measure services under this program/state plan service to eligible beneficiaries. The State will monitor performance on these standards through monthly expenditure reporting and quarterly progress reporting. Providers will use the MMIS to enroll individuals and enter visits provided in order to monitor individual enrollment and services rendered. The state will also review quality metrics for individual provider- and system-level goals.

The state will ensure that providers meet acceptable performance, including the process and health outcomes and case documentation/program reporting, and will address any identified non-compliance for these services. Audits will ensure case records are maintained as required.

K. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-C

STATE ARKANSAS

STANDARDS AND METHOD OF ASSURING HIGH QUALITY CARE

Revised: April 1, 1979

The following is a description of the methods that will be used to assure that the medical and remedial care and services are of high quality, and a description of the standards established by the State to assure high quality care:

a. Institutional care will be provided by facilities qualified to participate in Title XVIII and/or Title XIX;

b. Practitioners will be licensed by the State;

c. Medical institutions will be licensed by the State;

d. Patients can obtain needed medical services from the facility which, in the judgment of competent medical authority, is best able to meet their medical needs whether the facility is in or outside the State;

e. The scope of care and services offered includes the use of specialists and consultative services (board certified or board eligible);

f. The medical unit will continuously review and evaluate the utilization and equality of medical care and services;

g. The Peer Review Committees, at frequent intervals will review reports of care and services provided and make recommendations to the agency and to the health care disciplines involved concerning the appropriateness and/or utilization of the care and services offered or needed;

h. The Office of Long Term Care will provide for medical evaluation of each patient's need for long term care and services pursuant to Sec. 1902 (a)(26) of the Social Security Act of 1968, as amended; and

i. The Agency will impose Administrative Remedies and Sanctions, as contained in State regulations, against those providers who fail to comply with all federal/state laws, rules, and regulations of the Medicaid Program.

Sub. No. 79-5 Item No. 30

Approved by R. O. 2-15-80

The State Agency will provide that any individual eligible for medical assistance may obtain such assistance from any institution, agency or person qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services and who has signed an agreement to participate in the Medicaid Program.

Sub. No. 79-5 Item No. 30
Approved by R. O. 2-15-80

METHODS OF PROVIDING TRANSPORTATION

Revised: February 1, 2003

The Arkansas Division of Medical Services assures that necessary transportation of recipients to and from providers of service will be provided. The methods that will be used are as follows:

Any appropriate means of transportation which can be secured without charge through volunteer organizations, public services such as fire department s and public ambulance, or relatives will be used. If transportation is not available without charge, payment will be made for the least expensive means of transportation suitable to the recipient.

SUPERSEDES: TN- 86-23

STATE Arkansas	A
DATE RECD 2-19-03	
DATE APP'VD 4-29-03	
DATE EFF 2-1-03	
HCFA 179 03-03	

State/Territory: ARKANSAS

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The Arkansas Medicaid Program covers Corneal Transplants, Renal Transplants, Heart Transplants, Liver Transplants, Non-Experimental Bone Marrow Transplants and Lung Transplants for eligible Medicaid recipients of all ages. Pancreas/Kidney Transplants, **Liver/Bowel Transplants** and Skin Transplants for Burns are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

Corneal Transplants

Corneal transplants require prior authorization. Medicaid will pay for hospitalization, physician services and follow-up care when associated with corneal transplants. Covered benefits include the acquisition and preservation of the organ from a cadaver donor. Corneal transplants are subject to the same inpatient hospital, outpatient and physician benefit limits as all other covered inpatient, outpatient and physician services.

Renal Transplants

Renal transplants require prior authorization. Benefits are provided for the following services related to renal transplantation:

- Hospitalization and physician services for the removal of the organ from the living donor.
- Harvesting of the organ for renal transplant from a cadaver donor is reimbursed through the hospital cost settlement process.
- Transportation and preservation of the organ from a living or cadaver donor.
- Hospitalization and physician services for transplanting kidney into the receiver.
- Follow-up care.

Renal transplants are subject to the same inpatient hospital, outpatient and physician benefit limits as all other inpatient, outpatient and physician services for both donor and receiver.

SUPERSEDES TN 94-18

STATE Arkansas
DATE REC'D 12-8-04
DATE APPV'D 2-15-05
DATE EFF 12-3-04
HCFA 179 04-15

A

STANDARDS FOR THE COVERAGE OF
ORGAN TRANSPLANT SERVICES

Revised: December 3, 2004

Heart Transplants

Heart transplants require prior authorization. Benefits are provided for the following services related to heart transplantation:

- Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.
- Hospitalization and physician services for transplanting the heart into the receiver.
- Post-operative care until discharged from the hospital.

Liver and Liver/Bowel Transplants

Liver **and liver/bowel** transplants require prior authorization. **Liver/Bowel transplants are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program.** Benefits are provided for the following services related to liver **and liver/bowel** transplantation:

- Hospitalization and physician services for the removal of the organ from a living donor.
- Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.
- Hospitalization and physician services for transplanting the liver **and liver/bowel** into the receiver.
- Post-operative care until discharged from the hospital.

Heart, Liver **and Liver/Bowel** Transplants are not subject to the established benefit limits for inpatient hospital services described elsewhere in the State Plan. Services excluded from the inpatient benefit limit are those services provided from the date of the transplant procedure to the date of discharge. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

SUPERSEDES TN. 92-31

STATE Arkansas	A
DATE REC'D 12-8-04	
DATE APPV'D 2-15-05	
DATE EFF 12-3-04	
HCFA 179 04-15	

STANDARDS FOR THE COVERAGE OF
ORGAN TRANSPLANT SERVICES

Revised: December 1, 1991

Bone Marrow Transplants

Bone Marrow transplants which the board certified specialist at the PRO determine appropriate are covered with prior authorization. Benefits are provided for the following services related to bone marrow transplantation:

- Hospitalization and physician services for the removal of the bone marrow.
- Hospitalization and physician services for transplanting the bone marrow into the receiver.
- Post-operative care until discharged from the hospital.

Bone Marrow Transplants are not subject to the established benefit limit for inpatient hospital services described elsewhere in the State Plan. Services excluded from the inpatient benefit limit are those services provided from the date of admission for the transplant procedure to the date of discharge. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

STATE Arkansas
DATE REC'D DEC 30 1991
DATE APP'D JUN 23 1992
DATE EFF DEC 01 1991
HCFA I/D 91-62
A

Supersedes 91-39

STANDARDS FOR THE COVERAGE OF
ORGAN TRANSPLANT SERVICES

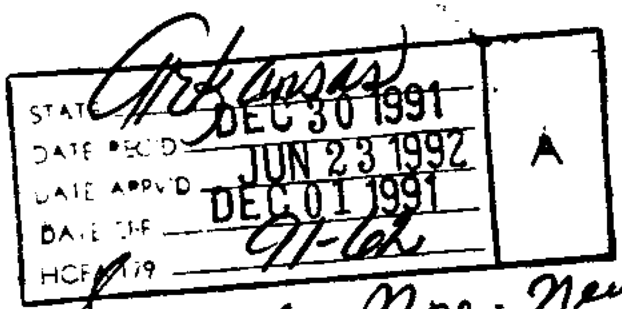
Revised: December 1, 1991

Pancreas/Kidney Transplants

Pancreas/kidney transplants are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program with a diagnosis of Juvenile Diabetes With Renal Failure. Prior authorization is required. Benefits are provided for the following services related to pancreas/kidney transplants:

- **Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.**
- **Hospitalization and physician services for transplanting the pancreas/kidney into the receiver.**
- **Post-operative care until discharged from the hospital.**

The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.



Supersedes - None - New Page

STANDARDS FOR THE COVERAGE OF
ORGAN TRANSPLANT SERVICES

Revised: September 1, 1994

Lung Transplants

Lung transplants are covered for eligible Medicaid recipients with prior authorization. Benefits are provided for the following services related to lung transplantation:

- **Procurement (harvesting) of the organ from a cadaver donor. Cost will be included in the hospital charges.**
- **Hospitalization and physician services for transplanting the lung into the receiver.**
- **Post-Operative care until discharge from the hospital.**

The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

STATE Arkansas
DATE REC'D 8-19-94
DATE APPV'D 10-25-94
DATE EFF 9-01-94
HCFA 179 94-18

A

SUPERSEDES: TN 91-62

Skin Transplants for Burns

Skin Transplants for Burns of greater than 70% of the body surface area with more than 50% of that being full thickness or a third degree burn are covered for eligible Medicaid recipients in the Child Health Services (EPSDT) Program. This coverage is for those patients whose burns are so widespread that conventional grafting to cover the burned area is impossible as there is no other available source of skin. Prior authorization is required. Benefits are provided for the following services related to skin transplantation:

- **Hospitalization and physician services for removal of the skin from the donor site.**
- **Hospitalization and physician services for transplanting the skin.**
- **Post-Operative care until discharge from the hospital.**

The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

Transplant criteria is reviewed every six months by the Medical Care Advisory Committee.

STATE Arkansas
DATE RECD DEC 30 1991
DATE APP'D JUN 23 1992
DATE EFF DEC 01 1991
HCFA ID: 91-62

A

Supersedes-None-New Page

State: Arkansas

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Arkansas enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☐ MCO
   a. ☐ Capitation
   b. ☐ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☒ PCCM (individual practitioners)
   a. ☒ Case management fee
   b. ☐ Other (please explain below)

Reimbursement is a set per member per month rate paid through MMIS. There are no performance-based incentive payments in PCCM.

a. The Medicaid beneficiary chooses a primary care physician (PCP) who, through an on-going provider/beneficiary relationship, coordinates health care services, including referrals for necessary specialty services, physician's services, hospital care and other services. The PCCM provider will assist enrollees with locating medical services and coordinate and monitor their enrollees prescribed

Citation	Condition or Requirement

medical and rehabilitation services. PCCM will be mandatory for most Medicaid beneficiaries.

The beneficiaries have a free choice of specialists within the state and bordering states. A beneficiary must enroll with a PCCM whose practice is in the beneficiary's county of residence, a county adjacent to the beneficiary's county of residence or a county adjoining a county adjacent to the beneficiary's county of residence. PCCM providers have free choice of referrals specialists and ancillary providers

Under this PCCM program, the PCCM provider manages the enrolled beneficiary's health by working directly with beneficiaries and their treatment by providing:

1) 24-hour, 7 days per week telephone access to a live voice (an employee of the primary care physician or an answering service). Reasonable 24- hour availability and adequate hours of operation, referral and treatment with respect to medical emergencies.
2) Response to after-hours calls regarding non-emergencies must be within 30 minutes.
    - PCPs must make the after-hours telephone number as widely available as possible to their patients.
    - When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up-to-date.
    - PCPs in underserved and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone.
    - As regards access to services, PCPs are required to provide the same level of service for their ConnectCare enrollees as they provide for their insured and private-pay patients.
    - Physicians and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations and any other pertinent information to the PCP for inclusion in the patient's medical record.
    - A PCP may not refer ConnectCare enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

Citation	Condition or Requirement

3) Increases to the beneficiaries' and/or their caregivers' understanding of their disease so that they are:

- Better able to understand their disease
- Better able to access regular preventative health care by improving their self-management skills
- Better able to understand the appropriate use of resources needed to care for their disease
- Better able to improve the beneficiary's quality of life by assisting them in self-managing their disease and in accessing regular preventative health care.

b. Arkansas Department of Human Services engages a network of credentialed primary care physicians to meet medical needs for enrolled beneficiaries. The PCCM provider is responsible for overall health care services for beneficiaries.

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans.
☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
☐ Oversight responsibilities for the activities of FFS providers in the FFS program
☐ Provision of payments to FFS providers on behalf of the State.
☐ Provision of enrollee outreach and education activities.
☐ Operation of a customer service call center.
☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

State: Arkansas

Citation	Condition or Requirement

☐ Coordination with behavioral health systems/providers.
☐ Coordination with long-term services and supports systems/providers.
☐ Other (please describe): _____

42 CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*
If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

A statewide promulgation process was completed in 2013, which allowed for a 30-day public comment period. At the time the state consulted with the State Medical Care Advisory Committee. The beneficiary has the right to appeal or grieve through the Division of Medical Services or Office of Chief Counsel.

D. State Assurances and Compliance with the Statute and Regulations.
If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ☐ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ☒ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. ☐ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

State: Arkansas

Citation	Condition or Requirement
42 CFR 438.10(g)(2)(vii)	
1932(a)(1)(A)	5. ☐ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CFR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ☐ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	8. ☒ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.
45 CFR 75.326	9. ☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements: ☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.
1932(a)(1)(A) 1932(a)(2)	E. <u>Populations and Geographic Area.</u> 1. **<u>Included Populations.</u>** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

State: Arkansas

Citation | Condition or Requirement

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
2. Pregnant Women	§435.116	X			Statewide	Required to enroll with a PCCM only if they need non-obstetrical services which require a PCP referral.
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	X			Statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X				Required only if deemed medically frail
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			Statewide	

State: Arkansas

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X			Statewide	Exclude Medicare Beneficiaries.
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A—AR is a 1634 State.
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X			Statewide	Exclude Medicare Beneficiaries.
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137	X			Statewide	Exclude Medicare Beneficiaries.
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138	X			Statewide	Exclude Medicare Beneficiaries.
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X			Statewide	Exclude Medicare Beneficiaries.
14. Disabled Adult Children	1634(c) of SSA	X			Statewide	

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229					N/A
3. Independent Foster Care Adolescents Under Age 21	§435.226					N/A
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A
5. Optional Reasonable Classifications of Children Under Age 21	§435.222					N/A
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A

State: Arkansas

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230					N/A
8. Individuals eligible for Cash except for Institutionalized Status	§435.211			X		
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			X		
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					N/A
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236			X		
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			X		
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA			X		Institutionalized
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA	X			Statewide	Exclude Medicare Beneficiaries. (AR entitles ARSeniors)
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA					N/A
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA	X			Statewide	Exclude Medicare Beneficiaries. (AR entitles Workers with Disabilities)
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219			X		

State: Arkansas

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214					N/A
22. Individuals with Tuberculosis	§435.215					N/A
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213					N/A

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)			X		
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)			X		
3. Medically Needy Children Age 18 through 20	§435.308					N/A
4. Medically Needy Parents and Other Caretaker Relatives	§435.310			X		
5. Medically Needy Aged	§435.320			X		
6. Medically Needy Blind	§435.322			X		
7. Medically Needy Disabled	§435.324			X		
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					N/A

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X		

State: Arkansas

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X		
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	X		Statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA	X		Statewide	This population is covered under 1115 TEFRA Waiver
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	X		Statewide	
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227	X		Statewide	
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.		X		Statewide	

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

State: Arkansas

Citation | Condition or Requirement

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance		X	
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		X	
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		X	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define):			

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specicifed in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

      State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.
      i. Please indicate the length of the enrollment choice period:

State: Arkansas

Citation	Condition or Requirement

c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
   i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).
   ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

_____

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

Medicaid provides the Arkansas Medicaid Handbook online through Medicaid.mmis.arkansas.gov as well as by simply typing in AR Medicaid handbook. This handbook provides information on how to enroll in Medicaid and how to contact ConnectCare, who assists our beneficiaries as well as providers in enrollment, and change of primary care provider. The Handbook provides all information that may be needed as to definitions, coverage, and how to reach a customer representative. Our contractor AFMC, who also holds the contract for ConnectCare, provides education sessions across the state for Medicaid beneficiaries through AFMC Medicaid Beneficiary Education. Each enrollee also receives notification by either mail or email of rights and processes to choose or change providers as well as how to access coverage and definitions.

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
      i. Please indicate the length of the enrollment choice period:

_____

   c. ☐ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
      i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

State: Arkansas

Citation	Condition or Requirement

d. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

1932(a)(4)
42 CFR 438.54

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

42 CFR 438.52

a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52:

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
ii. Medicaid beneficiaries with mandatory enrollment in a primary care casse management system will have a choice of at least two primary care case managers employed by or contracted with the State;
iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.56(g)

c. ☐ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☒ This provision is not applicable to this 1932 State Plan Amendment.

State: Arkansas

Citation	Condition or Requirement
42 CFR 438.71	d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.
1932(a)(4) 42 CFR 438.56	G. Disenrollment. 1. The state will☐/ will not☒ limit disenrollment for managed care.
	2. The disenrollment limitation will apply for N/A (up to 12 months).
	3. ☒ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.
	4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)* A letter or email (recipient's choice) is sent to the recipient from ConnectCare when the recipient is first enrolled in Medicaid. The letter/email informs the recipient of who their PCP/PCCM is and how to disenroll or change their PCP/PCCM.
	5. Describe any additional circumstances of "cause" for disenrollment (if any).
	H. Information Requirements for Beneficiaries.
1932(a)(5)(c) 42 CFR 438.50 42 CFR 438.10	☒ The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	I. List all benefits for which the MCO is responsible. Complete the chart below to indicate every State Plan-Approved services that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary. In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State: Arkansas

Citation | Condition or Requirement

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Ex. Physical Therapy	*3.1-A*	*4*	*11.a*

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☐ The state assures that each MCO has established an internal grievance and appeal system for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.62
42 CFR 438.68
42 CFR 438.206
42 CFR 438.207
42 CFR 438.208

K. Services, including capacity, network adequacy, coordination, and continuity.

☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.

☐ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.

State: Arkansas

Citation	Condition or Requirement
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.350 42 CFR 438.354 42 CFR 438.364	M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option. To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will ☐/will not ☒ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* A PCCM must establish his or her Medicaid caseload limit, of a maximum of 2500. The state will permit higher maximums in areas the federal government has designated as medically underserved. The state may permit higher maximum caseloads for Primary Care Providers who so request if the limit would create a hardship on their practice. 4. ☐ The selective contracting provision in not applicable to this state plan.

State: Arkansas

Citation | Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

State: Arkansas

Citation Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD – currently 4/30/17)

Citation	Condition or Requirement

1932(a) (1) (A)

A. Section 1932(a)(1)(A) of the Social Security Act.

Arkansas Patient Centered Medical Home (PCMH) program aims to improve efficiency, economy and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who deliver high-quality care.

Initially, participation in the PCMH program is open to practices as described in the DMS PCMH Provider Manual that have physicians who are primary care case managers as defined by the DMS Primary Care Case Management (ConnectCare) program. In addition, practices must meet the eligibility requirements described in the DMS PCMH Provider Manual. Practices that participate in the Comprehensive Primary Care Initiative (CPC) are eligible to receive shared savings incentive payments.

The State of Arkansas enrolls most Medicaid beneficiaries into mandatory primary care case management (PCCM). This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
X ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

a. The Medicaid beneficiary chooses a primary care physician (PCP) who, through an on-going provider/beneficiary relationship, coordinates health care services, including referrals for necessary specialty services, physician's services, hospital care and other services. The PCMH provider will assist enrollees with locating medical services and coordinate and monitor their enrollees prescribed medical and rehabilitation services.

The beneficiaries have a free choice of specialists within the state and bordering states. PCMH providers have free choice of referrals specialists and ancillary providers

Citation	Condition or Requirement

Under this PCMH program, the PCMH provider manages the enrolled beneficiary's health by working directly with beneficiaries and their treatment by providing:

1. **A PCP must make available 24-hour, 7 days per week telephone access to a live voice (an employee of the primary care physician or an answering service) Reasonable 24- hour availability and adequate hours of operation, referral and treatment with respect to medical emergencies.**
2. **Response to after-hours calls regarding non-emergencies must be within 30 minutes.**

   PCPs must make the after-hours telephone number as widely available as possible to their patients.

   When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date.

   PCPs in underserved and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone.

   As regards access to services, PCPs are required to provide the same level of service for their PCMH enrollees as they provide for their insured and private-pay patients.

   Physicians and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations and any other pertinent information to the PCP for inclusion in the patient's medical record.

   A PCP may not refer PCMH enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

3. **Increasing the beneficiaries' and/or their caregivers' understanding of their disease so that they are:**
   - **Better able to understand their disease**
   - **Better able to access regular preventative health care by improving their self-management skills**
   - **Better able to understand the appropriate use of resources needed to care for their disease**

Citation	Condition or Requirement

- Better able to improve the beneficiary's quality of life by assisting them in self-managing their disease and in accessing regular preventative health care.

b. Arkansas Department of Human Services engages a network of credentialed primary care physicians to meet medical needs for enrolled beneficiaries. The PCMH provider is responsible for overall health care services for beneficiaries.

42 CFR 438.50(b) (2)
42 CFR 438.50(b) (3)

2. The payment method to the contracting entity will be:

____i. fee for service;
____ii. capitation;
__X_iii. a case management fee;
_ X_iv. a bonus/incentive payment;
_____v. a supplemental payment, or
____vi. other. (Please provide a description below).

DMS offers two types of payments to Arkansas Patient Centered Medical Homes (PCMHs): (1) care coordination payments and (2) **performance-based** incentive payments.

The care coordination payment may be used by participating practices for care coordination efforts, whether these are executed by a vendor on behalf of the practice or directly by the practice. Care coordination payments are risk adjusted to account for the varying levels of care coordination services needed for patients with different risk profiles.

Performance-based incentive payments are annual payments made to a **PCMH** for delivery of economic, efficient and quality care.

Each year the **PCMHs are assessed in cost utilization measures. Those PCMHs that fall into the negotiated threshold of cost utilization measures will be eligible for performance-based incentive payments. Performance-based incentive payments will be risk and time adjusted.**

DMS will also select a yearly focus measure to reward top performing PCMHs. The focus measure will focus on an area in which the state performance is significantly lower than national average.

DMS has established **top performance thresholds** for **utilization measures**, as described in the DMS PCMH Provider Manual. These thresholds will help **determine rewards for efficient, economic, and quality care.**

<RESERVED>

Citation	Condition or Requirement

DMS will:

· Provide CMS, at least annually, with data and reports supporting achievements in the goals of improving health, increasing quality and lowering the growth of health care costs.

· Provide CMS with updates, as conducted, to the state's metrics.

· Review and renew the payment methodology as part of the evaluation.

· Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment submissions.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

Citation	Condition or Requirement
	__X_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. The State established a website (www.paymentinitiative.org) to keep the public informed during the design of the PCMH program and provide current information on progress towards implementation. The website is a 'one stop shop' for documents and information PCMH and includes an email address for interested parties to send suggestions. The State also established a toll free number manned by service representatives to answer public/provider questions on PCMH program. These service representatives triage and escalate as needed, and catalogue questions for changes to the technical design, operational processes, or communications. The PCMH Provider Manual explaining the program in detail is posted on the website. Webinars on program overview, enrollment process, benefits and requirements are also posted on the website along with FAQs on relevant topics. There **is** a statewide promulgation process **including** a 30 day public comment period, after which feedback is incorporated into **the** version that **is** submitted for State legislative approval.

Citation	Condition or Requirement

Meaningful updates to the provider manual will be shared with CMS to enable continued collaboration and open lines of communication

1932(a)(1)(A)

5. The state plan program will **X** /will not _implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary____enrollment will be implemented in the following couties::

   i. county/counties (mandatory) _____

   ii. area/areas (mandatory)_____

   iii. area/areas (voluntary)_____

B. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ___The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __X The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)

3. _ The state assures that all the applicable requirements of section 1932

Citation		Condition or Requirement
42 CFR 438.50(c)(3)		(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	_X___The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	__X__The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	___The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	_X__ The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	__X__The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

Section 1931 children and related populations, pregnant women under SOBRA (SOBRA women are required to enroll with a Primary Care Case Manger only if they need non-obstetrical services which require a PCP referral)., Section 1931 Adults and Related populations, poverty level, Blind/Disabled Adults and related populations age 18 or older, Blind/Disabled Children, Aged and related populations. Ages 65 or older who are not Medicare beneficiaries. Foster Care Children, ARKids First B children, pregnant women and infants, Blind/Disabled adults 18 and older, Foster Care children.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.

1932(a)(2)(B) i. _____Beneficiaries who are also eligible for Medicare.

Citation	Condition or Requirement
42 CFR 438(d)(1)	If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Beneficiaries who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C)	ii. _X___Indians who are beneficiaries of Federally recognized Tribes except when 42 CFR 438(d)(2) the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii _X__Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under Title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. __X_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) of- 42 CFR 438.50(3)(iii)	v. _X__Children under the age of 19 years who are in foster care or other out- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _X___Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii)	vii. _X ___Children under the age of 19 years who are receiving services through a 42 CFR 438.50(3)(v) family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs. Note: Voluntary provider enrollment is allowed under the PCMH program. This program no way impacts direct services to Arkansas Medicaid beneficiaries.

E. Identification of Mandatory Exempt Groups

1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* N/A

Citation		Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	2.	Place a check mark to affirm if the state's definition of title V children is determined by: ____i. program participation, ____ii. special health care needs, or _ X_iii. both
1932(a)(2) 42 CFR 438.50(d)	3.	Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. __X_i. yes ___ _ii. no
1932(a)(2) 42 CFR 438.50 (d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base. iii. Children under 19 years of age who are in foster care or other out-of-home placement; The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base. iv. Children under 19 years of age who are receiving foster care or adoption assistance. The state identifies this group as defined by categories at time of enrollment or reenrollment via the eligibility data base.

Citation	Condition or Requirement

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

PCMH follows the PCCM process in which the state requires PCCM's to allow enrollees to self–refer under certain circumstances. Arkansas Medicaid has no special definition for" special needs" children who are Medicaid beneficiaries. Connectcare includes mandatory enrollment for all of them who are not excluded for some other reason, such as having Medicare as their primary insurance.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care:

i. Beneficiaries who are also eligible for Medicare.

The state uses aid categories on the eligibility system and the MMIS claims processing system to identify groups who are exempt from mandatory enrollment.

ii. Indians who are beneficiaries of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

The state uses aid categories on the eligibility system and the MMIS claims processing system to identify groups who are exempt from mandatory enrollment.

42 CFR 438.50

F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u>

Medicare dual eligible, poverty level pregnant women (SOBRA ;SOBRA women are required to enroll with a Primary Care Case Manger only if they need non-obstetrical services which require a PCP referral), Beneficiaries who reside in a nursing facilities or intermediate care facilities for the mentally retarded, Home

Citation	Condition or Requirement
	and Community Based Waiver beneficiaries, Medicaid beneficiaries for the period of retroactive eligibility, medically needy spend down, family planning waiver, pregnant women: presumptive eligibility
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis N/A
	H. Enrollment process.
1932(a)(4) 42 CFR 438.50	1. Definitions **i. An existing provider-beneficiary relationship is one in which the provider was the main source of Medicaid services for the beneficiary during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient. Enrollees are permitted to disenroll from their PCMH or transfer between PCMHs.** **ii. A provider is considered to have "traditionally served" Medicaid beneficiaries if it has experience in serving the Medicaid population.**
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: **i. the existing provider-recipient relationship (as defined in H.1.i).** **A beneficiary may enroll with a PCMH at the office of the PCMH, at the regional district state office, through Connectcare or through the emergency room. The PCMH's staff telephones a Voice Response System; the entire process is automated via proprietary hardware and software;** **ii. the relationship with providers that have traditionally served Medicaid beneficiaries (as defined in H.2.ii).** **iii. the equitable distribution of Medicaid beneficiaries among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42**

Citation	Condition or Requirement

CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).

The state has set enrollment limits for each PCCM provider. The PCCM provider is limited to 2500 enrollees. If that limitation creates a hardship for the practitioner, threatens the PCCM's practice or creates a problem of access and availability for beneficiaries, the PCCM may request in writing to the Director of Medical Services additional case load.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will____/will not x use a lock-in for managed care.

ii. The time frame for beneficiaries to choose a health plan before being auto-assigned will be N/A.

iii. Describe the state's process for notifying Medicaid beneficiaries of their auto-assignment. *(Example: state generated correspondence.)*

N/A

iv. Describe the state's process for notifying the Medicaid beneficiaries who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

N/A

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

N/A

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

N/A

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. X The state assures it has an enrollment system that allows beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. X The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   X This provision is not applicable to this 1932 State Plan Amendment.

5. ____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   X This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not X use lock-in for managed care.

2. The lock-in will apply for _N/A_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

   X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

Citation	Condition or Requirement

1. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
CFR 438.50
42 CFR 438.10

X The state assures that its state plan program complies with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
Developmental Disabilities Services Community and Employment Support
Family Planning
Anesthesia
Alternative Waiver Programs
Adult Developmental Day Treatment Services Core Services only
Disease Control Services for Communicable Diseases
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Medication-Assisted Treatment Services for opioid use disorder when part of a Medication Assisted Treatment plan
Mental health services as follows:
a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. Rehabilitative Services for Youth and Children
Nurse Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, delivery, and postpartum) services
Pharmacy
Physician Services for inpatients acute care
Transportation

Citation	Condition or Requirement

Sexual Abuse Examination.
Targeted case management provided by the Division of Youth Services or the Division of Children and Family services under an interagency agreement with the Division of Medical Services.

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will___will not___X___ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. X The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option.

N/A

1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Supported Employment; Behavior Assistance; Adult Rehabilitation Day Treatment; Peer Support; Family Support Partners; Residential Community Reintegration; Respite; Crisis Stabilization Intervention; Assertive Community Treatment; Therapeutic Host Home; Recovery Support Partners (for Substance Abuse); Substance Abuse Detox (Observational); Pharmaceutical Counseling; Supportive Life Skills Development, Child and Youth Support; Partial Hospitalization, Supportive Housing; and Therapeutic Communities.

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
◉	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☒	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
	Provider-Led Arkansas Shared Savings Entity (PASSE) Program, AR.0007.R01.01

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☒	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

	☐	§1915(b)(2) (central broker)	☒	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
⊙	The State plan HCBS benefit is operated by *(name of agency)*		
	Division of Aging, Adult, and Behavioral Health Services (DAABHS)		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☑	☐	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☑	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☐	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☑	☑	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10 Quality assurance and quality improvement activities	☑	☑	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The PASSEs will assist with 4, 5, 6, and 8.
The contracted actuary will assist with 8.

The External Quality Review Organization (EQRO) that contracts with Division of Medical Services (DMS) will assist with 3, 5, and 10.

DAABHS, as the operating agency, will assist with 1, 2, 3, 8, 9, & 10

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	March 1, 2024	February 28, 2025	38,000
Year 2	March 1, 2025	February 28, 2026	
Year 3	March 1, 2026	February 28, 2027	
Year 4	March 1, 2027	February 29, 2028	
Year 5	March 1, 2028	February 28, 2029	

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
⊙	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	Evaluations and re-evaluations are conducted by DHS's contracted vendor, Optum, who completes the independent assessment. Eligibility is determined using the results of the independent assessment and the individual's diagnosis.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

After completion of the independent assessment of functional need, DAABHS makes the 1915(i) eligibility determination for all clients based on the results of the independent assessment and the individual's diagnosis contained in his or her medical record. 1915(i) eligibility is re-evaluated on an annual basis. Reevaluations of 1915(i) eligibility may be conducted in person or through the use of interactive video that is recorded with the permission of the individual or telephonically that is recorded with the permission of the individual and the approval of the respective DHS program staff. The states HIPAA officer has reviewed and approved the HIPAA plan and assures compliance with HIPAA regulations.

4. ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

After medical eligibility has been determined through diagnosis, the following needs-based criteria is used:
The beneficiary must receive a minimum of a Tier 2 on the Arkansas Independent Assessment (ARIA). To meet a Tier 2, the beneficiary must have the need for assistance because of certain behaviors that require non-residential services to help with functioning in home and community-based settings and moving towards recovering and is not a harm to his or herself or others.
The state utilizes the ARIA tool to determine needs-based eligibility based on the measurement of an individual's needs as assessed under the following domains:
Adaptive, personal/social, communication, motor, and cognitive. The ARIA tool takes into account the individuals' ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs. Needs assessed are due to manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)

The client must receive a minimum of a Tier 2 functional assessment for HCBS behavioral health services. To meet a Tier 2, the client must have difficulties with certain behaviors that require a full array of services to help with functioning in home and community-based settings and moving towards recovery and is not a harm to his or herself or others. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.	Must meet at least one of the following three criteria as determined by a licensed medical professional: 1. The individual is unable to perform either of the following: A. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/ locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or, B. At least two (2) of the three (3) activities of daily living (ADLs) of transferring/ locomotion, eating or toileting without assistance from another person; or, 2.The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or, 3.The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. 4.No individual who is otherwise eligible for	1) Diagnosis of developmental disability that originated prior to age of 22; 2) The disability has continued or is expected to continue indefinitely; and 3)The disability constitutes a substantial handicap to the person's ability to function without appropriate support services, including but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. Must also be in need of and able to benefit from active treatment and unable to access appropriate services in a less restrictive setting. Individuals must be assessed a Tier 2 or Tier 3 to receive services in the CES Waiver or an ICF/IID.	There must be a written certification of need (CON) that states that an individual is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if an individual applies for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment. Tests and evaluations used to certify need cannot be more than one (1) year old. All histories and information used to certify need must have been compiled within the year prior to the CON. In compliance with 42 CFR 441.152, the facility-based and independent CON teams must certify that: A. Ambulatory care resources available in the community do not meet the treatment needs of the beneficiary; B. Proper treatment of the beneficiary's psychiatric condition requires inpatient services under the direction of a physician and C. The services can be reasonably expected to prevent further regression or to improve the beneficiary's condition so that the services will no longer be needed. Specifically, a physician must make a medical necessity determination that services must be provided in a hospital setting because the individual is a danger to his or herself or other and

	waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.		cannot safely remain in the community setting.

*Long Term Care/Chronic Care Hospital **LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

1.) Targeted to individuals age 4 and older with a mental health diagnosis, categorical eligible developmental diagnosis, or both.

2.) Adults up to and including 133 percent of the FPL who meet the other criteria specified in Section1902(a)(10)(A)(i)(VIII) of the Social Security Act and covered under the Arkansas Section 1115 Demonstrative Waiver ("ARHOME") who are determined to be "Medically Frail".

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. ☑ **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	⊙	**The provision of 1915(i) services at least monthly**
		Monthly monitoring of the individual when services are furnished on a less than monthly basis If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

This State Plan benefit renewal, along with the concurrent 1915(b) PASSE Waiver and 1915(c) Community and Employment Supports (CES) Waiver, is subject to the HCBS Settings requirements.

The 1915(i) service settings are fully compliant with the home and community-based settings rule or are covered under the statewide transition plan under another authority where they have been in operation before March of 2014.

The state assures that this State Plan benefit renewal is subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The assessor must have a Bachelor's Degree or be a registered nurse with one (1) year of experience with mental health populations.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The Provider Led Arkansas Shared Savings Entity (PASSE) Care coordinator is responsible for providing care coordination to all clients receiving State plan HCBS services, including development of the PCSP. The care coordination service is offered through the 1915(b) Waiver. These care coordinators must meet the following qualifications:

1. Be a registered nurse, a physician or have a bachelor's degree in a social science or a health-related field; or

2. Have at least one (1) year experience working with developmentally or intellectually disabled clients or behavioral health clients.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

From the time an individual makes contact with DHS PASSE unit regarding receiving HCBS state plan services, DHS informs the individual and their caregivers of their right to make choices about many aspects of the services available to them and their right to advocate for themselves or have a representative advocate on their behalf. It is the responsibility of everyone at DHS, the PASSE who receives the individual and provides care coordination, and the services providers to make sure that the PASSE individual is aware of and is able to exercise their rights and to ensure that the individual and their caregivers are able to make choices regarding their services.

Immediately following enrollment in a PASSE, the PASSE care coordinator must develop an interim service plan (ISP) for the individual. If the individual was already enrolled in a program that required PCSPs, then that PCSP may be the ISP for the individual. The ISP may be effective for up to 60 days, pending completion of the full PCSP.

The PASSE's care coordinator is responsible for scheduling and coordinating the PCSP development meeting. As part of this responsibility the care coordinator must ensure that anyone the individual wishes to be present is invited. Typically, the development team will consist of the individual and their caregivers, the care coordinator, service providers, professionals who have conducted assessments or evaluations, and friends and persons who support the individual. The care coordinator must ensure that the individual does not object to the presence of any participants to the PCSP development meeting. If the individual or the caregiver would like a party to be present, the care coordinator is responsible for inviting that individual to attend.

During the PCSP development meeting, everyone in attendance is responsible for supporting and encouraging the individual to express their wants and desires and to incorporate them into the PCSP when possible. The care coordinator is responsible for managing and resolving any disagreements which arise during the PCSP development meeting.

After enrollment, and prior to the PCSP development meeting, the care coordinator must conduct a health questionnaire with the individual. The care coordinator must also secure any other information that may be needed to develop the PCSP, including, but not limited to:

a) Results of any evaluations that are specific to the needs of the individual;
b) The results of any psychological testing;
c) The results of any adaptive behavior assessments;
d) Any social, medical, physical, and mental health histories; and
a risk assessment.

The PCSP development team must utilize the results of the independent assessment, the health questionnaire, and any other assessment information gathered. The PCSP must include the individual's goals, needs (behavioral, developmental, and health needs), and preferences. All needed services must be noted in the PCSP and the care coordinator is responsible for coordinating and monitoring the implementation of the PCSP.

The PCSP must be developed within 60 days of enrollment into the PASSE. At a minimum, the PCSP must be updated annually.

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Before an individual can access HCBS state plan services, they must be enrolled in a PASSE under the 1915 (b) Provider Led Shared Savings Entities Waiver. The PASSE is responsible for providing all needed services to all enrolled individuals and may limit an individual's choice of providers based on its provider network. The provider network must meet minimum adequacy standards set forth in the 1915(b)Waiver, the PASSE Provider Manual, and the PASSE Provider Agreement.

The individual has 90 days after initial enrollment to change their assigned PASSE. Once a year, there is an open enrollment period that lasts at least 30 days, in which the individual may change his or her PASSE for any reason. At any time during the year, an individual may change his or her PASSE for cause, as defined in 42 CFR 438.56.

The State has a DHS PASSE Unit to assist the individual in changing PASSE's, including informing the individual of their rights regarding choosing another PASSE and how to access information on each PASSE's provider network.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

DAABHS, DMS, or the External Quality Review Organization (EQRO) arranges for a specified number of service plans to be reviewed annually, using the sampling guide, "A Practical Guide for Quality Management in Home and Community-Based Waiver Programs," developed by Human Services Research Institute and the Medstat Group for CMS in 2006. A systematic random sampling of the active case population is drawn whereby every "nth" name in the population is selected for inclusion in the sample. The sample size is based on a 95% confidence interval with a margin of error of +/- 8%. An online calculator is used to determine the appropriate sample size for the Waiver population. To determine the "nth" integer, the sample is divided by the population. Names are drawn until the sample size is reached.

The PASSE is required to submit the PCSP for all individuals in the sample. DAABHS or the EQRO conducts a retrospective review of provided PCSPs based on identified program, financial, and administrative elements critical to quality assurance. DAABHS or the EQRO reviews the plans to ensure they have been developed in accordance with applicable policies and procedures, that plans ensure the health and welfare of the individual, and for financial and utilization components. DMS or the EQRO communicates findings from the review to the PASSE for remediation. Systemic findings may necessitate a change in policy or procedures. A pattern of non-compliance from one PASSE may result in sanctions to that PASSE under the PASSE Provider Manual and Provider Agreement. DMS has ultimate authority and responsibility in the operation and oversight of the PCSP approval process. Either DMS or the EQRO communicates the finding from the review and the state requires PASSE remediation.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

	Medicaid agency		Operating agency		Case manager
☒	Other (*specify):*	The PASSE			

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Supported Employment
Service Definition (Scope):	
Supported Employment is designed to help client's acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany individuals on interviews and providing ongoing support and/or on-the-job training once the individual is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate clients from mainstream society. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the individual to be successful in integrating into the job setting. Services may be provided in integrated community work settings in the general workforce. Services may be provided in the home when provided to establish home-based self-employment. Services maybe provided in either a small group setting or on an individual basis. Transportation is not included in the rate for this service. Supported employment must be competitive, meaning that wages must be at or above the State's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work. Service settings may vary depending on individual need and level of community integration, and may include the individual's home.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*

	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Behavior Assistance

Service Definition (Scope)*:*

A specific outcome oriented intervention provided individually or in a group setting with the individual and/or their caregivers that will provide the necessary support to attain the goals of the PCSP and the behavioral health treatment plan. Service activities include applying positive behavioral interventions and supports within the community to foster behaviors that are rehabilitative and restorative in nature. The service activity should result in sustainable positive behavioral changes that improve functioning, enhance the quality of life and strengthen skills in a variety of life domains.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Adult Rehabilitation Day Treatment

Service Definition (Scope)*:*

A continuum of care provided to recovering clients living in the community based on their level of need. This service includes educating and assisting the client**s** with accessing supports and services needed. The service assists recovering individuals to direct their resources and support systems.

Activities include training to assist the clients to improve employability, and to successfully adapt and adjust to a particular environment. Adult rehabilitation day treatment includes training and assistance to live in and maintain a household of their choosing in the community. In addition, activities can include transitional services to assist clients after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Adult rehabilitative day treatment is an array of face-to-face rehabilitative day activities providing a

preplanned and structured group program for identified individuals that are aimed at long-term recovery and maximization of self-sufficiency. These rehabilitative day activities are person and family centered, recovery based, culturally competent, and provided needed accommodation for any disability.These activities must also have measurable outcomes directly related to the individual's treatment plan. Day treatment activities assist the individual with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness.

The intent of these services is to restore the fullest possible integration of the individual as an active and productive member of his or her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement the client's behavioral health treatment plan. Meals and transportation are not included in the rate for Adult Rehabilitation Day Treatment.

Adult rehabilitation day treatment can occur in a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Peer Support

Service Definition (Scope)*:*

A person-centered service where adult peers provide expertise not replicated by professional training.

Peer support providers are trained peer specialists who work with individuals to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Peer support specialists may assist with navigation of multiple systems (housing, supported employment, supplemental benefits, building/rebuilding natural supports, etc.) which improve the individual's functional ability. Services are provided on an individual or group basis and may be provided in the home or the community.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Community Support System Provider (CSSP)			

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Family Support Partners

Service Definition (Scope)*:*

A service provided by peer counselors, or Family Support Partners (FSP), who model recovery and resiliency for caregivers of children and youth with behavioral health care needs. FSP come from legacy families and use their lived experience, training, and skills to help caregivers and their families identify goals and actions that promote recovery and resiliency. A FSP may assist, teach and model appropriate child-rearing strategies, techniques and household management skills. This service provides information on child development, age-appropriate behavior, parental expectations, and childcare activities. It may also assist the individual's family in securing resources and developing natural supports.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Pharmaceutical Counseling

Service Definition (Scope)*:*

A one-to-one or group intervention by a nurse with individual(s) and/or their caregivers, related to their psychopharmacological treatment. Pharmaceutical Counseling involves providing medication information orally or in writing to the individual and/or their caregivers. The service should encompass all the parameters to make the individual and/or family understand the diagnosis prompting the need for medication and any lifestyle modifications required.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*

	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Supportive Life Skills Development

Service Definition (Scope)*:*

A service that provides support and training for youth and adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the individual into their community as they develop their recovery plan or habilitation plan. This service is designed to assist individuals in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist individuals in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented decisions related to independent living. Services are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

Other topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition.

The PCSP should address the recovery or habilitation objective of each activity performed under Life Skills Development and Support.

In a group setting, an individual to staff ratio of 10:1.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Child and Youth Support

Service Definition (Scope)*:*

Clinical services for principal caregivers designed to increase a child's positive behaviors and encourage compliance with parents at home; working with teachers/schools to modify classroom environment to increase positive behaviors in the classroom; and increase a child's social skills, including understanding of feelings, conflict management, academic engagement, school readiness, and cooperation with teachers and other school staff. This service is intended to increase parental skill development in managing their child's symptoms of illness and training the parents in effective interventions and techniques for working with the schools.

Service activities may include an In-Home Case Aide, which is intensive therapy in the individual's home or a community-based setting. Youth served may be in imminent risk of out-of-home placement or have been recently reintegrated from an out-of-home placement. Services may deal with family issues related to the promotion of healthy family interactions, behavior training, and feedback to the family.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Therapeutic Communities

Service Definition (Scope)*:*

A setting that emphasizes the integration of the individual within his or her community; progress is measured within the context of that community's expectation. Therapeutic Communities are highly structured environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the individual on their PCSP. Therapeutic Communities employ community-imposed consequences and earned privileges as part of the recovery and growth process. These consequences and privileges are decided upon by the individuals living in the community. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the community setting. Participants and staff members act as facilitators, emphasizing self-improvement.

Therapeutic Communities services may be provided in a provider-owned apartment or home, or in a provider-owned facility with fewer than 16 beds.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Residential Community Reintegration

Service Definition (Scope)*:*

Serves as an intermediate level of care between Inpatient Psychiatric facilities and outpatient behavioral health services. The program provides 24 hours per day intensive therapeutic care in a small group home setting for children and youth with emotional and/or behavior problems which cannot be remedied with less intensive treatment. The program is intended to prevent acute or sub-acute hospitalization of youth, or incarceration. Community reintegration may be offered as a step-down or transitional level of care to prepare a youth for less intensive treatment.
Residential Community Reintegration programs must ensure (1) there are a minimum of two direct care staff available at all times; and (2) educational services are provided to all beneficiaries enrolled in the program.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Respite

Service Definition (Scope)*:*

Temporary direct care and supervision for an individual due to the absence or need for relief of the non-paid primary caregiver. Respite can occur at medical or specialized camps, day-care programs, the individual's home or place of residence, the respite care provider's home or place of residence, foster homes, or a licensed respite facility. Respite does not have to be listed in the PCSP.

The primary purpose of Respite is to relieve the principal caregiver of the individual with a behavioral health need so that stressful situations are de-escalated, and the caregiver and individual have a therapeutic and safe outlet. Respite must be temporary in nature. Any services provided for less than fifteen (15) days will be deemed temporary. Respite provided for more than 15 days should trigger a need to review the PCSP.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Assertive Community Treatment (ACT)

Service Definition (Scope)*:*

Assertive Community Treatment (ACT) is an evidence-based practice provided by a multidisciplinary team providing comprehensive treatment and support services available 24 hours a day, seven (7) days a week wherever and whenever needed. Services are provided in the most integrated community setting possible to enhance independence and positive community involvement. An individual

appropriate for services through an ACT team has needs that are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community. Typically, this service is targeted to individuals who have serious mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Therapeutic Host Homes

Service Definition (Scope)*:*

A home or family setting that that consists of highly intensive, individualized treatment for the individual whose behavioral health or developmental disability needs are severe enough that they would be at risk of placement in a restrictive residential setting.

A therapeutic host parent is trained to implement the key elements of the individual's PCSP in the context of family and community life, while promoting the PCSP's overall objectives and goals. The host parent should be present at the PCSP development meetings and should act as an advocate for the individual.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:			
	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Aftercare Recovery Support (for Substance Abuse)

Service Definition (Scope)*:*

A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Meals and transportation are not included in the rate for Aftercare Recovery

Support.Aftercare Recovery Support can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

All medically necessary 1905(a) services are covered for EPSDT eligible clients in accordance with 1905(r) of the Social Security Act.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Substance Abuse Detoxification (Observational)

Service Definition (Scope)*:*

A set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize the individual by clearing toxins from his or her body. Detoxification (detox) services are short term and may be provided in a crisis unit, inpatient, or outpatient setting. Detox services may include evaluation, observation, medical monitoring, and addiction treatment. The goal of detox is to minimize the physical harm caused by the abuse of substances and prepare the individual for ongoing substance abuse treatment.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Partial Hospitalization

Service Definition (Scope)*:*

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of no more than 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum: intake, individual therapy, group therapy, and psychoeducation.

Partial Hospitalization shall be at a minimum of (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If an individual receives other servicesduring the week but also receives Partial Hospitalization, the individual must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.

Partial Hospitalization can occur in a variety of clinical settings for adults, similar to adult day cares or adult day clinics. All Partial Hospitalization sites must be certified by the Division of Provider Servicesand Quality Assurance as a Partial Hospitalization Provider.

All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security Act.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:

	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Supportive Housing

Service Definition (Scope)*:*

Supportive Housing is designed to ensure that clients have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists clients in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community

life; and facilitates the individual's recovery journey.

Supportive Housing includes assessing the clients individual housing needs and presenting options, assistingin securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history), searching for housing, communicating with landlords, coordinating the move, providing training in how to be a good tenant, and establishing procedures and contacts to retain housing.

Supportive Housing can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

None.

☐ Medically needy *(specify limits):*

N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. *(Check each that applies)*:			
	Participant-directed	☑	Provider managed

Service Specifications ***(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):***	
Service Title:	Crisis Stabilization Intervention

Service Definition (Scope)*:*

Crisis Stabilization Intervention is a scheduled face-to-face treatment activities provided to an individual who has recently experienced a psychiatric or behavioral crisis that are expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. Services are to be congruent with the age, strengths, needed accommodation for any disability and cultural framework of the individual and his/her family.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
	None.
☐	Medically needy *(specify limits):*
	N/A

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	N/A	N/A	1. All other provider standards and requirements in accordance with the 1915(b) requirements as defined in the currently approved 1915(b) waiver program.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Behavioral HealthAgency Or Community Support System Provider (CSSP)	DMS	Annually. Proof of credentialing must be submitted to DMS.

Service Delivery Method. ***(Check each that applies)*:**

	Participant-directed	☑	Provider managed

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

a) Relatives may be paid to provide HCBS services, provided they are not the parent, legally responsible individual, or legal guardian of the individual.

b) The HCBS services that relatives may provide are: supported employment, peer support, family support partners, therapeutic host home, life skills development, and respite.

c) All relatives who are paid to provide the services must meet the minimum qualifications set forth in this State Plan 1915 (i) and may not be involved in the development of the Person Centered Service Plan (PCSP).

d) These individuals must be monitored by the PASSE to ensure the delivery of services in accordance with the PCSP. Each month, the care coordinator will monitor the delivery of services and check on the welfare of the individual.

e) Payments are not made directly from the Medicaid agency to the relative. Instead, the State pays the PASSE a per individual per month (PMPM) prospective payment for each attributed individual. The PASSE may then utilize qualified relatives to provide the service.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

Election of Participant-Direction. (S*elect one):*

⊙	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.

○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

1. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):**

2. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

3. **Participant-Directed Services**. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

4. **Financial Management.** (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

5. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

	The state does not offer opportunity for participant-employer authority.	
	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

The state does not offer opportunity for participants to direct a budget.
Participants may elect Participant–Budget Authority.
Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Requirement 1: Service Plans Address Needs of Participants, are reviewed annually and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of PCSPs developed by PASSE Care Coordinators that which provide 1915(i) State Plan HCBS that meet the requirements of 42 CFR §441.725. Numerator: Number of PCSPs that adequately and appropriately address the individual's needs. Denominator: Total Number of PCSPs reviewed.
Discovery Activity *(Source of Data & sample size)*	A representative sample will be used based on the sample size selected for PCSP review by DAABHS or EQRO The sample size will be determined using a confidence interval of 95 percent confidence level and +/- 5 percent margin of error. The data will be derived from the PASSE and must include copies of the PCSP and all updates, the Independent Assessment, the health questionnaire and other documentation used at the PCSP development meeting.
Monitoring	DAABHS or the EQRO.

	Responsibilities *(Agency or entity that conducts discovery activities)*	
	Requirement	Requirement 1: Service Plans
	Frequency	Sample will be selected and reviewed quarterly
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PASSE will be responsible for remediating deficiencies in PCSPs/treatment plans of their individuals. If there is a pattern of deficiencies noticed, action will be taken against the PASSE, up to and including, instituting a corrective action plan or sanctions pursuant to the PASSE Provider Agreement and the Medicaid Provider Manual.
	Frequency *(of Analysis and Aggregation)*	Findings will be reported to the PASSE on a quarterly basis. If a pattern of deficiency is noted, this may be made public.

Requirement	Requirement 2: Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence One *(Performance Measure)*	The number and percent of clients who are evaluated annually allowing for the receipt of 1915 (i) services. Numerator: The number of clients who are evaluated and assessed for eligibility in a timely manner. Denominator: The total number of clients who are identified for the 1915(i) HCBS State Plan Services eligibility process.
Discovery Activity One *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of the application packets for individuals who undergo the eligibility process will be reviewed for compliance with the timeliness standards. The data will be collected from the Independent Assessment Vendor, a documented mental health diagnosis, and/or the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DHS PASSE Unit , DMS Waiver Compliance Unit, or the EQRO
Discovery Evidence Two	The Percentage of individuals for whom the appropriate eligibility process and instruments were used to determine initial eligibility for HCBS State Plan Services.

	Numerator: Number of individual's application packets that reflect appropriate processes and instruments were used. Denominator: Total Number of application packets reviewed.
Discovery Activity Two	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of the application packets for individuals who went through the eligibility determination process will be reviewed. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and/or the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibility	DHS PASSE Unit or the EQRO
Discovery Evidence Three	The percentage of individuals who are re-determined eligible for HCBS State Plan Services before their annual PCSP expiration date. Numerator: The number of individuals who are re-determined eligible timely (before expiration of PCSP). Denominator: The total number of individuals re-determined eligible for HCBS State Plan Services.
Discovery Activity Three	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of the application packets for individuals who went through the eligibility re-determination process will be reviewed. The data will be collected from the Independent Assessment Vendor, the DDS Psychology Unit, and/or the DHS Dual Diagnosis Evaluation Committee.
Monitoring Responsibilities	DHS PASSE Unit or the EQRO
Requirement	Requirement 2: Eligibility Requirements
Frequency	Sample will be selected and reviewed quarterly.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	For Independent Functional Assessments: The Independent Assessment Vendor is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submits monthly reports to DMS's Independent Assessment Contract Manager. When deficiencies are noted, a corrective action plan will be implemented with the Vendor.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.

Requirement	Requirement 3: Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of providers certified and credentialed by DPSQA. Numerator: Number of provider agencies that obtained annual certification in accordance with DPSQA's standards. Denominator: Number of HCBS provider agencies reviewed.
Discovery Activity *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of HCBS providers credentialed by the PASSEs will be reviewed by the Division of Provider Services and Quality Assurance(DPSQA). Without this certification, the provider cannot enroll or continue to be enrolled in Arkansas Medicaid.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS Waiver Compliance Unit
Requirement	Requirement 3: Providers meet required qualifications.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Remediation associated with provider credential and certification that is not current would include additional training for the PASSE, as well as remedial or corrective action, including possible recoupment of PMPM payments. Additionally, if a PASSE does not pass the annual readiness review, enrollment in the PASSE may potentially be suspended.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported annually.

Requirement	Requirement 4: Settings that meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider owned apartments or homes that meet the home and community-based settings requirements. Numerator: Number of provider owned apartments and homes that are reviewed by DMS or its agents. Denominator: Number of provider owned apartments and homes that meet the HCBS Settings requirements in 42 CFR 441.710(a)(1) & (2).
Discovery Activity	Review of the Settings Review Report sent to the PASSEs. The reviewed apartments or homes will be randomly selected. A typical review will consist of at

(Source of Data & sample size)	least 10% of each PASSE providers' apartments and homes (if they own any) each year.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DQSQA or the EQRO
Requirement	Requirement 4: Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Frequency	Provider owned homes and apartments will be reviewed and the report compiled annually.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The PASSE will be responsible for ensuring compliance with HCBS Settings requirements. If there is a pattern of deficiencies noticed by DMS or its agents, action will be taken against the PASSE, up to and including, instituting a corrective action plan or sanctions pursuant to the PASSE Provider Agreement.
Frequency *(of Analysis and Aggregation)*	Annually.

Requirement	Requirement 5: The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of policies developed must be promulgated in accordancewith the DHS agency review process and the Arkansas Administrative ProceduresAct (APA). Numerator: Number of policies and procedures appropriately promulgated in accordance with agency policy and the APA; Denominator: Number of policies and procedures promulgated. Number and percentage of policies developed must be promulgated in accordance with the DHS agency review process and the Arkansas Administrative Procedures Act (APA). Numerator: Number of policies and procedures appropriately promulgated in accordance with agency policy and the APA; Denominator: Number of policies and procedures promulgated.
Discovery Activity *(Source of Data & sample size)*	100% of policies developed must be reviewed for compliance with the agency policy and the APA.
Monitoring Responsibilities	DMS Waiver Compliance Unit

	(Agency or entity that conducts discovery activities)	
	Requirement	Requirement 5: The SMA retains authority and responsibility for program authority and oversight.
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DMS's policy unit is responsible for compliance with Agency policy and with the APA. In cases where policy or procedures were not reviewed and approved according to DHS policy, remediation includes DHS review of the policy upon discovery, and approving or removing the policy.
	Frequency *(of Analysis and Aggregation)*	Each policy will be reviewed for compliance with applicable DHS policy and the APA.

Requirement	Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence One *(Performance Measure)*	Number and percent of services delivered and paid for with the PMPM as specified by the individual's PCSP. Numerator: Number of provider agencies reviewed or investigated who delivered and paid for services as specified in the PCSP. Denominator: Total number of provider agencies reviewed or investigated.
Discovery Activity One *(Source of Data & sample size)*	Utilization review of a random sampling of individual's services will be conducted to compare services delivered to the individual's PCSP. Sample will match sample pulled for PCSP review.
Discovery Evidence Two	Each PASSE meets its own established Medical Loss Ratio (MLR). Numerator: Number of PASSE's that meet the MLR; Denominator: Total number of PASSE's
Discovery Activity Two	The PASSE must report its MLR on the Benefits Expenditure Report required to be submitted to DMS on a quarterly basis.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DAABHS, DMS or the EQRO
Requirement	Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Frequency	Quarterly.

Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DHS's PASSE Unit and its agents are responsible for oversight of the PASSE's including review of the quarterly Beneficiary Expenditure Report, the MLR, and the utilization review.
	Frequency *(of Analysis and Aggregation)*	Data will be gathered quarterly.

Requirement		Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percentage of HCBS Provider entities that meet criteria for abuse and neglect, including unexplained death, training for staff. Numerator: Number of provider agencies investigated who complied with required abuse and neglect training, including unexplained death set out in the Waiver and the PASSE provider agreement; Denominator: Total number of provider agencies reviewed or investigated.
	Discovery Activity *(Source of Data & sample size)*	During the review or investigation of PASSE Providers, DPSQA will ensure that appropriate training is in place regarding unexplained death, abuse, neglect, and exploitation for all PASSE Providers.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS Waiver Compliance Unit
	Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
	Frequency	Annually, and continuously, as needed, when a complaint is received.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	DQPSA will investigate all complaints regarding unexplained death, abuse, neglect, and exploitation.
	Frequency *(of Analysis and Aggregation)*	Data will be gathered annually. Individual Provider training records will be reviewed as necessary.

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Discovery	
Discovery Evidence One *(Performance Measure)*	Number and percentage of PASSE Care Coordinators and HCBS Providers who reported critical incidents to DMS or DDS within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Total number of critical incidents that occurred and were reviewed.
Discovery Activity One *(Source of Data & sample size)*	DMS and DDS will review all the critical incident reports they receive on a quarterly basis.
Discovery Evidence Two	Number and percentage of HCBS Providers who adhered to PASSE policies for the use of restrictive interventions. Numerator: Number of HCBS providers who adhered to PASSE policies for the use of restrictive interventions as documented on an incident report; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.
Discovery Activity Two	DMS, DPSQA and DDS will review the critical incident reports regarding the use of restrictive interventions and will ensure that PASSE policies were properly implemented when restrictive intervention was used.
Discovery Evidence Three	Number and percentage of PASSE Care Coordinators and HCBS Providers who took corrective actions regarding critical incidents to protect the health and welfare of the individual. Numerator: Number of PASSE Care Coordinators and HCBS Providers who took corrective actions; Denominator: Number of PASSE Care Coordinators and HCBS Providers required to take protective actions regarding critical incidents.
Discovery Activity Three	DMS, DPSQA and DDS will review the critical incident reports received to ensure that PASSE policies were adequately followed and steps were taken to ensure that the health and welfare of the individual was ensured.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS or the EQRO

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

By using encounter data, the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for individuals receiving HCBS State Plan services. The state will utilize the encounter data to monitor services provided to determine a baseline, median and any statistical outliers for those service costs. Additionally, the state will monitor grievance and appeals filed with the PASSE regarding HCBS State Plan services under the broader Quality Improvement Strategy for the 1915(b) PASSE Waiver.

2. Roles and Responsibilities

The State will work with an External Quality Review Organization (EQRO) to assist with analyzing the encounter data and data provided by the PASSEs on their quarterly reports.

The DHS PASSE unit will proactively monitor service provision for individuals who are receiving 1915(i) services. Additionally, the team will review PASSE provider credentialing and network adequacy.

3. Frequency

Encounter data will be analyzed quarterly by the DHS PASSE unit and annually by the EQRO.

Network adequacy will be monitored quarterly.

4. Method for Evaluating Effectiveness of System Changes

The DHS PASSE Unit will utilize multiple methods to evaluate the effectiveness of system changes. These may include site reviews, contract reviews, encounter data, complaints, and any other information that may provide a method for evaluating the effectiveness of system changes.

Any issues with the provision of 1915(i) services that are continually uncovered may lead to sanctions against providers or the PASSE that is responsible for access to 1915(i) services.

DAABHS or the EQRO will randomly audit each PCSP that is maintained by each PASSE to ensure compliance.

1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Partial Hospitalization; Adult Rehabilitative Day Service; Supported Employment; Supportive Housing; Adult Life Skills Development; Therapeutic Communities; Peer Support; and Aftercare Recovery Support

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

◉	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:*
(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
(b) the geographic areas served by these plans;
(c) the specific 1915(i) State plan HCBS furnished by these plans;
(d) how payments are made to the health plans; and
(e) whether the 1915(a) contract has been submitted or previously approved.

☐ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

○	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
	○ The Medical Assistance Unit *(name of unit)*:	
	○ Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) *This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.*	
⊙	The State plan HCBS benefit is operated by *(name of agency)*	
	Division of Aging, Adult and Behavioral Health Services (DAABHS)	
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1. Individual State plan HCBS enrollment	☑	☑	☑	☐
2. Eligibility evaluation	☑	☑	☑	☐
3. Review of participant service plans	☑	☐	☑	☐
4. Prior authorization of State plan HCBS	☑	☐	☑	☐
5. Utilization management	☑	☐	☑	☐
6. Qualified provider enrollment	☑	☐	☐	☐
7. Execution of Medicaid provider agreement	☑	☐	☐	☐
8. Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☑	☐
9. Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☑	☐	☐
10. Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The state's contracted vendor, Gainwell will assist with 1,6, and 7; Optum will assist with 2; Osource the state's contracted External Quality Review Organization (EQRO) will assist with 3 and 10; Kepro will assist with 4 and 5; and Milliman, the state's contracted actuary will assist with 8.

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected
Year 1	March 1, 2024	February 28, 2025	150
Year 2	March 1, 2025	February 28, 2026	
Year 3	March 1, 2026	February 28, 2027	
Year 4	March 1, 2027	February 29, 2028	
Year 5	March 1, 2028	February 28, 2029	

2. ☐ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.
☑ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
⊙	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	DHS's contracted vendor, Optum.

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

For the behavioral health population, the assessor must have:

a. Bachelor's Degree (in any subject) or be a registered nurse,
b. One (1) year of experience with mental health populations.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Eligibility is re-evaluated on an annual basis and all individuals who have an existing Tier 2 or above determination and meet Medicaid eligibility requirements are referred for annual evaluation. Reevaluations may be conducted in person or through the use of telehealth.

After the independent assessment of functional need is completed, DHS's contracted vendor, Optum determines whether an individual is eligible for 1915(i) through an evaluation of the client's functional deficit through an evaluation of the client and caregiver report.

4. ☑Reevaluation Schedule. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑Needs-based HCBS Eligibility Criteria. *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

After medical eligibility has been determined through diagnosis, the following needs-based criteria is used:
The beneficiary must receive a minimum of a Tier 2 on the Arkansas Independent Assessment (ARIA). To meet a Tier 2, the beneficiary must have the need for assistance because of certain behaviors that require non-residential services to help with functioning in home and community-based settings and moving towards recovering and is not a harm to his or herself or others.
The state utilizes the ARIA tool to determine needs-based eligibility based on the measurement of an individual's needs as assessed under the following domains:
Adaptive, personal/social, communication, motor, and cognitive. The ARIA tool takes into account the individuals' ability to provide his or her own support, as well as other natural support systems, as well as the level of need to accomplish ADLs and IADLs. Needs assessed are due to manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors.

6. ☑ Needs-based Institutional and Waiver Criteria. *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and

participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
The beneficiary must receive a minimum of a Tier 2 functional assessment for HCBS behavioral health services. To meet a Tier 2, the beneficiary must have difficulties with certain behaviors that require a full array of services to help with functioning in home and community-based settings and moving towards recovering and is not a harm to his or herself or others. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors. The state utilizes the Arkansas Independent Assessment (ARIA) tool to determine needs-based eligibility.	Must meet at least one of the following three criteria as determined by a licensedmedical professional: 1. The client is unable to perform either of the following: A. At least one (1) of the three (3) activitiesof daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from ortotal dependence upon another person; or, B. At least two (2) of the three (3) activities of dailyliving (ADLs) of transferring/locomotion, eating or toileting withoutlimited assistance from another person; or, 2. The client has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she	1) Diagnosis of developmental disability that originated prior to ageof 22; 2) The disability has continued or is expected to continue indefinitely; and 3) The disability constitutes a substantial handicap tothe person's ability to function without appropriate support services, including butnot limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment. Must also be in need of andable to benefit from active treatment and unable to access appropriate servicesin a less restrictive setting.	There must be a written certification of need (CON)that states that a client is or was in need of inpatient psychiatric services. The certification must be made at the time of admission, or if a client applies for Medicaid while in the facility, the certification must be made before Medicaid authorizes payment. Tests and evaluations usedto certify need cannot be more than one (1) year old. All histories and information used to certifyneed must have been compiled within the year prior to the CON. In compliance with 42 CFR441.152, the facility-based and independent CON teams must certify that: A. Ambulatory care resources available in the community do not meet the treatment needs of the client; B.Proper treatment of

	engages in inappropriate behaviors which pose serious health orsafety hazards to himself or others; or, 3. The client has a diagnosed medical condition which requires monitoring or assessment atleast once a day by a licensed medical professional and the condition, if untreated, would be life-threatening. 4. No client who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical conditionwhich is temporary and expected to last no more than twenty-one (21) days. However, that client shall not receive waiver services or benefits when subject to a condition or change of condition which would render the client ineligible if expected to last more than twenty-one (21)days.		the client's psychiatric condition requires inpatient services under the direction of a physician and C. The services can bereasonably expected to prevent further regression or to improvethe client's condition so that the services will no longer be needed. Specifically, a physician must make a medical necessity determination that services must be provided in a hospital setting because the client cannot safely remain in the community setting.

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

The State will target this 1915(i) State plan HCBS benefit to clients in the following eligibilitygroups:

1.) Clients who qualify for Medicaid through spend-down eligibility.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* One	
ii.	**Frequency of services**. The state requires (select one):	
	⊙	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The 1915(i) service settings are fully compliant with the home and community-based settings.

The process that the state Medicaid agency used to assess and determine that the new service settings meet the HCB settings requirements and that the new services continue to meet the HCB settings requirements is overseen by the Division of Provider Services and Quality Assurance (DPSQA). DPSQA reviews all provision of services to ensure they are performed in home and community settings and integrated in order to support full access of individuals receiving Medicaid HCBS to the greater community and in compliance with 42 CFR §441.301(c)(4)(i) on an annual basis.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

For the behavioral health population, the assessor must have:

a. Bachelor's Degree (in any subject) or be a registered nurse,
b. One (1) year of experience with mental health populations.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

Allowable practitioners that can develop the PCSP are:

- Independently Licensed Clinicians (Master's/Doctoral)
- Non-independently Licensed Clinicians (Master's/Doctoral)
- Advanced Practice Nurse (APN)
- Physician

Providers who complete the PCSP are not allowed to perform HCBS services allowed under this 1915(i) authority. Arkansas Medicaid requires that the performing provider (orindividual who has clinical responsibility of the services provided) is indicated on claims when submitting billing.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

During the development of the Person-Centered Service Plan for the individual, everyone in attendance is responsiblefor supporting and encouraging the client to express their wants and desires and to incorporate them into the PCSP when possible.

The PCSP is a plan developed in cooperation with the client to deliver specific mental health services to restore, improve, or stabilize the client's mental health condition. The Plan must be based on individualized service needs as identified in the ARIA results and service provider documentation. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify, specific treatment modalities prescribed for the client, and time limitations for services. The plan must be congruent with the age and abilities of the client, person-centered and strength-based; with emphasis on needs as identified by the client and demonstrate cultural competence.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Each participant has the option of choosing their 1915(i) State plan service provider. If, at any point during the course of treatment, the current provider cannot meet the needs of the participant, they mustinform the participant as well as their Primary Care Physician / Person Centered Medical Home.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The PCSP is a plan developed in cooperation with the client (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the client's mental health condition. The PCSP must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. PCSP will be signed by all individuals involved in the creation of the treatment plan, the client (or signature of parent/guardian/custodian if under the age of 18), and the physician responsible for treating the mental health issue. Plans should be updated annually, when a significant change in circumstances or need occurs, and/or when the client requests, whichever is most frequent.

PCSP's will be completed by a vendor using a standard PCSP template. The Division of Medical Services (DMS) approves all contractual requirements and manages the contract to ensure compliance with federal regulations (including 42 CFR 441.725). Contract language for the process used to complete the PCSP, qualifications of the individual completing the PCSP as well as level of supervision of that staff member ensure that all beneficiaries receive the required individual attention that results in a PCSP prepared to meet their needs. DMS has ultimate authority and responsibility in the operation and oversight of the PCSP approval process. Either DMS or the EQRO communicates the finding from the review and the state requires vendor remediation.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☑	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Supported Employment
Service Definition (Scope)*:*	
Supported Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, asset development and career advancement services. Other workplace support services	

including services not specifically related to job skill training that enable the beneficiary to be successful in integrating into the job setting.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☑ Medically needy *(specify limits):*

Service authorized based on client need

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurances	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-

			training sufficient to perform all tasks assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Adult Rehabilitat**ive** Day Service

Service Definition (Scope)*:*

A continuum of care provided to recovering clients living in the community based on their level of need. This service includes educating and assisting the clients with accessing supports and services needed. The service assists recovering clients to direct their resources and support systems.

Activities include training to assist the clients to improve learn, retain or improve specific job skills and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In additional, transitional services to assist beneficiaries in stepping down after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

This service include**s** an array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified clients that are aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person and family centered, recovery based, culturally competent, and provide needed accommodation for any disability and must have measurable outcomes.These activities assist the beneficiary with compensating for or eliminating

functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness.

The intent of these services is to restore the fullest possible integration of the client as an active and productive member of his or her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management, and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement the client's behavioral health treatment plan.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☑ Medically needy *(specify limits):*

Staff to client ratio: 1:15

Daily Maximum of Units: 6

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP) (enhanced level)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following:

			1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Adult Life Skills Development

Service Definition (Scope)*:*

A service that provides support and training for adults on a one-on-one or group basis. This service should be a strength-based, culturally appropriate process that integrates the client into their community as they develop their recovery plan or habilitation plan. This service is designed to assist clients in acquiring the skills needed to support as independent a lifestyle as possible, enable them to reside in their community (in their own home, with family, or in an alternative living setting), and promote a strong sense of self-worth. In addition, it aims to assist clients in setting and achieving goals, learning independent life skills, demonstrating accountability, and making goal-oriented

decisions related to independent living. Services are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.

Other topics may include: educational or vocational training, employment, resource and medication management, self-care, household maintenance, health, socialization, community integration, wellness, and nutrition.

The PCSP should address the recovery or habilitation objective of each activity performed under Supportive Life Skills Development.

In a group setting, the provider must maintain a beneficiary to staff ratio of 10:1

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☑	Medically needy *(specify limits):* Daily Maximum of Units: 8

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following:

			1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	Department of Human Services, Division Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Partial Hospitalization

Service Definition (Scope)*:*

Partial Hospitalization is an intensive nonresidential, therapeutic treatment program delivered in a community-based clinic setting. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to- beneficiary ratio sufficient to ensure necessary therapeutic services. Partial Hospitalization may be appropriate as a time-limited response to stabilize acute symptoms, transition (an inpatient setting), or as a stand-alone service to stabilize a deteriorating

condition and avert hospitalization.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☑ Medically needy *(specify limits):*

A provider may not bill for any other services on the same date of service.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Servicesand Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks

			assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Therapeutic Communities

Service Definition (Scope)*:*

A setting that emphasizes the integration of the client within his or her community; progress is measured within the context of that community's expectation. Therapeutic Communities are highly structured environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the client on their PCSP. Therapeutic Communities employ community-imposed consequences and earned privileges as part of the recovery and growth process. These consequences and privileges are decided upon by the individual clients living in the community. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the community setting. Participants and staff clients act as facilitators, emphasizing self-improvement. These activities must also have measurable outcomes directly related to the beneficiary's PCSP.

Therapeutic Communities services may be provided in a provider-owned apartment or home, or in a provider-owned facility with fewer than 16 beds.

All medically necessary 1905(a) services are covered for EPSDT eligible individuals in accordance with 1905(r) of the Social Security Act.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☑ Medically needy *(specify limits):*

None

A provider may not bill for any other services on the same date of service.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Supportive Housing

Service Definition (Scope)*:*

Supportive Housing is designed to ensure that clients have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists clients in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey.

Supportive Housing includes assessing the client's individual housing needs and presenting options, assistingin securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history), searching for housing, communicating with landlords, coordinating the move, providing training in how to be a good tenant, and establishing procedures and contacts to retain housing.

Supportive Housing can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope

than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☑	Medically needy *(specify limits):*
	Services authorized based on client need

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: Peer Support

Service Definition (Scope)*:*

A person-centered service where adult peers provide expertise not replicated by professional training.

Peer support providers are trained peer specialists who work with clients to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach his or her fullest potential. Peer specialists may assist with navigation of multiple systems (housing, supported employment, supplemental benefits, building/rebuilding natural supports, etc.) which improve the client's functional ability. Services are provided on an individual or group basis and may be provided in the home or the community.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☑	Medically needy *(specify limits):*
	Service authorized based on client need

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*

Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral HealthAgency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Aftercare Recovery Support (for Substance Abuse)

Service Definition (Scope)*:*

A continuum of care provided to recovering clients living in the community based on their level of need. This service includes educating, face-to-face monitoring, and supporting the beneficiary with accessing supports and services needed. The service assists the recovering beneficiary to direct their resources and support systems and provide face-to-face supportive services including monitoring of symptoms, assessment of relapse factors and referral when appropriate. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.

Aftercare Recovery Support can occur in following:

- The individual's home;
- In community settings such as school, work, church, stores, or parks; and
- In a variety of clinical settings for adults, similar to adult day cares or adult day clinics.

All medically necessary 1905(a) services are covered for EPSDT eligible clients in accordance with 1905(r) of the Social Security Act.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☑	Medically needy *(specify limits):*

Service authorized based on client need

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	N/A	Certified by the Arkansas Department of Human Services, Division of	• Enrolled as a Behavioral Health Agency in Arkansas Medicaid • Cannot be on the National or State Excluded Provider List. Individuals who perform 1915(i) Adult

		Provider Services and Quality Assurance	Behavioral Health Services for Community Independence Behavioral Health Services must work under the direct supervision of a mental health professional. Allowable performing providers of 1915(i) Adult Behavioral Health Services for Community Independence are the following: 1. Qualified Behavioral Health Provider – non-degreed 2. Qualified Behavioral Health Provider – Bachelors 3. Registered Nurse – (Must be licensed as an RN in the State of Arkansas) All performing providers must have successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Behavioral Health Agency Or Community Support System Provider (CSSP)	Department of Human Services, Division of Medical Services	Behavioral Health Agencies must be re-certified every 3 years as well as maintain national accreditation. Behavioral Health Agencies are required to have yearly on-site inspections of care (IOCs).

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

2. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

a) Medicaid Enrolled Behavioral Health Agencies and Community Support System Providers are able to provide State Plan HCBS under authority of this 1915(i). Relatives of clients who are employed by a Behavioral Health Agency or Community Support System Providers as a Qualified Behavioral Health Provider or Registered Nurse may be paid to provide HCBS services, provided they are not the parent, legally responsible individual, or legal guardian of the client.
b) The HCBS services that relatives may provide are: supportive housing, supported employment, adult rehabilitative day treatment, therapeutic communities, partial hospitalization and life skills development.
c) All relatives who are paid to provide the services must meet the minimum qualifications set forth in this1915(i) and may not be involved in the development of the PCSP.
d) All services are retrospectively/retroactively reviewed for medical necessity. Each Behavioral Health Agency or Community Support System Provider is subject to Inspections of Care (IOCs) as well as monitoring by the Office of Medicaid Inspector General.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

⊙	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct*

their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. ***(****Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
	☐ **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐ **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○ The state does not offer opportunity for participants to direct a budget.
○ Participants may elect Participant–Budget Authority.
Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	Requirement 1, A: Service Plans Address Needs of Participants are reviewed annually and document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of PCSPs developed by the state's contracted vendor which provide 1915(i) State Plan HCBS that meet the requirements of 42 CFR §441.725. Numerator: Number of PCSPs that adequately and appropriately address the client's needs. Denominator: Total Number of PCSP**s** reviewed.
Discovery Activity *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of PCSPs are retrospectively/retroactively reviewed as well as all HCBSprovided to eligible client**s**. Retrospective/retroactive reviews of services will occur at least annually for all services provided. The data will be produced by the Behavioral Health Agencies or Community Support System Providers and must remain in the medical record of the client.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DAABHS and EQRO
Requirement	Requirement 1, B: Service Plans

	Frequency	Sample will be selected and reviewed annually.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	The state's contracted vendor will be responsible for remediating deficiencies in the client**s'** PCSPs. If there is a pattern of deficiencies noticed, action may be taken against the vendor.
	Frequency *(of Analysis and Aggregation)*	Findings will be reported to the vendor on a quarterly basis. If a pattern of deficiency is noted, this may be made public.

Requirement	Requirement 2: Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i)benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence One *(Performance Measure)*	1. The number and percent of beneficiaries who are independently assessed and evaluated for eligibility within 14 days of successful contact with the beneficiary. Numerator: The number of beneficiaries who are evaluated and assessed for eligibility within 14 days after the date of successful contact. Denominator: The total number of beneficiaries who are referred for the 1915(i) HCBS State Plan Services and who are successfully contacted by the Independent Assessment vendor.
Discovery Activity One *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of the application packets for beneficiaries who undergo the eligibility process will be reviewed for compliance with the timeliness standards. The data will be collected from the Independent Assessment Vendor.
Monitoring Responsibilities	The Independent Assessment Vendor, EQRO, DAABHS, and DMS.

	(Agency or entity that conducts discovery activities)	
	Frequency	Quarterly
	Remediation	
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	For Independent Functional Assessments: The Independent Assessment Vendor is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submitsmonthly reports to DMS. When deficiencies are noted, a corrective action plan will be implemented with the Vendor.
	Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.
	Discovery Evidence Two	The number and percent of beneficiaries for whom the appropriate eligibility process and instruments were used to determine initial eligibility for HCBS State Plan Services. Numerator: Number of beneficiaries' application packets that reflect appropriate processes and instruments were used. Denominator: Total Number of application packets reviewed
	Discovery Activity Two	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of the application packets for clients who went through the eligibility determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
	Monitoring Responsibility	The Independent Assessment Vendor, EQRO, DAABHS, and DMS
	Discovery Evidence Three	The number and percent of beneficiaries who are re-determined eligible for HCBS State Plan Services prior to the expiration of the current IA. Numerator: The number of beneficiaries who are re-determined eligible for HCBS State Plan Services prior to the expiration of the current IA. Denominator: The total number of beneficiaries whose IA is set to expire during the specific year.
	Discovery Activity Three	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of a 100% of the application packets for clients who went through the eligibility re-determination process will be reviewed. The data will be collected from the Independent Assessment Vendor.
	Monitoring Responsibilities	The Independent Assessment Vendor, EQRO, DAABHS, and DMS
	Frequency	Sample will be selected and reviewed quarterly.

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	For Independent Functional Assessments: The Independent Assessment Vendor is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submitsmonthly reports to DHS's Independent Assessment Contract Manager. When deficiencies are noted, a corrective action plan will be implemented with the vendor.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	For Independent Functional Assessments: The Independent Assessment Vendor is responsible for developing and implementing a quality assurance process, which includes monitoring for accuracy, data consistency, integrity, and completeness of assessments, and the performance of staff. This must include a desk review of assessments with a statistically significant sample size. Of the reviewed assessments, 95% must be accurate. The Independent Assessment Vendor submits monthly reports to DHS's Independent Assessment Contract Manager. When deficiencies are noted, a corrective action plan will be implemented with the vendor.
Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported quarterly.

Requirement	Requirement 3: Providers meet required qualifications.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of Behavioral Health Agencies and Community Support System providers certified and credentialed by DPSQA. Numerator: Number of Behavioral Health Agencies and Community Support System providers that obtained annual certification in accordance with DPSQA's standards. Denominator: Number of Behavioral Health Agencies and Community Support System providers reviewed.
Discovery Activity *(Source of Data & sample size)*	A statistically valid sample utilizing a confidence interval with at least a 95 percent confidence level and +/- 5 percent margin of error of 100% of Behavioral Health Agencies and Community Support System Providers certified by DPSQA will be reviewed. Data will be collected from DMS's Provider Enrollment Unit and DPSQA.
Monitoring Responsibilities	DPSQA, DAABHS, DMS, and EQRO

	(Agency or entity that conducts discovery activities)	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Remediation for the provider who does not meet the certification requirements is disenrollment from the Arkansas Medicaid Program. Remediation associated with provider certification that is not current would include an examination of the communication and processes between DPSQA and the provider enrollment contractor payments.
	Requirement	Requirement 3: Providers meet required qualifications.
	Frequency *(of Analysis and Aggregation)*	Data will be aggregated and reported annually.

Requirement	Requirement 4, A: Settings that meet the home and community-based setting requirements as specified in this SPA and in accordance with42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of provider owned apartments/homes reviewed that meet the home and community-based setting requirements as specified 42 CF 441.710(a)(1) & (2). Numerator: Number of provider owned apartments/homes reviewed that meet the home and community-based setting requirements as specified in specified 42 CF 441.710(a)(1) & (2). Denominator: Total number of provider owned apartment/home settings reviewed.
Discovery Activity *(Source of Data & sample size)*	Review of the Settings Review Report sent to DMS. The reviewed providers will be randomly selected. A typical review will consist of at least 10% of applicable providers each year.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DPSQA and DMS
Frequency	Annually
Remediation	
Remediation Responsibilities	The Behavioral Health Agencies or CSSP providers will be responsible for ensuring compliance with HCBS Settings requirements. If there is a pattern of deficiencies noticed by DPSQA DMS, action will be taken against the

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Behavioral Health Agency or CSSP provider, up to and including, instituting a corrective action plan or sanctions pursuant to the Provider Agreement.
Frequency *(of Analysis and Aggregation)*	Annually.

Requirement	Requirement 5: The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of rules developed by DAABHS must be reviewed and approved by DMS and promulgated in accordance with the DHS agency review process and the Arkansas Administrative Procedures Act (APA)**.** Numerator: Number of rules appropriately promulgated in accordance with agency policy and the Arkansas Administrative Procedures Act (APA). Denominator: Number of rules promulgated.
Discovery Activity *(Source of Data & sample size)*	100% of rules developed must be reviewed for compliance with the agency policy and the APA.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DMS Waiver Compliance Unit or its agents
Requirement	Requirement 5: The SMA retains authority and responsibility for program authority and oversight
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates*	DMS is responsible for compliance with Agency policy and with the APA. In cases where policy or procedures were not reviewed and approved according to DHS policy, remediation includes DHS review of the policy upon discovery, and approving or removing the policy.

	remediation activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Each policy will be reviewed for compliance with applicable DHS policy and the APA.

Requirement		Requirement 6: The SMA maintains financial accountability through payment of claims for services that are authorized andfurnished to 1915(i) clients by qualified providers.
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of claims reviewed that are coded and paid in accordance with the reimbursement methodology specified and only for services rendered. Numerator: Number of encounter claims reviewed that are coded and paid in accordance with the reimbursement methodology specified and only for services rendered. Denominator: Number of claims reviewed.
	Discovery Activity *(Source of Data & sample size)*	Utilization review of a statistically valid sample of claims to validate services were rendered by an enrolled Medicaid HCBS provider and paid in accordance with program requirements.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DAABHS, DMS or the EQRO
	Frequency	Annually
	Remediation	
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Action will be taken against the provider up to and including, instituting a corrective action plan or sanctions.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	Requirement 7: The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death, including the use of restraints.
Discovery Evidence One *(Performance Measure)*	Number and percent of Behavioral Health Agencies or Community Support System Provider who reported critical incidents to DMS or DAABHS within required time frames. Numerator: Number of critical incidents reported within required time frames; Denominator: Total number of critical incidents that occurred and were reviewed.
Discovery Activity One *(Source of Data & sample size)*	DPSQA and DAABHS will review all the critical incident reports they receive on a quarterly basis.
Discovery Evidence Two	Number and percent of Behavioral Health Agencies or Community Support System Provider Providers who adhered to Provider policies for the use of restrictive interventions. Numerator: Number of incident reports reviewed where the Provider adhered to policies for the use of restrictive interventions; Denominator: Number of individuals for whom the provider utilized restrictive intervention as documented on an incident report.
Discovery Activity Two	DMS will review the critical incident reports regarding the use of restrictive interventions and will ensure that Provider policies were properly implemented when restrictive intervention was used.
Discovery Evidence Three	Number and percent of Behavioral Health Agencies or Community Support System Providers who took corrective actions regarding critical incidents to protect the health and welfare of the client. Numerator: Number of critical incidents reported when Behavioral Health Agencies or Community Support System Provider took protective action in accordance with State Medicaid requirements and policies; Denominator: Number of critical incidents reported.
Discovery Activity Three	DPSQA and DAABHS will review the critical incident reports received to ensure that Provider policies were adequately followed and steps were taken to ensure that the health and welfare of the client was ensured.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	DAABHS and DPSQA
Remediation	

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The State will work with a contracted vendor to develop PCSP with client and identified service provider will begin providing HCBS and mental health professional services. The service provider will use the PCSP and develop a treatment plan identifying all treatment services they are providing with goals and objectives.

Through Medicaid claims data the State will have the ability to measure the amount of services provided compared to what is described within the Person Centered Service Plan (PCSP) that is required for clients receiving HCBS State Plan services.

The State will work with an External Quality Review Organization (EQRO) to assist with comparison of service indicated on PCSP and claims submitted for those same services.

The State will investigate and monitor any complaints about agencies certified to provide 1915(i) services.

2. Roles and Responsibilities

The State (including DAABHS, DMS, DPSQA, and its agents) will be responsible for oversight of BehavioralHealth Agencies and Community Support System Providers providing 1915(i) FFS services.

3. Frequency

On-going monitoring will occur. Quarterly and annual reports will be analyzed and reviewed by the appropriate AR DHS divisions.

4. Method for Evaluating Effectiveness of System Changes

The State will utilize multiple methods to evaluate the effectiveness of system changes. These mayinclude site reviews, contract reviews, claims data, complaints, and any other information that may provide a method for evaluating the effectiveness of system changes.

Any issues with the provision of 1915(i) services that are continually uncovered may lead to sanctions against providers or the Behavioral Health Agencies that are responsible for access to 1915(i) services.

Mandatory Coverage for Eligible Juveniles who are Inmates of a Public Institution Post Adjudication of Charges

State/Territory: Arkansas

General assurances. State must indicate compliance with all four items below with a check.

☑ In accordance with section 1902(a)(84)(D) of the Social Security Act, the state has an internal operational plan and, in accordance with such plan, provides for the following for eligible juveniles as defined in 1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution following adjudication:

> ☑ In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements, including a behavioral health screening or diagnostic service.
>
> ☑ In the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

☑ The state acknowledges that a correctional institution is considered a public institution and may include prisons, jails, detention facilities, or other penal settings (e.g., boot camps or wilderness camps).

PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 50 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Additional information provided (optional):

☐ No

☑ Yes [provide below]

The state may determine that it is not feasible to provide the required services during the pre-release period in certain carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g. unexpected release or short-term stays). The state will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the state determines that it is not feasible to provide for the required services during the pre-release period. This information is available to CMS upon request. Services will be provided post-release, including the mandatory 30-days of targeted case management, screening, and diagnostic services.

The state will maintain clear documentation in its internal operational plan indicating which carceral facility/facilities are furnishing required services during the pre-release period but not enrolling in or billing Medicaid. This information is available to CMS upon request.

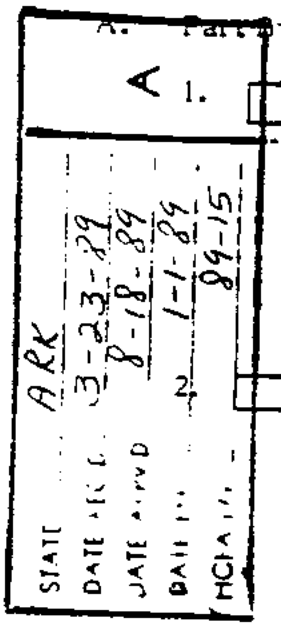
PRA Disclosure Statement - This use of this form is mandatory and the information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 5121 of the Consolidated Appropriations Act, 2023. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #85). Public burden for all of the collection of information requirements under this control number is estimated to take about 50 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE ARKANSAS

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:



A. Part A buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☐ Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes ☐ No ☐

2. ☐ Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes ☐ No ☐

3. ☒ All individuals eligible under the State's approved title XIX plan.

4. ☒ Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment billing arrangement ~~entered into~~ with the ~~Social Security Administration.~~ This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. All eligible recipients enrolled in Medicare.

3. The State does not provide the full range of services available under Medicare Part B to recipients not covered by Medicare.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: ARKANSAS

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

STATE AR
DATE RECD JUL 1 1987
DATE EFFECTIVE JUL 30 1987
DATE LET See HCFA-179
HCFA 179 87-12
A

Revision: - HCFA-AT-80-38 (HPP)
May 22, 1980

State ARKANSAS

Citation	4.2 Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34	The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

TN # 74-16
Supersedes
TN #

Approval Date 5/31/74 Effective Date 4/24/74

State/Territory: ARKANSAS

Citation

42 CFR 431.301

AT-79-29

4.3 Safeguarding Information on Applicants and Recipients

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967

All other requirements of 42 CFR Part 431, Subpart F are met.

STATE AR
DATE RECD OCT 16 1987
DATE APVD SEP 13 1988
MAY 28 1987
DATE EFF
HCFA ID 87-24
A

TN No. 87-24
Supersedes
TN No. 84-16

Approval Date SEP 13 1988

Effective Date MAY 28 1987

HCFA ID: 1010P/0012P

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938
MARCH 1987
Revised: July 1, 1988
State/Territory: ARKANSAS

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessme system that meets the requirements of 431.800(e (g), (h) and (k).

/ / Yes.

/X/ Not applicable. The State has an approved Medicaid Management Information System (MMI

* Pen and ink change made per PM-87-14

STATE ARK
DATE REC'D 7-15-88
DATE APPVD 8-15-88
7-1-88
88-18
A

TN No. 88-17
Supersedes
TN No. 87-12

Approval Date 8-15-88 Effective Date 7-1-

HCFA ID: 1010P/0

Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-01
SEPTEMBER 1988

State/Territory: ARKANSAS

Citation
42 CFR 455.12
AT-78-90
48 FR 3742
52 FR 48817

4.5 Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.2 for prevention and control of program fraud and abuse.

STATE AR
DATE DEC 22 1988
DATE JAN 11 1989
DATE OCT 01 1988
HCFA 88-38

TN No. 88-38
Supersedes
TN No. 82-11

Approval Date JAN 11 1989 Effective Date

HCFA ID: 1010P/0012P

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: Arkansas

Citation
Section 1902(a)(64) of the Social Security Act
P.L. 105-33

4.5a Medicaid Agency Fraud Detection and Investigation Program

The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

STATE Arkansas
3-14-00
4-7-00
1-1-00
00-04
A

SUPERSEDES: NONE (NEW PAGE)

TN No. 00-04
Supersedes TN No. _____ Approval Date 4-7-00 Effective Date 1-1-00

Revision: February 1, 2025 **State Arkansas**

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation

Section 1902(a)(42)(B)(i) of the Social Security Act

___ The State established a program under which it contracts with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

X The state is seeking an exception to establishing such program from February 1, 2025, to January 31, 2027, for the following reasons:

Section 1902(a)(42)(B)(ii)(I) of the Act

- The majority of Medicaid covered working-aged adults in Arkansas are covered through ARHOME, which is a private option plan for the expansion population, and a small portion of Arkansans are covered in its PASSE managed care program for specialized populations. Combined with the existing program integrity operation discussed next, a RAC program is not likely to be financially feasible in the state.
- Arkansas has a robust and effective program integrity operation; therefore, a RAC is not necessary. Arkansas has numerous program integrity measures in place to combat fraud, waste, and abuse in our state's Medicaid program, including:
  - The Office of Medicaid Inspector General (OMIG) housed within the Arkansas Department of Inspector General, independent of the state Medicaid agency, serves as the state's Medicaid program integrity unit performing the following functions:
    - Prevention, detection, and investigation of fraud, waste, and abuse (FWA) within the Arkansas Medicaid program
    - Audits of Medicaid providers
    - Referral of appropriate cases for criminal prosecution
    - Recovery of improperly expended Medicaid funds;
  - OMIG uses advanced program integrity data analytics proven effective in identifying FWA;
  - Federal Unified Program Integrity Contractor;
  - The state Medicaid agency housed within the Department of Human Services (DHS) requires pre and post payment review for 1667 individual Medicaid claims and prior authorization for 7154 individual procedure codes;
  - DHS contracts with multiple vendors to perform retrospective review of clinical, hospital, and specialty population claims;
  - The DHS Office of Payment Integrity reviews Medicaid claims and program policy to identify program policy improvements that will reduce the occurrence of FWA.

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program (continued)

Citation

Section 1902(a)(42)(B)(i) of the Social Security Act

___ The State/Medicaid agency contracts the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

Place a check mark to provide assurance of the following:

Section 1902(a)(42)(B)(ii)(I) of the Act

___ The State will make payments to the RAC(s) only from amounts recovered.

___ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (percentage has not been determined):

___ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

___ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

___ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program (continued)

Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	_	The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): **The State is seeking an exception to the contingency fee methodology described in Section 1902(a)(42)(B)(ii)(I) of the Act. (See attached Arkansas legislation.)**
Section 1902 (a)(42)(B)(ii)(III) of the Act	X	The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	X	The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act	X	The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section1902 (a)(42)(B)(ii)(IV)(cc) of the Act	X	Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **ARKANSAS**

4.46 Provider Screening and Enrollment

Citation	The State Medicaid agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING __X__Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.
42 CFR 455.422	APPEAL RIGHTS __X__Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **ARKANSAS**

4.46 Provider Screening and Enrollment

42 CFR 455.432 SITE VISITS

__X__ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKGROUND CHECKS

__X__ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

__X__ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

__X__ Assures that the State Medicaid agency requires that National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

__X__ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460

APPLICATION FEE

__X__ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

__X__ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

Revision: HCFA-Region VI
June 21, 1991

State ARKANSAS

Citation
42 CFR 431.16
AT-79-29,
Section 1927 of the
Social Security Act

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met. The Medicaid agency will comply with the reporting requirements for State drug utilization information and on restrictions to coverage. The Medicaid agency will keep the drug unit rebate amount confidential and will not disclose it for purposes other than rebate invoicing and verification. All reporting and confidentiality requirements of Section 1927 of the Social Security Act are met.

TN # 91-10
Supersedes
TN # _____

Approval Date AUG 19 1991 Effective Date JAN - 1 1991

STATE Arkansas
DATE REC'D MAR 25 1991
DATE APPV'D AUG 19 1991
DATE EFF JAN - 1 1991
HCFA ID 91-10
Supersedes

A

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 431.18 (b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN # 74-14
Supersedes
TN #

Approval Date 5/17/74 Effective Date 4/8/74

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

TN # 74-14
Supersedes
TN # _____

Approval Date 5/17/74 Effective Date 4/8/74

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: Arkansas

Citation

4.10 Free Choice of Providers

42 CFR431.51
AT-78-90
46 FR 48524
48 FR23212
1902 (a) (23)
of the Act
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 4113)

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual--

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or

Section 1902(a)(23)
of the Social Security Act
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

Arkansas
3-14-00
4-7-00
1-1-00
00-04

A

TN No. 00-04
Supersedes
TN No. 97-13
Approval Date 4.7.00 Effective Date 1-1-00

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

Revised: February 1, 2003

State ARKANSAS

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Arkansas Department of Health and Arkansas Division of Medical Services

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Arkansas Division of Medical Services

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Centers for Medicare and Medicaid Services on request.

STATE Arkansas
DATE RECD 2-19-03
DATE APPVD 4-24-03
DATE EFF 2-1-03
HCFA ID 03-03

A

SUPERSEDES TN 86-23

TN # 03-03
Supersedes
TN # 86-23

Approval Date 4-24-03 Effective Date 2-1-03

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

Revised: February 1, 2003

State ARKANSAS

Citation	
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d) The Arkansas Department of Health and Arkansas Division of Medical Services (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

STATE Arkansas DATE RECD 2-19-03 DATE APP'D 4-24-03 DATE EFF 2-1-03 HCFA 179 03-03	A

SUPERSEDES TN 86-23

TN # 03-03
Supersedes
TN # 86-23

Approval Date 4-24-03 Effective Date 2-1-03

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

Revised: July 1, 1982

State ARKANSAS

Citation
42 CFR 431.105 (b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105 (b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

☒ Yes, as listed below:

All services covered under the State Plan.

☐ Not applicable. Similar services are not provided to other types of medical facilities.

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Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ARKANSAS

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

☐ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

TN No. 91-52
Supersedes TN No. 87-12 Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT 1 1991
HCFA 179 91-52

A

Revised: September 30, 2003

State/Territory: [ARKANSAS]

Citation			
1902 (a)(58)			
1902(w)	4.13	(e)	For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

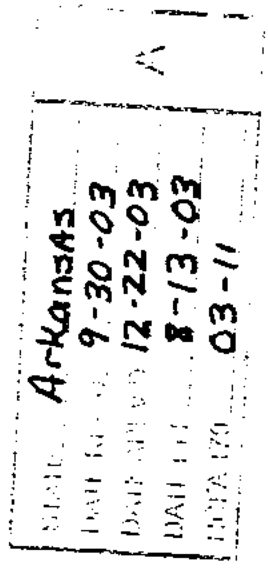
(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether



TN # 03-11
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SUPERSEDES TN 91-55

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State/Territory: [ARKANSAS]

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

Arkansas 9-30-03 12-22-03 8-13-03 03-11

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law Or court decision exist regarding advance directives.

TN # 03-11
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SUPERSEDES: TN- 91-55

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DECEMBER 1991

State/Territory: ARKANSAS

Citation
42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

4.14 Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

X Directly

X By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO--

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

___ Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.

1902(a)(30)(C)
and 1902(d) of the
Act, P.L. 99-509
(section 9431)

___ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

STATE Arkansas
DATE RECD DEC 30 1991
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Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: ARKANSAS

Revised: November 1, 198

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

[X] Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

[ ] Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

[ ] All hospitals (other than mental hospitals).

[ ] Those specified in the waiver.

[X] No waivers have been granted.

STATE	AR
DATE RECD	11-25-87
DATE APP'D	12-8-87
DATE EFF	11-1-87
HCFA 179	87-29

A

TN No. 87-29
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JULY 1985

State/Territory: ARKANSAS

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/ / Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/ / All mental hospitals.

/ / Those specified in the waiver.

/X/ No waivers have been granted.

/ / Not applicable. Inpatient services in mental hospitals are not provided under this plan.

APPROVED BY HHS/HCFA/BPO
DATE: NOV 7 1985
TRANSMITTAL NO: 85-21

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: ARKANSAS

OMB NO: 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/ / All skilled nursing facilities.

/X/ Those specified in the waiver.

/ / No waivers have been granted.

APPROVED BY DHHS/HCFA/DPO
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TN No. 85-21
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MAY 1985

State: ARKANSAS

OMB NO: 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /x/ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/ / Facility-based review.

/x/ Direct review by personnel of the medical assistance unit of the State agency.

/ / Personnel under contract to the medical assistance unit of the State agency.

/ / Utilization and Quality Control Peer Review Organizations.

/ / Another method as described in ATTACHMENT 4.14-A.

/ / Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/ / Not applicable. Intermediate care facility services are not provided under this plan.

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Citation

1902(a)(30) and 1902(d) of the Act, P.L. 99-509 (Section 9431) P.L. 99-203 (section 4113)

4.14 Utilization/Quality Control (Continued)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

___ A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ A private accreditation body.

___ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

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Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: ARKANSAS

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

___ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

___ ICFs/MR;

___ Inpatient psychiatric facilities for recipients under age 21; and

___ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

_X_ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

___ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

_X_ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

___ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

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DATE EFF DEC 01 1991
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Effective Date DEC 01 1991

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

TN # 74-13
Supersedes
TN #

Approval Date 5/16/74 Effective Date 4/8/74

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of
the Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

____ The State imposes liens on real property on account of benefits incorrectly paid.

____ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

____ The State imposes liens on both real and personal property of an individual after the individual's death.

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TN No. 95-19
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Revision: HCFA-PM-95-3 (MB)
May 1995
Revised: **June 1, 2010**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **ARKANSAS**

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h) – (i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) X The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

__ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

None

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June 1, 2010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **ARKANSAS**

4.17(b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery – Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

STATE Arkansas
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DATE EFF 7-1-08
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A

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May 1995
July 1, 2008

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: **ARKANSAS**

(4) ____ The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

____ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

____ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

____ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

1917(b)1(C) **X** If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

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Supersedes
TN No. 95-19

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SUPERSEDES: TN- 95-19

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MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

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DATE APP'D JUL 2 5 1995
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MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

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Revised: March 1, 1993
State/Territory: ARKANSAS

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/X/ Not applicable. There is no maximum.

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AUGUST 1991

OMB No.: 0938-

State/Territory: ARKANSAS

Citation			
1916(c) of the Act	4.18(b)(4)	☑	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5)	☑	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6)	☑	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

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A

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: ARKANSAS

Citation

4.18(c) ☑ Individuals are covered as medically needy under the plan.

42 CFR 447.51 through 447.58

(1) ☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

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State/Territory: ARKANSAS

Citation 4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

☐ Not applicable. No such charges are imposed.

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Revised: September 1, 1992
State/Territory: ARKANSAS

Citation 4.18(c)(3) **Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.**

☐ **Not applicable. No such charges are imposed.**

(i) **For any service, no more than one type of charge is imposed.**

(ii) **Charges apply to services furnished to the following age group:**

☒ 18 or older

☐ 19 or older

☐ 20 or older

☐ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

TN No. 92-33
Supersedes TN No. 91-52 Approval Date FEB 03 1993 Effective Date SEP 01 1992

HCFA ID: 7982E

STATE Arkansas
DATE REC'D SEP 08 1992
DATE APPV'D FEB 03 1993
DATE EFF SEP 01 1992
HCFA 179 92-33

A

State/Territory: ARKANSAS

Citation		
	4.18(c)(3) (Continued)	
447.51 through 447.58		(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:
		(A) Service(s) for which charge(s) is applied;
		(B) Nature of the charge imposed on each service;
		(C) Amount(s) of and basis for determining the charge(s);
		(D) Method used to collect the charge(s);
		(E) Basis for determining whether an individual is unable to pay the charge(s and the means by which such an individua is identified to providers;
		(F) Procedures for implementing and enforcin the exclusions from cost sharing contained in 42 CFR 447.53(b); and
		(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.
		☒ Not applicable. There is no maximum.
447.57	4.18(d)	The Medicaid agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, co-insurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under 42 CFR 447.57(b).

TN No. 93-05
Supersedes TN No. 92-33
Approval Date MAR 23 1993
Effective Date MAR 01 1993

HCFA ID: 7982E

STATE Arkansas
DATE RECD FEB 16 1993
DATE APPVD MAR 23 1993
DATE EFF MAR 01 1993
HCFA 179 93-05

A

TOTAL P.02

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ARKANSAS

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

☐ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

☒ Inappropriate level of care days are not covered.

PM 93-5 1902(e)(7) of the act

TN No. 91-52
Supersedes TN No. 87-12

Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA I/I 91-52

A

Revision: HCFA-PM-93- 6 (MB) OMB No.: 0938-
August 1993

State/Territory: ARKANSAS

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

STATE Arkansas
DATE REC'D 8-27-93
DATE APPV'D 9-3-93
DATE EFF 8-1-93
HCFA 179 93-27

A

No. 93-27 TN
Supersedes TN No. 92-04 Approval Date 9-3-93 Effective Date 8-1-93

*U.S. G.P.O.:1993-342-239:80149

Revision: HCFA-AT-80-38 (BPP)
- May 22, 1980

State ARKANSAS

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

Revision: HCFA - Region VI
November 1990

60

State/Territory: ARKANSAS

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141
Section 1902(a)(13)(A) of Act (Section 4211 (h)(2)(A) of P.L. 100-203).

4.19 (d)

(1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for nursing facility services and intermediate care facility services for the mentally retarded.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for nursing facility services and intermediate care facility services for the mentally retarded.

(2) The Medicaid agency provides payment for routine nursing facility services furnished by a swing-bed hospital.

☐ At the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

[X] Not applicable. The agency does not provide payment for NF services to a swing-bed hospital.

STATE Arkansas
DATE REC'D DEC 19 1990
DATE APP'VD 4-19-91
DATE EFF OCT - 1 1990
HCFA 179 90-61

A

TN No. 90-61
Supersedes
TN No. 87-22

Approval Date _____ Effective Date OCT - 1 1990

Revision: HCFA-Region VI
March 1991

State ARKANSAS

Citation		
42 CFR 447.45 AT-79-50 Sec. 1915(b)(4), (Sec. 4742 of P.L. 101-508)	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

STATE Arkansas
DATE RECD 3-29-91
DATE APPV'D 4-9-91
DATE EFF 1-1-91
HCFA 179 91-13

A

TN# 91-13 Approval Date 4/9/91 Effective Date 1/1/91
Supersedes
TN# 79-11

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: ARKANSAS

Citation	
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing charge.

AR
JUL 1 1987
JUL 30 1987
See HCFA-179
87-12

TN No. 87-12
Supersedes
TN No. 83-8

Approval Date JUL 30 1987 Effective Date See HCFA-17

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

TN # 79-12
Supersedes TN # _____

Approval Date 10/9/79 Effective Date 8/6/79

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State ARKANSAS

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19 (i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

TN # 79-12
Supersedes
TN #

Approval Date 10/9/79 Effective Date 8/6/79

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: ARKANSAS

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

TN No. 91-52
Supersedes TN No. 87-21 Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-52

A

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: ARKANSAS

Citation

1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Arkansas
DEC 07 1992
DEC 23 1992
OCT 01 1992
92-41

TN No. 92-41
Supersedes TN No. One-Time Only Approval Date DEC 23 1992 Effective Date OCT 01 1992

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: ARKANSAS

Citation		
4.19 (m)		Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
1928(c)(2)(C)(ii) of the Act	(i)	A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.
	(ii)	The State:

___ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

_X_ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

$8.69

1926 of the Act	(iii)	Medicaid beneficiary access to immunizations is assured through the following methodology:

Other - (The method to assure Medicaid beneficiary access to immunizations is pending subject to further guidance by the Federal Government.)

STATE Arkansas
DATE REC'D 05-01-95
DATE APPV'D 05-09-95
DATE EFF 07-01-95
HCFA 179 95-07

A

TN No. 95-07
Supersedes TN No. 94-27
Approval Date 05/9/95
Effective Date 07/1/95

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

State ARKANSAS

Citation

42 CFR 447.10(c)
AT-78-90
46 FR 42699

4.21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: ARKANSAS

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.

1902(a)(25)(H) and (I) Act.
of the Act

(4) Sections 1902(a)(25)(H) and (I) of the

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

STATE Arkansas
DATE REC'D 4-11-94
DATE APPV'D 4-26-94
DATE EFF 2-1-94
HCFA 179 94-07

A

TN No. 94-07
Supersedes TN No. 90-22
Approval Date 4/26/94
Effective Date 2/1/94

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: ARKANSAS

Citation

42 CFR 433.139(b)(3)(ii)(A) ___ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

STATE Arkansas
DATE [illegible] 4-11-94
DATE APPV'D 4-26-94
DATE EFF 2-1-94
HCFA ID 94-07

A

TN No. 94-07
Supersedes TN No. 90-22
Approval Date 4/26/94 Effective Date 2/1/94

November 2023

State/Territory: ARKANSAS

Citation		
Section 1902(a)(25)(E) **42 CFR 433.139(b)(3)(i)**	**(1)**	**The State will make payment for pediatric preventive services, including early and periodic screening, diagnosis, and treatment services, without regard to third party liability and seek reimbursement from any liable third party to the extent of such legal liability.**
Section 1902(a)(25)(F) **42 CFR 433.139(b)(3)(ii)**	**(2)**	**For services covered under the plan that are provided to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency, the State will make payment for such services without regard to third party liability up to 100 days that is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by the State Title IV-D agency, and seek reimbursement from such liable third party to the extent of legal liability.** **Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.**
Section 1902(a)(25)(E) **42 CFR 433.139(b)(3)(i)**	**(3)**	**The State shall make payment without regard to third party liability for pediatric preventive services unless a Determination related to cost-effectiveness and access to care that warrants cost avoidance up to 90 days has been made.**
Section 1902(a)(25)(E)	**(4)**	**The State will use standard coordination of benefits cost avoidance when processing claims for prenatal services, labor and delivery, and postpartum care claims.**

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: ARKANSAS

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s)--

___

___

___ Other appropriate agency(s) of another State--

___

___

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

X The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

STATE Arkansas DATE S 4-11-94 DATE A 4-26-94 DATE E 2-1-94 HCFA 179 94-07	A

TN No. 94-07
Supersedes TN No. 93-31
Approval Date 4/26/94 Effective Date 2/1/94

Revised: September 30, 2003

State/Territory: [Arkansas]

Citation		
42 CFR Part 434 48 FR 54013	4.23	Use of Contracts The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434. ☐ Not applicable. The State has no such contracts.

STATE Arkansas
DATE R 9-30-03
DATE 12-22-03
DATE EFF 8-13-03
HCFA ID 03-11
A

SUPERSEDES: TN: 84-06

TN # 03-11
Supersedes TN # 9406

Effective Date 8-13-03
Approval Date 12-22-03

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: ARKANSAS

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

STATE Arkansas
DATE REC'D 3-28-94
DATE APPV'D 4-11-94
DATE EFF 4-1-94
HCFA 179 94-05

A

No. 94-05 TN
Supersedes TN No. None-New Page Approval Date 4/11/94 Effective Date 4/1/94

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

TN # 74-4
Supersedes
TN #

Approval Date 3/3/74 Effective Date 12/31/73

Revision: HCFA-PM- (MB)

State/Territory: **ARKANSAS**

Citation

1927(g) 42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

-Appropriate
-Medically necessary
-Are not likely to result in adverse medical results

1927(g)(1)(a) 42 CFR 456.705(b) and 456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

-Potential and actual adverse drug reactions
-Therapeutic appropriateness
-Overutilization and underutilization
-Appropriate use of generic products
-Therapeutic duplication
-Drug disease contraindications
-Drug-drug interactions
-Incorrect drug dosage or duration of drug treatment
-Drug-allergy interactions
-Clinical abuse/misuse

1927(g)(1)(B) 42 CFR 456.703 (d)and(f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

-American Hospital Formulary Service Drug Information
-United States Pharmacopeia-Drug Information
-American Medical Association Drug Evaluations

STATE Arkansas
DATE REC'D APR 26 1993
DATE APP'D JUN 01 1993
DATE EFF APR 01 1993
HCFA I/9 93-17
A

TN No. 93-17
Supersedes TN No. 93-06 Approval Date JUN 01 1993 Effective Date APR 01 1993

Revision: HCFA-PM- (MB)

State/Territory: ARKANSAS

Citation		
1927(g)(1)(D) 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in: ___ Prospective DUR _X_ Retrospective DUR.
1927(g)(2)(A) 42 CFR 456.705(b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g)(2)(A)(i) 42 CFR 456.705(b), (1)-(7))	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Drug-interactions with non-prescription or over-the-counter drugs -Incorrect drug dosage or duration of drug treatment -Drug allergy interactions -Clinical abuse/misuse
1927(g)(2)(A)(ii) 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.
1927(g)(2)(B) 42 CFR 456.709(a)	F.1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: -Patterns of fraud and abuse -Gross overuse -Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

STATE Arkansas
DATE RECD APR 26 1993
DATE APPV'D JUN 01 1993
DATE EFF APR 01 1993
HCFA 179 93-17

A

TN No. 93-17
Supersedes TN No. 93-06
Approval Date JUN 01 1993 Effective Date APR 01 1993

Revision: HCFA-PM- (MB)

State/Territory: ARKANSAS

Citation	
1927(g)(2)(C) 42 CFR 456.709(b)	F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: -Therapeutic appropriateness -Overutilization and underutilization -Appropriate use of generic products -Therapeutic duplication -Drug-disease contraindications -Drug-drug interactions -Incorrect drug dosage/duration of drug treatment -Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3. The DUR program through its State DUR Board, using data provided by the Board, provides active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1. The DUR program has established a State DUR Board either: _X_ Directly, or ____ Under contract with a private organization
1927(g)(3)(B) 42 FR 456.716 (A) and (B)	2. The DUR Board membership includes health professionals (**at least 1/3 but no more than fifty-one percent (51%) licensed and actively practicing physicians and at least 1/3 licensed and actively practicing pharmacists**) with knowledge and experience in one or more of the following: -Clinically appropriate prescribing of covered outpatient drugs. -Clinically appropriate dispensing and monitoring of covered outpatient drugs. -Drug use review, evaluation and intervention. -Medical quality assurance.
1927(g)(3)(C) 42 CFR 456.716(d)	3. The activities of the DUR Board include: -Retrospective DUR, -Application of Standards as defined in section 1927(g)(2)(C), and -Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Revision: HCFA-PM- (MB)

State/Territory: ARKANSAS

Citation

1927(g)(3)(C)
42 CFR 456.711
(a)-(d)

G.4. The interventions include in appropriate instances:
-Information dissemination
-Written, oral, and electronic reminders
-Face-to-Face discussions
-Intensified monitoring/review of prescribers/dispensers

P.L. 115-271
Section 1004 of the
SUPPORT Act

H.1. The DUR program meets the requirements of Section 1004 of the SUPPORT Act for substance use-disorder prevention that promotes opioid recovery and treatment. Opioid claim review limitations for initial and subsequent refills require prospective safety edits and comprehensive retrospective claims review processes.

a) Prospective point-of-sale safety edits

- **Therapeutic duplication edit**
- **Maximum daily quantity edit**
- **Maximum monthly quantity edit**
- **Morphine Milligram Equivalent edit**
- **Refill too soon logic**
- **Age edit**
- **Maximum days' supply edits for treatment naïve and treatment experienced**

b) Retrospective claims review

- **Morphine Milligram Equivalent review per recipient and prescriber**
- **Concurrent opioid and benzodiazepine usage prompts prescriber or pharmacy provider notification by letter**
- **Concurrent opioid and antipsychotic medication usage prompts prescriber or pharmacy provider notification by letter**
- **Review opioid use in adolescents**
- **Review prescribing and dispensing patterns on opioid claims**
- **Retrospective reviews on opioid prescriptions exceeding these above limitations on an ongoing basis**

Revision: HCFA-PM- (MB)

State/Territory: ARKANSAS

Citation		
		H.2. Program to monitor antipsychotic medication use by children **a) Prospective point-of-sale edits** • **Age edits for recipients < 18 years old** • **Therapeutic duplication edit** • **Maximum dose edit** • **Antipsychotic medication usage in children including those in foster care are monitored in monthly reports by a staff psychiatrist** • **Routine metabolic labs required** **b) Retrospective claims review** • **Monitor antipsychotic use patterns in children including foster care** • **Doses of antipsychotic medications monitored**
		H.3. Fraud and Abuse Identification **a) Lock-in program for recipients identified by Retrospective DUR for possible abuse or misuse of controlled substances** **b) Prescriber and pharmacy provider patterns of misuse/overprescribing** • **Identified by Retrospective DUR** • **Identified by contracted auditor(s)** **c) Prescription Drug Monitoring programs enable prescribers and pharmacy providers to search the PDMP for monitoring narcotic use behavior including access to other states**
1927(g)(3)(D) **42 CFR 456.712** **(A) and (B)**	**X**	**I. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.**
1927(h)(1) **42 CFR 456.722**		**J.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:** **-real time eligibility verification** **-claims data capture** **-adjudication of claims** **-assistance to pharmacists, etc. applying for and receiving payment.**
1927(g)(2)(A)(i) **42 FR 456.705(b)**	**—**	**2. Prospective DUR is performed using an electronic point of sale drug claims processing system.**
1927(j)(2) **42 CFR 456.703(c)**		**K. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.**

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

TN # 80-6
Supersedes
TN #

Approval Date 4/14/80 Effective Date 10/15/79

Revision: HCFA-PM-93-1
January 1993

(BPD)

State/Territory: ARKANSAS

Citation	4.28 Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

STATE Arkansas
DATE REC'D APR 05 1993
DATE APPV'D MAY 12 1993
DATE EFF JAN 29 1993
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TN No. 93-13
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Approval Date MAY 12 1993 Effective Date JAN 29 1993

Revised: September 30, 2003

State: [Arkansas]

Citation	
1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

STATE: Arkansas
DATE RECEIVED: 9-30-03
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TN # 03-11
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Approval Date 12-22-03

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: ARKANSAS

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

[X] The agency, under the authority of State law, imposes broader sanctions.

STATE AR
DATE RECD 2-2-88
APPROVED 2-18-88
EFF DATE 9-30-86
HCFA ID 88-3
A

TN No. 88-3
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Approval Date 2-18-88
Effective Date 9-30-86

HCFA ID: 1010P/0012P

Revised: September 30, 2003

State/Territory: [Arkansas]

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation—
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

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SUPERSEDES: TN- 00-04

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: ARKANSAS

Citation

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by--

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of--

1902(a)(41)
of the Act
P.L. 96-272,
(sec. 308(c))

(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

STATE AR
DATE RE... 2-2-88
... 2-16-88
DATE ... 10-1-87
... QE-3
A

REGION VI
Revised: July 1, 2010

State/Territory: [Arkansas]

Citation

455.103
44 FR 41644
1902(a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967
P.L. 100-360
(Sec. 411(k)(15))

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: ARKANSAS

Citation
1902(a)(48) of the Act, P.L. 99-570 (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

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DATE APPVD	2-18-88
DATE EFF	10-1-87
HCFA ID	88-3

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Approval Date 2-18-88 Effective Date 10-1-87

HCFA ID: 1010P/0012P

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: Region VI
September 1989

State/Territory: ARKANSAS

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

P.L.100-360
(Sec. 411(k)(15))

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988, except for aliens seeking medical assistance for treatment of emergency medical conditions under Section 1903(v)(2) of Social Security Act.

☐ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☐ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

☐ Total waiver

☐ Alternative system

☐ Partial implementation

ARKANSAS
12-4-89
12-15-89
1-1-87
89-44

TN No.
Supersedes
TN No.

Approval Date

Effective Date

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: ARKANSAS

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

STATE Arkansas
DATE RECD JUL 03 1995
DATE APPVD SEP 29 1995
DATE EFF JUL 01 1995
HCFA 179 95-20

A

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: ARKANSAS

Citation

c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

X (1) Termination
X (2) Temporary Management
X (3) Denial of Payment for New Admissions
X (4) Civil Money Penalties
X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

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JUNE 1995

State/Territory: ARKANSAS

Citation

42 CFR §488.406(b) §1919(h)(2)(B)(ii) of the Act.

(ii) ___ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

___ (1) Temporary Management
___ (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303(b) 1910(h)(2)(F) of the Act.

(e) ___ State Incentive Programs

___ (1) Public Recognition
___ (2) Incentive Payments

STATE Arkansas
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DATE APPROVED SEP 29 1995
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HCFA ID 79 95-20
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Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: ARKANSAS

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-52
A

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DECEMBER 1991

State/Territory: ARKANSAS

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38		Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a)	The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	X	(b)	The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1) if NA fails evaluation 3 times.
	X	(c)	The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d)	The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	___	(e)	The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	X	(f)	The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

STATE Arkansas
DATE REC'D DEC 3 0 1991
DATE APP'D FEB 0 5 1992
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HCFA 179 91-63

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TN No. ~~Not Used Before~~
89-17, pg. 72, item 4.24(b)

Approval Date FEB 0 5 1992 Effective Date DEC 0 1 1991

State/Territory: ARKANSAS

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

STATE Arkansas
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Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
	(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
	(o)	The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
	(p)	The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
X	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
	(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

STATE Arkansas
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Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(s)	When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
	(t)	The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
	(u)	The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
	(v)	The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
	(w)	Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
X	(x)	The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
	(y)	The State has a standard for successful completion of competency evaluation programs.

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Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	X	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	X	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	X	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

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Citation
Secs.
1902(a)(28)(D)(i)
and 1919(e)(7) of
the Act;
P.L. 100-203
(Sec. 4211(c));
P.L. 101-508
(Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

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Page 26-TN 88-38
Page 92, Item 4.24(c)-TN 89-17

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January 1993

State/Territory: ARKANSAS

4.39 (Continued)

____ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

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Page 78, Item 4.24(e) -TN 89-17

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
APRIL 1992

State/Territory: Arkansas

Citation Sections	4.40 Survey & Certification Process	
1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1) (B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.
1919(g)(1) (C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.
1919(g)(1) (C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1) (C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1) (C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

STATE Arkansas
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TA 179 92-23

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TN No. 92-22
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HCFA ID: _____

Revision: HCFA-PM-92-3 (HSQB) OMB No:
APRIL 1992

State/Territory: Arkansas

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

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1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. **Attachment 4.40-D** describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. **Attachment 4.40-E** describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: ARKANSAS

Citation	4.41	Resident Assessment for Nursing Facilities
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b)	The State is using:
	X	the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	____	a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

Arkansas
STATE
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TN No. 92-23
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STANDARDS FOR INSTITUTIONS

Revised: August 1, 2004

1. The health related standards setting authority, Arkansas Department of Health (in cooperation with the Arkansas Division of Medical Services), shall be responsible for:

   a. Establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the State Plan receive care of services;

   b. Establishing a plan for review by professional health personnel for appropriateness and quality of care and services furnished to recipients and where applicable, for providing guidance to Arkansas Division of Medical Services.

   c. Performing the function of determining whether institutions and agencies meet the requirements for participation under Title XIX;

   d. Cooperating in full with Arkansas Division of Medical Services in application of provider standards;

   e. Promptly taking steps to insure full compliance with federal/state laws, rules and regulations and shall report the results of these efforts to the Arkansas Division of Medical Services; and

   f. Licensing rehabilitative hospitals.

2. The non-health related standard setting authority Arkansas Division of Medical Services (in cooperation with the Arkansas Department of Health), shall be responsible for:

SUPERSEDES TN: 95-16

STATE Arkansas	A
DATE RECD 6-14-04	
DATE APP'D 9-1-04	
DATE EFF 8-23-04	
HCFA 179 04-10	

a. Establishing and maintaining standards and procedures for all Long Term Care Facilities participating in the Medicaid Program (Title XIX); procedures shall be developed as follows:

1. Establishing procedures for Utilization Control for Title XIX facilities;
2. Establishing procedures for management of personal allowance funds for Title XIX recipients;
3. Establishing procedures for Reasonable Cost-Related Reimbursement to Title XIX Long Term Care Facilities

b. Providing consultation to institution providers to enable them to qualify for payments under Title XIX

c. Recording and reporting evidence of non-compliance with federal/state laws. Repeat deficiencies will be subject to the sanctions listed in Arkansas Division of Medical Services Administrative Remedies and Sanctions (including the withholding of all or part of the monthly vendor payment). The withheld vendor payment(s) may be returned to the provider if so determined as a result of the appropriate appeal procedures specified in said regulations

d. The Division of Medical Services' Office of Long Term Care is responsible for validation and complaint surveys of Psychiatric Residential Treatment Facilities (PRTFs) to establish whether the facilities are in compliance with federal regulations regarding the use of restraint and seclusions.

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AGENCIES AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

Revised: February 1, 2003

Arkansas Division of Medical Services has written agreements with the Arkansas Department of Health and the Arkansas Division of Rehabilitation Services which clearly establish the working relationship between the agencies involved. **Both the Title XIX Program and the Children's Medical Services Program under Title V of the Social Security Act are organizationally located within the Department of Human Services.** The following is a description of the cooperative arrangements with the State Health Agencies, State Rehabilitation Agency, State Services for the Blind and Title V Grantees by means of which the services administered or supervised by those agencies will be utilized to the maximum degree and will be coordinated with the medical care and services provided by the Arkansas Division of Medical Services under the plan:

a. The cooperative arrangement with these agencies includes the following methods by which these services administered by these agencies are utilized to the maximum degree and are coordinated with the medical care and services provided by Arkansas Division of Medical Services under the plan for medical assistance:

(1) Reciprocal referral services;

(2) Exchange of reports or service;

(3) Coordination of plan for the individual;

(4) Joint evaluation of policies that affect the cooperative work of the agencies;

(5) Joint planning for changes that may be needed to achieve the joint goals;

(6) Continuous liaison;

(7) Designation of staff responsible for carrying out liaison activities of state and local levels; and

(8) Mutually agreeable arrangement for reimbursement.

STATE Arkansas	A
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HCFA 179 03-03	

SUPERSEDES: TN- 95-16

b. **The Title XIX Program shall refer all children with the kinds of medical conditions for which the Children's Medical Services can provide services and the Children's Medical Services Program shall accept such children to the extent its services allow.** Payment for treatment shall be made by the Title XIX Program for those eligible under the Title XIX Plan within the limits of the Program. This same plan applies to other Title V Grantees.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

A physician's statement will be obtained prior to initial certification and at annual reviews thereafter for individuals under age 55.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

N/A

STATE Arkansas
DATE RECD JUL 06 1995
DATE APPD JUL 25 1995
DATE EFF MAY 01 1995
HCFA 179 95-19

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3. The State defines the terms below as follows:

- estate

  All real and personal property owned by an individual at death.

- individual's home

  The principal place of residence where the individual resided prior to institutionalization and in which the individual had ownership interest.

- equity interest in the home

  The market value of the home less the debt against the home.

- residing in the home for at least one or two years on a continuous basis, and

  N/A

- lawfully residing.

  N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

4. **The State defines undue hardship as follows:**

Undue hardship exists when the survivors rely on assets of the estate as their sole source of income, when the income producing asset is the sole asset of the survivors, and when income is limited.

5. **The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:**

(1) The Executor gives the state agency notice of probate.
(2) The state agency gives the Executor notice that we may recover and procedures to apply for a hardship waiver along with the requirement to provide the value of the estate.
(3) The Executor will make application and furnish the state agency proof of hardship.
(4) The Department of Human Services, Central Office Committee makes a decision regarding undue hardship and whether collection is cost effective.

6. **The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):**

Cost effectiveness will exist when the estimated amount to be recovered from an estate will be greater than the estimated costs of recovery.

7. **The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):**

Notice will include intent to recover Medicaid payments, procedures for filing hardship waiver application within 30 days, right to a hearing if appeal is made in 30 days.

If hardship waiver is requested, Agency committee will make determination.

If individual disagrees, he/she may appeal decision within 30 days.

If no hardship waiver is requested within 30 days, the state will proceed with recovery.

A claim will be filed in the estate.

STATE Arkansas
DATE REC'D JUL 26 1995
DATE APP'D JUL 25 1995
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

NOT APPLICABLE

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

NOT APPLICABLE

*Description provided on attachment.

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STATE Arkansas
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

NOT APPLICABLE

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

NOT APPLICABLE

*Description provided on attachment.

STATE Arkansas
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DATE APPV'D DEC 13 1991
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

NOT APPLICABLE

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

NOT APPLICABLE

*Description provided on attachment.

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APP'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-52

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

NOT APPLICABLE

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

NOT APPLICABLE

*Description provided on attachment.

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APP'VD DEC 13 1991
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES **Revised: October 1, 2014**

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1. Inpatient Hospital Services

The State has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

In accordance with Section 1902(s) of the Social Security Act, we do not impose dollar limits on any inpatient hospital services for children under age one (or children that are hospitalized on their first birthday). This includes the $850.00 per diem cost limit, the TEFRA rate of increase limit, the customary charge upper limit or the $150,000 bone marrow transplant limit. This applies to all inpatient hospitals.

Effective for claims with dates of service on or after January 1, 2007, all acute care hospitals with the exception of Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals, Out-Of-State Hospitals and Critical Access Hospitals will be reimbursed based on reasonable cost with interim per diem rates and year-end cost settlements, with a cost limit of $850 per day.

Effective for dates of services October 1, 2014 and after for recipients age 21 and older, all acute care, Pediatric, Border-City University-affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals will be reimbursed a $400 prospective per diem rate with no cost settlement for hospital days beyond 24 during the State Fiscal Year. The $400 prospective per diem rate does not apply to beneficiaries age 21 and older who receive inpatient services in accordance with special diagnosis criteria identified in Attachment 3.1-A Page 1a, Section1.

Arkansas Medicaid will use the lesser of cost or charges or the $850 per diem cost limit multiplied by total hospital Medicaid days **24 and under** to establish cost settlements. Except for malpractice insurance, graduate medical education costs and the base period for determining the TEFRA target limits, the interim per diem rates and the cost settlements are calculated in a manner consistent with the method used by the Medicare Program. The definition of allowable costs to be used is as follows:

(a) The State will use the Medicare allowable costs as stated in the HIM-15/PRM-15.

The State will use the criteria referenced in 42 CFR, Section 413.8**9**(e) - Criteria for allowable bad debt, to determine allowable bad debt.

(b) Physicians/Administrative/Teachers will be included in costs as recognized by Medicare reimbursement principles.

1. Inpatient Hospital Services **(continued)**

At cost settlement, Arkansas Medicaid will limit reimbursement to the lowest of the following:

(a) Allowable costs after application of the TEFRA rate of increase limit. The TEFRA rate of increase limit is the hospital's TEFRA target rate multiplied by its total number of Medicaid discharges.

Effective for cost reporting periods ending on or after June 30, 2000, the TEFRA rate of increase limit will no longer be applied to Arkansas State Operated Teaching Hospitals.

(b) The hospital's customary charges to the general public for the services. (This will be applied on an annual basis at cost settlement.)

(c) A maximum limit per Medicaid days. The maximum limit is the total number of Medicaid inpatient days during the cost reporting period multiplied by the $850.00 per diem cost limit.

1. Inpatient Hospital Services (Continued)

Effective for cost reporting periods beginning on or after February 1, 1992, an exception may be granted by the Arkansas Medicaid Program to acute care/general hospitals in the following circumstances:

a. Exceptions - The State may adjust a hospital's operating cost upward or downward, as appropriate under circumstances listed below. The State makes an adjustment only to the extent that the hospital's costs are reasonable, attributable to the circumstances specified and separately identified by the hospital.

1. Extraordinary Circumstances - The hospital must demonstrate to the State that it incurred increased costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to strikes, fire, earthquakes, floods or similar unusual occurrences with substantial cost effects. For the above circumstances, the TEFRA limit would be waived for the cost reporting period in which the extraordinary circumstances occurred. The TEFRA limit would be applied for the next cost reporting period with the current inflation factor and the preceding year's inflation factor applied.

2. Changes in Case Mix - The hospital has added or discontinued services in a year after its base period or has experienced a change in case mix. Also, the addition or discontinuation of a new hospital unit(s) such as, but not limited to, a new burn unit or psychiatric unit could result in a change in case mix. The hospital must demonstrate to the State that the change in case mix resulted in a distortion in the rate of cost increase and the hospital must submit data to the State summarizing the case mix changes and the resulting changes in costs. The TEFRA limit will be adjusted to reflect the increase in cost for the year that the change in case mix occurred.

3. TEFRA Limit for Psychiatric Units - Effective for services on or after February 1, 1992, the Arkansas Medicaid Program will implement a separate TEFRA limit which will be calculated and applied to psychiatric units in acute care/general hospitals which did not have a psychiatric unit when the TEFRA limit was established. The base year for calculating the TEFRA limit will be the first full cost reporting period beginning on or after February 1, 1992. The TEFRA limit will be applied beginning the first cost reporting period after the base year.

STATE Arkansas
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DATE EFF 2-1-92
SUPERSEDES 92-03

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Supersedes - None - New Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-A
Page 2

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: May 1, 2004

1. Inpatient Hospital Services (Continued)

Arkansas' method of reimbursing malpractice insurance will be a simple calculation made outside the cost report and the result added back on to the Medicaid settlement page of the report. The calculation would apply a Medicaid utilization factor based on cost to the portion of total malpractice expense (91.5%) which is reimbursed for Medicare on worksheet D-8 of the cost report. The remaining 8.5% remains on worksheet A of the cost report and flows through to be reimbursed like any other administrative cost. The final result would be to reimburse malpractice for Medicaid as though all malpractice expense remained on worksheet A and simply flowed through the cost report.

For those hospitals determined as rural hospitals as of January 1, 1989, the base period for determination of TEFRA limits will be the first full cost reporting period beginning on or after January 1, 1989 – inflation index based on Medicare principles (the CMS Market Basket Index or the Congressional Set Inflation Factor).

For all other Arkansas acute care hospitals, with the exception of Pediatric Hospitals and Arkansas State Operated Teaching Hospitals, the base period for determination of TEFRA limits will be the first full cost reporting period beginning on or after July 1, 1991. The inflation index based on Medicare principles (the CMS Market Basket Index or the Congressional Set Inflation Factor) will be applied beginning the first year after the base year. Thereafter, the TEFRA limit will be updated annually using the CMS Market Basket Index or the Congressional Set Inflation Factor.

STATE ARKANSAS DATE REC'D April 20, 04 DATE APP'D JUNE 21, 04 DATE EFF MAY 1, 04 HCFA 179 04-07	A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: December 3, 2004

1. Inpatient Hospital Services (Continued)

Direct medical education costs, including graduate medical education costs, are reimbursed based on Medicare reasonable cost rules in effect prior to the effective date of the September 29, 1989 rule.

TRANSPLANT SERVICES

A. **In-State Acute Care/General Hospitals, All Bordering City Hospitals and All Out-of-State Hospitals**

1. Corneal, Renal and Pancreas/Kidney Transplants

Inpatient hospital services required for corneal, renal and pancreas/kidney transplants are reimbursed in the same manner as other inpatient hospital services.

2. Bone Marrow Transplants

Interim reimbursement for bone marrow transplants will be 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed. Reimbursement will not exceed $150,000. Reimbursement includes all medical services relating to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000 maximum, reimbursement for each provider type will be decreased by an equal percentage resulting in an amount which does not exceed the maximum dollar limit.

3. Other Covered Transplants

Hospital services (does not include organ acquisition) relating to other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow) are reimbursed at 45% of submitted charges. Reimbursement includes all allowable medical services relating to the covered transplant from the date of the transplant procedure to the date of discharge. Transplant hospitalization days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Inpatient hospital days prior to the transplant date will be reimbursed in accordance with the applicable State Plan methodology for the hospital type in which the transplant is performed.

Readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant service at 45% of submitted charges. All excess length of stay approval requirements also apply.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: September 1, 2006

1. Inpatient Hospital Services (Continued)

A. In-State Acute Care/General Hospitals, All Bordering City Hospitals and All Out-of-State Hospitals (Continued)

3. Other Covered Transplants (Continued)

Reimbursement for the actual organ to be transplanted (organ acquisition) will be at (a) 100% of the submitted organ invoice amount from an outside organ provider organization or (b) reasonable cost with interim reimbursement and year-end cost settlement. The hospital has the choice of using either method. If (a) is used, the provider will submit a copy of the invoice for the organ acquired and Medicaid will reimburse 100% of the invoice amount and no additional amounts will be reimbursed to the hospital. If (b) is used, an interim amount will be reimbursed to the hospital and a year-end cost settlement will be calculated. The interim amount reimbursed and the year-end cost settlement will be calculated in a manner consistent with the method used by the Medicare Program for organ acquisition costs.

B. In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals

1. Corneal, Renal and Pancreas/Kidney Transplants

Inpatient hospital services required for corneal, renal and pancreas/kidney transplants are reimbursed in the same manner as other inpatient hospital services.

2. Bone Marrow Transplants

Interim reimbursement for bone marrow transplants will be 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed. Reimbursement will not exceed $150,000. Reimbursement includes all medical services relating to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000 maximum, reimbursement for each provider type will be decreased by an equal percentage resulting in an amount which does not exceed the maximum dollar limit.

3. **Other Covered Transplants**

Hospital services provided by In-State Pediatric Hospitals and Arkansas State Operated Teaching Hospitals relating to other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow) are reimbursed in the same manner as other inpatient hospital services with interim reimbursement and final cost settlement. Reimbursement includes all allowable medical services relating to the covered transplant from the date of the transplant procedure to the date of discharge. Transplant hospitalization days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Effective for discharge dates occurring on or after September 1, 2006, the TEFRA rate of increase limit will no longer be applied to in-state Pediatric Hospitals for other covered transplant procedures (does not include corneal, renal, pancreas/kidney and bone marrow).

Inpatient hospital days prior to the transplant date will be reimbursed in accordance with the applicable State Plan methodology for the hospital type in which the transplant is performed.

Readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant service. All excess length of stay approval requirements also apply.

C. Recipient Financial Services

The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

STATE ARKANSAS
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HCFA 179 06-07
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: July 1, 2006

1. Inpatient Hospital Services (Continued)

Effective for claims with dates of service on or after July 1, 1994, hospitals in bordering cities will be reimbursed based on reasonable costs with interim per diem rates and year-end cost settlements, with **the same per diem cost limit as is reimbursed to in-state hospitals.**

The following cities are considered bordering cities: Poplar Bluff, Missouri; Greenville, Mississippi; Poteau, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

Effective for claims with dates of service on or after March 1, 1999, hospitals located in Springfield, Missouri will qualify to be designated as a bordering city hospital.

All other reimbursement information contained in Attachment 4.19-A, Pages 1 through 3, pertains to bordering city hospitals.

The TEFRA base year will be the first full cost reporting period beginning on or after July 1, 1991.

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DATE REC'D
DATE APP'VD MAR 21 2007
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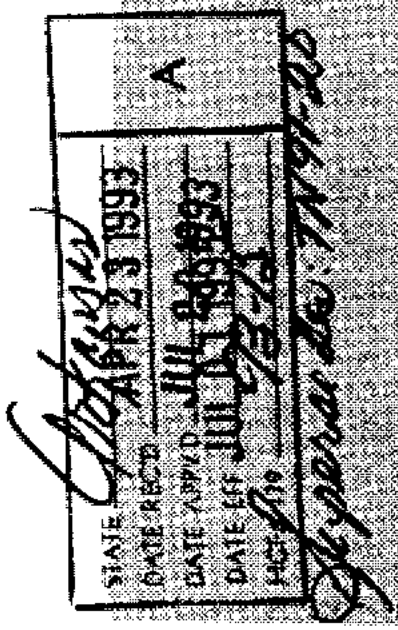
1. Inpatient Hospital Services (Continued)

Pediatric Hospitals

Pediatric hospitals are classified as a separate class group. The Medicaid definition of a pediatric hospital is: A hospital is a pediatric hospital if it has in effect an agreement to participate as a hospital and the majority of its patients are individuals under the age of 21.

Pediatric hospitals are reimbursed based on interim per diem rates with year end cost settlement for cost reporting periods ending on or after June 30, 1988. Arkansas Medicaid will use the lesser of cost or charges to establish cost settlements. Except for malpractice insurance, the gross receipts tax and graduate medical education costs, the interim per diem rates and cost settlements are calculated in a manner consistent with the method used by the Medicare Program. The definition of allowable costs to be used is as follows:

(a) The State will use the Medicare allowable costs as stated in the HIM-15 including the cost limitations of TEFRA with the exception of the gross receipts tax. The gross receipts tax is not an allowable cost. The State will use the criteria referenced in 42 CFR, Section 413.80(e) - Criteria for allowable bad debt, to determine allowable bad debt. Hospitals reimbursed based on Medicare allowable costs with year end cost settlement may request an exemption from, or exception or adjustment to, the rate of cost increase ceiling (TEFRA limits). The request must be made to the State within 180 days from the ending date of the cost reporting period for which the need of such a request is determined. The State responds to the request within 180 days from the date the State receives the request and notifies the hospital of the State's decision.



1. Inpatient Hospital Services (Continued)

Pediatric Hospitals (Continued)

1.a. An exception or exemption may be granted by the State in the following circumstances:

(1) Exemptions - New Hospitals

A new hospital may be either a hospital currently enrolled in Arkansas Medicaid which has changed its subspeciality to a pediatric hospital for reimbursement purposes only or a new pediatric hospital which has never been enrolled as a provider.

New hospitals that request and receive an exemption from the State are not subject to the rate of increase ceiling. A new pediatric hospital is a provider of inpatient hospital services for which the State has granted approval to participate in the Medicaid Program as a subspeciality pediatric hospital within the past three years. The first cost reporting period, beginning at least two years after the State granted approval for the hospital to operate under Medicaid as this type of hospital, will be the hospital's base year.

(2) Exceptions

The State may adjust a hospital's operating costs upward or downward, as appropriate under circumstances listed below. The State makes an adjustment only to the extent that the hospital's costs are reasonable, attributable to the circumstances specified and separately identified by the hospital.

STATE Arkansas
DATE RCVD MAY 31 1991
DATE APPVD DEC 23 1991
DATE EFF JUL - 1 1991
HCFA ID 91-20
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-A
Page 6

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: May 1, 2004

1. Inpatient Hospital Services (Continued)

Pediatric Hospitals (Continued)

(a) Extraordinary Circumstances. The hospital must demonstrate to the State that it incurred increased costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to strikes, fire, earthquakes, floods or similar unusual occurrences with substantial cost effects. For the above circumstances, the TEFRA limit would be waived for the cost reporting period in which the extraordinary circumstances occurred. The TEFRA limit would be applied for the next cost reporting period with the current inflation factor and the preceding year's inflation factor applied.

(b) Changes in Case Mix. The hospital has added or discontinued services in a year after its base period or has experienced a change in case mix. Also, the addition or discontinuation of a new hospital unit(s) such as, but not limited to, a new burn unit or psychiatric unit could result in a change in case mix. The hospital must demonstrate to the State that the change in case mix resulted in a distortion in the rate of cost increase and the hospital must submit data to the State summarizing the case mix changes and the resulting changes in costs. The TEFRA limit will be adjusted to reflect the increase in cost for the year that the change in case mix occurred.

1.b. The Medicaid per diem will be subject to rate of increase granted under Medicare to PPS exempt hospitals.

1.c. If the provider does not qualify or apply for the exception, the base period (TEFRA Year) will be the initial cost reporting period when the hospital enrolled as a pediatric hospital in the Arkansas Medicaid Program. The inflation index based on Medicare principles (the CMS Market Basket Index or the Congressional set inflation factor) would be applied beginning the first year after the base year.

1.d. Physicians/Administrative/Teachers will be included in costs as recognized by Medicare reimbursement principles.

STATE ARKANSAS	A
DATE REC'D April 20, 04	
DATE APPV'D June 21 04	
DATE EFF MAY 1, 04	
HCFA 179 04-07	

1. Inpatient Hospital Services (Continued)

Pediatric Hospitals (Continued)

Refer to Attachment 4.19-A, Page 3, 3a **and 3b,** for the reimbursement methodology for transplant services.

Arkansas' method of reimbursing malpractice insurance for pediatric hospitals will be a simple calculation made outside the cost report and the result added back on to the Medicaid settlement page of the report. The calculation would apply a Medicaid utilization factor based on cost to the portion of total malpractice expense (91.5%) which is reimbursed for Medicare on worksheet D-8 of the cost report. The remaining 8.5% remains on worksheet A of the cost report and flows through to be reimbursed like any other administrative cost. The final result would be to reimburse malpractice for Medicaid as though all malpractice expense remained on worksheet A and simply flowed through the cost report.

Direct medical education costs, including graduate medical education costs, are reimbursed based on Medicare reasonable cost rules in effect prior to the effective date of the September 29, 1989 rule.

Border City University-Affiliated Pediatric Teaching Hospitals

Special consideration is given to border city university-affiliated pediatric teaching hospitals due to the higher costs typically associated with such hospitals. Arkansas Medicaid cost-settles with enrolled Medicaid providers for inpatient services provided to patients age 1 to 21 by border city university-affiliated pediatric teaching hospitals on a per diem basis. The per diem is the provider's actual allowable Medicaid per diem cost for all the inpatient Medicaid days for persons over age one that were furnished by the enrolled provider within the most recent completed cost reporting period. As a condition of the cost settlement, the provider shall certify the number of patient days for patients age 1 to 21 provided by the border city university-affiliated pediatric teaching hospital during the cost settlement period.

A border city university-affiliated pediatric teaching hospital is defined as a hospital located within a bordering city (see Attachment 4.19-A page 3b) that submits to the Arkansas Medicaid Program a copy of a current and effective affiliation agreement with an accredited university, and documentation establishing that the hospital is university-affiliated, is licensed and designated as a pediatric hospital or pediatric primary hospital within its home state, maintains at least five different intern pediatric specialty training programs, and maintains at least one-hundred (100) operated beds dedicated exclusively for the treatment of patients under the age of 21.

STATE Ark
DATE RECD
DATE APP'D APR 25 2007
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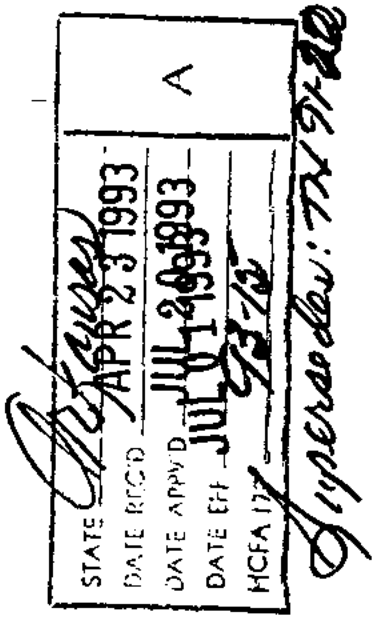
1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals

Arkansas State Operated Teaching Hospitals are classified as a separate class group. The Medicaid definition of a state operated teaching hospital is: A hospital is a state operated teaching hospital if it has in effect an agreement to participate in Medicaid as a hospital, is operated by the State of Arkansas and has current accreditation from the North Central Association of Colleges and Schools.

Arkansas State Operated Teaching Hospitals are reimbursed based on interim per diem rates with year end cost settlement for cost reporting periods ending on or after July 1, 1989. Arkansas Medicaid will use the lesser of cost or charges to establish cost settlements. Except for malpractice insurance, the gross receipts tax and graduate medical education costs, the interim per diem rates and the final cost settlements are calculated in a manner consistent with the method used by the Medicare Program. The definition of allowable costs to be used is as follows:

(a) The State will use the Medicare allowable costs as stated in the HIM-15 including the cost limitations with the exception of malpractice insurance and the gross receipts tax. For malpractice insurance, a simple calculation will be made outside the cost report and the result added back on to the Medicaid settlement page of the report. The calculation would apply a Medicaid utilization factor based on cost to the portion of total malpractice expense (91.5%) which is reimbursed for Medicare on worksheet D-8 of the cost report. The remaining 8.5% remains on worksheet A of the cost report and flows through to be reimbursed like any other administrative cost. The final result would be to reimburse malpractice for Medicaid as though all malpractice expense remained on worksheet A and simply flowed through the cost report. The gross receipts tax is not an allowable cost.



The State will use the criteria to determine allowable bad debt referenced in 42 CFR, Section 413.80(e) - criteria for allowable bad debt.

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

(b) Effective with cost reporting periods beginning on or after July 1, 1993, direct medical education costs, including graduate medical education, will be reimbursed using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rule will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments.

Effective for cost reporting periods beginning on or after January 1, 1997 **and for dates of service up through December 31, 2013**, Arkansas Medicaid will begin excluding graduate medical education (GME) cost from the interim rate. A separate payment for GME reimbursement will be made quarterly and will be calculated based on the number of paid days for that quarter, arrived from the Medicaid Management Information System, multiplied by the GME reimbursement per day determined by the previous cost reporting period. A reimbursement settlement for GME will be made at the time the cost settlements are processed. The GME reimbursement will be calculated using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rules will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments. GME payments will not be subject to the upper limit.

Effective for dates of service beginning on or after January 1, 2014, Arkansas Medicaid will make a separate payment for GME costs on a quarterly basis. The payments will be equal to the product of (i) the direct GME costs as reported on the State Operated Teaching Hospital's Medicare cost report , and (ii)the Medicaid Ratio. The Medicaid Ratio is the total of Medicaid patient days for traditional Medicaid beneficiaries plus patient days for Medicaid Private Option beneficiaries divided by total hospital patient days. The quarterly payments will be made on an interim basis, estimated using prior year data trended forward to the current year or, where prior year Private Option data is not available, another appropriate proxy. Payments will be subject to an annual settlement to actual costs based on the filed cost report.

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

(c) The base period for the determination of the TEFRA limit will be current year which is the fiscal year ending immediately prior to the first period this change goes into effect. EXAMPLE: The University of Arkansas for Medical Sciences' (UAMS) base period for determination of TEFRA limits will be fiscal year ending June 30, 1989. Only inpatient operating costs are subject to the limit.

Arkansas Medicaid will use the CMS Market Basket Index or the Congressional Set Inflation Factor for hospitals not subject to the Medicare prospective payment system.

Effective for cost reporting periods ending on or after June 30, 2000, the TEFRA rate of increase limit will no longer be applied to Arkansas State Operated Teaching Hospitals.

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

(d) Physicians/Administrative/Teachers will be included in costs as recognized by Medicare HIM-15 reimbursement principles.

(e) Arkansas State Operated Teaching Hospital Adjustment: Effective May 9, 2000, Arkansas State Operated Teaching Hospitals shall qualify for an inpatient rate adjustment. The adjustment shall result in total payments to the hospitals that are equal to but not in excess of the individual facility's Medicare-related upper payment limit. The adjustment shall be calculated as follows:

1. Using the most current audited data, Arkansas shall determine each State Operated Teaching Hospital's base Medicare per discharge rate and base Medicaid per discharge rate.
2. The base per discharge rates shall be trended forward to the current fiscal year using an annual Consumer Price Index inflation factor.
3. Once the per discharge rates have been trended forward, the Medicare per discharge rate will be divided by the Medicare case mix index and the Medicaid per discharge rate will be divided by the Medicaid case mix index. The Medicare case mix index reflects the hospital's average diagnosis related group (DRG) weight for Medicare patients. The Medicaid case mix index reflects the hospital's average DRG weight for Medicaid patients using the Medicare DRGs.
4. The base Medicaid per discharge rate shall be subtracted from the base Medicare per discharge rate.
5. The difference shall be multiplied by the hospital's Medicaid case mix index.
6. The adjusted difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent fiscal year. The result shall be the amount of the annual State Operated Teaching Hospital Adjustment.
7. Payment shall be made on an annual basis before the end of the state fiscal year.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

Any costs associated with heart, liver, non-experimental bone marrow, lung and skin transplants will not be reimbursed through a cost settlement. Refer to Attachment 4.19-A, Page 3, for the reimbursement methodology for these procedures.

1. Inpatient Hospital Services (Continued)

Rehabilitative Hospitals

Effective for dates of service on or after August 1, 1991, rehabilitative hospitals are reimbursed hospital-specific prospective per diem rates, subject to an upper limit, with no cost settlement. Rates will be effective July 1 of each year. The rate year is the State fiscal year, July 1 through June 30.

Effective October 1, 2014, for recipients age 21 and older, all in-state and out-of-state rehabilitative hospitals will be reimbursed a $400 prospective per diem rate for hospital days beyond 24 during the State Fiscal Year.

The prospective per diem rates are established using total reimbursable costs under Medicare principles of reasonable cost reimbursement, except that the gross receipts tax is not an allowable cost. The initial per diem rate is calculated from the hospital's most recent unaudited cost report submitted to Medicare prior to July 1, 1991, trended forward for inflation. Arkansas Medicaid will calculate a new per diem rate annually, based on the provider's most recent unaudited cost report, and adjust the per diem rate for inflation.

The inflation factor used will be the Consumer Price Index for all urban consumers (CPI-U), U.S. city average for all items. We will use the change in the CPI-U during the calendar year before the start of the rate year. For example, we will use the 12-month change in the CPI-U as of December 31, 1991, to set the rates that will be effective July 1, 1992. The inflation adjustment will be made at the beginning of each rate year.

The upper limit is set annually at the 70th percentile of all rehabilitative hospitals' inflation-adjusted Medicaid per diem rate. Arkansas Medicaid will negotiate with the Arkansas Hospital Association annually (State fiscal year July 1 through June 30) regarding adjustment of the 70th percentile upper limit.

Rehabilitation Services in Acute Care Inpatient Hospitals other than Rehabilitative Hospitals

Effective for dates of service on or after July 1, 2026, all inpatient acute care hospitals, including Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Inpatient Psychiatric Hospitals, Out-of-State Hospitals, and Critical Access Hospitals, are reimbursed at the same hospital-specific prospective per diem rates used for rehabilitative hospitals when only rehabilitative services are provided in an acute care setting. These rates are subject to an upper limit with no cost settlement. Rates will be effective July 1 of each year. The rate year is State fiscal year, July 1 through June 30.

1. Inpatient Hospital Services (Continued)

Substance Use Disorder Residential Treatment provided in Acute Care Hospitals for Individuals under age 21

Effective for dates of service on or after July 1, 2026, for Inpatient Substance Use Disorder Residential Treatment Unit that is in a separate licensed unit within the acute care hospital, the hospital will be reimbursed for this unit at the same hospital-specific per diem rate of $850.00 with no cost settlement.

1. Inpatient Hospital Services (Continued)

Inpatient Psychiatric Services For Individuals Under **21** Years of Age

Private and Public Providers Excluding Arkansas State Operated Psychiatric Hospitals

Effective for dates of service on or after August 8, 1991, inpatient psychiatric hospitals are reimbursed for services provided to individuals under **21** years of age using hospital-specific prospective per diem rates. **P**prospective **per diem** rates are established using Medicare Principles of Reasonable Cost Reimbursement **(42 CFR Part 413) to determine allowable costs.**

The rates for inpatient psychiatric hospitals are calculated utilizing the lesser of the hospital=s per diem **allowable** cost inflated by the consumer price index for all urban consumers (CPI-U), U.S. city average for all items, plus a $69 professional component or the **maximum per diem limit**. The $69 professional component is the average of the rates for the individual psychotherapy procedure codes as of August 8, 1991. Effective for claims with dates of service on or after February 1, 1994, the **maximum per diem limit** is established annually at the 60th percentile of all in-state inpatient psychiatric hospitals= inflation adjusted per diem **costs** plus the $69 professional component. The calculation of the **maximum per diem limit** is rounded up (0.5000 or greater) or down (0.4999 or less) if the 60th percentile is not a whole number. This is a prospective rate with no cost settlement.

Rates are calculated annually and are effective for dates of service occurring during the next State Fiscal Year (July 1st through June 30th). Per diem costs and the **maximum per diem limit** are calculated from the most recent submitted hospital cost reports with ending dates occurring in the previous calendar year. Less than full year cost reports and out-of-state provider cost reports will not be included when calculating the 60th percentile. For hospitals with a cost report period of less than a full six months, the new State Fiscal Year per diem rate is calculated by inflating the previous State Fiscal Year=s per diem rate by the CPI-U. The **maximum per diem limit** will not be adjusted after being set should new providers enter the program or late cost reports be received.

New providers are required to submit a full year=s annual budget for the current State Fiscal Year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the **maximum per diem limit** in effect as of the first day of their enrollment. The interim rate for new providers will be retroactively adjusted to the allowable per diem cost as calculated from the provider=s first submitted cost report for a period of at least a full six months.

STATE ARK
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DATE APPV'D AUG 29 2007
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES Revised: July 1, 2007

1. Inpatient Hospital Services (Continued)

Inpatient Psychiatric Hospital Services For Individuals Under 21 Years of Age (Continued)

Residential Treatment Units Within Private and Public Providers Excluding Arkansas State Operated Psychiatric Hospitals

Effective for dates of service on or after July 1, 1993, **Residential Treatment Units located within an inpatient psychiatric hospital will be reimbursed based on reasonable cost with interim per diem rates and year-end cost settlements.** . The State will reimburse the lesser of audited cost or a maximum **per diem limit** of $316.00 per day. Medicare Principles of Reasonable Cost Reimbursement (42 CFR Part 413) will be used to determine allowable costs, subject to cost settlement.

Allowable costs will include the professional component costs. The professional component cost included in the allowable cost is capped at $69.00 per day which is the average of the rates for the individual psychotherapy procedure codes as of August 8, 1991.

The initial maximum **per diem limit** of $316.00 represents the average budgeted cost per day of the in-state freestanding residential treatment centers for State Fiscal Year 1994. The State will review the maximum **per diem limit** annually (July 1 through June 30). The budgeted data for the upcoming State Fiscal Year submitted by the instate freestanding residential treatment centers prior to the end of the State Fiscal Year will be used to determine the new maximum **per diem limit** for each new State Fiscal Year. The new maximum **per diem limit** will be effective for dates of service on or after July 1 of the new State Fiscal year. For each State Fiscal Year after the initial year, the State will set the maximum per diem **limit** at the average budgeted cost per day (mean) for instate freestanding residential treatment centers (RTCs). If the average budgeted cost per day for the in-state freestanding RTCs changes at all, the State will calculate a new **maximum per diem limit**, and the new **limit** will be equal to the average of instate freestanding RTCs. The **maximum per diem limit** will not be **adjusted** after being set should new Residential Treatment Centers enter the program or late budgets be received.

Interim reimbursement rates are implemented at the lesser of the per diem cost as calculated from the most recent submitted unaudited cost report (including the allowable professional component cost) or the **maximum per diem limit** in effect as of the first day after the cost report ending date.

New providers are required to submit a full year=s annual budget for the current State Fiscal Year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate of the lesser of the budgeted allowable cost per day or the **maximum per diem limit** in effect as of the first day of their enrollment.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: July 1, 2007

1. Inpatient Hospital Services (Continued)

Inpatient Psychiatric Hospital Services For Individuals Under 21 Years of Age (Continued)

Private and Public Providers Excluding Arkansas and State Operated Psychiatric Hospitals

Sexual Offender Programs

Sexual Offender Programs are designed specifically for the treatment of those patients designated as sexual offenders who cannot be treated with other mental health patients. These services are provided in separate units in the psychiatric hospital. These units meet all the requirements of Subpart D of 42 CFR Part 441 for inpatient psychiatric services for individuals under 21. In addition, they must meet any certification requirements of the Division of **Behavioral** Health Services.

Effective for cost reporting periods beginning on or after September 1, 1995, **Sexual Offender Program** providers will be reimbursed **based on reasonable cost with interim per diem rates and year-end cost settlements.** Medicare Principles of Reasonable Cost Reimbursement (42 CFR Part 413) **will be used to determine allowable costs,** subject to cost settlement. The initial interim rates for these programs will use reasonable budgeted cost reports. Once audited cost reports are available the most recent audited cost report will be used to set the interim rate. Interim rates will be adjusted every six months if costs increase more than 10%.

New providers are required to submit a full year=s annual budget for the current State Fiscal Year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per day or the **maximum per diem limit** in effect as of the first day of their enrollment.

Year end cost reports must be submitted and will be audited in the same manner as audits for Residential Treatment Units (RTUs) and will be cost settled.

Interim rates and cost settlements are calculated using the same methodology as Residential Treatment Units with the same professional component cap and the same annual State Fiscal Year **maximum per diem limit.**

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Arkansas State Operated Psychiatric Hospitals

Arkansas State Operated Psychiatric Hospitals are classified as a separate class group. A hospital is an Arkansas State Operated Psychiatric Hospital if it has in effect an agreement to participate in the Arkansas Medicaid Program as a psychiatric hospital and is operated by the State of Arkansas.

Effective for dates of service occurring on and after July 1, 2007, Arkansas State Operated Psychiatric Hospitals are reimbursed based on interim per diem rates with year end cost settlements and no per diem cost limits. Arkansas Medicaid will use the lesser of cost or charges to establish cost settlements. Services to be reimbursed at cost are (1) inpatient psychiatric services, (2) residential treatment unit services and (3) sexual offender program services.

Cost settlements and interim per diem rates will be determined using the same criteria and requirements as are used for Arkansas State Operated Teaching Hospitals except GME costs will not be reimbursed separately.

1. Inpatient Hospital Services (Continued)

Annual Cost Report

Each hospital participating in the Arkansas Medicaid Program shall submit an annual cost report following Medicare's principles of cost reimbursement. Said cost report shall be submitted within five (5) months after the close of the fiscal year end. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid agency, shall result in suspension of reimbursement until the cost report is filed.

Access to Subcontractor's Records

When the facility has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a 12-month period, the contract must contain a clause giving the Department access to the subcontractor's books. Access must also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access until three years have expired after the services have been furnished.

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SUPERSEDES: TN • 91-20

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: November 1, 1995

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1. Inpatient Hospital Services (Continued)

Audit Function

Under a common audit agreement, the Medicare intermediary performs any audit required for both Title XVIII and XIX purposes. However, the Medicaid Program may choose to audit even though Medicare does not.

Rate Appeal and/or Cost Settlement Process

A medical facility administrator may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the facility of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the facility to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference if he/she so wishes for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the facility of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the Assistant Director's, Division of Medical Services, decision is unsatisfactory, the facility may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the Arkansas Hospital Association and a member of the DHS Management Staff who will serve as chairman.

STATE Arkansas
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: November 1, 1995

1. Inpatient Hospital Services (Continued)

Rate Appeal Process (Continued)

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

STATE Arkansas
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HCFA ID 95-26

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95-16

1. Inpatient Hospital Services (Continued)

Out-of-State Hospital Reimbursement

Reimbursement rates for out-of-state hospital inpatient services (except bordering cities - see Attachment 4.19-A page 3a) will be calculated/adjusted annually. The rate year is the calendar year. The in-state hospital cost reports received by the Division of Medical Services (DMS) during a calendar year will be used to calculate reimbursement rates effective for the following calendar year. For Example:

> **Effective 5/1/98, all audited cost reports received by DMS as of 9/30/97 will be used to calculate the reimbursement rates for the next calendar year (1998).**

In order to determine reimbursement rates for out-of-state hospital inpatient services, except bordering cities (see Attachment 4.19-A, Page 3a), out-of-state hospitals will be class-grouped according to bed size. The class groups are as follows:

Group Number	Bed-Size
1	Over 300
2	151 - 300
3	101 - 150
4	51 - 100
5	0 - 50

Reimbursement by Class Group

Reimbursement rates for all class groups are set at the 40th percentile of all in-state hospitals' interim per diem rates with the same bed size group, with no cost settlement.

The rates and Medicaid days associated with in-state university-affiliated teaching hospitals are excluded when calculating the base rate for Out-of-State hospitals.

STATE Arkansas
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SUPERSEDES: Same TN - 98-02

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: October 1, 2002

1. Inpatient Hospital Services (Continued)

Out-of-State Hospital Reimbursement (Continued)

University-affiliated Teaching Hospitals

Special consideration is given to university-affiliated teaching hospitals due to the higher costs associated with such hospitals. The rates for Out-of-State university-affiliated teaching hospitals are established at 105 percent of the 40th percentile rate of all in-state hospitals' per diem rates within the same bed size group, with no cost settlement.

In order to qualify as a university-affiliated teaching hospital, a hospital must submit documentation to the Arkansas Medicaid Program substantiating that the hospital is university-affiliated and maintains at least three different intern speciality training programs.

Hospitals Serving a Disproportionate Number of Medicaid Eligibles

Special consideration is given for hospitals serving a disproportionate number of Medicaid eligibles. Rates for hospitals serving a disproportionate number of Medicaid eligibles are established at 150 percent of the 40th percentile rate of all in-state hospitals' interim per diem rates within the same bed size group, with no cost settlement.

In order to qualify as a hospital serving a disproportionate number of Medicaid eligibles, a hospital must submit documentation (i.e. cost report data) verifying that Medicaid days exceed 20 percent of the total hospital days.

Indian Health Services and Tribal 638 Health Facilities

Effective for dates of service on or after October 1, 2002, inpatient services provided by Indian Health Services' (Indian Health Services) and Tribal 638 Health facilities will be reimbursed the IHS inpatient daily rate published by the Office of Management and Budget (OMB) in the Federal Register. This rate is an all-inclusive rate with no year-end cost settlement. The initial rate is the published IHS inpatient rate for calendar year 2002. The rate will be adjusted to the OMB published rate annually or for any other period identified by OMB.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: November 1, 2004

1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment

Effective April 19, 2001 **through June 30, 2005**, all Arkansas non-state government-owned or operated acute care and critical access hospitals (that is, all acute care and critical access government hospitals within the state of Arkansas that are neither owned nor operated by the state of Arkansas) shall qualify for a public hospital inpatient rate adjustment. **Effective November 1, 2004 through June 30, 2005, Arkansas may provide a public inpatient rate adjustment to non-state government owned or operated acute care regional medical center hospitals located outside of Arkansas (that is, acute care hospitals outside of Arkansas that are neither owned nor operated by any state) that - a) provide level 1 trauma and burn care services; b) provide level 3 neonatal care services; c) are obligated to serve all patients, regardless of State of origin; d) are located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including Arkansas; e) serve as a tertiary care provider for patients residing within a 125 mile radius; and f) meet the criteria for disproportionate share hospital under Section 1923 of the Social Security Act in at least one State other than the one in which the hospital is located.** The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 C.F.R. § 447.272. The adjustment shall be calculated as follows:

1. Using data from the hospital's most recently audited cost report, Arkansas shall determine each **eligible** non-state public hospital's base Medicare per discharge rate and base Medicaid per discharge rate. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.

   For hospitals who, for the most recently audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine their rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports who were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

2. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 C.F.R. § 447.272 for non-state government owned or operated hospitals. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent. The result shall be the adjusted Medicare per discharge rate.

3. The base Medicaid per discharge rate shall be subtracted from the adjusted Medicare per discharge rate determined pursuant to step 2.

SUPERSEDES 01-06

STATE Arkansas
DATE RECD 8-16-04
DATE APPVD 11-30-04
DATE EFF 11-1-04
HCFA 179 04-13

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1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment (continued)

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

5. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.

Effective July 1, 2005, all Arkansas non-state government-owned or operated acute care and critical access hospitals (that is, all acute care and critical access government hospitals within the state of Arkansas that are neither owned nor operated by the state of Arkansas) shall qualify for a public hospital inpatient rate adjustment. Effective **April 1, 2009**, Arkansas may provide a public inpatient rate adjustment to non-state government owned or operated acute care regional medical center hospitals located outside of Arkansas (that is, acute care hospitals outside of Arkansas that are neither owned nor operated by any state) that - a) provide level 1 trauma and burn care services; b) provide level 3 neonatal care services; c) are obligated to serve all patients, regardless of State of origin **and ability to pay**; d) are located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States, including Arkansas; e) serve as a tertiary care provider for patients residing within a 125 mile radius; and f) meet the criteria for disproportionate share hospital under Section 1923 of the Social Security Act in at least one State other than the one in which the hospital is located. The adjustment shall result in total payments to each hospital that are equal to but not in excess of the individual facility's Medicare-related upper payment limit, as prescribed in 42 C.F.R. §447.272. The adjustment shall be calculated as follows:

1. Using data from the hospital's most recently audited cost report, Arkansas shall determine each eligible non-state public hospital's base Medicare per discharge rate and base Medicaid per discharge rate. Base Medicare and Medicaid per discharge rates will include respective Case Mix Index (CMI) adjustments in order to neutralize the impact of the differential between Medicare and Medicaid case mixes.

   For hospitals who, for the most recently audited cost report year filed a partial year cost report, such partial year cost report data shall be annualized to determine their rate adjustment; provided that such hospital was licensed and providing services throughout the entire cost report year. Hospitals with partial year cost reports who were not licensed and providing services throughout the entire cost report year shall receive pro-rated adjustments based on the partial year data.

2. The base Medicare per discharge rate shall be multiplied by the applicable upper payment limit (percentage) specified in 42 C.F.R. §447.272 for non-state government owned or operated hospitals. For example, to the extent that such federal regulation permits Medicaid payments up to 150 percent of the amount that would be paid under Medicare reimbursement principles, the base Medicare per discharge rate shall be multiplied by 150 percent. The result shall be the adjusted Medicare per discharge rate.

1. Inpatient Hospital Services (Continued)

Non-State Public Hospital Inpatient Adjustment (continued)

3. The base Medicaid per discharge rate shall be subtracted from the adjusted Medicare per discharge rate determined pursuant to step 2.

4. The difference shall be multiplied by the number of Medicaid discharges at the hospital for the most recent audited fiscal year. The result shall be the amount of the annual Non-State Public Hospital Adjustment.

5. Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30, for Non-State Public Hospital Adjustment. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

1. Inpatient Hospital Services (Continued)

Limited Acute Care Hospital Inpatient Quality Incentive Payment

Effective for claims with dates of service on or after January 1, 2007, all acute care hospitals with the exception of Pediatric Hospitals, Border City University-Affiliated Pediatric Teaching Hospitals, Arkansas State Operated Teaching Hospitals, Rehabilitative Hospitals, Inpatient Psychiatric Hospitals, Critical Access Hospitals, and Out-of-State Hospitals may qualify for an Inpatient Quality Incentive Payment. The Inpatient Quality Incentive Payment shall be a per diem amount reimbursed in addition to the hospital's cost-based interim per diem rate and shall be payable for beneficiaries ages 1 and above only (does not include children hospitalized on their first birthday). The Inpatient Quality Incentive Payment shall equal $50 or 5.9% of the interim per diem rate, whichever is lower. The Inpatient Quality Incentive Payment reimbursement amounts shall not be included when calculating hospital year-end cost settlements.

The State Agency will determine which quality measures will be designated for the Inpatient Quality Incentive Payment for the upcoming year and the required compliance rate for each measure. The State Agency will utilize quality measures which are reported by hospitals under the Medicare program. In order to qualify for an Inpatient Quality Incentive Payment, a hospital must meet or exceed the compliance rate on two-thirds of the designated quality measures designated by the State Agency for the most recently completed reporting period. A hospital that meets or exceeds the compliance rate on two-thirds of the designated quality measures shall receive an Inpatient Quality Incentive Payment for that year.

1. Inpatient Hospital Services (Continued)

Private Pediatric Hospital Inpatient Adjustment

Effective April 19, 2001, all private pediatric hospitals within the state of Arkansas as previously defined in this section of Attachment 4.19-A shall qualify for a pediatric hospital inpatient rate adjustment. The amount of the adjustment shall be determined annually by Arkansas Medicaid based on available funding. Each qualifying hospital's adjustment amount shall be equal to their pro rata share of the total adjustment based on the hospital's Medicaid discharges for the most recent audited fiscal year. In no case shall the pediatric hospital adjustment be in an amount that results in aggregate Medicaid inpatient payments to all private hospitals (including the private hospital inpatient rate adjustment) that are in excess of the applicable Medicare related upper payment limit specified in 42 C.F.R. 447.272.

Payment shall be made on a quarterly basis within 15 days after the end of the quarter for the previous quarter. Payment for SFY 2001 shall be prorated proportional to the number of days between April 19, 2001 and June 30, 2001 to the total number of days in SFY 2001.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES **Revised: April 6, 2024**

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1. Inpatient Hospital Services (continued)

Inpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009, all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901(7) shall be eligible to receive inpatient hospital access payments. The inpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid inpatient hospital payments.

1. For each rate year, the state shall determine for each hospital and in total the number of Medicaid inpatient discharges for private hospitals eligible for this supplemental payment.
2. For each rate year, the state shall identify, on the basis of paid inpatient discharge claims adjudicated through the State's MMIS, reimbursement for inpatient hospital services that were delivered by the private hospitals identified in step one.
3. The state shall estimate the amount that would have been paid for the services identified in step two using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.272.
4. The maximum allowable aggregate Medicaid inpatient hospital access payment for private hospitals shall not exceed 97% of the difference between the results of step three (Medicare UPL) and results of step two (Medicaid based payment).
5. Using discharge data identified in step one, the state shall determine each eligible hospital's pro rata percentage which shall be a fraction equal to the number of the hospital's Medicaid discharges divided by the total number of Medicaid discharges for all eligible hospitals. This percentage will be calculated annually.
6. Each eligible hospital's inpatient hospital access payment shall be determined by multiplying the aggregate inpatient access payment identified in step 4 by the pro rata percentage identified in step 5. The current year's adjustment will be based on discharge data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Inpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their inpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Inpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

1. Inpatient Hospital Services (continued)

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
____ Additional Other Provider-Preventable Conditions identified below:

For per diem payments or cost-based reimbursement, the number of covered days shall be reduced by the number of days associated with the diagnosis not present on admission for any HAC.

No payment shall be made for inpatient services for Hospital Acquired conditions defined to include the full list of Medicare's previous inpatient "hospital-acquired conditions" (HAC) and for Other Preventable Conditions (OPPCs). OPPCs include the three Medicare National Coverage Determinations; wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; and surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider-preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider-preventable conditions would otherwise result in an increase in payment.

ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

1. Inpatient Hospital Services (continued)

Long-Acting Reversible Contraceptives (LARC)

Effective for claims with dates of service on or after January 1, 2024, all acute care hospitals will be reimbursed in addition to the per diem rates for Food and Drug Administration approved Long-Acting Reversible Contraceptives (LARCs) to include the IUD and contraceptive implants, and insertion and removal. LARC reimbursement will be the same as found in Attachment 4.19-B page 1v.

Select Carved-Out Drugs from Hospital Settings

Effective for dates of service on or after January 1, 2026, prescribed drugs identified as carved out of the inpatient and outpatient hospital payment methodologies are reimbursed under this section and reimbursed separately from hospital payment rates. The list of carved-out prescribed drugs is maintained on the State's website at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/. Reimbursement for these drugs will be based on the provider's Actual Acquisition Cost for the drug, verified by the purchasing invoice. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES **Revised: October 1, 2020**

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated as provided in the chart.

Episodes of Care	Final Reconciliation Episode Report Date
CORONARY ARTERIAL BYPASS GRAFT (CABG)	7/31/2020
ASTHMA	10/31/2020
UPPER RESPIRATORY INFECTION - NON SPRECIFIC, SINUSITIS, PHARYNGITIRS (URINS, URIS, URIP)	1/31/2021
CHOLECYSTECTOMY (CHOLE)	1/31/2021
PERINATAL	1/31/2021
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)	4/30/2021
CONGESTSIVE HEART FAILURE (CHF)	4/30/2021
COLONOSCOPY (COLON)	4/30/2021
TONSILLECTOMY (TONSIL)	4/30/2021
TOTAL JOINT REPLACEMENT (TJR)	4/30/2021

1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%) or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: October 1, 2020

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://medicaid.mmis.arkansas.gov/provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes **- Sunset date for final reconciliation report 1/31/2021**

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes **- Sunset date for final reconciliation report 4/30/2021**
(2) Total Joint Replacement Episodes **- Sunset date for final reconciliation report 4/30/2021**

2. Disproportionate Share Payment

Hospitals eligible for disproportionate share payment are acute care, inpatient psychiatric and rehabilitative hospitals in Arkansas or commonly used out-of-state hospitals (border city hospitals). Eligibility will be determined annually by the Department of Human Services and/or the State Medicare intermediary. The disproportionate share payment will be effective July 1, 1988.

Hospital cost reports and questionnaires will be used to determine disproportionate share payment eligibility in the first year. Subsequent years' questionnaire information regarding inpatient revenues, care subsidies from state and local governments, charges directly attributable to charity care and obstetrical staffing information, cost of services to Medicaid patients and cost of services to uninsured patients to establish the disproportionate share limit, etc., will be included with the cost report when submitted by the hospitals to the State Medicaid Office. The Department of Human Services will develop a standardized worksheet requesting this additional information which will be included with the cost report.

Hospital cost reports ending in the previous state fiscal year and corresponding revenue and charges information will be used to determine disproportionate share payment eligibility for the state fiscal year ending June 30th.

EXAMPLE

Disproportionate Share Payment For State Fiscal Year	**Determined From 12 Month Hospital Cost Report Ending**
1996 (7-1-95 - 6-30-96)	Anytime between 7-1-94 - 6-30-95

STATE Arkansas
DATE FEB 23 1996
APR 16 1996
DATE APR 01 1996
HCFA 96-03

A

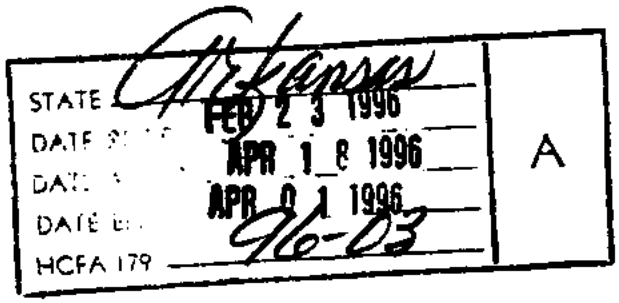
SUPERSEDES: TN 95-15

2. Disproportionate Share Payment (Continued)

Disproportionate share settlement payment to eligible hospitals will be made when the cost report is desk reviewed. This settlement payment will be calculated based on desk reviewed cost report information and statistics. This desk reviewed payment is considered to be final and no further adjustments will be made.

The four minimum criteria that a hospital must meet annually in order to qualify for disproportionate share payments are listed below. These criteria must be met during the cost report period ending in the previous state fiscal year. A hospital must meet all four criteria to be eligible to receive disproportionate share payment.

1. **A full twelve month cost report period ending in the previous state fiscal year.** Hospitals with cost report periods of less than one year will under no circumstances be eligible for disproportionate share payment. Hospital statistical information from cost report periods of less than one year will not be included in determining the Medicaid inpatient utilization rate criteria described in #2 on pages 14 and 15. Out-of-state hospitals with 850 or less Medicaid paid days by the Arkansas Department of Human Services for dates of service during the hospital's cost report period will not be eligible to receive disproportionate share payment.



SUPERSEDES: TN • 95-15

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

2. Rural Hospitals - A Medicaid inpatient utilization rate at least one-half standard deviation above the mean Medicaid inpatient utilization rate for all in-state hospitals (See A), or a low income utilization rate (See B) exceeding 25%. See #3 definition of Rural Hospital.

Urban Hospitals - A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for all in-state hospitals (See A), or a low income utilization rate (See B) exceeding 25%. See #3 definition of Urban Hospital.

Arkansas
STATE A
DATE RECD MAY 25 1995
DATE APPVD AUG 08 1995
EFF DATE JUL 01 1995
HCFA ID: 93-23

Only hospitals physically located in the State of Arkansas, cost report inpatient statistics will be used to determine the mean Medicaid inpatient utilization rate.

(A) For a hospital, the Medicaid inpatient utilization rate is the total number of its Medicaid covered inpatient days in a cost reporting period divided by the total number of the hospital's inpatient days in that same period. This information will be taken from the hospital's cost report.

The Medicaid utilization rate (MUR) formula is specified in §1923(b)(2) of the Social Security Act. This formula is generally computed as follows:

MUR % = 100 x M/T

M = Hospital's number of inpatient days attributable to patients who for these days were eligible for Medical Assistance under the State Plan

T = Hospital's total inpatient days

2. Disproportionate Share Payment (Continued)

In calculating the Medicaid inpatient utilization rate, the Statute requires States to include newborn days, days in specialized wards, and administratively necessary days. States, in computing the Medicaid utilization rate for a particular hospital, are also to account for days attributable to individuals eligible for Medicaid in another State.

It is important to note that the numerator of the MUR formula does not include days attributable to Medicaid patients between 21 and 65 years of age in institutions for Mental Disease (IMDs). These patients are not eligible for Medical Assistance under the State Plan for the days in which they are inpatients of IMD's and may not be counted as Medicaid days in computing the Medicaid utilization rate.

The new limitation on qualification does not require that disproportionate share facilities meet the one percent threshold in the payment year. Rather, they must meet the one percent limit in the cost report period ending in the previous state fiscal year for which the State's Medicaid Plan determines disproportionate share qualification.

STATE Arkansas
DATE RECD FEB 2 3 1996
DATE APPVD APR 1 8 1996
DATE EFF APR 0 1 1996
HCFA 179 96-25

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SUPERSEDES: TN • 95-15

2. Disproportionate Share Payment (Continued)

(B) For a hospital, the low income utilization rate is the sum (expressed as a percentage) of the fraction calculated as follows:

- Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from the state and local governments in a cost reporting period, divided by the total amounts of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; plus,

- The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources), less cash subsidies received from state and local governments in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan), that is, reductions in charges given to other third party payers such as HMOs, Medicare or Blue Cross.

STATE Arkansas
DATE REC'D MAY 31 1991
DATE APP'V'D DEC 23 1991
DATE EFF JUL - 1 1991
HCFA I.D. 9120
A
Supersedes 88-26

2. Disproportionate Share Payment (Continued)

3. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a Medicaid State Plan. In the case of a hospital located in a rural area, (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budgets), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. An obstetrician in an urban setting is defined as a board certified obstetrician with staff privileges at the urban hospital who performs non-emergency obstetric procedures.

The above section does not apply to a hospital which:

- The inpatients are predominantly individuals under 18 years of age; or,
- Does not offer non-emergency obstetric services as of December 21, 1987.

Hospitals must notify the Arkansas Medicaid Program immediately of obstetrical physician staffing changes that affect their disproportionate share eligibility according to the above criteria. Hospitals will not receive disproportionate share payments for any period of time in which the hospital does not meet the obstetrical physician criteria. The State Medicaid Program will verify/audit for any changes in the above obstetrical physician status.

4. **Effective July 1, 1995, the hospital must have, at a minimum, a Medicaid Utilization Rate (MUR) of one percent.**

STATE Arkansas
DATE RCVD MAY 25 1995
DATE APPVD AUG 08 1995
DATE EFF JUL 01 1995
HCFA 179 95-13
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SUPERSEDES: TN - 91-20

2. Disproportionate Share Payment (Continued)

Rural area hospitals are defined as all hospitals that are not in a Metropolitan Statistical Area (MSA). The following list includes all of the currently identified Arkansas MSA counties and some of the currently identified border state MSA counties. Hospitals located in a MSA are defined as urban area hospitals.

1. Crawford County, AR
2. Crittenden County, AR
3. Faulkner County, AR
4. Jefferson County, AR
5. Lonoke County, AR
6. Miller County, AR
7. Pulaski County, AR
8. Saline County, AR
9. Sebastion County, AR
10. Washington County, AR
11. Desota County, MS
12. Sequoyah County, OK
13. Shelby County, TN
14. Tipton County, TN
15. Bowie County, TX

Calculation of the Disproportionate Share Payment Adjustments

Rural acute care hospitals qualifying under the Medicaid inpatient utilization rate.

Each rural hospital's disproportionate share payment adjustment will be based on standard deviation increments above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

Effective July 1, 1995, each rural hospital's annual disproportionate share payment adjustment is calculated on the following formula, but will not exceed the disproportionate share hospital limit.

A $1,000 minimum payment amount, plus

A year end cost settlement based on Medicaid paid days for that period using the following percentages:

Standard Deviation Above the Mean	Year End Cost Settlement
At least .5 and less than 1	7 percent
At least 1 and less than 2	8 percent
At least 2 and less than 3	9 percent
At least 3 or greater	10 percent

STATE Arkansas
DATE RECD MAY 25 1995
DATE APPVD AUG 08 1995
DATE EFF JUL 01 1995
HCFA 179 95-13

A

SUPERSEDES: TN # 91-27

2. Disproportionate Share Payment (Continued)

Urban acute care hospitals qualifying under the Medicaid inpatient utilization rate.

Each hospital's disproportionate share payment adjustment will be based on the percentage by which its Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

Effective July 1, 1995, each hospital's annual disproportionate share payment adjustment is calculated on the following formula, but will not exceed the disproportionate share hospital limit.

A $1,000 minimum payment amount, plus

10 percent (X) [individual hospital's Medicaid inpatient utilization rate minus one standard deviation above the mean Medicaid inpatient utilization rate] (X) [the hospital's fiscal year Medicaid per diem reimbursement].

The fiscal year Medicaid per diem reimbursement is the allowable costs from each provider's cost report and not the interim per diem payments made during the year.

STATE Arkansas
DATE RECD MAY 25 1995
DATE APPVD AUG 08 1995
DATE EFF JUL 01 1995
HCFA ID 95-15

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SUPERSEDES: TN • 91-27

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

Acute care hospitals qualifying under the low-income utilization rate.

Each hospital's disproportionate share payment adjustment will be based on the hospital's low-income utilization rate.

Effective July 1, 1995, each hospital's annual disproportionate share payment is calculated on the following formula, but will not exceed the disproportionate share hospital limit.

A $1,000 minimum payment amount, plus

4 percent (X) [individual hospital's low-income utilization rate minus 25 percent] (X) [the hospital's fiscal year Medicaid per diem reimbursement].

The fiscal year Medicaid per diem reimbursement is the allowable cost from each provider's cost report and not the interim per diem payments made during the year.

If an acute care hospital qualifies as a disproportionate share hospital under both the Medicaid inpatient utilization rate and low-income utilization rate, Arkansas Medicaid will only make a disproportionate share payment under one method. For those hospitals that qualify for disproportionate share payment under the Medicaid inpatient utilization rate and also under the low-income utilization rate, Arkansas Medicaid will use the method which gives the hospital the larger payment.

STATE Arkansas
DATE RECD MAY 25 1995
DATE APPD AUG 08 1995
DATE EFF JUL 01 1995
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SUPERSEDES: TN - 91-22

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

Inpatient psychiatric and rehabilitative hospitals.

Inpatient psychiatric and rehabilitative hospitals meeting disproportionate share payment eligibility criteria will receive a disproportionate share payment year end cost settlement equal to the rate which is paid to the urban acute care hospitals.

For inpatient psychiatric and rehabilitative hospitals (both urban and rural) that qualify under the Medicaid inpatient utilization rate, the disproportionate share hospital payment adjustment will be determined using the methodology for urban acute care hospitals qualifying under the Medicaid inpatient utilization rate. It is important to note that the numerator of the MUR formula does not include days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMDs). These patients are not eligible for Medical Assistance under the State Plan for the days in which they are inpatients of IMD's and may not be counted as Medicaid days in computing the Medicaid utilization rate. For inpatient psychiatric and rehabilitative hospitals (both urban and rural) that qualify under the low-income utilization rate, the disproportionate share hospital payment adjustment will be determined using the methodology for acute care hospitals qualifying under the low-income utilization rate.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

General DSH Payment Provisions Applicable to all DSH Providers

All disproportionate share payments will be based on desk reviewed cost report information and statistics.

The annual disproportionate share payment adjustment to each disproportionate share hospital shall not exceed the limit for that hospital.

The calculation of the limit is as follows:

The limit applicable to disproportionate share payment adjustments is composed of two parts. The first part of the limit is the Medicaid "shortfall." The "shortfall" is the cost of services furnished to Medicaid patients, less the amount paid under the non-disproportionate share payment method under the State Plan.

The second part of the formula is the cost of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients.

Disproportionate Share Hospital Limit = M + U

M = Cost of Services to Medicaid patients, less the amount paid by the State under the non-disproportionate share payment provisions of the State Plan

U = Cost of Services to Uninsured Patients, less any cash payments made by them

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Cost of Services

The definition of the cost of services includes all inpatient costs allowable under the Medicare principles of reasonable cost reimbursement.

Uninsured Patients

Uninsured patients is defined as patients who do not possess health insurance or do not have a source of third party payment for services provided, including individuals who do not possess health insurance which applies to services for which the individual sought treatment.

SUPERSEDES: NONE - NEW PAGE

2. Disproportionate Share Payment (Continued)

If the total of all disproportionate share payment amounts for all disproportionate share hospitals (acute care, inpatient psychiatric, rehabilitative hospitals and border city hospitals) exceed in any given year the federally determined disproportionate share allotment for Arkansas, the disproportionate share payments will be reduced proportionately among disproportionate share hospitals to a level in compliance with the federal disproportionate share allotment. Cities which are located within a fifty (50) mile trade area are considered bordering cities. **See list of bordering cities in Attachment 4.19-A, Page 3a.**

Rate Appeal Process

Participating hospitals are provided the following mechanism to appeal their disproportionate share eligibility and/or rate.

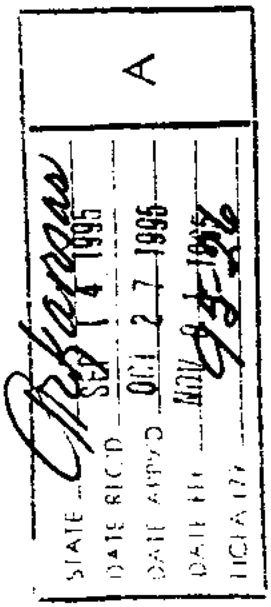
A. All hospitals will be notified of their eligibility status for the disproportionate share payment and of this disproportionate rate, by certified mail. A hospital administrator may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services.

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2. Disproportionate Share Payment (Continued)

This request must be received within 20 calendar days following receipt of the certified letter which notifies the hospital of their disproportionate eligibility status and/or rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference if he wishes for a full explanation of the factors involved in the program decision. Following review of the appeal request, the Assistant Director will notify the hospital of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

B. If the Assistant Director's, Division of Medical Services, decision is unsatisfactory, the facility may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the Arkansas Hospital Association and a member of the DHS Management Staff who will serve as chairman.



The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question within 15 calendar days after receipt of a request for such appeal. The question will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services for approval.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-A
Page 22

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES

Revised: May 1, 2004

3. Additional Disproportionate Share Payment

Effective April 5, 2001, the total annual Disproportionate Share Hospital (DSH) payments to all qualifying hospitals (acute care, inpatient psychiatric, rehabilitative and border city), as calculated per Section #2 of Attachment 4.19-A, is capped at a maximum annual total of $2,745,367. This maximum annual DSH total does not include the additional DSH amounts payable to Arkansas State Operated Psychiatric Hospitals and Arkansas State Operated Teaching Hospitals as identified in this Section. The DSH payment to each qualifying hospital will be reduced proportionately if the total of the individual hospital DSH payable amounts exceeds the annual $2,745,367 maximum.

Effective April 5, 2001, the Arkansas State Operated Psychiatric Hospitals shall qualify to receive an additional DSH amount. Arkansas State Operated Psychiatric Hospitals are classified as a separate class group for DSH purposes. The Medicaid DSH definition of a State Operated Psychiatric Hospital is a psychiatric hospital that has in effect an agreement to participate in Medicaid as an inpatient psychiatric hospital and is operated by the State of Arkansas. The additional payable amount is the difference between the annual State DSH maximum amount for psychiatric hospitals (Federal plus State Share) and the DSH payable amounts to all psychiatric hospitals as calculated per Section #2 of Attachment 4.19-A. The State Operated Psychiatric Hospitals must qualify under either the Medicaid inpatient utilization rate or low-income utilization rate methods and must meet all other requirements of Section #2 in order to receive the additional DSH reimbursement. The State DSH maximum amount for psychiatric hospitals is identified annually by the **Centers for Medicare and Medicaid Services (CMS)** and is included in the federally (CMS) determined annual State DSH allotment. If qualified, the State Operated Psychiatric Hospitals are reimbursed both the DSH amount as calculated per Section #2 plus the additional DSH amount. Arkansas State Operated Psychiatric Hospitals are provided the same mechanism to appeal their additional DSH payment eligibility and/or rate as is identified in Section #2.

Effective April 5, 2001, the Arkansas State Operated Teaching Hospitals shall qualify to receive an additional DSH amount. Arkansas State Operated Teaching Hospitals are classified as a separate class group for DSH purposes. The additional payable amount is the difference between the annual DSH allotment amount (Federal plus State Share) and the total other DSH payable amounts, including all amounts payable to the State Operated Psychiatric Hospitals. The State Operated Teaching Hospitals must qualify under either the Medicaid inpatient utilization rate or low-income utilization rate methods and must meet all other requirements of Section #2 in order to receive the additional DSH reimbursement. The State DSH allotment is identified annually by the **Centers for Medicare and Medicaid Services (CMS)**. If qualified, the State Operated Teaching Hospitals are reimbursed both the DSH amount as calculated per Section #2 plus the additional DSH amount. Arkansas State Operated Teaching Hospitals are provided the same mechanism to appeal their additional DSH payment eligibility and/or rate is identified in Section #2.

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3a. Annual Disproportionate Share Hospital (DSH) Audit

In addition to any other audits which may occur, independent certified audits of the DSH payments shall be conducted annually in accordance with 42 CFR 455.301 and 42 CFR 455.304. Reporting of the audit shall follow the guidelines stated in 42 CFR 447.299. In accordance with 42 CFR 455.304(e), any overpayments of DSH funds shall be redistributed to other eligible hospitals within the state, provided each acute care hospital remains below their hospital specific DSH limit in the following manner:

(a) The amount of the DSH payment made to the acute care hospital will be recouped by the State of Arkansas to the extent necessary to reduce the DSH payment to an allowable amount.

(b) Amounts recouped from acute care hospitals with payments in excess of the audited hospital specific DSH limits, will be placed into an acute care hospital redistribution pool. Redistribution will be made to remaining acute care hospitals that do not exceed their hospital specific DSH limit. The allocation will be made based on these remaining acute care hospitals available uncompensated care. No acute care hospital shall exceed its hospital specific DSH limit after redistribution.

(c) Additionally, DSH funds not otherwise paid to qualifying acute hospitals shall be paid, subject to the uncompensated care cost limits and annual DSH allotment, to the Arkansas State Operated Teaching Hospital.

4. Reimbursement for Inpatient Hospital Services for Children Under Age One (or Children that are Hospitalized on Their First Birthday)

Medically necessary inpatient hospital services furnished to children under age one (or children that are hospitalized on their first birthday) will be exempt from any dollar limits on any inpatient hospital service.

Inpatient hospital services **(excluding other covered transplant services for In-State Acute Care/General Hospitals, all Bordering City Hospitals and all Out-of-State Hospitals)** for these individuals will be cost settled separately from all other Medicaid recipients and no dollar limits will be applied.

Arkansas Medicaid will not consider these costs in the Medicare TEFRA rate of increase limit computation.

SUPERSEDES: 01-08

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5. Alternative Benefit Plan (ABP)

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover inpatient acute hospital days in excess of twenty-four days (during a state fiscal year) for those beneficiaries covered under the Alternative Benefit Plan (APB). The per diem rate for ABP inpatient acute hospital days twenty-five and above will be 400 dollars per day. The intent of the policy change is to increase access to care in all hospitals in the state of Arkansas. Inpatient Acute hospital days under twenty-five will be reimbursed in accordance with the methodology set forth in Attachment 4.19A page 1. Except as otherwise noted in the Plan, this rate is the same for both governmental and private providers of inpatient acute hospital services.

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover inpatient rehabilitation hospital days in excess of twenty-four days (during a state fiscal year) for those beneficiaries covered under the Alternative Benefit Plan (ABP). The per diem rate for ABP inpatient rehabilitation hospital days twenty–five and above will be 400 dollars per day. The intent of the policy change is to increase access to care in all hospitals in the state of Arkansas. Inpatient rehabilitation hospital days under twenty-five will be reimbursed in accordance with the methodology set forth in Attachment 4.19A page 9a. Except as otherwise noted in the State Plan, this rate is the same for both government and private providers of inpatient rehabilitation hospital services.

6. Reimbursement for Acute Crisis Units

Acute Crisis Units provide acute care hospital diversion and step-down services to Medicaid clients experiencing psychiatric or substance use disorder related distress in a safe environment with psychiatry and substance use disorder services available on-site, as well as on-call psychiatry available 24 hours per day. Effective for dates of service on or after July 1, 2021, reimbursement for Acute Crisis Units is based on 80% of the current (7/1/2021) daily rate for the Arkansas State Hospital. No room and board costs, or other unallowable facility costs, are built into the daily rate. State developed fee schedule rates are the same for both governmental and private providers. The fee schedule can be accessed at Fee Schedules - Arkansas Department of Human Services.

7. Cost Settlement Reopening Process

The state will compute interim payments for providers and subsequently reconcile the interim payments with final payments for which providers are eligible based on billed claims. The interim payment methodology is not a prepayment prior to services being furnished but represents interim payments for services furnished that are subject to final reconciliation.

A medical facility administrator or an identified facility representative such as the cost report preparer, DHS representative, a Medicare Administrative Contractors (MAC) representative, or a relevant contract representative may request a hospital cost report reopening by writing to the Reimbursement Unit of the Division of Medical Services. The request must be received no later than three (3) years after the date of the determination (Notice of Program Reimbursement ("NPR") or Revised NPR) or decision that is the subject of the reopening. This request must reflect a reimbursement impact that totals a cumulative amount of at least $10,000 increase due to new and material issues within the individual cost report. Each issue cited must be reviewed and determined as new and material to be counted in the cumulative total.

Any cost reports reopened due to unforeseen and unavoidable events that are between two (2) and three (3) years after the NPR was issued and which result in a payment above the interim payments will qualify for an exception under 45 CFR 95.19(a).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: April 1, 2003

2.a. Outpatient Hospital Services

(1) Acute Care/General

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum was established utilizing 80% of the **Blue Cross/Blue Shield** customary as reflected in their 10/90 publication.

For those procedures which Blue Shield did not have a comparable code, the rates were increased by 35%. The 35% represents the average overall increase for all services.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

Effective April 1, 2003, all Arkansas non-state government-owned or operated acute care/ general hospitals (that is, all acute care government hospitals within the State of Arkansas that are neither owned nor operated by the State of Arkansas) shall qualify for an annual upper payment limit (UPL) reimbursement adjustment. Psychiatric hospitals, pediatric hospitals, rehabilitative hospitals and critical access hospitals are not eligible for an adjustment. Payment shall be made before the end of the State Fiscal Year (SFY). The adjustment will be calculated and based on each hospital's previous SFY outpatient Medicare-related upper payment limit (UPL as specified in 42 CFR 447.321) for Medicaid reimbursed outpatient services. The adjustments will be calculated as follows:

1. **For each qualifying hospital, Arkansas Medicaid will annually identify the total Medicaid outpatient expenditures during the most recent completed SFY.**

2. **For each qualifying hospital, the total Medicaid expenditures, as determined in step 1, are divided by 80% to estimate the amount that would have been paid using Medicare reimbursement principles.**

3. **The difference between step 1 identified Medicaid expenditures and step 2 estimated Medicare amounts is the UPL annual adjustment amount that will be reimbursed.**

   Eligible hospitals that were not licensed and providing services throughout the most recent completed SFY shall receive a pro-rated adjustment based on the partial year data.

4. **Payment for SFY 2003 shall be prorated proportional to the number of days between April 1, 2003 and June 30, 2003 to the total number of days in SFY 2003.**

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SUPERSEDES: CC-10

2.a. Outpatient Hospital Services (continued)

Outpatient Hospital Access Payments

Effective for services provided on or after July 1, 2009, all privately operated hospitals within the State of Arkansas except for rehabilitative hospitals and specialty hospitals as defined in Arkansas Code Ann. § 20-77-1901 (7) (D) and (E) shall be eligible to receive outpatient hospital access payments. The outpatient hospital access payments are considered supplemental payments and do not replace any currently authorized Medicaid outpatient hospital payments. The outpatient hospital access payments shall be determined on the basis of cost and calculated as follows:

1. For each rate year the state shall identify, on the basis of paid claims adjudicated through the State's MMIS, reimbursement for outpatient hospital services that were delivered by the private hospitals eligible for this supplemental payment.
2. The state shall estimate the amount of cost for the same dates of service identified in step one using Medicare cost principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321. The State will utilize cost data in a manner approved by CMS.
3. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals shall not exceed the difference between the results of step one (Medicaid based payment) and results of step two (Medicaid outpatient hospital services cost).
4. The maximum allowable aggregate Medicaid outpatient hospital access payment for private hospitals identified in step three shall be divided by the total Medicaid outpatient hospital services base payment for eligible hospitals identified in step one to arrive at an adjustment percentage. This percentage will be calculated annually.
5. Each eligible hospital's outpatient hospital access payment shall be determined by multiplying the Medicaid outpatient hospital services payment identified in step one by the adjustment factor determined in step four. The current year's adjustment will be based on cost data from the most recently audited fiscal year for which there is complete data. In this manner, the State will make supplemental payment to eligible hospitals for current year Medicaid utilization.

Outpatient hospital access payments shall be paid on a quarterly basis.

For hospitals that, for the most recently audited cost report period filed a partial year cost report, such partial year cost report data shall be annualized to determine their outpatient access payment; provided that such hospital was licensed and providing services throughout the entire cost report period. Hospitals with partial year cost reports that were not licensed and providing services throughout the entire cost report period shall receive pro-rated adjustments based on the partial year data.

Effective August 1, 2015, and forward, if an audited cost report is more than 2 years old, the State will elect to use the most recent cost report available as of June 30 for Outpatient Hospital Access Payments. Most recently submitted partial year cost report data will be annualized in the same matter as was used for audited cost report periods as described above.

(2) Pediatric Hospitals

Effective for claims with dates of service on or after April 1, 1992, outpatient hospital facility services provided at a pediatric hospital will be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The State will utilize cost data in a manner approved by CMS consistent with the method used for identifying cost for the private hospital access payments.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed based on Medicare cost rules in effect prior to the September 29, 1989, rule change.

2.a. Outpatient Hospital Services (continued)

(3) Arkansas State Operated Teaching Hospitals

Effective for cost reporting periods ending June 30, 2000 or after, outpatient hospital services provided at an Arkansas State Operated Teaching Hospital will be reimbursed based on reasonable costs with interim payments in accordance with 2.a.(1) and a year-end cost settlement.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. Except for graduate medical education costs, the cost settlements will be calculated using the methods and standards used by the Medicare Program. Graduate medical education costs are reimbursed as described in Attachment 4.19-A, Page 8a for inpatient hospital services.

(4) **Speech Generating** Device Evaluation

Effective for dates of service on or after September 1, 1999, reimbursement for a **Speech Generating** Device **(SGD)** Evaluation is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The XIX (Medicaid) maximum is based on the current hourly rate for both disciplines of therapy involved in the evaluation process. The Medicaid maximum for speech**-language** therapy is $25.36 per (20 mins.) unit x's 3 units per date of service (DOS) and occupational therapy is $18.22 per (15 mins.) unit x's 4 units per DOS equals a total of $148.96 per hour. Two (2) hours per DOS is allowed. This would provide a maximum reimbursement rate per DOS of $297.92.

(5) Outpatient/Clinic-Indian Health Services

Effective for dates of service on or after November 1, 2002, covered outpatient/clinic services provided by Indian Health Services (IHS) and Tribal 638 Health Facilities will be reimbursed the IHS outpatient/clinic rate published by the Office of Management and Budget (OMB). Covered IHS outpatient/clinic services include only those services that are covered under other Arkansas Medicaid programs. This rate is an all-inclusive rate with no year-end cost settlement. The initial rate is the published IHS outpatient rate for calendar year 2002. The rate will be adjusted to the OMB published rate annually or for any other period identified by OMB.

2.a. Outpatient Hospital Services (continued)

(6) Border City University-Affiliated Pediatric Teaching Hospitals

Special consideration is given to border city university-affiliated pediatric teaching hospitals due to the higher costs typically associated with such hospitals. Effective for claims with dates of service on or after January 1, 2018, outpatient hospital facility services provided to patients under the age of 21 at border city university-affiliated pediatric teaching hospitals will be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The State will utilize cost data in a manner approved by CMS consistent with the method used for identifying cost for the private hospital access payments as outlined in this Attachment 4.19-B, Page 1a.

Arkansas Medicaid will use the lesser of the reasonable costs or customary charges to establish cost settlements. The cost settlements will be calculated using the methods and standards used by the Medicare Program.

A border city university-affiliated pediatric teaching hospital is defined as a hospital located within a bordering city (see Attachment 4.19-A page 3b) that submits to the Arkansas Medicaid Program a copy of a current and effective affiliation agreement with an accredited university, and documentation establishing that the hospital is university-affiliated, is licensed and designated as a pediatric hospital or pediatric primary hospital within its home state, maintains at least five different intern pediatric specialty training programs, and maintains at least one-hundred (100) operated beds dedicated exclusively for the treatment of patients under the age of 21.

(7) Effective for claims with dates of service on or after June 1, 2022, all Arkansas hospitals shall be paid based on 100% of the Medicare average comprehensive payment rate as of June 1, 2022 for the vagus nerve stimulation therapy, device and procedure. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers.

(8) Select Carved-Out Drugs from Hospital Settings

Effective for dates of service on or after January 1, 2026, prescribed drugs identified as carved out of the inpatient and outpatient hospital payment methodologies are reimbursed under this section and reimbursed separately from hospital payment rates. The list of carved-out prescribed drugs is maintained on the State's website at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/. Reimbursement for these drugs will be based on the provider's Actual Acquisition Cost for the drug, verified by the purchasing invoice. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.a. Outpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.a. Outpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.a. Outpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://medicaid.mmis.arkansas.gov/provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes **- Sunset date for final reconciliation report 1/31/2021**

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes **- Sunset date for final reconciliation report 4/30/2021**
(2) Total Joint Replacement Episodes **- Sunset date for final reconciliation report 4/30/2021**

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic.

In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001 and after, payments to Rural Health Clinics (RHCs) for Medicaid covered services will be made using a prospective payment system (PPS) based on a per visit basis. A visit means a face-to-face encounter between an RHC patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The PPS per visit rate for each facility will be calculated based on 100 percent of the average of the facility's reasonable costs for providing Medicaid covered services as determined from audited Medicare cost reports with ending dates in calendar year 1999 and calendar year 2000. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413 with no lesser of costs or charges limits and no per visit payment limit. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid will use the most recent cost report to calculate rates. Adjustments to the Medicare RHC Program allowable costs per the cost report may be necessary due to differences with Medicaid Program covered services.

PPS per visit rates will be calculated by adding the total audited allowable costs as determined from the 1999 and 2000 cost reports and dividing the total by the total audited visits for these same two periods. Until audited cost report information is available, interim rates will be implemented as of January 1, 2001 at the average cost per visit as determined from the two most recent provider cost reports. Interim rates will be calculated by adding the two period's per visit costs and dividing the total by two. Interim rates will be retroactively adjusted to January 1, 2001, when audited cost report information becomes available and final rates are calculated.

Each facility's PPS per visit rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as 1) an addition or deletion of an RHC covered service, 2) a change in the magnitude, intensity, or character of currently offered RHC covered services, 3) a change in regulatory requirements 4) a change due to relocation, remodeling, opening a new clinic site or closing an existing clinic site, 5) a change in applicable technologies and medical practices, or 6) a change due to recurring taxes, malpractice insurance premiums or workmens comp. insurance premiums that were not recognized and included in the base year's rate calculation. Written requests for both cost increases and cost decreases due to scope of services changes must be submitted by the provider. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences.

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03-27-01
06-25-01
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AK 01-04

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (Continued)

In order to qualify for a PPS rate change, the scope of services changes must equal to at least a 5% total difference in the allowable per visit cost as determined for the fiscal period and the changes must have existed during the last full 6 month period of the fiscal period. Arkansas Medicaid will review the submitted documentation and will notify the provider within 90 days as to whether a PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service change and be effective as of the later of the first date that the scope of service changed or the beginning date of the fiscal period. PPS rate changes will also be made due to scope of service changes identified through an audit or review process. If this occurs, the effective date of the PPS rate change will be the later of the first date that the scope of services changed or the beginning date of the cost report period for which the changes should have been reported.

Independent (Freestanding) RHCs that do not have minimal 1999 and 2000 cost report periods (at least 6 months) or who enroll in Medicaid after 2000, will have their initial PPS per visit rate established at the average of the current rates of the three nearest independent RHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Provider based RHCs that do not have minimal 1999 and 2000 cost report periods (at least six months) or who enroll in Medicaid after 2000 will have their initial PPS per visit rate established at the average of the current rates of the provider hospital's other enrolled RHCs with similar caseloads. Should a newly enrolled provider based RHC be the only clinic operated by the hospital, the initial PPS rate shall be established at the average of the current rates of the three nearest provider based RHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Beginning July 1, 2001, interim rates, initial PPS rates and final PPS rates will annually be adjusted as of July 1st of each year by the regional Medicare Economic Index (MEI) for primary care services. Rate adjustments will be equal to the previous calendar year's index percentage change.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE** **Revised: October 1, 2020**

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued)

A. ALTERNATE PAYMENT METHODOLOGY TO INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE**:** In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued)

A. ALTERNATE PAYMENT METHODOLOGY TO INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal **fifty percent (**50%**)** of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

For Rural Health Centers (RHCs), the negative incentive adjustment will not result in payment at less than the rate required under the PPS methodology, but Medicaid reserves the right to adjust total reimbursements to RHCs based on appropriate utilization under our utilization control responsibility to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments consistent with regulations at 42 CFR Part 456.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (continued)

A. ALTERNATE PAYMENT METHODOLOGY TO INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://medicaid.mmis.arkansas.gov/provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes **- Sunset date for final reconciliation report 1/31/2021**

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes **- Sunset date for final reconciliation report 4/30/2021**
(2) Acute Exacerbation of Asthma Episodes **- Sunset date for final reconciliation report 10/31/2020**

Effective for dates of service on or after March 14, 2014, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Ambulatory Upper Respiratory Infection (URI) Episodes **- Sunset date for final reconciliation report 1/31/2021**

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

For FQHC Facilities Agreeing To The Alternative Payment Methodology

Written and signed agreements will be obtained from all FQHC providers who choose this alternative method.

In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001 and after, FQHCs will be reimbursed an interim per visit rate for Medicaid covered services with cost settlement at the greater of 100% of reasonable costs or the allowable per visit rate as determined under the prospective payment system (PPS). Cost settlement will be determined from provider submitted cost reports. Separate cost settlements will be made for cost reporting periods with dates of service occurring before and beginning January 1, 2001 based on the number of Medicaid visits provided before and beginning January 1, 2001. A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The PPS per visit rate for each facility will be calculated based on 100 percent of the average of the facility's reasonable costs for providing Medicaid covered services as determined from audited cost reports with ending dates in calendar year 1999 and calendar year 2000. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413 with no lesser of costs or charges limits and no per visit payment limit. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid will use the most recent cost report to calculate rates.

PPS per visit rates will be calculated by adding the total audited allowable costs as determined from the 1999 and 2000 cost reports and dividing the total by the total audited visits for these same two periods. Interim rates will be implemented as of January 1, 2001 at the average cost per visit as determined from the two most recent provider cost reports. Interim rates will be calculated by adding the two period's per visit costs and dividing the total by two. Providers may request reductions of up to 20% of their January 1, 2001 interim rates by submitting a written request within 21 days after notification by Medicaid of their new interim rate. Thereafter, interim rates will be established at the allowable cost per visit as determined from the most recent audited cost report and will be effective as of the first day after the audited cost report period. Providers may also request reductions of up to 10% of these interim rates by submitting a written request within 21 days after notification by Medicaid of their new interim rate.

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2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

Each facility's PPS per visit rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as 1) an addition or deletion of an FQHC covered service, 2) a change in the magnitude, intensity, or character of currently offered FQHC covered services, 3) a change in regulatory requirements, 4) changes due to relocation, remodeling, opening a new clinic site or closing an existing clinic site, 5) a change in applicable technologies and medical practices, or 6) a change due to recurring taxes, malpractice insurance premiums or workmens comp. insurance premiums that were not recognized and included in the base year's rate calculation. Written requests for both cost increases and cost decreases due to scope of services changes must be submitted by the provider. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences. In order to qualify for a PPS rate change, the scope of services changes must equal to at least a 5% total difference in the allowable per visit cost as determined for the fiscal period and the changes must have existed during the last full 6 month period of the fiscal period. Arkansas Medicaid will review the submitted documentation and will notify the provider within 90 days as to whether a PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service change and be effective as of the later of the first date that the scope of service changed or the beginning date of the fiscal period. PPS rate changes will also be made due to scope of service changes identified through an audit or review process. If this occurs, the effective date of the PPS rate change will be the later of the first date that the scope of services changed or the beginning date of the cost report period for which the changes should have been reported .

FQHCs that do not have minimal 1999 and 2000 cost report periods (at least 6 months) or who enroll in Medicaid after 2000, will have their initial PPS per visit rate established at the average of the current rates of the three nearest FQHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Effective for provider fiscal periods beginning January 1, 2001 and after, interim rates, initial PPS rates and final PPS rates will annually be adjusted as of the first day of the provider's fiscal period by the regional Medicare Economic Index (MEI) for primary care services. Rate adjustments will be equal to the previous calendar year's index percentage change.

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2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

For FQHC Facilities Not Agreeing To The Alternative Payment Methodology

In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001 and after, payments to Federally Qualified Health Centers (FQHCs) for Medicaid covered services will be made using a prospective payment system (PPS) based on a per visit basis. A visit means a face-to-face encounter between an FQHC patient and any health professional whose services are reimbursed under the State Plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

The PPS per visit rate for each facility will be calculated based on 100 percent of the average of the facility's reasonable costs for providing Medicaid covered services as determined from audited cost reports with ending dates in calendar year 1999 and calendar year 2000. Reasonable costs are defined as those costs which are allowable under Medicare cost principles outlined in 42 CFR 413 with no lesser of costs or charges limits and no per visit payment limit. Cost reports used for rate setting purposes must cover a fiscal period of at least a full six months. If a provider has more than one cost report period ending in the same calendar year, Arkansas Medicaid will use the most recent cost report to calculate rates.

PPS per visit rates will be calculated by adding the total audited allowable costs as determined from the 1999 and 2000 cost reports and dividing the total by the total audited visits for these same two periods. Until audited cost report information is available, interim rates will be implemented as of January 1, 2001 at the average cost per visit as determined from the two most recent provider cost reports. Interim rates will be calculated by adding the two period's per visit costs and dividing the total by two. Interim rates will be retroactively adjusted to January 1, 2001, when audited cost report information becomes available and final rates are calculated.

Each facility's PPS per visit rate will be adjusted to account for increases or decreases in scope of services. Scope of services changes are defined as 1) an addition or deletion of an FQHC covered service, 2) a change in the magnitude, intensity, or character of currently offered FQHC covered services, 3) a change in regulatory requirements 4) a change due to relocation, remodeling, opening a new clinic site or closing an existing clinic site, 5) a change in applicable technologies and medical practices, or 6) a change due to recurring taxes, malpractice insurance premiums or workmens comp. insurance premiums that were not recognized and included in the base year's rate calculation.

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2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

Written requests for both cost increases and cost decreases due to scope of services changes must be submitted by the provider. The request must be submitted (postmarked) within 5 months after the end of the provider's fiscal period and the request must identify the beginning date that the change occurred and include detailed descriptions, documentation and calculations of the changes and costs differences. In order to qualify for a PPS rate change, the scope of services changes must equal to at least a 5% total difference in the allowable per visit cost as determined for the fiscal period and the changes must have existed during the last full 6 month period of the provider's fiscal period. Arkansas Medicaid will review the submitted documentation and will notify the provider within 90 days as to whether a PPS rate change will be implemented. If implemented, the PPS rate change will reflect the cost difference of the scope of service change and be effective as of the later of the first date that the scope of service changed or the beginning date of the fiscal period. PPS rate changes will also be made due to scope of service changes identified through an audit or review process. If this occurs, the effective date of the PPS rate change will be the later of the first date that the scope of services changed or the beginning date of the cost report period for which the changes should have been reported .

FQHCs that do not have minimal 1999 and 2000 cost report periods (at least 6 months) or who enroll in Medicaid after 2000, will have their initial PPS per visit rate established at the average of the current rates of the three nearest FQHCs with similar caseloads. Nearest will be determined per map mileage. A final PPS per visit rate shall be established using the facility's allowable costs as determined from the provider's first two audited cost reports with reporting periods of at least a full six months. The final PPS rate will be made effective as of the first day after the provider's second fiscal cost report period used for rate setting.

Beginning July 1, 2001, interim rates, initial PPS rates and final PPS rates will annually be adjusted as of July 1st of each year by the regional Medicare Economic Index (MEI) for primary care services. Rate adjustments will be equal to the previous calendar year's index percentage change.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: April 1, 2004

3. Laboratory, X-ray Services and Other Tests

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed.

For hospital outpatient providers, reimbursement rates for services with a technical component are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

When medical professionals provide a service that is linked to a service with a technical component, reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds subject to any other specific State Plan reimbursement requirements (Examples - *Clinical Laboratory Services are reimbursed using a separate methodology. *The nurse practitioner is reimbursed 80% of the physician rate for some identified services).

For dates of service occurring July 1, 1994 through March 31, 2004, reimbursement rates are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

For dates of service occurring April 1, 2004 and after:

A. Reimbursement rates are increased by 10% up to a maximum or benchmark rate of 80% of the 2003 Arkansas Blue Cross/Blue Shield (BC/BS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than 80% of the 2003 BC/BS fee schedule rate, no increase will be given. A minimum rate or floor amount of 45% of the 2003 BC/BS fee schedule rate will be reimbursed. For those rates that after the 10 % increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.

B. Reimbursement rate maximums are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.

C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:

(1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.

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DATE RECEIVED: 4-1-04
DATE APPROVED: 11-2-04
DATE EFFECTIVE: 4-1-04
SUPERSEDES: 04-05(a)

TN: 01-30

3. **Laboratory, X-ray Services and Other Tests (continued)**

(2) **Decreases: If one component rate is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.**

(1) Clinical Laboratory Services

Effective for dates of service occurring February 1, 2002 and after, clinical lab services as identified by the Medicare Clinical Lab Fee Schedule, will be reimbursed at the lesser of the 2001 Medicare rate or the amount billed.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at mutually acceptable increases or decreases from the maximum rates. Market forces, such as Medicare and private insurance rates, medical and general inflation figures, changes in service's costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increases or decreases will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

Codes deleted from future Medicare Clinical Lab Fee Schedules will also be removed from Medicaid reimbursable services. New codes added to the annual Medicare Clinical Lab Fee Schedule will be implemented at the current Medicare Clinical Lab Fee Schedule rate.

(2) Portable X-ray Services

The Title XIX (Medicaid) maximum for portable X-ray services shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds. Refer to Attachment 4.19-B, Item 3, for X-ray services reimbursement for physicians and other licensed practitioners.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rate, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

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DATE APPVD 11-2-04	
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE **Revised: February 3, 2009**

3. Laboratory and X-ray Services and Other Tests (Continued)

(3) Chiropractor X-ray Services

Effective for dates of service on or after June 1, 1998, the Arkansas Medicaid maximum for an X-ray will be calculated by using the average of the 1997 Medicare Physician's Fee Schedule (participating fee) rates at 100% for the complete components for procedure codes 72010, 72040, 72050, 72070, 72100 and 72110; or such procedure codes implemented by Medicare, as the AMA (or it's successor) shall declare are the replacements for, and successor's thereto. The average rate will be established as the Medicaid maximum for procedure code Z1928 (Chiropractic X-ray), or such procedure code implemented by Arkansas Medicaid for the purpose of billing a Chiropractic X-ray.

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor a comparison between the previous and current year's Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates, for all of the above CPT radiology procedure codes, as reflected in the current Medicare Physician's Fee Schedule.

4.a. Nursing Facility Services (other than services in an institution for mental diseases) for individuals 21 Years of Age or Older - SEE ATTACHMENT 4.19-D

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found.

(1) Reimbursement for Child Health Services (EPSDT) is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum.

SUPERSEDES TN: 07-17

STATE Arkansas
DATE REC'D 2-2-09
DATE APP'D 4-8-09
DATE EFF 2-3-09
HCFA 179 09-03

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: February 3, 2009

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

(2) Apnea (Cardiorespiratory) Monitors - Reimbursement is based on the lesser of the provider's actual charges for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum is based on 10% of the lowest purchase price. This is a rental only item.

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HCFA 179 09-03
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SUPERSEDES TN 07-17

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

February 3, 2009

RESERVED

SUPERSEDES: NONE - NEW PAGE

STATE Arkansas
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DATE EFF 2-3-09
HCFA 179 09-03

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

(3) Early Intervention Day Treatment **(EIDT)**

Reimbursement for comprehensive evaluation is based on the lesser of the amount billed or the Title XIX (Medicaid) charge allowed. The Title XIX maximum was established based on a 1980 survey conducted by Developmental Disabilities Services (DDS) of 85 Arkansas Developmental Day Treatment providers of their operational costs excluding their therapy services. An average operational cost **and average number of units were** derived for each service. The average operational cost for each service was divided by the average units for that particular service to arrive at a maximum rate.

The Title XIX (Medicaid) maximum rates were established based on the following:

1. Auditory, developmental and neuropsychological testing services listed in the 1990 Blue Cross/Blue Shield Fee Schedule that are not subject to the other specifically identified reimbursement criteria are reimbursed based on 80% of the October 1990 Blue Cross/Blue Shield Fee Schedule amounts. For those services that were not included on the **October** 1990 Blue Cross/Blue Shield Fee Schedule, rates are established per the most current Blue Cross/Blue Shield Fee Schedule amount less 2.5% and then multiplied by 66%.

2. Psychological diagnosis/evaluation services **provided by Early Intervention Day Treatment (EIDT) providers certified as Academic Medical Centers (AMCs)** are reimbursed from the **Outpatient Behavioral Health** Fee Schedule as described in Attachment 4.19-B, Item 13.d.1.

3. Medical professional services reimbursement is based on the physician's fee schedule. Refer to the physician's reimbursement methodology as described in Attachment 4.19-B, Item 5.

4. The maximum rate for **one hour of day habilitation** services is **$18.27**. This rate was calculated based on analysis of current **2019-2020** costs to provide quality services in compliance with governing regulations. The rates have been demonstrated to be consistent with the Clinic Upper Payment Limit at 42 CFR 447.321. **The** maximum **services without an extension of benefits are** 5 hours per day. State developed fee schedule rates are the same for both public and private providers of EIDT services.

5. The maximum rate for **five minutes of registered** nursing services is **$4.77**. **The maximum rate for five (5) minutes of licensed practical nursing services is $3.17.** Reimbursement for registered nurses and licensed practical nurses is based on the Private Duty Nursing Fee Schedule as described in Attachment 4.19B, Item 8.

6. The Title XIX maximum for occupational, physical and speech therapy diagnosis and evaluation is equal to the Title XIX (Medicaid) maximum established for the stand-alone therapy program. Refer to the stand-alone therapy reimbursement methodology as described in Attachment 4.19-B, Item 4b. (19).

   Extensions of benefits will be provided for all EIDT services, if medically necessary.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

(3) Child Health Management Services (Continued)

Arkansas State Operated Teaching Hospital pediatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The lesser of reasonable costs or customary charges will be used to establish cost settlements.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(5) Private Duty Nursing Services for High Technology Non-Ventilator Dependent Recipients

Refer to Attachment 4.19-B, Page 3, Item 8.

(6) Cochlear Implants

Reimbursement for the cochlear device implantation procedure is made at the lower of (a) the provider's actual charge for the service or (b) the allowable fee from the State's physician fee schedule based on reasonable charge. Reimbursement for the cochlear device is based on the cost of the device as indicated by the manufacturer.

STATE Arkansas
DATE REC'D 8-24-93
DATE APPV'D 9-2-93
DATE EFF 7-1-93
HCFA ID 93-26
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Supersedes: TN 90-33

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(7) (RESERVED)

(8) The following services that are not otherwise covered under the Arkansas State Plan will be reimbursed when provided as a result of a Child Health Services (EPSDT) screening/referral:

a. Case Management Services

Reimbursement for the social and educational components of case management will be based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure. Case management services are billed on a per unit basis. One unit equals 15 minutes.

STATE Arkansas
DATE REC'D APR - 4 1991
DATE APP'D MAY - 9 1991
DATE EFF FEB - 1 1991
HCFA 179 91-13
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Supersedes: 90-51

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(8) The following services that are not otherwise covered under the Arkansas State Plan will be reimbursed when provided as a result of a Child Health Services (EPSDT) screening/referral (Continued):

a. Case Management (Continued)

The maximum rates are based on a Social Services Worker III, Department of Human Services position, which most closely matches the duties of a case manager as defined in the Targeted Case Management amendment. Cost categories include salary ($25,480), overhead and administration ($2,548 – using salary as the allocation base), benefits ($5,096 – using salary as the allocation base), and travel expenses reimbursed at state approved rates associated with case management (average annual mileage of (9,149 X 0.25 per mile = $2,287.25). As such, the targeted case management unit rate is $4.25 [$25,480 + $2,548 + $5,096 + $2,287.25 = $35,411.25/2080 (52 weeks X 40 hours per week) = $17.02. Rounding per diem to the nearest dollar on the basis of:

. 51 cents or higher, increase to next dollar
. 50 cents or lower, decrease to next lower dollar

17.00/4 = 4.25 per 15 minute unit]. These costs are appropriate for other types of case management providers because they encompass the types of duties, overhead costs, and travel costs associated with case managers currently performing the service.

STATE Arkansas
DATE RECD 11-29-91
DATE APPVD 12-11-91
DATE EFF 7-1-91
HCFA ID 91-31
Supersedes: 90-51

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

(8) The following services that are not otherwise covered under the Arkansas State Plan will be reimbursed when provided as a result of a Child Health Services (EPSDT) screening/referral (Continued):

b. Respiratory Care Services

Respiratory Therapy Services for Ventilator-Dependent

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum was established based on a 1990 survey of three Arkansas durable medical companies who employ respiratory therapists. The rate was established by using the median rate obtained by the DME companies.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rate was decreased by 20%.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

(8) The following services that are not otherwise covered under the Arkansas State Plan will be reimbursed when provided as a result of a Child Health Services (EPSDT) screening/referral (Continued):

c. Services of Christian Science Nurses

Christian Science nurses are not licensed to practice in the State.

d. Care and Services Provided in Christian Science Sanatoria

There are no Christian Science Sanatoria facilities in the State.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

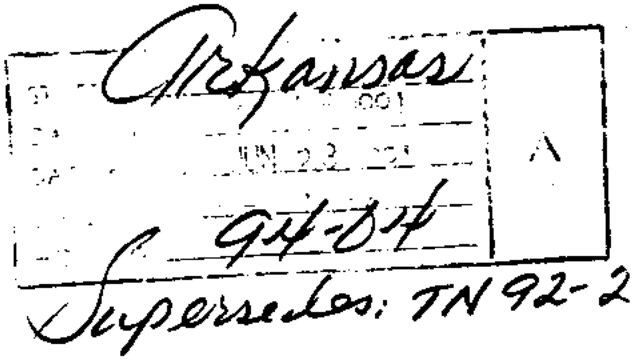
Revised: July 1, 1994

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(8) Dentures

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. **The Medicaid maximums were calculated using 80% of the 1992 Blue Shield Fee Schedule.**

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.



METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: April 1, 2004

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(10) Hearing Aid Dealers

Hearing aid vendors are reimbursed at 68% of retail price. Maintenance and repairs are reimbursed according to the lesser of the amount billed not to exceed a maximum of $100.00 per repair/maintenance.

(11) Audiologist Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum for audiology services is 100% of the current physician Medicaid maximum.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rate, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

(12) Hearing Aids

Reimbursement based on 68% of retail price.

STATE Arkansas
DATE REC'T 4-1-04
DATE APP'D 11-2-04
DATE EFF 4-1-04
HCFA 179 04-05(M)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: October 1, 2007

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(13) Eye Prostheses and Cleaning, **Enlargement and Reduction**

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. The Medicaid maximum rates were established using the 2005 Medicare fee schedule. The State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule are published.

(14) Ear Molds

Reimbursement is based on the lesser of the amount billed or 68% of the dealer invoice.

(15) Desensitization Injections

Medicaid will pay a physician's fee up to the Title XIX (Medicaid) maximum for administering the injection and up to the Title XIX (Medicaid) maximum per vial of antigen. Refer to Attachment 4.19-B, Page 2, Item 5.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

SUPERSEDES: TN- 05-11

STATE Arkansas
DATE REC'D 7-20-07
DATE APP'VD 9-7-07
DATE EFF 10-1-07
HCFA 179 07-12

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

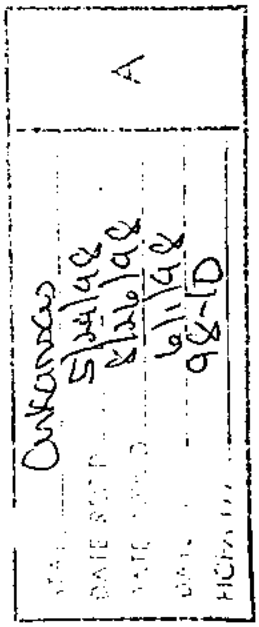
(16) **RESERVED**

(17) Psychology Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Some Medicaid maximums were established at 65% of the Blue Shield customary reflected in their publication dated 10/90. The other Medicaid maximums were established at 50% of the Rehabilitative Services for Persons with Mental Illness (RSPMI) fee schedule per procedure code. Refer to Attachment 4.19-B, Page 5a, Item 13.d.1.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

SUPERSEDED BY 94-04



**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE** **Revised: October 1, 2020**

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

4.b. Early and Periodic Screening and Diagnosis of Individuals Under **twenty-one (**21**)** Years of Age and Treatment of Conditions Found (Continued)

(17) Psychology Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

4.b. Early and Periodic Screening and Diagnosis of Individuals Under **twenty-one (**21**)** Years of Age and Treatment of Conditions Found (Continued)

(17) Psychology Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

IV. INCENTIVE ADJUSTMENTS (Continued)

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

4.b. Early and Periodic Screening and Diagnosis of Individuals Under **twenty-one (**21**)** Years of Age and Treatment of Conditions Found (Continued)

(17) Psychology Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Reserved for the potential addition of Episodes of Care subject to incentive adjustments

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(17) Dental Services

(a) Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. **The agency's rates were set as of November 21, 2007 and are effective for services on or after that date. All rates are published on the agency's website (www.medicaid.state.ar.us). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services.** Reimbursement rate maximums for Medicaid covered procedures are calculated at 95% of the 2007 Delta Dental Plan of Arkansas Inc.'s Premier rates. Upon CMS approval, the reimbursement rates calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v. Reynolds) for its approval.

Medicaid dental rates will be adjusted as follows. The Division of Medical Services and the Arkansas State Dental Association shall meet on two year cycles beginning January 1, 2007, to evaluate the dental rates considering the factors set out in 42 U.S.C. Section 1396a(a)(30)(A) and shall review Delta Dental's then current Premier rates, identify rate adjustment to be made, and agree on the implementation methodology and date.

Procedure code D0350 (oral/facial photographic images) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the Medicaid maximum rate for procedure code D0350 is $33.25. The rate is based on 47.5% of the $70.00 2006 Delta Dental Plan of Arkansas Inc.'s Premier rate for procedure code D0340 as of January 16, 2006.

Procedure code D9248 (non-intravenous conscious sedation) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D9248 is $96.74. The rate is based on 75% of the $128.99 physician reimbursement maximum rate for procedure code 99143 (conscious sedation). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.

Procedure code D9310 (consultation, second opinion examination) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D9310 is $40.13. The rate is based on 75% of the $53.50 physician reimbursement maximum rate for procedure code 99241 (office visit, consultation). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.

Procedure code D1320 (tobacco counseling) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D1320 is $25.00. The rate is based on 100% of the $25.00 physician reimbursement maximum rate for procedure code 99212 (office or other outpatient visit). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.

Procedure code D9920 (behavior management tobacco) is not covered by the 2006 Delta Dental Premier Plan. For dates of service beginning February 1, 2006, the maximum rate for procedure code D9920 is $20.00. The rate is based on 80% of the $25.00 physician reimbursement maximum rate for procedure code 99212 (office or other outpatient visit). See Attachment 4.19-B, Page 2 for Physician Services reimbursement methodology.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(17)(a) Dental Services, continued:

Beginning on or after September 1, 2025, reimbursement rates for oral and maxillofacial surgeons' dental services, including anesthesia; pediatric dental services, including anesthesia; and dental services for adults with special needs, including anesthesia; and excluding orthodontic services, are set to sixty (60) percent of the fiftieth percentile for national fees as determined by the 2025 edition of the National Dental Advisory Service (NDAS) Comprehensive Fee Report adjusted for Arkansas. To derive Arkansas's adjustment factor of 0.8145, the State identified and averaged the zip code multipliers for Arkansas as published in the NDAS to reflect differences in the median rates for ZIP codes representing geographic areas within the state.

The rates were calculated per CDT service code:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, currently 0.8145) x 0.60 × (NDAS-Reported National 50th Percentile Fee for CDT Code X), as evidenced by:
Medicaid Rate for D0120 = 0.8145 x 0.60 × $72 = $35.19

The State compared the new rates for affected services side-by-side to the existing fee schedule rates.

The State will review and update rates annually by using the most recent NDAS Comprehensive Fee Report and an updated Arkansas Adjustment factor according to the methodology established on September 1, 2025:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, updated for the year) x 0.60 × (Most current published NDAS-Reported National 50th Percentile Fee for CDT Code X)

Rates for the agency's dental fee schedule were set as of September 1, 2025, and are effective for services provided on or after that date. The fee schedule is based on sixty (60) percent of the fiftieth percentile of national fees from the National Dental Advisory Service (NDAS) Comprehensive Fee Report, adjusted for Arkansas, as described above. The State has in place a public process, which complies with the requirements of Section 1902(a)(30)(A) of the Social Security Act.

The agency's fee schedule is available to providers and the public and is published on the Medicaid agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(b) Oral Surgeons

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

For dates of service on and after February 1, 2006, oral surgeon rates for procedure codes that also may be billed by dentists shall be set in accordance with sub paragraph (a) above. Rates for other procedure codes are set as follows.

For dates of service occurring April 1, 2004 and after:

A. Reimbursement rates are increased by 10% up to a maximum or benchmark rate of 80% of the 2003Arkansas Blue Cross/Blue Shield (BC/BS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than 80% of the 2003 BC/BS fee schedule rate, no increase will be given. A minimum rate or floor amount of 45% of the 2003 BC/BS fee schedule rate will be reimbursed. For those rates that after the 10 % increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.

B. Reimbursement rates are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.

C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:

(1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.

(2) Decreases: If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.

04-05 (A)

STATE Arkansas
DATE RECD 3-30-06
DATE APVD 9-8-06
DATE EFF 2-1-06
HCFA 179 06-01

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(17) Dental Services (Continued)

(b) Oral Surgeons (Continued)

Beginning on or after September 1, 2025, reimbursement rates for oral and maxillofacial surgeons' dental services, including anesthesia, are set to sixty percent (60%) of the fiftieth percentile for national fees as determined by the annual National Dental Advisory Service Comprehensive Fee Report adjusted for Arkansas. To derive Arkansas's adjustment factor of 0.8145, the State identified and averaged the zip code multipliers for Arkansas as published in the NDAS to reflect differences in the median rates for ZIP codes representing geographic areas within the state.

The rates were calculated per CDT service code:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, currently 0.8145) x 0.60 × (NDAS-Reported National 50th Percentile Fee for CDT Code X), as evidenced by:
Medicaid Rate for D0120 = 0.8145 x 0.60 × $72 = $35.19

The State compared the new rates for affected services side-by-side to the existing fee schedule rates.

The State will review and update rates annually by using the most recent NDAS Comprehensive Fee Report and an updated Arkansas Adjustment factor according to the methodology established on September 1, 2025:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, updated for the year) x 0.60 × (Most current published NDAS-Reported National 50th Percentile Fee for CDT Code X)

Rates for the agency's dental fee schedule were set as of September 1, 2025, and are effective for services provided on or after that date. The fee schedule is based on sixty (60) percent of the fiftieth percentile of national fees from the National Dental Advisory Service (NDAS) Comprehensive Fee Report, adjusted for Arkansas, as described above. The State has in place a public process, which complies with the requirements of Section 1902(a)(30)(A) of the Social Security Act.

The agency's fee schedule is available to providers and the public and is published on the Medicaid agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(19) Physical Therapy, Occupational Therapy, and Speech-Language Therapy Services

Effective for dates of service on or after October **1**, 1999, the Arkansas Medicaid maximum rates for physical therapy services, occupational therapy services and speech-language therapy services are based on court-ordered rates issued by the United States District Court, Eastern District of Arkansas, Western Division and agreed upon by the Division of Medical Services and representatives of the Arkansas Physical Therapy Association, the Arkansas Occupational Therapy Association and the Arkansas Speech-Language-Hearing Association.

Effective April 9, 2022, the agency's fee schedule rates **for occupational therapy, physical therapy, and speech-language pathology treatment services** were set **based on an average of 2019 Medicare utilization data for the same services**. **The fee schedule rates for occupational therapy, physical therapy, and speech-language pathology evaluations were determined to be in line with Medicare and were not changed. The occupational therapy, physical therapy, and speech-language pathology treatment rate adjustments will be implemented over two (2) years. An initial rate increase of sixteen percent (16%) will be implemented on April 9, 2022, and the second increase of fifteen percent (15%) will be implemented on April 1, 2023.**

The applicable fee schedule **of** rates **at any given time** are published on the agency's website (Fee Schedules - Arkansas Department of Human Services). A uniform rate for these services is paid to all governmental and non- governmental providers unless otherwise indicated in the state plan. The State assures that physical therapists, occupational therapists and speech-language therapists will meet the requirements contained in 42 CFR 440.110.

Therapy Assistants - Effective for dates of service on or after October I, 1999, the Arkansas Medicaid maximum for the physical therapy assistant, occupational therapy assistant and the speech-language therapy assistant is based on 80% of the amount reimbursed to the licensed therapist.

Fee schedule service reimbursement is based on the lesser of the amount billed or the Arkansas Title XIX (Medicaid) maximum charge allowed.

1. Physical Therapy

Listed below are covered physical therapy services:

Description
Evaluation for physical therapy
Individual physical therapy Group
physical therapy
Individual physical therapy by physical therapy assistant Group
physical therapy by physical therapy assistant

At the beginning of each calendar year, Medicaid officials and the Arkansas Physical Therapy Association or its successor will arrive at mutually agreeable increase or decrease in reimbursement rates based on the market forces as they impact on access. Any agreed upon increase or decrease will be implemented at the beginning of the following state fiscal year, July 1 with any appropriate State Plan changes.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(19) Physical Therapy and Related Services (Continued)

2. Occupational Therapy

Listed below are covered occupational therapy services:

Description

Evaluation for occupational therapy Individual
occupational therapy
Group occupational therapy
Individual occupational therapy by occupational therapy assistant
Occupational therapy by occupational therapy assistant

At the beginning of each calendar year, Medicaid officials and the Arkansas Occupational Therapy Association or it-s successor will arrive at mutually agreeable increase or decrease in reimbursement rates based on the market forces as they impact on access. Any agreed upon increase or decrease will be implemented at the beginning of the following state fiscal year, July I with any appropriate State Plan changes.

3. Speech-**Language** Therapy

Listed below are covered speech-**language** therapy services:

Description
Evaluation of speech language voice, communication, auditory processing and/or aural rehabilitation status
Individual speech-**language**
therapy session
Group speech-**language therapy**
session
Individual speech-**language** therapy by speech-language pathology assistant
Group speech-**language** therapy by speech language pathology assistant

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(19) Physical Therapy and Related Services (Continued)

3. Speech-Language Therapy (Continued)

At the beginning of each calendar year, Medicaid officials and the Arkansas Speech-Language Therapy Association or its successor will arrive at mutually agreeable increase or decrease in reimbursement rates based on the market forces as they impact on access. Any agreed upon increase or decrease will be implemented at the beginning of the following state fiscal year, July 1 with any appropriate State Plan changes.

(19a) Applied Behavior Analysis (ABA) Therapy

Applied Behavior Analysis (ABA) therapy services are reimbursed on a per unit basis using fee schedule reimbursement methodology, where reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service under Arkansas Medicaid. DHS engaged an independent actuary to conduct a rate study on ABA therapy services during the summer of 2023 to determine appropriate service rates. The rate study considered direct wages (using Arkansas-specific May 2021 Bureau of Labor Statistics data), indirect and transportation costs, employee related expenses, and supervisor time, and used an independent rate model approach that captured the average expected costs a reasonably efficient Arkansas provider would incur while delivering ABA therapy services. The applicable fee schedule of ABA therapy service rates is published on the agency's website.

(20) Rehabilitative Services for Persons with Physical Disabilities (RSPD)

1. Residential Rehabilitation Centers

The per diem reimbursement for RSPD services provided by a Residential Rehabilitation enter will be based on the provider's fiscal year end 1994 audited cost report as submitted by an independent auditor plus a percentage increase equal to the HCFA Market Basket Index published for the quarter ending in March. A cap has been established at $395.00. This is a prospective rate with no cost settlement. Room and board is not an allowable program cost. The criteria utilized to exclude room and board is as follows: The total Medicaid ancillary cost was divided by total Medicaid inpatient days which equals the RSPD prospective per diem. The ancillary cost was determined based upon Medicare Principles of Reimbursement. There is no routine cost included.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

Outpatient Behavioral Health Services

The fee schedule was set as of July 1, 2017 and is effective for services provided on or after this date. Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

Effective January 1, 2024, the following services will be set to pay eighty percent (80%) of the 2022 Medicare non-rural rate for the State of Arkansas:

- **Individual Behavioral Health Counseling;**
- **Marital or Family Behavioral Health Counseling without Beneficiary Present;**
- **Marital or Family Behavioral Health Counseling with Beneficiary Present; and**
- **Mental Health Diagnosis.**

Effective January 1, 2024, the following services will be adjusted to pay one hundred percent (100%) of the 2022 Medicare non-rural rate for the State of Arkansas:

- **Group Behavioral Health Counseling; and**
- **Multi-Family Behavioral Health Counseling.**

All rates are published on the agency's website: Fee Schedules - Arkansas Department of Human Services

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

21. Rehabilitative Services

1. School-Based Mental Health Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule for school-based mental health services provided by school-based mental health services provider personnel except for services provided by a psychologist.

The Title XIX Medicaid Maximum for school-based mental health services provided by a psychologist is located on Attachment 4.19-B, Page 1o, Item 4.b.(17).

The fee schedule was set as of July 1, 2017 and is effective for services provided on or after this date Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The fee schedule can be accessed at https://www.medicaid.state.ar.us/Provider/docs/fees.aspx. Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

23. **Rehabilitative Services to Children**

A. **Unit Rate Establishment**

Unit rates for rehabilitative services to children will be determined as follows:

Compute the	**Actual cost of rehabilitative services billed and approved for payment during the most recently completed 6 month period for which actual costs data exists,**
Divided by	**Number of units billed and approved for payment in the sample period,**
Equals	**Average unit cost for rehabilitative services. This unit cost will be billed for each unit of rehabilitative services that each Medicaid recipient receives each month. Documentation of the units of rehabilitative services delivered will be retained in the client files.**

These rehabilitative service rates will be reviewed annually at the beginning of each State Fiscal Year to determine if an adjustment is necessary. Such adjustment will be made on a prospective basis only, utilizing the same methodology.

No Maintenance (room and board) amounts have been included in the "Rate" defined on the Federal Budget Impact Transmittal sheets that are a part of this "Rehab Option" amendment to the Arkansas Medicaid State Plan.

None of these services duplicate medical services or medical payments available under Title IV or Title XX.

B. **Rehabilitative services for children will be provided in the least restrictive setting appropriate to the child's assessed condition, plan of care, and service needs. Services shall be provided to children in one of the following settings:**

1. **Non-residential services provided to children who reside in a family home setting will be provided either in the child's home or in the customary place of business of a qualified provider.**

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

23. Rehabilitative Services to Children (Continued)

2. Residential services provided to children who reside outside of a family home will be provided in an appropriately state licensed and/or certified facility including:

(a) Residential treatment facilities licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services, and

(b) Therapeutic foster homes licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services.

3. Services shall not be reimbursed when provided in the following settings:

(a) Nursing facilities,

(b) Intermediate care facilities for the mentally retarded, and

(c) Institutions for the treatment of mental diseases.

C. Determination of Retroactive Payments

1. Statement of Division Regarding Maintenance Payments

(a) Retroactive payments to DCFS are defined as those meeting the above outlined criteria where services have occurred during a two-year prior period. (Beginning with approval of this amendment and going back two complete years.)

(b) No Maintenance (room and board) amounts have been included in the "Rate" defined on the Federal Budget Impact Transmittal sheets that are a part of this "Rehab Option" amendment to the Arkansas Medicaid State Plan.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(23) Rehabilitative Services to Youth

A. Unit Rate Establishment

Unit rates for rehabilitative services to youth will be determined as follows:

Compute the — Actual cost of rehabilitative services billed and approved for payment during the most recently completed 6 month period for which actual costs data exists.

Divided by — Number of units billed and approved for payment in the sample period.

Less — The daily room and board costs for residential based services.

Equals — Average unit cost for rehabilitative services. This unit cost will be billed for each unit of rehabilitative services that each Medicaid recipient receives each month. Documentation of the units of rehabilitative services delivered will be retained in the client files.

These rehabilitative service rates will be reviewed annually at the beginning of each State Fiscal Year to determine if an adjustment is necessary. Such adjustment will be made on a prospective basis only; utilizing the same methodology. Starting with State Fiscal Year 2002, room and board costs for residential settings will be increased by the lesser of the most recent CPI or the overall average percentage increase paid for services in the preceding State Fiscal Year.

B. Rehabilitation services for youth will be provided in the least restrictive setting appropriate to the youth's assessed condition, plan of care and service. Services shall be provided to youth in one or more of the following settings:

1. Non-residential services provided to youth who reside in a family home setting will be provided either in the youth's home or in the customary place of business of a qualified provider.

2. Residential services provided to youth who reside outside of a family home will be provided in an appropriately state licensed and/or certified facility including:

STATE Arkansas
DATE REC'D 08-06-98
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DATE EFF 10-01-98
HCFA ID: AR-98-12

SUPERSEDES: NONE THIS PAGE

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(23) Rehabilitative Services to Youth (Continued)

(a) Emergency shelter facilities licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services, and

(b) Residential treatment facilities licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services, and

(c) Therapeutic foster and group homes licensed and/or certified in accordance with the Minimum Licensing Standards for Child Welfare Agencies adopted by the Child Welfare Agency Review Board and the Arkansas Department of Human Services.

3. Services shall not be reimbursed when provided in the following settings:

(a) Nursing facilities,

(b) Intermediate care facilities for the mentally retarded, and

(c) Institutions for the treatment of mental diseases.

STATE Arkansas
DATE RECD 08-06-98
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SUPERSEDES: NONE - NEW PAGE

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(24) Other Licensed Practitioners

1. Licensed Certified Social Worker (LCSW)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

2. Licensed Professional Counselor (LPC)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

3. Licensed Marriage and Family Therapist (LMFT)

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) Maximum charge allowed. The Title XIX Maximum is 80% of the psychologist fee schedule.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(26) Developmental Rehabilitation Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. The Title XIX maximum for these services is based on the Child Health Management (CHMS) reimbursement methodology.

(27) Substance Abuse Treatment Services

(a) Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of personal care services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Medicaid website at www.medicaid.state.ar.us.

(b) Reimbursement for Substance Abuse Services is by fee schedule, at the lesser of the billed charge or the Title XIX (Medicaid) maximum allowable fee per unit of service. A benefit limit has been established per procedure with extension available based on medical necessity.

(c) The rates are set as of March 1, 2011 and are effective for services on or after that date.

4.c. Family Planning Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. State developed fee schedule rates are the same for both public and private providers.

1. The Title XIX (Medicaid) maximum for Family Planning services is one hundred percent **(**100%**)** of the current physician Medicaid maximum.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

2. Long-Acting Reversible Contraceptives (LARCs)

Effective for claims with dates of service January 1, 2014 and after, the intrauterine device (IUD) is reimbursed based on one hundred percent (100%) of the manufacturer's list price as of April 15, 2011. Effective for claims with dates of service October 1, 2014 and after, the fifty-two milligrams **(**52**)** mg Levon**or**gestrel-Releasing Intrauterine Contraceptive System is reimbursed based on one hundred percent **(**100%**)** of the manufacturer's list price as of November 18, 2013. Effective for claims with dates of service October 1, 2014 and after, the 13.5 mg Levonorgestrel-Releasing Intrauterine Contraceptive System is reimbursed based on one hundred percen**t (**100%**)** of the manufacturer's list price as of January 1, 2013.

Effective for claims with dates of service **January 1, 2023,** and after, the reimbursement of Food and Drug Administration approved Long-Acting Reversible Contraceptives (LARCs) to include the IUD and contraceptive implants, will be based on Wholesale Acquisition Cost **plus six percent (6%).** Reimbursement will also apply to replacement of LARCs per manufacturer recommendations, or sooner if medically necessary. Reimbursement information can be found at the following Physician Fee Schedule.

5. Physicians' Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

Arkansas only has one Medicare rate list for the entire state.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

This fee schedule is based on the November 2012 Deloitte fee schedule.

The State does not plan to change rates throughout the year to reflect Medicare adjustments.

Primary Care Services Affected by this Payment Methodology

☒ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

5. Physicians' Services (continued)

Primary Care Services Affected by this Payment Methodology (Continued)

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99224	99225	99226	99315	99316	99344	99345	99350
99358	99359	99374	99375	99378	99379	99380	99382
99383	99384	99385	99386	99387	99391	99392	99393
99394	99395	99396	99397	99401	99403	99404	99406
99407	99411	99412	99420	99429	99450	99455	99456
99499							

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $9.56.

5. Physicians' Services (continued)

Documentation of Vaccine Administration Rates in Effect 7/1/09 (continued)

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014. All rates, excluding the Medicare rates on which these supplemental quarterly payments are based, are published at the agency's website, (https://www.medicaid.state.ar.us/).

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014. All rates, excluding the Medicare rates on which these supplemental quarterly payments are based, are published at the agency's website, (https://www.medicaid.state.ar.us/).

Fee Schedule
The agency's website lists both the base Medicaid fee schedule and the enhanced fee schedule of Evaluation & Management codes and Vaccines for Children (VFC) Administration codes. The enhanced fee schedule can be found using the following link, (https://www.medicaid.state.ar.us/Download/provider/provdocs/Manuals/PHYSICN/PHYSICN-Supplement-fees.pdf).

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

5. Physicians' Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

For dates of service occurring July 1, 1994 through March 31, 2004, reimbursement rates are set at 66% of the Arkansas Physician's Blue CrossBlue Shield (BCBS) Fee Schedule dated October 1, 1993.

For dates of service occurring April 1, 2004 and after:

A. Reimbursement rates are increased by **ten percent (**10%**)** up to a maximum or benchmark rate of eighty percent (80%) of the 2003 Arkansas Blue Cross **and** Blue Shield (BCBS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than **eighty percent (**80%**)** of the 2003 BCBS fee schedule rate, no increase will be given. A minimum rate or floor amount of **forty-five percent (**45%**)** of the 2003 BCBS fee schedule rate will be reimbursed. For those rates that after the **ten percent (**10 %**)** increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.

B. Reimbursement rates are capped at **one hundred percent (**100%**)** of the 2003 BCBS rate. Rates that **exceed the cap** as of March 31, 2004, shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.

C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:

(1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is **thirty percent (**30%**)** of the combined rate**,** then **thirty percent (**30%**)** of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.

(2) Decreases: If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.

D. For dates of service beginning September 28, 2006, the maximum reimbursement rate for fitting of spectacles (procedure code 92340) is **fifty-one dollars and twenty-two cents (**$51.22**)**. The rate is based on **eighty percent (**80%**)** of the **sixty-four dollars and two cents (**$64.02**)**, **which is the** 2006 Arkansas Physician's Blue Cross/Blue Shield fee schedule rate.

E. **For dates of service beginning July 1, 2020, the maximum reimbursement rate for evaluation and management codes were increased based upon a routine rate study conducted by DMS in the Fall of 2019.**

5. Physician Services (Continued)

F. For dates of service beginning January 1, 2021, the maximum reimbursement rate for evaluation and management codes are increased by 3 percent of the 7/1/2020 fee-for-service rate for each of these codes. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of evaluation and management services. The agency's fee schedule rate was set as of January 1, 2021, and is effective for services provided on or after that date. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

G. For dates of service beginning July 1, 2025, the reimbursement rates for obstetrical care to include prenatal care, delivery, and postpartum care are increased by seventy percent. The increase is based on an analysis of private pay rates from state fiscal years 2023 and 2024, Arkansas Blue Cross Blue Shield and Centene. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

Effective for dates of service on or after July 1, 2020, the immunization administration fee for influenza will be based on the 2020 Medicare flu vaccine administration fee. All other immunization administration fees will be based on Medicare's 2020 physician fee schedule for the State of Arkansas. The rate is paid to all governmental and non-governmental providers, unless otherwise specified in the state plan. All rates are published at the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

For dates of service on or after June 1, 2026, the administration fee for an immunization or monoclonal antibody for protection against respiratory syncytial virus (RSV) disease in infants and toddlers is $19.54, which represents 100 percent of the maximum administration fee established for Arkansas under the Vaccines for Children (VFC) Program, as published in the Federal Register, Vol. 77, No. 215, November 6, 2012 (Table 1—Regional Maximum Administration Fee by State, p. 66690), available at https://www.govinfo.gov/content/pkg/FR-2012-11-06/pdf/2012-26507.pdf.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of immunization and monoclonal antibody administration services.

5. Physicians' Services (Continued)

Supplemental Payment to Certain Professionals Employed by UAMS

(a) Effective **January 1, 2008, certain** medical professional providers **employed by** the University of Arkansas for Medical Sciences (UAMS) shall be **eligible for a supplemental payment that equals the difference between the regular, base Medicaid rate and an estimate of the average commercial rate paid for each billing code.**

Eligible professionals **are:**

(i) **Physicians, psychiatrists, psychologists, social workers, psychological examiners, speech therapists, advanced practice nurses, physician assistants, nurse anesthetists, occupational therapists, physical therapists, podiatrists, audiologists, opticians and nutritionists;**

(ii) **Licensed by the State of Arkansas; and**

(iii) **Employed by the UAMS College of Medicine.**

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(b) **A supplemental payment will be made for services rendered by eligible professionals equal to the difference between the Medicaid payments otherwise made and payments at the Average Commercial Rate. This supplemental payment will, for the same dates of service, be reduced by any other supplemental payment for eligible professionals found elsewhere in the state plan. Payment will be made quarterly and will not be made prior to the delivery of services.**

(c) **The supplemental payment to eligible professionals will be determined as follows:**

(i) **Compute the Average Commercial Fee Schedule: Determine the average commercial allowed amount paid per procedure code by the top five payers with negotiated fee schedules. The State will develop separate Average Commercial Fee Schedules for services billed through UAMS, Area health Education Centers (AHECs) and Children's Hospital. Additionally, if there are any differences in payment on a per billing code basis for services rendered by different types of medical professionals, the State will calculate separate Average Commercial Fee Schedule(s) to reflect these differences. The data used to develop the Average Commercial Fee Schedule will be derived from the most recently completed state fiscal year.**

STATE Arkansas
DATE RECD 11-30-07
DATE APPVD 2-28-08
DATE EFF 1-1-08
HCFA 179 07-20 (a)
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Calculate the Average Commercial Payment Ceiling: For each quarter of the current fiscal year multiply the Average Commercial Fee Schedule as determined in 5(c)(i) above by the number of times each procedure code was paid in the quarter to eligible professionals on behalf of Medicaid beneficiaries as reported from the MMIS. The Average Commercial Payment Ceiling will be calculated separately for services billed through UAMS, Arkansas Children's Hospital and AHECs. If applicable, a separate payment ceiling will be set when payment for the same service differs according to the type of professional rendering the service.

(d) **The Supplemental Payment shall equal the difference between the Average Commercial Payment Ceiling for the quarter and the total Medicaid payments made for the quarter to eligible professionals for the procedure codes included in the calculation of the Average Commercial Fee Schedule in 5(c)(i) above, as reported from the MMIS.**

5. Physicians' Services (continued)

Reimbursement for physicians' services for bone marrow transplants is included in the $150,000 maximum as described in Attachment 4.19-A. Procedures will be manually priced based on professional medical review. The recipient may not be billed for Medicaid covered charges in excess of the State's reimbursement.

Reimbursement for physician's services for corneal, renal and pancreas/kidney transplants will be reimbursed in the same manner as other non-transplant related physician services.

Other Covered Transplant Services

Physician services relating to other covered transplant surgery procedures (does not include corneal, renal, pancreas/kidney and bone marrow) will be reimbursed at the lesser of negotiated rates or 80% of billed charges. Physician reimbursement at the lesser of negotiated rates or 80% of billed charges is applicable for all allowable physician services relating to the other covered transplant from the date of the transplant procedure to the date of discharge. Physician reimbursement at the lesser of negotiated rates or 80% of billed charges will be reimbursed for the same dates of service as are allowed for hospital services for other covered transplants (See Section 4.19-A). For hospitals, transplant related days in excess of transplant length of stay averages must be approved through medical review. Transplant length of stay averages by each transplant type will be determined from the most current written Medicare National Coverage Decisions.

Physician services provided prior to the date of transplant will be reimbursed in the same manner as other non-transplant related physician services.

Allowable services provided during dates of readmissions to the same hospital due to complications arising from the original transplant are reimbursed the same as the original transplant services at the lesser of negotiated rates or 80% of billed charges. All excess length of stay approval requirements also apply.

Payment is made directly to the physician or, upon request of the physician, payment is made under the Deferred Compensation Plan.

Participation in the Deferred Compensation Plan by a physician is entirely voluntary. The individual physician's authorization and consent is on file. The physician submits his claim in the usual manner, and after verification, the appropriate amount due the physician is deposited in an account administered by First Variable Life Insurance Company or The Variable Annuity Life Insurance Company up to the maximum amounts allowed by the Revenue Act of 1978. Each account in the investment funds is individualized as to each physician participating. Arkansas Division of Medical Services has no responsibility for management or investment of these funds. Federal matching is not claimed for any part of the administration of the Plan. This is a service designed to increase the number of participating physicians in the Medical Assistance Program.

Desensitization injections - Refer to Attachment 4.19-B, 4.b. (15).

04-05(A)

STATE Arkansas
DATE REC'D 12-8-04
DATE APP'VD 2-15-05
DATE EFF 12-3-04
HCFA 179 04-15

A

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE **Revised: October 1, 2020**

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

5. Physicians' Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

5. Physicians' Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

5. Physicians' Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Ambulatory Upper Respiratory Infection (URI) Episodes **- Sunset date for final reconciliation report 1/31/2021**
(2) Perinatal Care Episodes **- Sunset date for final reconciliation report 1/31/2021**

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes **- Sunset date for final reconciliation report 4/30/2021**
(2) Total Joint Replacement Episodes **- Sunset date for final reconciliation report 4/30/2021**

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Tonsillectomy Episodes **- Sunset date for final reconciliation report 4/30/2021**
(2) Cholecystectomy Episodes **- Sunset date for final reconciliation report 1/31/2021**
(3) Colonoscopy Episodes **- Sunset date for final reconciliation report 4/30/2021**
(4) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes **- Sunset date for final reconciliation report 4/30/2021**
(5) Acute Exacerbation of Asthma Episodes **- Sunset date for final reconciliation report 10/31/2020**
(6) Coronary Arterial Bypass Graft (CABG) episodes **- Sunset date for final reconciliation report 07/31/2020**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: April 1, 2004

6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners with the scope of their practice as defined by State Law.

a. Podiatrists' Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

For dates of service occurring July 1, 1994 through March 31, 2004, reimbursement rates are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

For dates of service occurring April 1, 2004 and after:

A. Reimbursement rates are increased by 10% up to a maximum or benchmark rate of 80% of the 2003 Arkansas Blue Cross/Blue Shield (BC/BS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than 80% of the 2003 BC/BS fee schedule rate, no increase will be given. A minimum rate or floor amount of 45% of the 2003 BC/BS fee schedule rate will be reimbursed. For those rates that after the 10 % increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.

B. Reimbursement rates are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.

C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:

(1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.

(2) Decreases: If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.

Additional Reimbursement for Podiatrist's Services Associated with UAMS

Refer to Attachment 4.19-B, item c.

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6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

b. Optometrist's Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum allowed. Effective for claims with dates of services on or after March 1, 1997, the Title XIX (Medicaid) maximum reimbursement for optometrist services is the same as the physician rates for applicable services.

For dates of service beginning September 27, 2006, the maximum reimbursement rate for a routine eye examination including refraction (procedure codes S0620 and S0621) is $60.23. The rate is based on 40% of the $150.57 2006 Arkansas Physician's Blue Cross/Blue Shield fee schedule rate for procedure code 92014.

c. Chiropractors' Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.

Effective for dates of service on or after June 1, 1998, the current Arkansas Medicaid maximum of $23.58 for procedure code A2000 (Manipulation of the Spine by Chiropractor) will be used to establish the reimbursement rate for each CPT procedure code for Chiropractic care. This care will be covered as described in the following procedure codes established by the American Medical Association (AMA) and published in their 1997 Physician's Current Procedural Terminology (CPT) Manual, or such procedure codes as AMA (or it's successor) shall declare are replacements for, and successor' to the following:

98940 Chiropractic manipulative treatment (CMT); spinal, one to two
98941 Chiropractic manipulative treatment (CMT); spinal, three of four regions
98942 Chiropractic manipulative treatment (CMT); spinal, five regions

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor, a comparison between the previous and current year's Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates for all of the above CPT procedure codes as reflected in the current Medicare Physician's Fee Schedule.

d. Other Practitioners' Services
(1) Hearing Aid Dealers - Refer to Attachment 4.19-B, Item 4.b. (10).
(2) Audiologist - Refer to Attachment 4.19-B, Item 4.b. (11).
(3) Optical Labs - Based on contract price. Established through competitive bidding.
(4) Nurse Anesthetists - Reimbursement is based on 80% of the Medicaid Physician Fee Schedule.
(a) Additional Reimbursement for Nurse Anesthetists Associated with UAMS – Refer to Attachment 4.19-B, item 5.

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

(a) Additional Reimbursement for Psychologists Services Associated with UAMS – Refer to Attachment 4.19-B, item 5.

(6) Obstetric-Gynecologic and Gerontological Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on eighty percent (80%) of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

Refer to Attachment 4.19-B, Item 27 (Attachment 4.19-B, page 14) for a list of the advanced practice nurse and registered nurse practitioner.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of services provided by Advanced Practice Nurse. The agency's fee schedule rate was set as of April 1, 2004, and is effective for services provided on or after that date. All rates are published on the agency's website@ www.medicaid.state.ar.us.

(7) Advanced Practice Nurses Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

(8) Licensed Clinical Social Workers' Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

(9) Physicians' Assistant Services Associated with UAMS – For additional reimbursement refer to Attachment 4.19-B, item 5.

(10) Registered Nurse Sexual Assault Nurse Examiner-Pediatric (SANE-P) Certified by the Internal Association of Forensic Nurses For additional reimbursement refer to Attachment 4.19-B, item 5 (Attachment 4.19-B, pages 1www, 2, 2.1, 2a)

6.d. Other Practitioner's Services (Continued)

(11) Emergency Medical Technicians who are licensed to provide advanced life support and basic life support services.

Reimbursement is established as equal to the rate for ground mileage per statute mile found at Attachment 4.19-B, Page 8 for the number of loaded miles one-way from point of call-out to point of service had a transport occurred. State developed fee schedule rates are the same for both public and private providers of advanced and basis life support services.

7. Home Health Services

a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area;
b. Home health aide services provided by a home health agency; and
c. Physical therapy

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. State developed fee schedule rates are the same for both public and private providers of home health services.

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a., b. and c. was established by dividing total allowable costs by total visits. This figure was then

7. Home Health Services (Continued)
a., b.**and c.** (Continued)

inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

The physical therapy reimbursement rate calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v Reynolds) for its approval.

For registered nurses (RN) and licensed practical nurses (LPN) the Full Time Equivalent Employees (FTEs) listed on cost report worksheet S-1, Part II, were used to allocate nursing costs and units of service (visits). It was necessary to make these allocations because home health agencies are not required by Medicare to separate their registered nurses and licensed practical nurse costs or visits on the annual cost report.

RN and LPN salaries and fringes were separated using an Office of Personnel Management Survey, which indicated that RNs, on an average, are paid 36% more than licensed practical nurses. Conversely, if RNs are paid 36% more than LPNs, then LPNs are paid, on an average, 73.5% of what RNs earn. Cost report salaries and fringes were allocated based on 100% of RN FTEs and 73.5% of LPN FTEs. Other costs and service units (visits) were allocated based on 100% of RN FTEs and 100% of LPN FTEs. RN and LPN unit service (visit) costs were then inflated and weighted as outlined above.

Since home health reimbursement is based on audited costs, the home health rates will be adjusted annually by the Home Health Market Basket Index. This adjustment will occur at the beginning of the State Fiscal Year, July 1. Every third year, the cost per visit will be rebased utilizing the most current audited cost report from the same three providers and using the same formula described above to arrive at a cost per visit inflated through the rebasing year. (The first rebasing will occur in 1996 to be effective July 1, 1997.)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home

(1) Medical Supplies

Effective for dates of service on or after October 1, 1994, medical supplies, for use by patient in their own home - Reimbursement is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified inAttachment 3.1-A and Attachment 3.1-B, Item 12.c.7.

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7. Home Health Services (continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (Continued)

(1) Medical Supplies (continued)

Effective August 1, 2024, specialized formula and associated supplies prescribed for enteral nutrition will be reimbursed at the lesser of one hundred percent (100%) of the non-rural Medicare rate for Arkansas, or eighty percent (80%) of the Arkansas Blue Cross Blue Shield rates with the minimum threshold set at eighty percent (80%) of the Medicare rate.

The applicable fee schedule **of** rates **at any given time** are published on the agency's website (Fee Schedules - Arkansas Department of Human Services). A uniform rate for these services is paid to all governmental and nongovernmental providers unless otherwise approved in the state plan.

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(2) Durable Medical Equipment (DME) - Reimbursement is based on amount billed not to exceed the Title XIX maximum.

Effective for claims with dates of service on or after April 1, 2020, the reimbursement rate maximums for codes subject to Section 1903(i)(27) of the Social Security Act will be set annually at the January 1 Medicare non-rural rate for the State of Arkansas. All rates are published on the agency's website (http://medicaid.mmis.arkansas.gov/). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

For all other DME claims not covered by Section 1903(i)(27) of the Social Security Act, rates will be set as follows.

Purchase: The Title XIX maximum for new equipment is based on Medicare's 1990 DME Fee Schedule. For those items which Medicare did not have a rate, the lowest manufacturer cost plus 10% was used. Arkansas Medicaid is following Medicare's policy of purchasing any item that costs $150.00 or less.

Rental or Capped Rental: Capped Rental equipment may not be rented for more than 455 consecutive days. The reimbursement rates for capped rental items will be established by dividing the purchase price by 455 days to arrive at a daily rental rate. Once the 455 day rental maximum is reached, Arkansas Medicaid will cease to pay rent on the equipment, however the equipment will remain in the recipient's home as long as determined medically necessary by the recipient's physician. The equipment will remain the property of the DME company.

A provider may bill for maintenance. However, this maintenance fee may not be billed until either 182 days have elapsed after the 455 day rental period or 182 days have elapsed from the end of the period the item is no longer covered under the suppliers or manufacturer's warranty, whichever is later. Maintenance will continue to be paid at six-month intervals if equipment is determined to be medically necessary. Reimbursement of the maintenance is the lesser of the amount billed or the Title XIX maximum. The Title XIX maximum was established by arraying all the Title XIX monthly maximums for capped rental items and utilizing the 50th percentile.

For those items which are rental only, the Medicare 1990 DME Fee Schedule monthly rental rate was used to calculate the Medicaid daily rental rate. The Medicare monthly rental rate was multiplied by 12 to determine the one-year rental amount and divided by 365 to arrive at the Medicaid daily rental amount.

7. Home Health Services (continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (Continued)

(2) Durable Medical Equipment (DME) (continued)

Effective August 1, 2024, equipment prescribed for administering enteral nutrition will be reimbursed at the lesser of one hundred percent (100%) of the non-rural Medicare rate for Arkansas, or eighty percent (80%) of the Arkansas Blue Cross Blue Shield rates with the minimum threshold set at eighty percent (80%) of the Medicare rate.

The applicable fee schedule of rates **at any given time** are published on the agency's website (Fee Schedules - Arkansas Department of Human Services). A uniform rate for these services is paid to all governmental and nongovernmental providers unless otherwise approved in the state plan.

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(3) DME/Nasal CPAP Device

DME/Nasal CPAP Device - Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum was established based on a 1989 survey conducted by the Division of Medical Services of four Arkansas durable medical equipment companies. Reimbursement for the nasal CPAP device is always on a rental basis only. The rate was established by utilizing the lowest monthly rental rate reflected by the survey. The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

(4) DME/Bi-Level Positive Airway Pressure (BIPAP) Equipment

Effective for claims with dates of service on or after February 1, 1995, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum for the BIPAP is based on 100% of the Medicare maximum for equipment and supplies reflected in the 1994 Arkansas Medicare Pricing File. The Medicaid monthly rental rate for equipment was used to calculate the daily rental rate. The BIPAP medical supply rate was established at 25% of the total for all supplies utilized with the BIPAP equipment. Reimbursement is a global rate for equipment, supplies and maintenance.

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(5) Aerochamber Device

Effective for dates of service on or after October 1, 1997, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX (Medicaid) maximum established was based on a 1997 survey of Durable Medical Equipment (DME) providers. The information obtained in the survey indicated there is only one major manufacturer and distributor of the aerochamber devices (with or without mask) to providers enrolled in the Arkansas Medicaid Program. It was determined the aerochamber devices are sold to each provider for the same price. As a result, the current Title XIX (Medicaid) maximum for the aerochamber devices (with or without mask) was established based on the actual manufacturer=s list prices. Thereafter, adjustments will be made based on the consumer price index factor to be implemented at the beginning of the appropriate State Fiscal Year, July 1.

(6) Specialized Wheelchairs, Seating and Rehab Items

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. Effective for claims with dates of service on or after May 1, 1995, the Title XIX (Medicaid) maximums were established utilizing the manufacturer's current published suggested retail price less 15%. The 15% is the median of Oklahoma Medicaid which is currently retail less 12% and Texas Medicaid which is currently retail less 18%. Effective for claims with dates of service on or after September 1, 1995, the following Kaye Products, procedure codes Z2059, Z2060, Z2061 and Z2062, are reimbursed at the manufacturer's current published suggested retail price. The State Agency and affected provider association representatives will review the rates annually and negotiate any adjustments.

(7) DME/Continuous Glucose Monitors.

Procedure Codes and Rates.

A. Rates. Effective for dates of service on or after January 1, 2022, reimbursement for Continuous Glucose Monitors (CGM) and related supplies is based on the Medicare non-rural rate for the State of Arkansas (effective as of July 28, 2021, and subject to change when Medicare rates are adjusted) for the allowable procedure codes. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

B. Effective for dates of service on or after April 1, 2024, reimbursement for Continuous Glucose Monitors (CGM) and related Diabetic Supplies including patch type insulin pumps is based on Wholesale Acquisition Cost (WAC) plus applicable professional dispensing fee. Traditional insulin pumps will remain at the Medicare non-rural rate as stated in A. above.

(7) DME/Continuous Glucose Monitors.

Procedure Codes and Rates.

A. Effective for dates of service on or after January 1, 2022, reimbursement for Continuous Glucose Monitors (CGM) and related supplies is based on the Medicare non-rural rate for the State of Arkansas (effective as of July 28, 2021, and subject to change when Medicare rates are adjusted) for the allowable procedure codes. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. Fee schedules can be found at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/.

B. Effective for dates of service on or after April 1, 2024, reimbursement for Continuous Glucose Monitors (CGM) and related Diabetic Supplies including patch type insulin pumps is based on Wholesale Acquisition Cost (WAC) plus applicable professional dispensing fee. Traditional insulin pumps will remain at the Medicare non-rural rate as stated in A above.

C. Effective for dates of service on or after May 01, 2026, Wholesale Acquisition Cost (WAC) plus applicable professional dispensing fee is no longer applicable to Durable Medical Equipment (DME) medical claim types but remains in effect for pharmacy claim types. DME medical claims reimbursement reverts to Medicare non-rural rates as described in Paragraph 7(A).

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(7) Augmentative Communication Device

Reimbursement is based on the manufacturer's charges. Providers must submit an itemized manufacturer's invoice with the claim. Reimbursement will include the cost of the device, software, carrying case and maintenance agreement, not to exceed a maximum of $7,500.00 If a recipient under age 21 in the Child Health Services (EPSDT) Program has met the lifetime benefit, and it is determined that additional equipment is medically necessary, the provider can request an extension of benefits. Training in the use of the device is not included and is not a covered cost. Repairs to the equipment or associated items outside the initial maintenance agreement are a covered service. Reimbursement for repairs of augmentative communication device components will be manufacturer's invoice price for parts plus 10%. Arkansas Medicaid reimburses for the labor based on the lesser of the amount billed not to exceed the Title XIX (Medicaid) maximum. The Medicaid maximum was calculated by conducting a survey of three manufacturers of augmentative communication devices who repair state-of-the art devices to the less complex devices. The three manufacturer's current hourly charge for labor was totaled, then divided by 3 to arrive at an average hourly rate. The hourly rate was divided by 4 to arrive at a 15 unit rate. Labor will be reimbursed per unit of service, (1 unit = 15 minutes limited to a maximum of 20 units per date of service allowed).

(8) Phototherapy (Bili-rubin) Light with Polometer

Effective for dates on or after May 1, 1999, the reimbursement rate is based on the lesser of the provider's actual charge for the service or the Title XIX maximum. The Title XIX (Medicaid) maximum was based on 100% of the Medicare maximum (daily rental rate) for the Phototherapy (Bili-rubin) Light with Polometer as reflected in the 1999 Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule. The reimbursement methodology includes a provision allowing adjustments based on fluctuations in the economy. Any adjustment to the rate will be based on the most current Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule.

d. Physical Therapy

Refer to Item 4.b.(19).

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(9) **Oxygen**

Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum for the oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir is based on the DME fiscal year 1981 Medicare Median.

(10) **Diapers**

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) Maximum. Effective March 1, 1991, the Medicaid Maximum was established based on the median cost for each item. The median cost was determined by surveying three medical supply companies.

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7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(11) Specialized Rehabilitative Equipment

Effective for claims with dates of service occurring on and after May 1, 2010, the reimbursement rate maximums for the following listed Medicaid covered specialized rehabilitative equipment will be 85% of the February 1, 2009 retail price.

Reimbursement for this specialized rehabilitative equipment is by fee schedule, at the lesser of the billed charge or the Title XIX (Medicaid) maximum allowable. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of this specialized rehabilitative equipment and the fee schedule is published on the Medicaid website at www.medicaid.state.ar.us.

Bath chair 56”
Tray for Gait Trainer
Corner chair w tray & casters, small
Corner chair w tray & casters, large
Low back activity chair
Supine stander 51”, small
Supine stander 71”, large
Prone stander 35”
Prone stander 42”
Prone stander 50”
Tray for stander, prone
Tray for stander, supine
Foot sandals for standers
Caster base for up-rite stander, small
Caster base for up-rite stander, medium
Caster base for up-rite stander, large
Tumble form tri stander w/tray, small
Tumble form tri stander w/tray, large
Mobile floor sitter, medium/large
Tray for toddler chair
Wrap around back support, small
Wrap around bath support, large
Toilet support w/high back, small
Toilet support w/high back, large
Adult gait trainer
Commode chair, extra wide and/or heavy duty
Standing frame syst., any size, w/wo wheels
Transition toddler chair, small
Gait trainer, ped size, posterior support, w/all Accessories
Adjustable abduction wedge w/hip stabilizer
Up-rite stander, small
Up-rite stander, medium
Up-rite stander, large
Tumble form feeder seat, small
Tumble form feeder seat, medium
Tumble form feeder seat, large
Seat & back pad for toddler chairs
T&S high back w/support activity chair, 14”
T&S high back w/support activity chair, 16”
Toilet seat reducer ring (padded)
4 wheel reverse walker
4 wheel front swivel reverse walked

7. Home Health Services (Continued)

c. Medical Supplies, Equipment, and Appliances Suitable for Use in the Home (continued)

(12) **Low-Profile** Skin Level Gastrostomy Tube and Percutaneous Cecostomy Tube and Supplies

Effective for dates of service on or after September 1, 2000, reimbursement is based on the lesser of the provider's actual charge for the **Low-Profile** kits and accessories or the Title XIX (Medicaid) maximum. The agency's rates were set as of September 1, 2000 and are effective for services on or after that date. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of DME services. The Title XIX (Medicaid) maximum for the kit and accessories is based on the manufacturer's list prices to the DME providers as of July 1, 2000 plus **ten percent (**10%**).** The State Agency will review the manufacturer's list prices annually and may adjust the Medicaid maximums if necessary. Arkansas Medicaid will reimburse providers for the kit and accessories as purchase only items.

Effective for dates of service on or after March 1, 2014, coverage of the **Low-Profile** for Percutaneous Cecostomy Tube will be reimbursed based on the above-mentioned methodology.

d. Physical Therapy

Refer to Item 4.b.(19).

8. Private Duty Nursing to enhance the effectiveness of treatment for ventilator-dependent beneficiaries, high technology non-ventilator beneficiaries or tracheotomy beneficiaries

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The State is under a U. S. District Court order that sets out the process for rates to be determined. That process includes evaluation of rates based upon market forces as they impact on access. Payment of the resultant rates is ordered by the court.

The agency's private duty nursing fee schedule rates were set as of July 1, 2015 and are effective for fee schedule services on or after that date. All fee schedule rates are published on the agency's website (https://medicaid.mmis.arkansas.gov/Provider/Docs/fees.aspx). Except as noted in the plan, state developed fee schedule rates are calculated using the same method for both governmental and private providers of private duty nursing services.

Effective for dates of service on or after October 1, 1994, reimbursement for private duty nursing medical supplies is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.1-A, page 3d, and Attachment 3.1-B, page 4a.

Effective for dates of service on or after July 1, 2015 **through December 31, 2018**, RN and LPN hourly reimbursement rate maximums are set based on market analysis of salaries, fringe benefits and administrative/overhead costs. Market analysis included the following steps:

- Acquired 2013 wage rates from the Federal Bureau of Labor Statistics for Arkansas,
- Determining employee benefit costs by using Skilled Nursing Facility cost reports submitted as of July 1, 2014,
- Assessing overhead costs by calculating the percent of direct to indirect costs reported in the most recent audited Medicare Home Health cost reports by the top 70% of Medicaid reimbursed non-hospital home health providers during SFY 2007, and
- It was estimated that a private duty nurse will travel approximately 8 miles each hour.

Effective for dates of service on or after January 1, 2019, RN and LPN hourly reimbursement rate maximums are set based on market analysis of salaries, fringe benefits and administrative/overhead costs. Market analysis included the following steps:

- **Wage rates from the Federal Bureau of Labor Statistics for Arkansas do not exceed two calendar years from the establishment of the hourly reimbursement rates,**
- **Determining employee benefit costs by using Skilled Nursing Facility cost reports submitted as of July 1st of the State Fiscal Year that precedes the effective date of the rates,**
- **Overhead costs percentage was calculated using Skilled Nursing Facility cost reports submitted as of July 1st of the State Fiscal Year that precedes the effective date of the rates, and**
- **It was estimated that a private duty nurse will travel approximately 8 miles each hour.**

The fee schedule will be published on the agency's website as referenced above.

8. Private Duty Nursing Services (Continued)

Refer to Attachment 4.19-B, Item 4.b.(5) for reimbursement information for private duty nursing services for high technology non-ventilator recipients in the **Early and Periodic Screening Diagnosis and Treatment (**EPSDT**)** Program.

9. Clinic Services

(1) Adult Developmental Day Treatment (ADDT) and Early Intervention Day Treatment (EIDT)

Reimbursement **for comprehensive evaluation services** is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX maximum was established based on a 1980 survey conducted by Developmental Disabilities Services (DDS) of 85 Arkansas Developmental Day Treatment providers of their operational costs excluding their therapy services. An average operational cost **and average number of units were** derived for each service. The average operational cost for each service was divided by the average units for that particular service to arrive at a maximum rate.

For dates of service occurring on or after **January** 1, **2020**, the maximum per unit rate for Adult **day habilitation services** increased to**$11.77**. These new rates were calculated based on analysis of the current **2019-2020** cost**s** to provide quality services in compliance with governing regulations. The rates have been demonstrated to be consistent with the Clinic Upper Payment Limit at 42 CFR 447.321. For ADDT **day habilitation services**, **there is a maximum** of 5 **hours of services** per day.

For EIDT, auditory, developmental and neuropsychological testing services listed in the 1990 Blue Cross/Blue Shield Fee Schedule that are not subject to the other specifically identified reimbursement criteria are reimbursed based on 80% of the October 1990 Blue Cross/Blue Shield Fee Schedule amounts. For those services that were not included on the **October** 1990 Blue Cross/Blue Shield Fee Schedule, rates are established per the most current Blue Cross/Blue Shield Fee Schedule amount less 2.5% and then multiplied by 66%.

For EIDT, Psychological diagnosis/evaluation services **provided by EIDTs certified as Academic Medical Centers (AMCs)** are reimbursed from the **Outpatient Behavioral Health Services (OBHS)** Fee Schedule as described in Attachment 4.19-B, Item 13.d.1.

For EIDT, Medical professional services reimbursement is based on the physician's fee schedule. Refer to the physician's reimbursement methodology as described in Attachment 4.19-B, Item 5.

The maximum rate for **five minutes of registered** nursing services is **$4.77**. **The maximum rate for five minutes of licensed practical nursing services is $3.17.** Reimbursement for registered nurse**s** and licensed practical nurses is based on the Private Duty Nursing Fee Schedule as described in Attachment 4.19B, Item 8.

State developed fee schedule rates are the same for both public and private providers of EIDT and ADDT services. Occupational, physical and speech therapy services under the EIDT and ADDT Program are reimbursed as is described in Item 4.b.(19).

Extensions of benefits will be provided for all EIDT and ADDT services, if medically necessary.

9. Clinic Services (Continued)

(2) Family Planning Clinic Services

Payment based on reasonable negotiated rate.

(3) Maternity Clinic Services

Payment based on reasonable negotiated rate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%

(4) Ambulatory Surgical Center Services

Act 1352 of the 2013 Arkansas General Assembly established reimbursement for Ambulatory Surgery Centers based on 80% of the Medicare Ambulatory Surgery Center procedure code reimbursement rates. Reimbursement is based on the lesser of the provider's actual charges for the service or the Title XIX (Medicaid) maximum. These rates are effective for dates of service beginning July 1, 2013 **through June 30, 2015**. All rates are published on the agency's website (www.medicaid.state.ar.us). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Ambulatory Surgical Center services. Medicaid will follow Medicare procedure code updates.

Effective July 1, 2015 Act 1236 as amended by the 2015 Arkansas General Assembly adjusted reimbursement for Ambulatory Surgery Centers to 95% of the Medicare Ambulatory Surgery Center procedure codes reimbursement rates. Also in accordance with this amendment Medicaid may adopt and assign a CPT code for a comparable procedure (if the procedure code is not listed on the Medicare ASC procedure code listing) only if the code was approved by Medicaid before the procedure was performed.

In accordance with the Act, Implantable Devices which are not bundled as part of the appropriate procedure code will be reimbursed at a pass-through cost; if the combined documented cost of the appropriate implantable devices is greater than 50% of the appropriate Medicaid maximum procedure code reimbursement rate. If multiple devices are included for one patient, then the total provided devices' cost is calculated and then compared to the appropriate procedure code. The implantable devices' reimbursement provision is also effective for dates of service beginning July 1, 2013 **through June 30, 2015**. These implantable devices are listed in the provider manual which can be found on the agency's website at **https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/asc.aspx.**

9. Clinic Services (Continued)

(5) End-Stage Renal Disease (ESRD) Facility Services

Reimbursement is made at the lower of: (a) the provider's actual charge for the service or (b) the allowable fee from the State's ESRD fee schedule based on reasonable charge.

The Medicaid maximum is based on the 50th percentile of the Arkansas Medicare facility rates in effect March 1, 1988. Rates will be reviewed annually.

After discussion with CMS, it was determined that the Arkansas Medicare 75th percentile is considered the norm for Arkansas Medicare reimbursement. Since the State reimburses at Arkansas Medicare's 50th percentile, the reimbursement rates will not exceed Arkansas Medicare on the aggregate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

Effective for dates of service on and after October 1, 2004, the Arkansas Medicaid Program covers training in peritoneal self-dialysis for beneficiaries with end-stage renal disease.

Reimbursement for peritoneal self-dialysis and training has been established as follows.

The Arkansas Medicaid maximum allowable daily fee for training in continuous ambulatory peritoneal dialysis (CAPD) equals the maximum allowable daily fee ($130) for a hemodialysis treatment plus $12.00 per day. This is the same methodology used by Medicare to calculate their CAPD training reimbursement rate.

The Arkansas Medicaid maximum allowable daily fee for training in continuous cycling peritoneal dialysis (CCPD) equals the maximum allowable daily fee ($130) for a hemodialysis treatment plus $20.00 per day. This is the same methodology used by Medicare to calculate their CCPD training reimbursement rate.

10. Dental Services

Refer to Attachment 4.19-B, Item 4.b. (17a).

The agency's rates were set as of November 21, 2007 and are effective for services on or after that date. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of dental services. Reimbursement rate maximums are calculated at 95% of the 2007 Delta Dental Plan of Arkansas Inc.'s Premier rates. Upon CMS approval, the reimbursement rates calculated under this method will be submitted to the United States District Court for the Eastern District of Arkansas (case of Arkansas Medical Society v. Reynolds) for its approval.

Beginning on or after September 1, 2025, reimbursement rates for oral and maxillofacial surgeons' dental services, including anesthesia; pediatric dental services, including anesthesia; and dental services for adults with special needs, including anesthesia; and excluding orthodontic services, are set to sixty percent (60%) of the fiftieth percentile for national fees as determined by the annual National Dental Advisory Service Comprehensive Fee Report adjusted for Arkansas. To derive Arkansas's adjustment factor of 0.8145, the State identified and averaged the zip code multipliers for Arkansas as published in the NDAS to reflect differences in the median rates for ZIP codes representing geographic areas within the state.

The rates were calculated per CDT service code:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, currently 0.8145) x 0.60 × (NDAS-Reported National 50th Percentile Fee for CDT Code X), as evidenced by:
Medicaid Rate for D0120 = 0.8145 x 0.60 × $72 = $35.19

The State compared the new rates for affected services side-by-side to the existing fee schedule rates.

The State will review and update rates annually by using the most recent NDAS Comprehensive Fee Report and an updated Arkansas Adjustment factor according to the methodology established on September 1, 2025:

Medicaid Rate for CDT Code X = (Arkansas Adjustment Factor, updated for the year) x 0.60 × (Most current published NDAS-Reported National 50th Percentile Fee for CDT Code X)

Rates for the agency's dental fee schedule were set as of September 1, 2025, and are effective for services provided on or after that date. The fee schedule is based on sixty (60) percent of the fiftieth percentile of national fees from the National Dental Advisory Service (NDAS) Comprehensive Fee Report, adjusted for Arkansas, as described above. The State has in place a public process, which complies with the requirements of Section 1902(a)(30)(A) of the Social Security Act.

The agency's fee schedule is available to providers and the public and is published on the Medicaid agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

11. Children's Advocacy Centers

Refer to Attachments 4.19-B, Item 5 and 4.19-B, Item 27.

The agency will reimburse for physician's and advance practice nurse practitioner's services provided through Children's Advocacy Centers in adherence to attachment 4.19-B, Item 5 for physician services and attachment 4.19-B, Item 27 for advance practice nurse practitioner services of this plan. Reimbursement will be limited to examinations needed to assess sexual assault, neglect or abuse of an individual under twenty-one (21) years of age.

4 Physical **Therapy** and Related Services

a. Physical Therapy - Refer to Attachment 4.19-B, Item 4.b.(19).

b. Occupational Therapy - Refer to Attachment 4.19-B, Item 4.b.(19).

c. Speech**-Language** Pathology - Refer to Attachment 4.19-B, Item 4.b.(19).

1. **Speech Generating** Device Evaluation

Effective for dates of service on or after September 1, 1999, reimbursement for an **Speech Generating** Device **(SGD)** Evaluation is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The XIX (Medicaid) maximum is based on the current hourly rate for both disciplines of therapy involved in the evaluation process. The Medicaid maximum for speech**-language** therapy is $25.36 per (20 mins.) unit x's 3 units per date of service (DOS) and occupational therapy is $18.22 per (15 mins.) unit x's 4 units per DOS equals a total of $148.96 per hour. Two (2) hours per DOS is allowed. This would provide a maximum reimbursement rate per DOS of $297.92.

11. Physical Therapy and Related Services (Continued)

c. Speech-**Language** Pathology - Reimbursement Is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum.

The Title XIX (Medicaid) maximum was established based on a 1985 survey conducted by the Division of Developmental Disabilities of private therapy providers, hospital providers and nursing home providers of their 1985 billed charges. The mean (arithmetic average) rate for therapy services established the Title XIX maximum. The rates include the professional and administrative components. Effective for dates of service on or after 7-1-91, rates were increased by 4%.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

A. Payment for ingredient cost for covered outpatient legend and non-legend drugs for all pharmacy and medication types that are not otherwise identified within this section shall be based upon the lesser of methodology.

Lesser of Methodology:

i. Brand Drugs

a. The usual and customary charge to the public or submitted ingredient cost;
OR
b. The National Average Drug Acquisition Cost (NADAC) plus the established professional dispensing fee;
OR
c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee;
OR
d. The calculated State Actual Acquisition Cost (SAAC), as defined in B, plus the established professional dispensing fee

ii. Generic Drugs

a. The usual and customary charge to the public or submitted ingredient cost;
OR
b. The National Average Drug Acquisition Cost (NADAC) plus the established professional dispensing fee;
OR
c. The ACA Federal Upper Limit (FUL) plus the established professional dispensing fee;
OR
d. The calculated State Actual Acquisition Cost (SAAC), as defined in B, plus the established professional dispensing fee

iii. Backup Ingredient Cost Benchmark

If NADAC is not available, the allowed ingredient cost, unless otherwise defined, shall be the lesser of Wholesale Acquisition Cost (WAC) + 0%, State Actual Acquisition Cost (SAAC) or ACA Federal Upper Limit.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist

a. Prescribed Drugs (Continued)

iv. Limited Access and Specialty Drugs

Limited Access Drugs are defined as drugs not available for dispensing in all retail pharmacies based on price or separate agreements between manufacturer and pharmacy. Limited Access Drugs and Specialty Drugs will be reimbursed at the Lesser of Methodology plus the established professional dispensing fee. If NADAC is not available, then the Backup Ingredient Cost Benchmark will apply which will use the lesser of Wholesale Acquisition Cost (WAC) plus zero percent (+0%) or State Actual Acquisition Cost (SAAC).

v. 340B Drug Pricing Program

a. Covered Legend and non-legend drugs, including specialty drugs, purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program, shall be reimbursed the lesser of the 340B actual invoice price or the 340B ceiling price [provided or calculated by Average Manufacturer Price (AMP) minus Unit Rebate Amount (URA)] plus the established professional dispensing fee. The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

b. Physician administered drugs, including specialty drugs, purchased through the 340B Program, will be reimbursed the lesser of the 340B actual invoice price or the 340B ceiling price [provided or calculated by Average Manufacturer Price (AMP) minus Unit Rebate Amount (URA)]. The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed.

vi. Federal Supply Schedule (FSS) and FQHC

Facilities purchasing drugs, specialty drugs, and physician administered drugs through the Federal Supply Schedule (FSS) or drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B Drug Pricing Program, shall be reimbursed no more than the Federal Supply Schedule price. The addition of the established professional dispensing fee for pharmacies will apply, except in the cases of physician administered drugs. Federally Qualified Health Centers (FQHC) that purchase drugs through the 340B program and carve in Medicaid will be reimbursed by the encounter rate, except in the case of Implantable Contraceptive Capsules, Intrauterine Devices, and Contraceptive Injections, in which case reimbursement will be no more than the 340B ceiling price. Federally Qualified Health Centers (FQHC) that do not participate in the 340B program, or carve out Medicaid, will be reimbursed by the encounter rate, except in the case of Implantable Contraceptive Capsules, Intrauterine Devices, and Contraceptive Injections, in which case reimbursement will be at the actual acquisition cost.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist

a. Prescribed Drugs (Continued)

vii. Clotting Factor

a. Pharmacies dispensing Antihemophilic Factor products will be reimbursed at the lesser of methodology plus the established professional dispensing fee. The lesser of methodology for the allowed ingredient cost shall be the Wholesale Acquisition Cost (WAC**)** plus zero percent (+0%) or State Actual Acquisition Cost (SAAC).

b. Pharmacies dispensing Antihemophilic Factor products purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program shall be reimbursed the lesser of methodology for the allowed ingredient cost shall be the 340B actual invoice price, Wholesale Acquisition Cost (WAC) plus zero percent (+0%) or State Actual Acquisition Cost (SAAC). The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed.

viii. Drugs Purchased at Nominal Price

Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall be reimbursed by their actual acquisition cost.

ix. Physician Administered Drugs

Reimbursement rates for Physician Administered Drugs are a "fee schedule" as determined by the Medicare fee schedule**.** If the Medicare rate is not available**,** then other published pricing Average Wholesale Price (AWP) less five percent (-5%) shall be used to determine reimbursement. Under the fee schedule methodology, reimbursement is based on the lesser of the billed charge for each procedure or the maximum allowable for each procedure.

x. Select Carved-Out Drugs from Hospital Settings

Effective for dates of service on or after January 1, 2026, prescribed drugs identified as carved out of the inpatient and outpatient hospital payment methodologies are reimbursed under this section and reimbursed separately from hospital payment rates. The list of carved-out prescribed drugs is maintained on the State's website at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/. Reimbursement for these drugs will be based on the provider's Actual Acquisition Cost for the drug, verified by the purchasing invoice. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

b. State Upper Limit (SUL) shall apply to certain drugs identified administratively, judicially, or by a federal agency as having a published price exceeding the ingredient cost. The calculated SAAC shall be obtained from actual acquisition costs from multiple resources, if available. Depending on the variance, either the highest acquisition cost, an average of the acquisition costs, or invoice price shall be used in determining a SAAC. When Brand and Generic drugs are available for the same ingredient, reimbursement will be based on the Generic State Actual Acquisition Cost (SAAC).

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs (Continued)

C. Investigational drugs are excluded from coverage.

D. The State does not have federally recognized tribes. Indian Health Services, tribal and urban Indian pharmacies payment methodology for outpatient administered medication does not apply.

E. Pharmacies providing covered outpatient prescription services for Certified Long-Term Care beneficiaries will be reimbursed for ingredient cost using the lesser of methodology plus the established professional dispensing fee.

F. The Professional Dispensing Fee for covered outpatient legend and non-legend drugs shall take into consideration the State's Preferred Drug List status for the drug being dispensed and equals the average professional dispensing fee in the aggregate:

- **Brand and Non-preferred Brand = $9.00**
- **Brand Preferred and Generic Medication drug = $10.50**

12. Prescribed drugs, dentures, prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

b. Dentures

Based on contract price established through competitive bidding.

c. Prosthetic Devices

(1) Eye Prostheses - Refer to Attachment 4.19-B, Item 4.b.(13).

(2) Hearing Aids - Refer to Attachment 4.19-B, Item 4.b.(12).

(3) Ear Molds - Refer to Attachment 4.19-B, Item 4.b.(14).

(4) Pacemakers and Internal Surgical Prostheses - Reimbursed at 80% of invoice price.

(5) Hyperalimentation - Reimbursement according to the lower of the amount billed or the Title XIX maximum charge allowed.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist (Continued)

c. Prosthetic Devices (continued)

(6) Orthotic Appliances and Prosthetic Devices

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed. State developed fee schedule rates are the same for both public and private providers of orthotic appliances and prosthetic devices.

Effective for dates of service occurring on and after September 1, 2006, reimbursement rate maximums for Medicaid covered orthotic appliances and prosthetic devises are based on one hundred percent (100%) of the 2006 DMEPOS Medicare rates.

For the following procedure codes not reflecting a rate on the 2006 DMEPOS Medicare fee schedule, reimbursement rate maximums for dates of service occurring September 1, 2006, and after, will be based on one hundred percent (100%) of the 2006 Arkansas Blue Cross/Blue Shield rate:

A5510 = $30.28, L0452 = $263.81, L3202 = $51.21, L3204 = $50.12, L3206 = $51.93, L3207 = $52.67, L3208 = $28.58, L3209 = $39.53, L3211 = $42.11, L3215 = $93.94, L3216 = $113.29, L3219 = $105.26, L3221 = $126.00, L3222 = $139.22, L3230 = $163.33, L3250 = $331.47, L3253 = $44.64, L3257 = $32.95, L3265 = $20.54, L3902 = $1,980.19, L4205 = $35.00, L4210 = $28.27, L7500 = $67.55, L7520 = $15.00

Effective for dates of service on or after January 1, 2023, reimbursement rate maximums for orthotic appliances and prosthetic devices will be set at ninety percent (90%) of the January 1, 2022 Medicare non-rural rate for the State of Arkansas. For orthotic and prosthetic codes not listed on the Medicare fee schedule, reimbursement rate maximums for dates of service on or after January 1, 2023, will be set at eighty percent (80%) of the January 1, 2022, Arkansas Blue Cross/Blue Shield rate. For orthotic and prosthetic codes not listed on the Medicare fee schedule or the Arkansas Blue Cross/Blue Shield fee schedule, the reimbursement rate will be calculated using the manufacturer's invoice price plus ten percent (10%).

All rates are published on the agency's website Fee Schedules - Arkansas Department of Human Services **. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.**

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

Arkansas provides eyeglasses when prescribed for vision correction through a competitively bid contract with an optical supply vendor.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan

a. Diagnostic Services - Not provided.
b. Screening Services - Not provided.
c. Preventive Services - Provided with limitations.

Arkansas covers vaccines and vaccine administration which includes approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

For dates of service on or after March 1, 2026, Arkansas reimburses certified community-based doulas and lactation and breastfeeding consultant services authorized under Section 13 of Attachments 3.1-A and 3.1-B using a state-developed fee schedule.

DHS selected Oklahoma doula rates in place prior to April 2025, including procedure codes and modifier structure. This selection is based on similar rural geography, established doula services programming, and similar payment rates to a neighboring state, Louisiana. While the billing rate basis varied across the comparator states did not allow for calculation of a specific common statistic, DHS reviewed the comparator state payment rates to assess for reasonableness.

For Lactation and breastfeeding services, DHS reviewed comparable state service rates. While the variation in the billing rate basis across the comparator states did not allow for calculation of a specific common statistic, DHS reviewed the comparator state payment rates to assess for reasonableness. DHS selected a rate between the rates of neighboring states, Missouri and Louisiana. The selected is also within the range of Illinois lactation services. All three comparison states are similar in rural versus urban geography and established lactation and breastfeeding counseling programming. Group rates were established based on an average group size of three.

Except as otherwise noted in the State Plan, fee schedule rates are the same for governmental and private providers. The agency's fee schedule was set as of March 1, 2026, and is effective for services furnished on or after March 1, 2026. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable. Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers of RSPMI services. The agency's fee schedule rates were set as of April 1, 1988, and are effective for services provided on or after that date. All rates are published on the agency's website at: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/ .

Effective for dates of service on or after April 1, 2004, reimbursement rates (payments) for inpatient visits in acute care hospitals by board certified psychiatrists shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds. Refer to Attachment 4.19-B, Item 5, for physician reimbursement.

The State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 1440 and 14460 and 42 CFR 441 Subparts C and D. Reimbursement of RSPMI services that are provided in IMD's will be discontinued for services provided on or after September 1, 2011.
For RSPMI services provided in clinics operated by State operated teaching hospitals.

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs. Medicaid shall issue interim payments at the established fee schedule rates. A year-end cost settlement shall be performed to reconcile interim payments with the provider's reasonable costs. The state will return to CMS the federal share of reconciled payments recouped from provider overpayments consistent with 42 CFR 433 Subpart F. The provider will be paid the lesser of actual costs identified using a CMS approved cost report or customary charges. Each Arkansas State Operated Teaching Hospital with qualifying psychiatric clinics shall submit an annual cost report. Said cost report shall be submitted within five (5) months after the close of the hospital's fiscal year. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid Agency, will result in suspension of reimbursement until the cost report is filed. The State Medicaid Agency will review the submitted cost report and make a tentative settlement within 60 days of the receipt of the cost report and will make final settlement in the following year after all Medicaid charges and payments have been processed. The final settlement will be calculated and made at the same time as the next year's tentative settlement is calculated and made.

Medical professionals affiliated with Arkansas State Operated Teaching Hospitals are not eligible for additional reimbursement for services provided in these clinics.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: October 1, 2020

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan (Continued)

(d) Rehabilitative Services (Continued)

(1) Rehabilitative Services for Persons with Mental Illness (RSPMI) (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan (Continued)

(d) Rehabilitative Services (Continued)

(1) Rehabilitative Services for Persons with Mental Illness (RSPMI) (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

IV. INCENTIVE ADJUSTMENTS (Continued):

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan (Continued)

(d) Rehabilitative Services (Continued)

Rehabilitative Services for Persons with Mental Illness (RSPMI) (Continued)

Incentives to improve care quality, efficiency, and economy (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Reserved for the potential addition of Episodes of Care subject to incentive adjustments

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

2. Extended Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Arkansas Non-State Operated Rehabilitative Hospitals

Refer to Attachment 4.19-A, Page 9a, for the reimbursement methodology, except no room and board charges will be reimbursed and the upper limit is set annually at the 70th percentile of all non-state operated rehabilitative hospitals' inflation-adjusted Medicaid per diem rate.

b. Arkansas State-Operated Rehabilitative Hospitals

Effective for claims with dates of service on or after 1-1-96, Arkansas State Operated Rehabilitative Hospitals are classified as a separate class group. The Medicaid definition of a state operated rehabilitative hospital is: A hospital that is recognized as a state operated rehabilitative facility.

The per diem reimbursement for Rehabilitative Services for Persons with Physical Disabilities (RSPD) provided by a State Operated Rehabilitative Hospital will be in accordance with the reimbursement methodology in Attachment 4.19-A, Page 9a, except; the initial per diem rate will be capped at $232.00, no room and board charges will be reimbursed and the annual inflation factor will be based on the HCFA Market Basket Index forecasts published by the HCFA Regional Office for the quarter ending in September. The inflation factor used is taken from the Excluded Hospital Input Price Index category. Arkansas Medicaid will review the per diem rate annually and adjust the rate, if necessary, based on the provider's unaudited cost report, and the annual inflation factor.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

Outpatient Behavioral Health Services

The fee schedule was set as of July 1, 2017, and is effective for services on or after this date. Rates for services provided under the Residential Community Reintegration Program are effective for dates of service on or after October 1, 2017. Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

Effective January 1, 2024, the following services will be set to pay eighty percent (80%) of the 2022 Medicare non-rural rate for the State of Arkansas:

- **Individual Behavioral Health Counseling;**
- **Marital or Family Behavioral Health Counseling without Beneficiary Present;**
- **Marital or Family Behavioral Health Counseling with Beneficiary Present; and**
- **Mental Health Diagnosis.**

Effective January 1, 2024, the following services will be adjusted to pay one hundred percent (100%) of the 2022 Medicare non-rural rate for the State of Arkansas:

- **Group Behavioral Health Counseling; and**
- **Multi-Family Behavioral Health Counseling.**

All rates are published on the agency's website: Fee Schedules - Arkansas Department of Human Services

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

Acute Crisis Units

The fee schedule was set as of July 1, 2017 and is effective for services provided on or after this date. Except as noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of behavioral health services. The fee schedule can be accessed at Fee Schedules - Arkansas Department of Human Services. Effective for dates of service on or after July 1, 2017, reimbursement for Acute Crisis Unit is based on prospective rate of $350.00 per day with no cost settlement and no budget submission necessary for all certified Acute Crisis Unit providers. No room and board costs, or other unallowable facility costs, are built into the daily rate. Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

Each provider furnishing this service must keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Medicaid agency any information maintained and any information regarding payments claimed by the provider for furnishing this service. The Division of Provider Services and Quality Assurance (DPSQA), in conjunction with the State's contracted review entity, will provide ongoing monitoring to assure that services provided under the bundled rate are of the type, quantity and intensity of services required to meet the medical need of beneficiaries.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: April 1, 2002

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

Not provided.

b. Nursing facility services

Not provided.

STATE Arkansas
DATE REC'D 03-18-02
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DATE EFF 04-01-02
HCFA 179 AR 02-09

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SUPERSEDES TN- AR 95-01 (pg. 5c)

15. Services in an intermediate care facility for the mentally retarded, as defined in Section 1905(d), (Other than in an institution for mental diseases) for individuals who are determined, in accordance with Section 1902(a)(31)(A), to be in need of such care.

SEE ATTACHMENT 4.19-D

16. Inpatient Psychiatric Facility Services For Individuals Under 22 Years of Age

Effective for dates of service on or after July 6, 1992, reimbursement for residential treatment centers is based on the lesser of the budgeted cost per day which includes the professional component or a limit of $350.00 per day with no cost settlement. The budgeted cost per day is based on the provider's current budget information. Arkansas Medicaid will negotiate with the Arkansas Hospital Association annually (State Fiscal Year - July 1 through June 30) regarding adjustment of the rate and/or the $350.00 per day limit. The Inpatient Psychiatric Hospital reimbursement methodology is reflected on Attachment 4.19-A, Page 9b.

The budgeted per diem cost is calculated from an annual budget, which all Residential Treatment Center providers are required to submit for the upcoming State Fiscal Year (July 1st through June 30th). Annual budgets are due by April 30th. Should April 30th fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. Failure to submit the budget by April 30th may result in the suspension of reimbursement until the budget is submitted. Rates will be calculated annually and will be effective for dates of service occurring during the State Fiscal year for which the budgets were prepared. This is a prospective rate with no cost settlement.

New providers are required to submit a full year's annual budget for the current State Fiscal Year (July 1st through June 30th) at the time of enrollment. This budget is used to set their rate at the lesser of the budgeted allowable cost per day, or the upper limit (cap) of $350 per day.

Sexual Offender Programs

Sexual Offender Programs are designed specifically for the treatment of those patients designated as sexual offenders who cannot be treated with other mental health patients. These services are provided in separate units in the psychiatric facility. These units meet all the requirements of Subpart D of 42 CFR Part 441 for inpatient psychiatric services for individuals under 21. In addition, they must meet any certification requirements of the Division of Mental Health Services.

Effective for cost reporting periods beginning on or after September 1, 1995, these providers will be reimbursed using Medicare Principles of Reasonable Cost Reimbursement, in 42 CFR Part 413, subject to cost settlement. The initial interim rates for these programs will use reasonable budgeted cost reports. Once audited cost reports are available the most recent audited cost report will be used to set the interim rate. Interim rates will be adjusted every six months if costs increase more than 10%.

SUPERSEDES: TN - AR-95-23

STATE Arkansas
DATE RECD 15 Mar, 01
DATE APPVD 18 Apr, 01
DATE EFF 1 Jun, 01
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A

16. Inpatient Psychiatric Facility Services For Individuals Under 22 Years of Age (Continued)

Sexual Offender Programs (continued)

New providers are required to submit a full year's annual budget for the current State Fiscal Year (July 1st through June 30th) at the time of enrollment if no cost report is available. This annual budget is used to set their interim rate at the lesser of the budgeted allowable cost per dayor the upper limit (cap).

Year end cost reports must be submitted and will be audited in the same manner as audits for inpatient psychiatric hospitalResidential Treatment Units (RTUs)and will be cost settled.

Interim rates and cost settlements are calculated using the same methodology as inpatient residential treatment units with the same professional component cap and the same annual State Fiscal year per diem cap.

17. Nurse Midwife Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum. The Title XIX Maximum for nurse-midwife services is 80% of the current physician Medicaid Maximum. Rhogam RhoD Immune Globulin is reimbursed at the same rate as the physician'srate since the cost and administration of the drug does not vary between the nurse midwife and physician.

(a) Additional Reimbursement for Nurse-Midwife Services Associated with UAMS - Refer to Attachment 4.19-B, item 5.

02-17

STATE Arkansas
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DATE APP 11-2-04
DATE EFF 4-1-04
HCFA 179 04-05(a)

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18. Hospice Care

Arkansas Medicaid reimburses hospice providers in accordance with the Medicaid fee schedule and hospice wage index requirements published annually by CMS. For the Routine Home Care and Continuous Home Care rates, the hospice wage index to be applied to the wage component subject to index is based on the location of the individual's home. For the Inpatient Respite Care and General Inpatient Care rates, the hospice wage index to be applied to the wage component subject to index is based on the location of the hospice. Public and private providers are reimbursed the same rates.

STATE Arkansas
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DATE APP'D 26 Oct 06
DATE EFF 1 Nov 06
HCFA 179 06-08
A

19. Case Management Services

A. Pregnant Women

Reimbursement is a **fee for service**.

19. Case Management Services (continued)

B. Persons Sixty years of Age and Older

TCM services, when prescribed by a physician or other medical professional designated by the Division of Medical Services, are available to beneficiaries age 60 and older **as well as beneficiaries age 21 and older with a physical disability or aged 65 and older who participate** in the **ARChoices In Homecare (ARChoices)** 1915 (c) waiver, who:

- have limited functional capabilities in two or more ADLs or IADLs, resulting in a need for coordination of multiple services and/or other resources; OR
- are in a situation or condition which poses imminent risk of death or serious bodily harm and one who demonstrates the lack of mental capacity to comprehend the nature and consequences of remaining in that situation or condition.

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure. Case management services are billed on a per unit basis. One unit equals 15 minutes.

The agency's targeted case management fee schedule rates were set as of October 1, 2012 and are effective for services on or after that date. All targeted case management fee schedule rates are published on the agency's website (www.medicaid.state.ar.us). A uniform rate for these services is paid to all governmental and non-governmental providers unless otherwise indicated in the state plan.

Cost per 15 minute unit = $7.50

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: August 1, 1994

19. Case Management Services (Continued)

C. **Medicaid recipients age twenty-two and older who are diagnosed as having a developmental disability of mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or require treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.**

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure. Case management services are billed on a per unit basis. One unit equals 15 minutes.

The maximum rates are based on a Social Services Worker III, Department of Human Services position, which most closely matches the duties of a case manager as defined in the Targeted Case Management amendment. Cost categories include salary ($25,480), overhead and administration ($2,548 -- using salary as the allocation base), benefits ($5,096 -- using salary as the allocation base), and travel expenses reimbursed at state approved rates associated with case management (average annual mileage of (9,149 X 0.25 per mile = $2,287.25). As such, the targeted case management unit rate is $4.25 [$25,480 + $2,548 + $5,096 + $2,287.25 = $35,411.25/2080 (52 weeks X 40 hours per week) = $17.02. Rounding to the nearest dollar on the basis of:

- 51 cents or higher, increase to next dollar
- 50 cents or lower, decrease to next lower dollar

17.00/4 = 4.25 per 15 minute unit]. These costs are appropriate for other types of case management providers because they encompass the types of duties, overhead costs, and travel costs associated with case managers currently performing the service.

STATE Arkansas
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DATE APPD JUL 06 1994
DATE EFF AUG 01 1994
HCFA ID 94-11

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19. Case Management Services (Continued)

D. **Medicaid recipients age twenty-one and younger who experience developmental delays; have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay; are determined to be at risk of having substantial developmental delay if early intervention services are not provided; are diagnosed as having a developmental disability which is attributable to mental retardation, cerebral palsy, epilepsy, autism or any other condition of a person found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with mental retardation or requires treatment and services similar to those required for such persons and are not receiving services through the DDS Alternative Community Services (ACS) Waiver Program.**

Refer to Attachment 4.19-B, Page 7a, Item 19.C. for the reimbursement methodology.

STATE Arkansas
JUN 09 1994
JUL 06 1994
AUG 01 1994
94-11

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19. Case Management Services

E. High-Risk Pregnant Women

Program Rates

Effective January 1, 2023, targeted case management services provided by a qualified enrolled provider described in Supplement 1-Attachment 3.1-A and Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women shall be reimbursed a per member per month rate (PMPM), in the amount of $300. At least one of the services described in Supplement 1-Attachment 3.1-A or Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women included in the PMPM must be provided within the service payment unit in order for providers to bill the PMPM rate.

Any provider delivering services through the PMPM will be paid the PMPM rate and cannot bill separately; and, Medicaid providers delivering separate services outside of the PMPM may bill for those separate services in accordance with the state plan.

Payment for targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Payments shall be limited to a maximum of 12 months postpartum.

Limitations

Case management does not include expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service.

Case management does not include expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

Program Rates Development and Adjustments

Existing state program costs reviewed included the State's 2021 Maternal and Infant Early Childhood Home Visiting (MIECHV) program budget request that included staff salaries, other direct program costs to provide the services, and administration. Room and board, and other unallowable facility costs were not considered in the rate development. The state will review data of all enrolled providers at least annually, ensure beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part per member per month rate.

19. Case Management Services (continued)

E-1. Incarcerated Juveniles

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable bundled rate.

Payment for Targeted Case Management services located at Supplement 1, Pages 39 - 45 is established prospectively using a standardized rate-setting methodology for eligible individuals who are under 21 years of age and eligible for any Medicaid eligibility group, or who are eligible under the mandatory former foster care group ages 18 through 25, and who were eligible for Medicaid immediately before becoming an inmate of a public institution or while an inmate of a public institution. Services are provided during incarceration when the individual is within thirty (30) days of their scheduled release date following adjudication and for at least thirty (30) days following release, as determined to be medically necessary. Payment is limited to one bundled unit per individual per thirty-day period

Rates reflect the reasonable and efficient costs a provider would incur and are developed using an independent rate build-up approach informed by publicly available economic data, including wage and compensation information from the U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics and Employer Costs for Employee Compensation. The bundled rate incorporates direct staff wages, associated fringe benefits and payroll taxes, supervisory costs, and allowable administrative and program support costs. The rate does not include costs related to room and board or other unallowable facility costs

All providers furnishing Targeted Case Management services under the bundled payment are reimbursed exclusively through the applicable bundled payment rate. Providers may not bill separately for individual service components, administrative activities, overhead costs, or any other services that are included in the bundled rate. Payment through the bundle constitutes payment in full for all covered Targeted Case Management services delivered during the applicable billing period, and no additional or duplicative reimbursement is permitted for the same services.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of (insert date here) and is effective for services provided on or after that date. All rates are published within Fee Schedules - Arkansas Department of Human Services on the Division of Medical Services website. Rates will be rebased at least once every three years.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: November 1, 1997

RESERVED

STATE ARKANSAS	A
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

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SUPERSEDES: TN - 96-09

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: January 1, 1998

19. Case Management Services (Continued)

F. Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or are abused or neglected children and are in the care or custody of the Department of Human Services, Division of Children and Family Services (DCFS).

An interim rate will be established. In order to ensure that such rate is reasonable for all providers, it will be based on - and continue to be bound to - the actual cost of DCFS in providing case management services to the target population. To the extent that payments will be made to governmental service providers, in accordance with Federal Office of Management and Budget Circular No. A-87 requirements, such payments shall not exceed the costs of providing such services.

These interim rates will be established for every six month period ending June 30 and December 31. After the actual costs for the period has been determined, all claims paid during this period will be adjusted to the actual rate. A new interim rate will be determined as described above. This will be repeated every six months to adjust claims paid at the interim rate to actual cost.

The Medicaid Targeted Case Management unit rate will be determined as follows:

Compute the Actual cost of providing targeted case management services through DCFS during its most recently completed 6 month period for which actual costs data exists, which includes case managers, their direct supervisory and support staff, and their indirect administrative staff. This cost includes salaries and benefits; other operating costs including travel, supplies, telephone and occupancy cost; and indirect administrative costs in accordance with Circular A-87.

Multiplied by Percentage of time spent by DCFS Family Service Workers in performing case management work on behalf of children in the care or custody of DCFS. This percentage will be taken from the current random moment time study (RMTS) which is performed quarterly. The RMTS is currently used to allocate worker time to various functions so as to properly allocate and claim funds from the appropriate programs.

Multiplied by Percentage of Medicaid recipients among number of clients serviced in the month. Taken together with the RMTS percentages, this will give the percentage of the total cost of service worker time described above that is allocable to targeted case management.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: January 1, 1998

19. Case Management Services (Continued)

F. Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are either at risk of abuse or neglect or are abused or neglected children and are in the care or custody of the Department of Human Services, Division of Children and Family Services (DCFS).

Equals	**Total cost for Medicaid Targeted Case Management Services.**
Divided by	**Six Months.**
Equals	**Average monthly cost of Medicaid Targeted Case Management Services.**
Divided by	**Number of clients in receipt of Medicaid to be served during the month.**
Equals	**Monthly cost per Medicaid eligible client for Medicaid Targeted Case Management Services. This is the monthly case management interim unit rate which will be billed for each Medicaid recipient in the target group each month. Documentation of case management services delivered will be retained in the service worker case files.**

The monthly case management interim unit rate is that amount for which the provider will bill the Medicaid Agency for one or more case management services provided to each client in receipt of Medicaid during that month. This "monthly case management unit" will be the basis for billing. A monthly case management unit is defined as the sum of case management activities that occur within the calendar month. Whether a Medicaid client receives twenty hours or two hours or less, as long as some service is performed during the month, only one unit of case management service per Medicaid client will be billed monthly.

STATE Arkansas
DATE REC'D January 6, 1998
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: March 1, 1998

19. Case Management Services (Continued)

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are at risk of delinquency as evidenced by being in the care or custody of the Department of Human Services, Division of Youth Services (DYS) or under the care of a designated provider (specified by DYS) for assessment, supervision or treatment.

There are two distinct targeted case management rates established for this target group. The first rate is established for services provided by qualified public sector providers within the Division of Youth Services. The second rate is established for qualified private sector providers. For each group of providers, an interim rate will be established. In order to ensure that such rate is reasonable for all providers, it will be based on - and continue to be bound to - the actual cost of providing case management services to the target population as reflected in DYS financial reports. To the extent that payments will be made to governmental service providers, in accordance with Federal Office of Management and Budget Circular No. A-87 requirements, such payments shall not exceed the costs of providing such services.

QUALIFIED PUBLIC SECTOR PROVIDERS

A

STATE Arkansas
DATE RECD 1/14/98
DATE APPVD 3/11/98
DATE EFF 3/11/98
HCFA 179 98-01

The Medicaid Targeted Case Management unit rate for qualified public sector providers will be determined as follows:

Compute the — Actual cost of providing targeted case management services through DYS during its most recently completed 6 month period for which actual costs data exists, which includes case managers, their direct supervisory and support staff, and their indirect administrative staff. This cost includes salaries and benefits; other operating costs including travel, supplies, telephone and occupancy cost; and indirect administrative costs in accordance with Circular A-87.

Multiplied by — Percentage of time spent by DYS case managers in performing case management work on behalf of children in the care or custody of DYS. This percentage will be taken from the current random moment time study (RMTS) which is performed each quarter by DYS. The RMTS is used to allocate and claim funds from the appropriate federal and non-federal programs.

Multiplied by — Percentage of Medicaid recipients among number of clients serviced in the month. Taken together with the RMTS percentages, this will give the percentage of the total cost of case manager time described above that is allocable to targeted case management.

Equals — Total cost for Medicaid Targeted Case Management Services.

SUPERSEDES: NONE - NEW PAGE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: March 1, 1998

19. Case Management Services (Continued)

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are at risk of delinquency as evidenced by being in the care or custody of the Department of Human Services, Division of Youth Services (DYS) or under the care of a designated provider (specified by DYS) for assessment, supervision or treatment.

Divided by Six Months.

Equals Average monthly cost of Medicaid Targeted Case Management Services.

Divided by Number of clients in receipt of Medicaid to be served during the month.

Equals Monthly cost per Medicaid eligible client for Medicaid Targeted Case Management Services. This is the monthly case management interim unit rate which will be billed for each Medicaid recipient in the target group each month. Documentation of case management services delivered will be retained in the service worker case files.

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DATE REC'D 1/14/98
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DATE EFF 3/1/98
HCFA 179 98-01

The monthly case management interim unit rate is that amount for which the provider will bill the Medicaid Agency for one or more case management services provided to each client in receipt of Medicaid during that month. This "monthly case management unit" will be the basis for billing. A monthly case management unit is defined as the sum of case management activities that occur within the calendar month. Whether a Medicaid client receives twenty hours or two hours or less, as long as some service is performed during the month, only one unit of case management service per Medicaid client will be billed monthly.

This case management rate will be reviewed at the end of each six-month period to determine if an adjustment is necessary. Such adjustment will be made on a prospective basis only utilizing the same methodology.

QUALIFIED PRIVATE SECTOR PROVIDERS

The Medicaid Targeted Case Management unit rate for qualified private sector providers will be determined as follows:

Compute the Actual cost of targeted case management and approved for payment during the most recently completed 6 month period for which actual costs data exists.

Divided by Number of units billed and approved for payment in the sample period.

SUPERSEDES: NONE - NEW PAGE

19. Case Management Services (Continued)

Target Group:

This service will be reimbursed when provided to children who are Medicaid recipients age 0-20 who are at risk of delinquency as evidenced by being in the care or custody of the Department of Human Services, Division of Youth Services (DYS) or under the care of a designated provider (specified by DYS) for assessment, supervision or treatment.

Equals **Average unit cost for Medicaid Targeted Case Management services. This unit cost will be billed for each unit of TCM services that each Medicaid recipient in the target group receives each month. Documentation of the units of case management services delivered will be retained in the client files maintained by the subcontractors.**

This case management unit rate will be reviewed as needed to determine if an adjustment is necessary. Such adjustment will be made on a prospective basis only utilizing the same methodology.

STATE Arkansas DATE REC'D 1/14/98 DATE APPV'D 3/21/98 DATE EFF 3/1/98 HCFA 179 98-01	A

SUPERSEDES: NONE - NEW PAGE

19. Case Management Services (Continued)

E. Target Group:

By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

Children's Medical Services (CMS), as the Title V agency for children with special health care needs, is entitled to full cost reimbursement for case management services to Medicaid clients pursuant to Section 1902 (a)(11) of the Social Security Act and 42 CFR Section 431.615 (c)(4), which allows Title V agencies to obtain Medicaid reimbursement for the cost of services. The following rate determination pertains to the rate paid to CMS. All other providers of case management services qualifying under this amendment will enroll, bill and be reimbursed according to the rate schedule established by Medicaid under the Targeted Case Management Program reimbursement methodology shown on Attachment 4.19-B, page 7.

Case management services will be billed at a unit rate which is based on one or more documented case management services provided to each client during a day. A case management unit is defined as the sum of case management activities that occur within a day. Thus, no matter whether a Medicaid client receives three hours or fifteen minutes of case management services during the day, only one unit of case management services per client will be billed for one day. The unit rate will be based on the total actual daily cost per client served by CMS. The unit rate includes all direct and indirect costs related to case management service delivery. Indirect costs are costs which cannot be directly identified with a particular program, but are necessary to the general operation of the Department of Human Services (in which CMS is located) or costs associated with an activity which performs services benefiting more than a single program. None of the indirect costs of CMS are duplicative of costs already being charged to the Title XIX program. CMS will use cost reporting principles described in "Cost Principles for State and Local Governments" published in the Office of Management and Budget Circular A-87.

STATE Arkansas	A
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HCFA 179 AR-01-01	

19. Case Management Services (Continued)

E. Target Group:

By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

Whenever it is determined that an individual Medicaid client has insurance, CMS will bill the insurance company for case management services.

The reimbursement rate for CMS case management services to Medicaid clients is computed by dividing CMS' total case management costs for Medicaid eligible clients per day by the average daily number of eligible clients who were provided case management services. The rate is based on a retrospective determination of actual costs from the most recent reporting periods plus an update factor for inflation or other known costs increases (Consumer Price Index for Medical Care for the Dallas-Ft. Worth region published monthly by the Bureau of Labor Statistics). This rate will be adjusted annually, based on the most recent actual cost determination. No retrospective cost/payment reconciliation will be made for a rate period. The initial rate to be effective January 12, 2001 through September 30, 2001 will be determined by trending the previous October 1, 1997 (before the November 1, 1997 removal from the State Plan) rate forward using the CPI for Medical Care - Dallas/Fort Worth region. The rate to be effective October 1, 2001 through September 30, 2002 will be determined from cost information obtained from the six month period January 1, 2001 through June 30, 2001. Thereafter, the State Fiscal Year cost information will be used to set new rates to be effective October 1 of each year.

For Medicaid clients who receive retroactive Medicaid (typically SSI/TEFRA and spenddown clients), a computer report will be generated to document the days in which these clients received case management services which were not billed to Medicaid but could have been under the retroactive date. This computer report will then be used to bill Medicaid for identifiable charges related to identifiable case management services for individual clients; these claims will be made separately from the regular billing procedure.

STATE Arkansas
DATE REC'D 01-22-01
DATE APP'VD 04-20-01
DATE EFF 01-12-01
HCFA 179 AR-01-01

A

19. Case Management Services (Continued)

E. Target Group:

By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

CMS will provide the state matching funds for Medicaid reimbursement to CMS out of the CMS general revenue appropriation. These matching funds for Medicaid reimbursement represent "overmatch" for the Title V grant and will not be used to match any other federal funds.

CMS has extensive computerized (as well as paper) documentation of the exact details of what case management services were provided for each Medicaid client and the dates of service.

19. Case Management Services (Continued)

E. Target Group:

By invoking the exception to comparability allowed by 1915 (g)(1) of the Social Security Act, this service will be reimbursed when provided to persons who are not receiving case management services under an approved waiver program, not placed in an institution and are:

- Aged 0-21 and meet the medical eligibility criteria of Children's Medical Services (CMS), the State's Title V Children with Special Health Care Needs Agency, or;
- SSI/TEFRA Disabled Children's Program clients aged 0-16 with any diagnoses.

The reimbursement rate for case management services for Medicaid eligible clients is computed as follows:

Compute the: Actual cost of providing case management services for Medicaid eligible clients, including cost of salaries and fringe benefits, travel, supplies, telephone, occupancy cost, etc. A weighted average rate will be calculated, based on the individuals performing the service, through the utilization of a Random Time Study.

Divided by: 249 working days (52 weeks x 5 days = 260 - 11 paid holidays)

Equals: Total daily cost of providing case management

Divided by: Total average daily number of eligible Medicaid clients provided case management services by CMS

Equals: Unit cost of providing case management

Multiplied by: Inflation factor (Consumer Price Index for Medical Care for the Dallas-Ft. Worth region published in October of the current year)

Equals: Case management unit rate

20. Extended Services for Pregnant Women

a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

Reimbursement for these services is described in Attachment 4.19-A and Attachment 4.19-B, e.g. inpatient hospital, outpatient hospital, physician services, etc.

b. Services for any other medical conditions that may complicate pregnancy.

Reimbursement for these services is described in Attachment 4.19-A and Attachment 4.19-B, e.g. inpatient hospital, outpatient hospital, physician services, etc.

c. Substance Abuse Treatment Services

i. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of personal care services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Medicaid website at www.medicaid.state.ar.us.

ii. Reimbursement for Substance Abuse Services is by fee schedule, at the lesser of the billed charge or the Title XIX (Medicaid) maximum allowable fee per unit of service. A benefit limit has been established per procedure with extension available based on medical necessity.

iii. The rates are set as of March 1, 2011 and are effective for services on or after that date.

21. RESERVED

22. Respiratory care services (in accordance with section 1920(e)(9)(A) through (C) of the Act).

1. See reimbursement methodology for respiratory therapy services for ventilator-dependent recipients under age 21 on Attachment 4.19-B, Page 1j.

2. Ventilator equipment - Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum is based on the following:

(a) The volume control ventilator and accessories are based on the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for new equipment and 75% of the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for used equipment.

(b) The suction pump is based on Medicare's rate in effect in August 1987 for new equipment. Used equipment is based on 75% of Medicare's rate.

(c) The negative pressure ventilator and accessories are based on the manufacturer's price plus 10% for the maintenance, delivery, set up, emergency call, 24/hr/day, 7 day/week availability.

(d) The oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, hospital bed and nebulizer are based on the DME Fiscal Year 1981 Medicare median.

(e) The ventilator supplies are based on the manufacturer's price.

(f) The pressure support ventilator is based on the 2007 Medicare rate.

The reimbursement methodology includes a provision for adjustments based on legislative committee review, as required.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

(1) The agency's ground transportation fee schedule rates are published on the agency's website. A uniform rate for these services is paid to all governmental and non-governmental providers unless otherwise indicated in the state plan.

Ground Ambulance: Services are reimbursed based on the lesser of the amount billed or the Title XIX (Medicaid) charge allowed.

Effective for claims with dates of service on or after March 1, 2009, the Arkansas Medicaid maximum mileage reimbursement rates are established for the Basic Life Support (BLS), Intermediate Life Support (ILS), and Advanced Life Support (ALS) ground ambulance services by using 86% of the Medicare rural base rate as of February 20, 2009, for the same services.

Effective for claims with dates of service on or after July 1, 2020, the Arkansas Medicaid maximum reimbursement rate for covered ambulance procedure codes increased based upon a routine rate study performed by DHS and its actuary.

(2) The agency's air transportation fee schedule rates were set as of July 1, 2008, and are effective for services on or after that date. All air transportation fee schedule rates are published on the agency's website (www.medicaid.state.ar.us). A uniform rate for these services is paid to all governmental and non-governmental providers unless otherwise indicated in the state plan.

Air Ambulance: Reimbursement for jet fixed wing, turboprop fixed wing, piston fixed wing, and rotary wing air ambulance services is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charges allowed.

The Air Ambulance service maximum reimbursement rates effective July 1, 2008, and after were developed as follows:

- Rotary wing, helicopter pick-up, and per mile rates were calculated by using 85% of Medicare Urban Rates as of 5/1/08 for the same services.
- Piston fixed wing, Turbo Prop fixed wing, and Jet fixed wing mileage rates were calculated by using 85% of Medicare Urban Rates as of 5/1/08 for the same services.
- Piston fixed wing, Turbo Prop fixed wing, and Jet fixed wing hourly rates were calculated by inflating the current rates by the change in the Consumer Price Index-All Urban Consumers (CPIU – not seasonally adjusted, U.S. city average, all items) between December 1, 2000 and April 1, 2008. This hourly reimbursement rate of medical personnel and medical equipment is only for time while the aircraft is in the air, on the runway for takeoff and landing, boarding and disembarking patient and crew, and taxiing.

Effective for dates of service occurring 7/1/2008 and after, reimbursement rate maximums for the turboprop fixed wing aircraft will be $6.54 per mile and $215.70 per hour, the maximums for piston propelled fixed wing aircraft will be $6.54 per mile and $50.32 per hour and the maximums for jet propelled aircraft will be $6.54 per mile and $215.70 per hour. Effective for 7/1/2008 and after, reimbursement rate maximums for helicopter rotary wing aircraft will be $17.43 per mile and $2,462.25 per pick up (one way).

The hourly reimbursement rate is for medical personnel and medical equipment and is only for time while the aircraft is in the air, on the runway for takeoff and landing, boarding and disembarking patient and crew, and taxiing. The per mile rate is to cover the cost of transportation equipment, the salary of the pilot, and non-medical supplies.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(2) Air Ambulance (Continued):

Effective for dates of service occurring May 1, 2001 and after, Arkansas Medicaid will reimburse ground transport salary and fringe expenses for the aircraft medical crew up to a maximum of $1000 per total roundtrip flight. The purpose of this separate reimbursement is to provide necessary additional life support and patient stabilizing medical services for the transported patient. Maximums of $9.40 per 15 minute increment for nursing services and $7.90 per 15 minute increment for paramedic services can be billed. These rates are based on unaudited costs reflected on provider submitted cost statements dated August 31, 2000. This reimbursement can only be made for medical crew assistance time while 1) the crew travels to the hospital to pick up the patient 2) the patient is being transported from the original hospital to the aircraft, 3) the patient is being transported from the aircraft to the receiving hospital and 4) the crew is traveling back to the aircraft after delivering the patient to the receiving hospital. The ground transport medical crew time is reimbursable whether or not the crew actually accompanies the patient in the ground transport ambulance. The crew may travel in a separate vehicle if necessary.

Effective for dates of service occurring May 1, 2001 and after, Arkansas Medicaid will reimburse air transport ventilator and respiratory therapist services. The $75 per hour reimbursement rate for this service is based on unaudited costs reflected on provider submitted cost statements dated August 31, 2000. This service will only be reimbursed when necessary for patient care during transportation. The hourly rate will only be reimbursed for time while the aircraft is in the air, on the runway for takeoff and landing, boarding and disembarking patient and crew, and taxiing.

The state covers round trip or running mileage. The rationale for the above is the expense the provider incurs prior to pickup and delivery of the patient.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(2) Air Ambulance (continued)

Pediatric Hospitals

1. Helicopter Ambulance: Effective for dates of service occurring August 15, 2001 and after, helicopter ambulance services provided by instate pediatric hospitals will be reimbursed based on reasonable costs with interim payments and year-end cost settlement. Interim payments are made at the lesser of the amount billed or the Title XIX (Medicaid) charge allowed. Arkansas Medicaid will use the lesser of the reasonable costs or customary charges as determined from the hospital's submitted cost report to establish cost settlements. The cost settlements will be calculated using the methods and standards used by the Medicare Program. Methods and standards refer to the allocation of costs on the cost report and do not include any current or future Medicare reimbursement limits for this particular service.

(3) Emergency Medical Transportation Access Payment

1. Effective for dates of service on or after April 1, 2020, qualifying medical transportation providers within the State of Arkansas; except for volunteer ambulance services, ambulance services owned by the state or county and political subdivisions, air ambulance services, specialty hospital based ambulance services, and ambulance services subject to the state's assessment on the revenue of hospitals; shall be eligible to receive emergency medical transportation access payments. All emergency medical transportation providers that meet this definition will be referred to as Qualified Emergency Medical Transportation (QEMT) providers for purpose of this section.

2. Payment Methodology

(A) The emergency medical transportation access payment to each QEMT shall be calculated on an annual basis and paid out quarterly. The access payment will be eighty percent (80%) of the difference between Medicaid payments otherwise made to QEMTs for the provision of emergency medical transportation services and the average amount that would have been paid at the equivalent community rate (hereinafter, average commercial rate or ACR).

(1) The Division shall align the paid Medicaid claims for each QEMT with the Medicare fees (Medicare Fee Schedule – Urban) for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code and calculate the Medicare payment for those claims.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(3) Emergency Medical Transportation Access Payment (continued)

(2) The Division shall calculate a separate Medicare equivalent of the ACR for each QEMT that qualifies for the access payment by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

(C) The specific payment methodology to be used in establishing the emergency medical transportation access payment for QEMTs is as follows:

(1) The Division shall send emergency medical transportation access payment data collection forms to QEMTs.

(2) For each QEMT who submits the required data, the Division shall identify the emergency medical transportation services for which the provider is eligible to be reimbursed.

(3) For each QEMT who submits the required data, the Division shall calculate the reimbursement paid to the QEMT for the provision of emergency medical ambulance transportation services excluding air ambulance services.

(4) For each QEMT, the Division shall calculate the QEMT's average commercial rate for all services identified under Subparagraph (2) of this Section.

(5) For each QEMT, the Division shall subtract an amount equal to the reimbursement calculation for each of emergency medical transportation service from the amount calculated for each of the emergency medical transportation services. [B (4)-B (3)]

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(3) Emergency Medical Transportation Access Payment (continued)

(6) For each QEMT, the Division shall calculate the sum of each of the amounts calculated for emergency medical transportation services in Subparagraph (B (5).

(7) The Division shall provide a demonstration that access payments are for the state fiscal year are within the applicable fee-for-service upper payment limits as defined in 42 CFR 447.272, when the upper payment limit demonstrations are due for the fiscal year. If the demonstration shows that payments for any category have exceeded the UPL, the state will take corrective action as determined by CMS.

(C) The Division shall reimburse QEMTs the access payment of eighty percent (80%) of their UPL gap.

(D) These access payments are considered supplemental payments and do not replace any currently authorized Medicaid payments for emergency medical transportation services.

(4) Early Intervention Day Treatment (EIDT) and Adult Developmental Day Treatment (ADDT) Transportation

Effective for claims with dates of service on or after **August** 1, **2022**, EIDT and ADDT transportation providers will be reimbursed on a per **person, per** mile basis at the lesser of the billed charges or the maximum Title XIX (Medicaid) charge **of $1.39 per person per mile** allowed. Transportation will be covered from the point of pick-up to the EIDT **or** ADDT facility and from the EIDT or ADDT facility to the point of delivery. The route must be planned to ensure that beneficiaries spend the least amount of time being transported.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(5) Non-Emergency

(a) Public Transportation

Effective for dates of service on or after December 1, 2001, the following reimbursement applies to public transportation services:

Taxi **and** Wheelchair Van - Reimbursement is based on the lesser of billed charges or the Title XIX maximum allowable. The billed charges must reflect the same charges made to all other passengers for the same service as determined by the local municipality which issues the permit to operate or by the Interstate Commerce Commission. The Title XIX maximum was established utilizing the 1991 Taxicab Fact Book issued by the International Taxicab and Livery Association. The calculations are as follows:

Taxi - The cost per mile of 1990 plus Market Basket Index of 1991 plus Market Basket Index of 1992 plus 25% = $1.13 per mile (unit).

Wheelchair Van - Must transport **six (**6**)** or more passengers comfortably.

The cost per mile of 1990 plus Market Basket Index of 1991 plus Market Basket Index of 1992 plus 65% = $1.50 per mile (unit). An additional 40% was added to the reimbursement per mile due to the added cost of wheelchair van adaptation for wheelchair accessibility and for additional provider compensation for physically assisting the disabled.

The State Agency will negotiate with the affected provider group representative should recipient access become an issue.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(5) Non-Emergency (Continued)

(b) Non-Public Transportation

Effective for dates of service on or after December 1, 2001, Non-Public Transportation Services reimbursement is based on the lesser charges or the Title XIX maximum allowable. The Title XIX maximum is based on the Internal Revenue Service (IRS) reimbursement for private mileage in a business setting, plus an additional allowance for the cost of the driver. The standard mileage private reimbursement is compliant to the 1997 Standard Federal Tax Report, paragraph #8540.011. The calculation of the additional allowance for the cost of the driver is based on the minimum wage per hour, plus 28% of salaries (minimum wage) for fringe benefits, plus a fixed allowance of $2.11 for the **provider's** overhead and billings, divided by 30 (average number of miles per trip). The average number of miles was determined by utilizing data from SFY 1996 and dividing the number of miles per trip by the number of trips made.

The State Agency will negotiate with the affected provider group representatives should recipients access become an issue.

(6) Volunteer Transportation: Amount of payment is agreed on by County Human Services Office and the Carrier. Medicaid reimburses the County Human Services Office for the agreed amount.

The rate of reimbursement equals the amount of travel reimbursement per mile for a state employee. Medicaid reimbursement will not be made for services provided free of charge.

(7) Domiciliary Care: Fixed price set by Assistant Director, Division of Medical Services, based on reasonable cost. The provider submits a statement of expenses, i.e. salaries, repairs, supplies, rent, etc. for their past fiscal year. These costs are reviewed by the **State's** auditors for reasonableness. These costs are reviewed annually and adjusted if necessary, therefore, an inflation factor is not applied.

The cost of meals and lodging are provided only when necessary in connection with transportation of a recipient to and from medical care.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

b. Services of Christian Science Nurses - Not Provided.

c. Care and Services Provided in Christian Science Sanatoria - Not Provided.

d. Nursing Facility Services for patients under 21 years of age

SEE ATTACHMENT 4.19-D

e. Emergency Hospital Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) maximum charge allowed. The Title XIX (Medicaid) maximum was established utilizing 80% of the Blue Shield customary as reflected in their 10/90 publication.

For those procedures which Blue Shield did not have a comparable cost, the rates were increased by 35%. The 35% represents the average overall increase for all services.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

Arkansas
STATE
DATE RCD JUL 20 1992
DATE APPVD JUN 30 1993
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Supersedes: TN 91-29

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: October 1, 2020

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

e. Emergency Hospital Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

e. Emergency Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

e. Emergency Hospital Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://medicaid.mmis.arkansas.gov/provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes **- Sunset date for final reconciliation report 1/31/2021**

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes **- Sunset date for final reconciliation report 4/30/2021**

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

f. Critical Access Hospitals (CAH)

Inpatient Reimbursement

Effective for dates of service occurring August 1, 2001 and after, inpatient services that are furnished by CAHs that are enrolled in the Arkansas Medicaid CAH Program will be reimbursed by interim per diem rates with year-end cost settlements. Cost settlements are determined from provider submitted cost reports and are based on 100% of reasonable costs. Reasonable costs is defined as total reimbursable costs under Medicare principles of cost reimbursement for CAHs.

Annual cost reporting requirements are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan. In addition to these requirements, a hospital that converts to a CAH, and whose effective date of Medicaid enrollment as a CAH is a date other than the day following the last day of the facility's established cost reporting period under its enrollment in the Arkansas Medicaid Hospital Program, must submit partial-year cost reports under each program in which it maintained enrollment during the cost reporting period.

Interim per diem rate calculations, access to subcontractor's records provisions, audit function responsibility and the rate appeal procedures are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan.

In addition to the interim per diem rate calculations identified in Attachment 4.19-A, a CAH's initial interim per diem rate will be the most recent interim per diem rate it received under its prior enrollment in the Arkansas Medicaid Hospital Program; or the interim per diem calculated from the most recent full year's cost report it submitted under its prior enrollment in the Arkansas Medicaid Hospital Program. In the event that a hospital enrolled in the Arkansas Medicaid Hospital Program converts to a CAH before it has had an interim per diem rate in effect for a full cost reporting period, the State will set the facility's CAH interim per diem rate at the mathematical mean of established CAHs per diem rates in effect on the date Medicaid establishes as the facility's date of enrollment in the Arkansas Medicaid Critical Access Hospital Program.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary (continued).

f. Critical Access Hospitals (CAH) (continued)

Outpatient Reimbursement

Effective for dates of service occurring August 1, 2001 and after, outpatient services that are furnished by CAHs that are enrolled in the Arkansas Medicaid CAH Program will be reimbursed by minimum interim payment in accordance with the Arkansas Medicaid Program outpatient fee schedule (at the lesser of the billed charge or the fee schedule maximum) with year-end cost settlements. Cost settlements are determined from provider submitted cost reports and are based on 100% of reasonable costs. Reasonable costs is defined as total reimbursable costs under Medicare principles of cost reimbursement for CAHs.

Annual cost reporting requirements are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan. In addition to these requirements, a hospital that converts to a CAH, and whose effective date of Medicaid enrollment as a CAH is a date other than the day following the last day of the facility's established cost reporting period under its enrollment in the Arkansas Medicaid Hospital Program, must submit partial-year cost reports under each program in which it maintained enrollment during the cost reporting period.

Access to subcontractor's records provisions, audit function responsibility and the rate appeal procedures are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan.

STATE Arkansas
DATE REC'D 05-30-01
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Revised: October 1, 2020

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

f. Critical Access Hospitals (CAH) (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

f. Critical Access Hospitals (CAH)(continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE** **Revised: October 1, 2020**

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

f. Critical Access Hospitals (CAH) (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes **- Sunset date for final reconciliation report 1/31/2021**

Effective for dates of service on or after February 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes **- Sunset date for final reconciliation report 4/30/2021**

Effective for dates of service on or after October 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes **- Sunset date for final reconciliation report 4/30/2021**
(2) Acute Exacerbation of Asthma Episodes **- Sunset date for final reconciliation report 10/31/2020**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: January 1, 1

24. Effective July 1, 1973, for public institutions furnishing services free of charge or at a nominal charge to the public, reimbursement will be based on reasonable cost of services.

STATE ARK	A
DATE REC'D 3-23-89	
DATE APP'VD 8-18-89	
DATE EFF 1-1-89	
HCFA ID 89-15	

Supersedes 87-12

25. Telemedicine Originating Site Facility Fee

Effective for dates of service on or after April 10, 2018, the reimbursement rate for the telemedicine originating site facility fee will be set at 10% of the Calendar Year 2017 Medicare Telemedicine Originating Site Facility Fee. All fee schedule rates are published on the agency's website (https://medicaid.mmis.arkansas.gov/General/Units/OCC.aspx). Except as otherwise noted in the State Plan, state developed fee schedule rates are the same for both governmental and private providers.

26. Personal care is furnished in accordance with the requirements at 42 CFR § 440.167 and with regulations promulgated, established and published for the Arkansas Medicaid Personal Care Program by the Division of Medical Services.

(a) Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of personal care services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Medicaid website at www.medicaid.state.ar.us.

(b) Reimbursement for Personal Care Program Services is by fee schedule, at the lesser of the billed charge or the Title XIX (Medicaid) maximum allowable fee per unit of service. Effective for dates of service on and after July 1, 2004, one unit equals fifteen minutes of service.

(c) Effective for dates of service on and after July 1, 2007, reimbursement to enrolled Residential Care Facilities (RCFs) for personal care services furnished to Medicaid eligible residents (i.e., clients) is based on a multi-hour rate system not to exceed one day, based on the individual clients' levels of care. A client's level of care is determined from the service units required by his or her service plan. Rates will be recalculated as needed to maintain parity with other Personal Care providers when revisions of the Title XIX maximum allowable fee occur. The effective date of any such revised rates shall be the effective date of the revised fee.

(d) Reimbursement to enrolled Assisted Living Facilities (ALF) for personal care services furnished to Medicaid eligible residents (i.e., clients) is based on a multi-hour rate system not to exceed one day, based on the individual clients' level of care. A client's level of care is determined from the service units required by his or her service plan. Rates will be recalculated as needed to maintain parity with other Personal Care providers when revisions of the Title XIX maximum allowable fee occur. The effective date of such revised rates shall be the effective date of the revised fee.

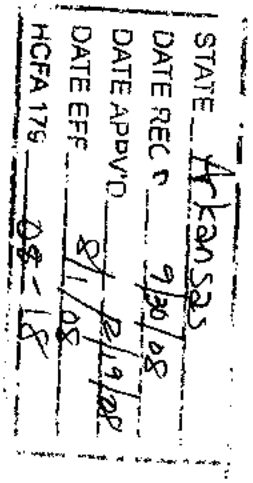
(e) Agencies rates are set as of January 1, **2021** and are effective for services on or after that date. All rates are published at the agency's website, (http://www.medicaid.state.ar.us/).

27. **Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing.**

Reimbursement is based on the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the **advanced practice nurse** and physician.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of services provided by Advanced Practice Nurse. The agency's fee schedule rate was set as of April 1, 2004 and is effective for services provided on or after that date. All rates are published on the agency's website@ www.medicaid.state.ar.us.



SUPERSEDES TN 00-16

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing. (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing. (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by **fifty percent (**50%**)** or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episode of care adjustments made during any calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021 the final reconciliation report will be generated on 4/30/2021.

(see chart on Attachment 4.19-A, Page 11e for specific sunset dates)

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing. (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Ambulatory Upper Respiratory Infection (URI) Episodes **- Sunset date for final reconciliation report 1/31/2021**
(2) Perinatal Care Episodes **- Sunset date for final reconciliation report 1/31/2021**

28. For self-directed personal assistance services under 1915(j) (see Supplement 4 to Attachment 3.1-A for a full description) the rate will be determined as follows:

Arkansas's methodology for determining the participant's budget is based on the assessment of needs for the participant and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for personal care under the state plan referenced in Supplement 4 to Attachment 3.1-A, Page 1, and are adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of **73.0%** of the expected waiver/state plan service reimbursement to calculate the participant's service budget for self- directed personal assistance services.

29. Alternative Benefit Plan (ABP)

All required ABP services and immunizations not specifically identified in the following are covered and reimbursed in accordance with the methodologies described elsewhere in the State Plan. The state's reimbursement methodologies otherwise set forth in the State Plan meet the minimum ABP requirements under the Affordable Care Act (ACA). All APB and non-ABP rates are published on the agency's website (www.medicaid.state.ar.us/download/provider/provdocs/manuals/). Fee schedules are located on the appropriate provider manual page. Except as otherwise noted in the Plan, the rates are the same for both governmental and private providers.

A. Cochlear Implants, Auditory Brain Stem Implants and Osseointegrated Hearing Aid Implants

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover these implants for all age ABP beneficiaries. Reimbursement will be the same as is currently covered for under age 21 non-ABP beneficiaries.

B. Diabetic Self-Management Training

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover Diabetic self-management training by a qualified health care professional for all age ABP beneficiaries. These services will only be provided in the outpatient hospital setting. Reimbursement will be based on the January 1, 2014 Medicare rates for these services.

C. Diagnosis and Treatment of Alcoholism and Drug Abuse, Including Detoxification Treatment and Counseling

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover Diagnosis and treatment of alcoholism and drug abuse, including detoxification treatment and counseling for all age ABP beneficiaries. Reimbursement will be the same as is currently covered for under age 21 non-ABP beneficiaries

D. Shingles Immunization

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover shingles immunization for ABP beneficiaries. These immunizations will be covered for age groups as recommended by the Centers for Disease Control (CDC). Reimbursement will be based on 80% of the 2014 Arkansas Blue Cross Blue Shield rate for this immunization.

29. Alternative Benefit Plan (ABP) (continued)

E. Human Papillomavirus (HPV) immunization

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover HPV immunization for ABP beneficiaries. These immunizations will be covered for age groups as recommended by the Centers for Disease Control (CDC). Reimbursement for ages 19 and over will be based on 80% of the 2014 Arkansas Blue Cross Blue Shield rate for this immunization. Reimbursement for ages 18 and under will be based on the Arkansas Medicaid Vaccines for Children (VFC) reimbursement rate for non-ABP beneficiaries as of January 1, 2014.

30. 1905(a)(29) Medication-Assisted Treatment (MAT)

Effective for dates of service on or after October 1, 2020, reimbursement is based on the rate methodology used for individual MAT services provided within other sections of the Medicaid State Plan, Attachment 4.19-B:

- Pages 1aaa through 1aaaa:
  - Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic
- Pages 1b through 1bbbb:
  - Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub-45-4) (continued)
- Pages 1c through 1ccc:
  - Laboratory and X-ray Services and Other Tests
- Page 2, 2.1, 2c:
  - Physician's Services
- Pages 4 through 4aaa:
  - Reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder (OUD) will be reimbursed using the same methodology as described for prescribed drugs as referenced in Attachment 4.19-B, Pages 4-4aaa, Section 12.a. for both dispensed and administered prescribed drugs.
- Page 5aa:
  - Outpatient Behavioral Health Services (Other diagnostic, screening, preventative and rehabilitative services)
- Page 14:
  - Advance Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Outpatient Behavioral Health Provider Agencies authorized to dispense unbundled prescribed drugs and biologicals used to treat opioid use disorder (OUD). The agency's fee schedule rate was set as of 5/27/2021 and is effective for services provided on or after that date. All rates are published on the agency's website: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

	HCBS Case Management
	HCBS Homemaker
	HCBS Home Health Aide
	HCBS Personal Care
	HCBS Adult Day Health
	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (Specify below):
	All HCBS Services provided under the 1915(i): Payment for these services will be made by the PASSE Organized Care entity who will receive a PMPM for each individual enrolled in the PASSE. The PMPM was developed based on historical utilization of services by the population being enrolled in the PASSEs. Please see the 1915(b) PASSE Waiver, Appendix D, for more information.

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

	HCBS Case Management
	HCBS Homemaker
	HCBS Home Health Aide
	HCBS Personal Care
	HCBS Adult Day Health
	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☑	HCBS Day Treatment or Other Partial Hospitalization Services
	Based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2019 and is effective for services provided on or after that date. All rates are published **at the Fee Schedules website**.
	HCBS Psychosocial Rehabilitation
	HCBS Clinic Services (whether or not furnished in a facility for CMI)

Other Services (Specify below):
Therapeutic Communities Effective November 1, 2022, the new rate for Therapeutic Communities is established with the highest intensity program set at 70% of the Arkansas State Hospital (ASH) inpatient rate, and the lowest intensity level of programming at 50% of the ASH inpatient rate. Because a rate comparison analysis of similar programs in other Region 6 states found no comparable programs, in- state facilities offering comparable levels of care were surveyed. Specifically, the rates for human development centers (HDCs) and the ASH were used for comparison because Therapeutic community provider actual costs for services were also considered in the rate setting process. A revised rate methodology was determined, focused on two levels of program intensity utilizing this method. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of November 1, 2022, and is effective for services provided on or after that date. All rates are published at the **Fee Schedules** website. For all other Adult Behavioral Health Services for Community Independence (ABHSCI) program services, the rate methodology is based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI) etc.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arkansas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item 1&2 of this attachment (see 3. above).

TN No. 99-15
Supersedes TN No. 95-18
Approval Date 9-17-99
Effective Date 9-1-99

HCFA ID: 7982E

STATE Arkansas
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95-18

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance
Other Medicaid Recipients	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance
Dual Eligible (QMB Plus)	Part A MR Deductibles	MR Coinsurance
	Part B MR Deductibles	MR Coinsurance

QMBs:	***Part A SP Deductibles**	**SP Coinsurance**	**Inpatient Hospital services only**
Other Medicaid Recipients	***Part A SP Deductibles**	**SP Coinsurance**	**Inpatient Hospital services only**
Dual Eligible (QMB Plus)	***Part A SP Deductibles**	**SP Coinsurance**	**Inpatient Hospital services only**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

***The payment of the Medicare Part A deductible and coinsurance for inpatient hospital services is based on the following.**

(1) If the Medicare payment amount equals or exceeds the Medicaid payment rate, the state is not required to pay the Medicare Part A deductible/coinsurance on a crossover claim.

(2) If the Medicare payment amount is less than the Medicaid payment rate, the state is required to pay the Medicare Part A deductible/coinsurance on a crossover claim, but the amount of payment is limited to the lesser of the deductible/coinsurance or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate.

Coverage of a recipient's deductible and/or coinsurance liabilities as specified in this section satisfies the state's obligation to provide Medicaid coverage for services that would have been paid in the absence of Medicare coverage.

The payment of all other Part A deductible and coinsurance is based on the Medicare rate.

(3) The Medicaid agency will use the Medicare all-inclusive payment rate for cost reimbursement of FQHC encounter coinsurance. The Medicaid agency will cost settle for the coinsurance percentage. The Medicaid agency will cost settle for the coinsurance percentage of the FQHC Medicare encounter cost after the final encounter cost has been determined by the Medicare intermediary.

(4) Effective for dates of service on or after September 1, 1999, the State will make copayments for Medicare/Medicaid recipients who are enrolled in a Medicare HMO. The service categories and maximum copayment amount are:

Service	Maximum Copayment
Emergency Room	$25.00 (payable to facility)
Physician/Chiropractor/Podiatrist (excluding Psychiatry/Psychology - see below)	$ 5.00 (payable to physician/ chiropractor/podiatrist
Occupational, Physical and Speech Therapy	$ 5.00 (payable to facility)
Psychiatrist/Psychologist	50% (payable to provider) – Medi-Pak HMO
	$20.00 (payable to provider) – Medicare Complete HMO

4.19 (c) Payment is made for reserving beds during a recipient's absence from an inpatient facility for the purpose indicated below:

(1) Long Term Care Facility

(a) Hospitalization

For periods of hospitalization for acute conditions, not to exceed five (5) consecutive days of hospitalization, and payment shall be made only if the Long Term Care Facility was at least 85% occupied on the last day of the billing month.

(b) Therapeutic Home Leave

No limitations on total number of therapeutic leaves of absences. However, a limitation of fourteen (14) consecutive days of absence exists. The recipient's plan of care must contain a statement that the physician has approved therapeutic home visits.

(2) Inpatient Psychiatric Facility for Individuals Under 22 Years of Age

(a) No limitations on total number of therapeutic leaves of absences. However, a limitation of seven (7) consecutive days of absences exists for therapeutic leave. The recipient's plan of care must clearly document the physician has prescribed therapeutic leave.

STATE Arkansas
DATE REC'D 1-21-92
DATE APPV'D 2-18-92
DATE EFF 3-1-92
HCFA 179 92-01
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Supersedes 88-36

4.19 (c) Payment is made for reserving beds during a recipient's absence from an inpatient facility for the purpose indicated below: (Continued)

(3) **Acute Care/General or Rehabilitative Hospital**

Effective for claims with dates of service on or after March 1, 1992, Arkansas Medicaid will allow a maximum of seven (7) days per State Fiscal Year for therapeutic leave for patients in an acute care/general or rehabilitative hospital. The benefit limit for State Fiscal Year 1992 will be calculated beginning with dates of service on or after March 1, 1992.

The therapeutic leave will be allowed for hospital leave when the leave is prescribed as a part of the treatment and/or discharge planning.

The hospital provider is eligible to receive 50% of the actual cost per day involving therapeutic leave. The established per diem rate of reimbursement for the hospital will be initially paid to the provider and the 50% calculation will be computed at the time of the cost settlement process.

STATE Arkansas
DATE REC'D 1-21-92
DATE APPV'D 2-18-92
DATE EFF 3-1-92
HCFA ID 92-01

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Supersedes New Page

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES Revised: April 1, 1979

4. a. Skilled Nursing Home Payment

Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

14. a. Services for individuals age 65 or older in institutions for tuberculosis

(2) Skilled nursing facility services -

Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

(3) Intermediate care facility services -

Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

14. b. Services for individuals age 65 or older in institutions for mental diseases.

(2) Skilled nursing facility services

Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

(3) Intermediate care facility services

(a) Private Nursing Care Facilities - Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

(b) State Operated Facilities - Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

15. Intermediate care facilties services (Other than such services in an institution for tuberculosis or mental diseases) for persons determined, in accordance with 1902 (a)(31)(A) of the Act, to be in need of such care.

Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

Sub. No. 79-5 Item No. 40
Approved by R. O. 2-15-80

15. a. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

(1) Private Facilities - Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

(2) State Operated Facilities - Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

17. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary

d. Skilled nursing facility services for patients under 21 years of age

Reimbursement on Reasonable Cost-Related Basis - See Appendix I.

Sub. No. 79-5 Item No. 42
Approved by R. O. 2-15-80

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

STATE Arkansas	A

Approval Date 8-3-98
Effective Date 4-1-98

Plan # 98-13
Supersedes Plan # _____

SUPERSEDES: NONE NEW PAGE

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (D) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
_____ Additional Other Provider-Preventable Conditions identified below:

No payment shall be made for services for the Other Preventable Conditions (OPPCs). OPPC is one category of Provider Preventable Conditions (PPC), as identified by the Centers for Medicare & Medicaid services, and applies broadly to any health care setting where an OPPC may occur. OPPCs include the three Medicare National Coverage Determinations; wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; and surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a provider-preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
Reductions in provider payment may be limited to the extent that the following apply:

- **i. The identified provider-preventable conditions would otherwise result in an increase in payment.**
- **ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.**

Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

TIMELY CLAIMS PAYMENT – DEFINITION OF A CLAIM **Revised: October 1, 1985**

Claims for Medicaid services submitted to the Arkansas Medical Assistance Program are defined according to the criteria below.

(1) The following claim types are defined as a line item for service:

a. Drug claim form

b. Nursing home turnaround document (TAD)

(2) All other claim types are defined as a bill for services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Requirements for Third Party Liability -
Identifying Liable Resources

Data Exchanges

TPL information is collected during SWICA file match for Title IV-A applicants all other Medicaid applicants and absent or custodial parents weekly. TPL information is collected during SWICA file match for Title IV-A recipients all other Medicaid recipients and absent or custodial parents monthly. TPL information is collected during SSA Wage and Earnings file match for Title IV-A applicants and recipients, all other Medicaid applicants and recipients and absent or custodial parents monthly. These intervals are are in accordance with the intervals specified in 42 CFR 435.948. The Title IV-A agency identifies Medicaid recipients that are employed and their employers at application and redetermination. Employers are queried within 30 days in order to identify legally liable third party resources and incorporate such infomration into the eligibility case file. Health insurance information obtained during the initial application and redeterminat processes is forwarded to the Third Party Liability Unit (TPL) and within 60 days the Third Party Liability Unit will verify and incorporate into the Third Party Data Base.

State Workers' Compensation declined entering into a written agreement; however, agreed to perform the match. This information is contained in documentation submitted with HCFA-179 Transmittal 87-24. Workers' Compensation match will be performed quarterly. A report is generated and forwarded to the Third Party Liability Unit. Follow-up is initiated within 30 days by the Third Party Liability Unit.

State Motor Vehicle Exchange was attempted but discontinued due to insufficient identifying information in Motor Vehicle Accident files. Documentation is submitted with HCFA-179 Transmittal 87-24.

Diagnosis and Trauma Code Edits

The MMIS System edits each claim for the presence of an accident or trauma diagnosis on all paid claims. If there is an accident or trauma diagnosis present, the MMIS System automatically generates an accident letter (TPL 013) to the recipient inquiring as to the nature of the accident (how, when, and where the accident took place) and if any claims were filed with an insurance company. If so, policy information is requested. The recipient has 30 days to respond to the accident inquiry or benefits will be terminated.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Requirements for Third Party Liability -
Identifying Liable Resources

Diagnosis and Trauma Code Edits (cont.)

If an insurance company has been billed, the insurance is notified of the claims paid by the Medicaid program within 30 days. If the liability has not been determined, the recipient is asked if litigation is planned. If litigation is planned, the name, address, and phone number of the attorney hired to represent the recipient is requested. The attorney is placed on notice of the Medicaid program's interest in the case within 60 days. Once an attorney has been placed on notice, subsequent follow-up notices are sent every 90 days. All information received in response to the automated accident letters are entered in the Third Party Liability letter file on-line on a daily basis. An accident and trauma report is produced weekly reflecting all claims paid with an accident or trauma diagnosis 800-999 (Except 994.6) as specified in 42 CFR 433.138 (e). This information is incorporated into the TPL files. The report will be reviewed semi-annually for diagnosis codes and collections associated with diagnosis codes during previous six-month period to determine the priority of follow-up activity. If health insurance is identified in accident and trauma follow-up activity, it will be incorporated into data base with 60 days.

STATE AR
DATE RCVD OCT 16 1987
DATE APPD SEP 13 1988
DATE MAY 28 1987
HCFA 87-24

A

TN No. 87-24
Supersedes TN No. 86-9 new page 4

Approval Date SEP 13 1988

Effective Date MAY 29 1987

HCFA ID:1076P/0019P

SUPPLEMENT 1 TO ATTACHMENT 4.22-A
July 1, 2007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **ARKANSAS**

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

STATE Arkansas DATE REC'D 07-20-07 DATE APPV'D 08-15-07 DATE EFF 07-01-07 HCFA 179 07-10	A

TN No. 07-10 Approval Date 15 Aug, 2007 Effective Date 1 July, 2007

SUPERSEDES: NONE - NEW PAGE

Revised: **November 1, 2023**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

**Requirements for Third Party Liability –
Payment of Claims**

If the provider bills the Medicaid Program, he/she must certify either:

(1) that he/she has not billed the known third party due to medical support enforcement, or

(2) that he/she has billed the known third party but has not received payment or denial from the third party within 30 days from the date of service.

Claims submitted for payment with certification that the provider attempted to collect from the third party are extracted and written to a report produced monthly. The report is reviewed monthly using a random sampling of 10% based on the total number of claims reported. Follow-up activity is performed with the third party to ensure that payment has not been made within 30 days of the provider's date of service.

The Agency does not use threshold amounts for any cases other than Tort/Casualty cases to determine whether to seek reimbursement from a liable third party. Threshold amounts vary from $25.00 to $100.00 depending on the type of service. Total TPL program expense divided by the number of claims recovered (monthly figures are used) are utilized in this calculation. This limit is determined annually.

A timeframe of six months is allocated for the allowed amount on individual claims to be collected for comparison with the threshold level of each valid third party source's coverage areas. If the cumulative or individual allowed amount total exceeds the threshold level then each applicable third party source is pursued.

Medicare claims are reflected in Arkansas' MMIS as cost avoidance.

The State makes payment for pediatric preventive services, including early and periodic screening, diagnosis, and treatment services (EPSDT), without regard to third party liability and seeks reimbursement from any liable third party to the extent of such legal liability.

For services covered under the plan that are provided to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency, the State makes payment for such services without regard to third party liability up to 100 days that is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by the State Title IV-D agency, and seeks reimbursement from such liable third party to the extent of legal liability.

Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

The State makes payment without regard to third party liability for pediatric preventive services unless a determination related to cost-effectiveness and access to care that warrants cost avoidance up to 90 days has been made.

The State will use standard coordination of benefits cost avoidance when processing claims for prenatal services, labor and delivery, and postpartum care claims.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arkansas

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

When the State discovers that an eligible recipient is responsible for payment of a group health insurance premium, the State reviews both historical incidence of Medicaid payable claims and, if available, the recipient's likelihood of ongoing, coverable medical expenses and compares these to the cost of the premium required to continue the health insurance coverage. This review is conducted by staff of the Division of Medical Services, Utilization Review Unit and the Medical Assistance Unit, with assistance from professional medical consultants, as necessary.

STATE Arkansas
DATE RECD 05-23-95
DATE APPD 06-20-95
DATE EFF 04-01-95
HCFA ID 95-16
A

* U.S. Government Printing Office : 1991 - 312-149/40352

State/Territory: ARKANSAS

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

STATE Arkansas
DATE REC'D 9-23-92
DATE APPV'D 10-6-92
DATE EFF 8-1-92
HCFA I.D. 92-35
A

TN No. 92-35
Supersedes TN No. One-New Page

Approval Date 10/6/93 Effective Date 8-1-92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARKANSAS

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
AFDC/Medicaid REQUESTS TO OTHER STATE AGENCIES

In compliance with 42 CFR 435.948(a)(6), Arkansas currently has an integrated on-line system for AFDC and Medicaid. The system automatically checks to see if eligibility has already been established and benefits being issued before allowing a case to be accepted for benefit delivery.

The system also has on-line edits to assure that the income and resource amounts entered are below the limits established. If the amount exceeds the maximum allowable, the system rejects the transaction and highlights the fields in error.

SWICA/Unemployment Compensation

All applicants are submitted to the Arkansas Employment Security Division on a weekly basis for information regarding wages and unemployment compensation. Hard copy reports are generated to the County Human Services offices for matches received.

Recipients are submitted to EDS on a quarterly basis and here again hard copy reports are generated.

In addition, the State agency has on-line access to the state employment and unemployment compensation files. This provides immediate access availability for the eligibility workers to utilize in determining eligibility.

Food Stamps

Although the Food Stamp system is not integrated with the AFDC/Medicaid system, all information is available on-line for the eligibility workers. An on-line cross reference file also captures all programs in which a recipient has or is currently receiving benefits.

Other States

At this time, Arkansas is not matching with any other states for possible duplicate assistance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

The method of issuance will be the same as for all other Medicaid recipients in that the county office system certification will trigger system issuance of Medicaid card to the address of client's choice.

STATE AR
DATE RECD JUL 1 1987
DATE APPVD JUL 30 1987
DATE EFF See HCFA-179
HCFA ID 87-12

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Under Arkansas Law, if you are a competent adult age 18 or older, you have the right to participate in making your own medical treatment decisions, including the right to accept or refuse specific forms of health care. As one means of exercising this right, the law allows you to complete written declarations containing instructions as to the kinds of health care decisions you wish to have made on your behalf if you become terminally ill or permanently unconscious and unable to make such decisions on your own. These declarations serve much the same purpose under Arkansas law as "living wills" serve in other states. To be effective, the declaration(s) must be signed by the patient or by someone else acting at his/her direction and must be witnessed by two individuals.

Any physician or other health care provider who is unwilling to carry out the instructions of a patient or health care proxy under the law has an obligation to take all reasonable steps necessary to transfer the care of such patient to another physician or health care provider who will do so.

Refer to Attachment 4.34-A, Page 2, for a copy of the Declaration Form to be used for residents of Arkansas.

STATE Arkansas
DATE RECD 11-22-91
EFF APP'D 12-5-91
12-1-91
HCFA ID 91-55

A

For Residents of ARKANSAS

STATE ARKANSAS

DECLARATION

(In the Event of a Terminal Condition)

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to:

(CHECK ONE BOX):

___ 1. Withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain;

___ 2. Follow the instructions of _____
(Name)

_____
(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____, _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

DECLARATION

(In the Event of Permanent Unconsciousness)

If I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act to:

(CHECK ONE BOX)

___ 1. Withhold or withdraw life-sustaining treatments that are no longer necesary to my comfort or to alleviate pain;

___ 2. Follow the instructions of _____
(Name)

_____
(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

STATE Arkansas
DATE RECD 10-22-91
DATE APP'D 12-5-91
12-1-91
91-55

A

Source: ARC 20-17-202

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

Not Applicable.

STATE Arkansas
DATE RECD JUL 03 1995
DATE APPVD SEP 29 1995
DATE EFF JUL 01 1995
HCFA 179 95-20

A

TN No. 95-20
Supersedes TN No. 90-15
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Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE Arkansas
DATE RECD JUL 03 1995
DATE APPVD SEP 29 1995
DATE EFF JUL 01 1995
HCFA 179 95-20
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TN No. 95-20
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Arkansas
STATE
JUL 03 1995
SEP 20 1995
JUL 01 1995
HCFA 179 95-20
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TN No. 95-20
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE Arkansas
DATE JUL 0 3 1995
DATE APP SEP 2 9 1995
DATE OF JUL 0 1 1995
HCFA 179 95-20
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Approval Date: 9/29/95
Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE Arkansas
DATE REC'D JUL 03 1995
DATE APPD SEP 29 1995
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE Arkansas
DATE RCVD JUL 03 1995
DATE APPVD SEP 29 1995
DATE EFF JUL 01 1995
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE Arkansas
DATE RECD JUL 03 1995
DATE APPD SEP 29 1995
DATE EFF JUL 01 1995
HCFA 179 95-20

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

Not Applicable.

STATE Arkansas
DATE RECD JUL 03 1995
DATE APPVD SEP 29 1995
DATE EFF JUL 01 1995
HCFA 179 95-20

A

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Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The contractor must advise in advance any individual who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's NA/HHA registry and all information required on the registration application shall be available for public disclosure.

The registry record for each individual who has successfully obtained NA/HHA certification must, at a minimum, contain the following data fields.

- individual's full name;
- date of birth;
- Social Security Number;
- name and date of State approved training program(s) successfully completed;
- Registration number; the registration number assigned by the contractor to the individual when he or she successfully completes the competency evaluation program. The registration number must include a modifier which indicates the type of registration (see below).
- place of employment;
- date of last employment;
- most recent certification date;
- and if applicable, documentation of investigations showing sustained findings of patient or resident neglect, abuse, mistreatment, or misappropriation of patient or resident property by the NA/HHA including a summary of the findings, and where applicable the date and results of the hearing or date of a waiver of hearing, and a statement by the NA/HHA disputing the findings of the investigation (documentation of the investigation to be provided to the contractor for data entry by the Department).

The registry is required to assign registration numbers with modifier codes indicating the type of registration; such as NA only, HHA only or combination NA/HHA. Also required are modifier codes indicating deemed status, grandparenting or interstate reciprocity. The contractor will be responsible, with Department approval, to establish the modifier code system.

STATE A
DATE RECD DEC 30 1991
DATE APPVD FEB 05 1992
DATE EFF DEC 01 1991
HCFA I/T AR-63

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

Refer to attachment 4.38, page 1 which shows additional information.

STATE Arkansas
DATE REC'D DEC 3 0 1991
DATE APPV'D FEB 0 5 1992
DATE EFF DEC 0 1 1991
HCFA 179 91-63

A

* U.S. Government Printing Office : 1991 - 312-349/40433

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: *Arkansas*

DEFINITION OF SPECIALIZED SERVICES

Specialized Services are those services which, when combined with services provided by the nursing facility or other service providers, result in the continuous, aggressive implementation of an individualized care plan directed toward those nursing facility residents with MI or MR/DD who have been identified through PASARR evaluation to have needs requiring continuous supervision, treatment and training by qualified mental health and/or mental retardation/developmental disability personnel and arranged for by the State. These additional Specialized Services provided by the State will not be included in the nursing facility rate.

Mental Health	Mental Retardation Developmental Disability
Intervention Services	*Case Management
Behavior Management	DDTCS
Outpatient Psychiatric Services	Functional Academics
Medication Management/Monitoring	Socialization/self Help Skills
Community Support Services	Pre-vocational Training
Individual/Family Psychotherapy	Speech & Language Pathologies
Psychiatric Consultation	Occupational Therapy for Developmentally Disabled
Crisis Stabilization	Gross Motor Development
Inpatient Psychiatric Care	

*Case Management services are available 30 days prior to discharge from the NF.

STATE Arkansas
DATE REC'D APR 05 1993
DATE APPV'D MAY 12 1993
DATE EFF JAN 29 1993
HCFA 179 93-13

A

TN No. 93-13
Supersedes
TN No. Page 26-TN 88-38
Page 75 Item 4.D.6.1-TN 89-17

Approval Date MAY 12 1993 Effective Date JAN 29 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

CATEGORICAL DETERMINATIONS

Arkansas applies categorical determinations in PASRR to individuals with the following conditions: 1. Terminally Ill, Comatose, 2. Ventilator Dependent, 3. Severely Ill, **4. the short term convalescence resident, the individual being admitted from a hospital for convalescent care not to exceed 120 days and is not a danger to self or others,** and Mental Retardation with a concurrent diagnosis of dementia. The individual, to whom the previous conditions apply, has an impairment so severe that the individual could not be expected to benefit from specialized services.

SUPERSEDES: TN- 06-18

STATE Arkansas
DATE REC'D 9-25-07
DATE APP'VD 12-10-07
DATE EFF 12-1-07
HCFA 179 07-13

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arkansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

Upon written request the Office of Long Term Care, through its Training Coordinator, provides persons with appropriate technical expertise to train staff and residents (and their representatives) on current regulations, procedures and policies.

STATE Arkansas
DATE REC'D JUN 29 1992
DATE APPV'D JUL 28 1992
DATE EFF OCT 01 1990
HCFA 179 92-25

A

TN No. 92-25
Supersedes
TN No. One Preceding Page

Approval Date JUL 28 1992 Effective Date OCT 01 1990

HCFA ID: _____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arkansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

STATE LICENSING REGULATIONS REGARDING THE PROCESS FOR THE RECEIPT OF ALLEGATIONS OF NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY ARE SPECIFIED ON PAGES 1 THROUGH 13 BELOW.

LTC.300 4-01-1992

306 REPORTING SUSPECTED ABUSE/NEGLECT, INCIDENTS, ACCIDENTS, DEATHS FROM VIOLENCE AND UNUSUAL OCCURRENCES

The facility shall develop and implement written policies and procedures to ensure that incidents, including suspected abuse/neglect of residents, accidents, deaths from violence and unusual occurrences are reported and documented as required by all applicable state and federal laws and these regulations.

Facility policies and procedures regarding occurrences addressed in these regulations will be included in orientation training for all new employees and will be addressed at least annually in in-service training for all facility staff.

306.1 INCIDENTS/OCCURRENCES REPORTABLE WITHIN ONE HOUR

The Office of Long Term Care shall be notified by telephone (refer to Section 306.5 for content of telephoned report) within one hour of occurrence of the following incidents ;

- Any accident or unusual occurrence that results in the death of a resident.

- Any fire or explosion within a Long Term Care Facility.

- Any disaster in a Long Term Care Facility, i.e., tornado, flood, nuclear disaster, toxic waste spill, etc.

- Violent acts within a Long Term Care Facility such as shooting, rape, robbery, or assault.

- Major power outages or losses of heat/air conditioning lasting

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arkansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

—for more than two hours.

- Any suspected occurrences of abuse and/or neglect to residents, whether or not occurring on facility premises. Refer to Section 306.4 and to Arkansas child and adult abuse and neglect reporting statutes.

- Absence/elopement of a resident from the facility as defined below.

Absence/elopement shall mean circumstances where the resident cannot be located or has left the premises without authorization. If the resident cannot be located within one hour, he or she shall be considered absent. For the purpose of this section, a resident is authorized to leave the premises in any manner consistent with the resident's plan of care, or pursuant to specific authorization by a physician, the facility administrator, or the administrator's designee. Any legally competent resident may execute discharge documents. If there is reason to believe such a resident, upon discharge, may be an endangered adult (see Section 306.4.6) the facility remains obligated to make reports required by law (see Section 306.4).

306.2 INCIDENTS/OCCURRENCES REPORTABLE WITHIN TWO HOURS

The following incidents shall be reported by telephone (refer to Section 306.5 for content of telephoned report) to the Office of Long Term Care within two (2) hours of the incident if the incident occurs during normal business hours (8:00 a.m. to 4:30 p.m., Monday through Friday, except holidays), or before 10:00 a.m. on the next workday if the incident occurs after normal business hours:

- Accidents, incidents, or unusual occurrences involving injury or illness to a resident that require medical treatment or services outside the facility.

- All cases of reportable disease.

- Loss of heat/air conditioning or fire alarm systems of less than a two (2) hour duration.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arkansas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

- Theft or misappropriation of resident funds or property.

306.3 AFTER HOURS REPORTING

After business hours, weekends and holidays, incidents specified in Section 306.1 shall be reported by calling the emergency number provided by the Office of Long Term Care for this purpose.

306.4 REPORTING SUSPECTED ABUSE/NEGLECT

The facility's written policies and procedures shall include, at a minimum, requirements specified in this section.

306.4.1 The requirement that the Administrator or his designated agent immediately report all cases of suspected abuse/neglect of residents of a long term care facility as specified below:

a. Suspected abuse/neglect of an adult (18 years old or older) shall be reported to the sheriff of the county in which the facility is located, as required by Arkansas Code Annotated 5-28-203 (b).

b. Suspected abuse/neglect of a child (under 18 years of age) shall be reported to the local law enforcement agency or to the central intake unit of the Department of Human Services, as required by Act 1208 of 1991. Central intake may be notified by telephone at 1-800-482-5964.

306.4.2 The requirement that the Administrator or his designated agent report suspected abuse/neglect to the Office of Long Term Care as specified in Section 306.1 above.

306.4.3 The requirement that facility personnel, including but not limited to, licensed nurses, nursing assistants, physicians, social workers, mental health professionals and other employees in the facility who have reasonable cause to suspect that a resident has been subjected to conditions or circumstances which have or could have resulted in abuse/neglect are required to immediately notify the Administrator or his designated agent.

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

306.4.4 The requirement that, upon hiring, each facility employee be given a copy of the abuse/neglect reporting policies and procedures and sign a statement that the policies and procedures have been received and read. The statement shall be filed in the employee's personnel file.

306.4.5 The requirement that all facility personnel receive annual in-service training in identifying and reporting suspected abuse/neglect.

306.4.6 Definitions (from Arkansas Code Annotated 5-28-101) for reporting suspected abuse of adult residents of long term care facilities as follows:

(1) "Endangered adult" means:

(A) An adult eighteen (18) years of age or older who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to that person and who demonstrates the lack of capacity to comprehend the nature and consequences of remaining in that situation or condition; or

(B) A resident eighteen (18) years of age or older of a long-term care facility which is required to be licensed under [Arkansas Code Annotated] 20-10-224 who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to such person and who demonstrates the lack of capacity to comprehend the nature and consequences of remaining in that situation or condition.

(2) "Abuse" and "maltreatment" means any willful or negligent act which results in negligence, malnutrition, physical assault or battery, physical or psychological injury inflicted by other than accidental means, and failure to provide necessary treatment, rehabilitation, care, sustenance, clothing, shelter, supervision, or medical services;

(3) "Exploitation" means any unjust or improper use of another person for one's own profit or advantage.

(4) "Imminent danger to health or safety" means a situation in

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which death or severe bodily injury could reasonably be expected to occur without intervention. The burden of proof shall be upon the department to show by clear and convincing evidence that such imminent danger exists.

306.4.7 Definitions (from Act 1208 of 1991) for reporting suspected abuse/neglect of children as follows:

(1) "Child" or "juvenile" means an individual who:

(A) Is under the age of eighteen (18) years, whether married or single;

(B) Is under the age of twenty-one (21) years, whether married or single, who was adjudicated delinquent under the Arkansas Juvenile Code for an act committed prior to the age of eighteen (18) years and for whom the court retains jurisdiction; or

(C) Was adjudicated dependent-neglected under the Arkansas Juvenile Code before reaching the age of eighteen (18) years and who, while engaged in a course of instruction or treatments, requests the court to retain jurisdiction until the course has been completed.

(2) "Parent" means a biological mother, an adoptive parent, a man to whom the biological mother was married at the time of conception or birth, or who has been found, by a court of competent jurisdiction, to be the biological father of the juvenile.

(3) "Child maltreatment" means abuse, sexual abuse, neglect, sexual exploitation, or abandonment;

(4) "Abuse" means any of the following acts or omissions by a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the juvenile's welfare:

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

— (A) Extreme and repeated cruelty to juvenile; or

(B) Physical, psychological, or sexual abuse of any juvenile which includes, but is not limited to, intentionally, knowingly, or negligently and without justifiable cause:

(i) Engaging in conduct creating a substantial possibility of death, permanent or temporary disfigurement, illness, impairment of any bodily organ, or an observable and substantial impairment in the intellectual or psychological capacity of the juvenile to function within his normal range of performance and behavior with due regard to his culture except when the juvenile is being furnished with treatment by spiritual means alone through prayer, in accordance with the tenets and practices of a recognized religious denomination by a duly accredited practitioner thereof in lieu of medical treatment;

(ii) Any nonaccidental physical injury or mental injury; or
(iii) Any injury which is at variance with the history given.

(5) "Sexual abuse" includes solicitation or participation in sexual activity with a juvenile by an adult or person responsible for the care and maintenance of the juvenile. Sexual abuse also includes any offense relating to sexual activity, abuse, or exploitation, including rape and incest, as set out and defined in the Arkansas Criminal Code and amendment thereto, [Section] 5-1-101 et seq.

(6) "Neglect" means those acts or omissions, of a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, custodian, guardian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible under state law for the juvenile's welfare which constitute:

(A) Failure or refusal to prevent the abuse of the juvenile when such person knows or has reasonable cause to know the juvenile is or has been abused;

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

— (B) Failure or refusal to provide the necessary food, clothing, shelter, and education required by law, or medical treatment necessary for the juvenile's well-being, except when the failure or refusal is caused primarily by the financial inability of the person legally responsible and no services for relief have been offered or rejected, or when the juvenile is being furnished with treatment by spiritual means alone through prayer, in accordance with the tenets and practices of a recognized religious denomination by a duly accredited practitioner thereof in lieu of medical treatment;

(C) Failure to take reasonable action to protect the juvenile from abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness where the existence of such condition was know or should have been known;

(D) Failure or irremedial inability to provide for the essential and necessary physical, mental, or emotional needs of the juvenile;

(E) Failure to provide for the juvenile's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care; or

(F) Failure, although able, to assume responsibility for the care and custody of the juvenile or participate in a plan to assume such responsibility.

(7) "Sexual exploitation" means allowing, permitting, or encouraging participation or depiction of the juvenile in prostitution, obscene photographing, filming, or obscenely depicting a juvenile for any use or purpose.

(8) "Abandonment" means the failure of the parent to provide reasonable support and to maintain regular contact with the juvenile through statement or contact, when the failure is accompanied by an intention on the part of the parent to permit the condition to continue for an indefinite period in the future, and failure to support or maintain regular contact with the juvenile without just cause for a period of one (1) year shall constitute a rebuttable presumption of abandonment

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(9) "Caretaker" means a parent, guardian, custodian, foster parent, or any person ten (10) years of age or older who is entrusted with a child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for a child's welfare;

(10) "Severe Maltreatment" means sexual abuse, sexual exploitation, acts or omissions which may or do result in death, abuse involving the use of a deadly weapon as defined by the Arkansas Criminal Code, bone fracture, internal injuries, burns, immersions, suffocation, abandonment, medical diagnosis of failure to thrive, or causing a substantial and observable change in the behavior or demeanor of the child except that a child shall not be considered to be severely maltreated when the child is being furnished with treatment by a spiritual means alone, through prayer, in accordance with the tenants and practices of a recognized religious denomination by a duly accredited practitioner thereof in lieu of medical treatment;

306.5 CONTENT OF TELEPHONED INCIDENT AND ACCIDENT REPORTS

The telephoned incident/accident report will include the following information:

- Full name, age, race and sex of any involved residents.

- Full name, age, race and sex of any involved facility personnel.

- Full name, age, race and sex of any alleged perpetrator.

- Time and location of incident.

- Time and date of the report. The identity of the person the report is given to.

- Name, address and telephone number of the facility Administrator, or, in his/her absence, designee in charge of

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handling the situation.

- Description/summary of the incident.

- Status of the situation at the time the report is made.

306.6 WRITTEN INCIDENT AND ACCIDENT REPORTS

Written reports of all incidents and accidents shall be completed as soon as possible after occurrence. The written incident and accident reports shall be comprised of all information specified in Section 306.5 regarding the content of telephoned incident reports and in Section 306.7 regarding resident follow-up.

All written reports will be promptly reviewed, initialed and dated by the facility Administrator or designee. All reports involving accident/injury to residents will also be reviewed, initialed and dated by the Director of Nursing Services or other facility R.N.

A copy of the written report on all incidents specified in Section 306.1 (Incidents/Occurrences Reportable Within One Hour), including available initial examination and shift notes on involved residents, will be sent to the Office of Long Term Care immediately following the Administrator's/designee's review. Incidents specified in Section 306.2 (Incidents/Occurrences Reportable Within Two Hours) will be submitted if requested by the Office of Long Term Care.

The Administrator/designee will review and track all incident and accident reports and prepare a summary for review by the facility's Quality Assessment and Assurance Committee (refer to Section 306.9) during its quarterly meetings. The purpose of this quarterly review is to identify health and safety hazards.

The written report may be amended and re-submitted at any time circumstances require. In any event, written follow-up reports must be submitted to the Office of Long Term Care in instances whereby the case/incident is not closed; when a significant change in the situation, plan, or outcome occurs; or when necessary or directed by the Office of Long Term Care.

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All written incident and accident reports shall be maintained on file in the facility for a period of five (5) years.

306.7 RESIDENT FOLLOW-UP

- The complete vital signs, including temperature, of any involved residents shall be included in the initial examination of the resident following the incident/accident.

- The condition of any residents involved in the incident shall be addressed on the nurses' notes each shift for a minimum of forty-eight hours.

306.8 OTHER REPORTING REQUIREMENTS

The facility Administrator is also required to make any other reports of incidents, accidents, suspected abuse/neglect, actual and suspected criminal conduct, etc. as required by state and federal laws and regulations.

306.9 QUALITY ASSESSMENT AND ASSURANCE COMMITTEE

Each facility shall maintain a Quality Assessment and Assurance Committee consisting of:

- The Director of Nursing Services;
- A physician designated by the facility; and
- At least three (3) other members of the facility's staff.

The Quality Assessment and Assurance Committee will:

- Meet at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and
- Develop and implement appropriate plans of action to

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

— correct identified quality deficiencies.

Documentation of committee meetings, topics covered, plans of action developed and status of corrections implemented will be maintained in the facility's files.

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PROCEDURES FOR THE TIMELY REVIEW AND INVESTIGATION OF ALLEGATIONS OF NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY BY A NURSE AIDE OR A RESIDENT IN A NURSING FACILITY OR BY ANOTHER INDIVIDUAL USED BY THE FACILITY IN PROVIDING SERVICES TO SUCH A RESIDENT ARE SPECIFIED BELOW:

The State has established statewide toll-free telephone numbers with 24-hour coverage to receive complaints of suspected abuse/neglect to children and adults, including residents of nursing facilities. In addition, Office of Long Term Care (OLTC) staff are available during normal business hours, and are on-call (through a State-wide beeper system) after-hours, to receive incident reports as specified in pages 1 through 11 above. Incidents involving nursing facilities are referred to the Office of Long Term Care and the County Sheriff for investigation. If the alleged victim is a child, the Division of Children and Family Services is also involved in the investigation.

Upon receipt in the OLTC Complaints Section, the complaint report is typed on a standard report form, logged in, reviewed, categorized according to type of complaint (for example, abuse, neglect, resident rights; nursing; medications; etc.), and assigned a priority status according to federal regulations. Any required internal Departmental notifications are also made. These activities are accomplished within a day of the receipt of the complaint. If the complaint involves suspected abuse or neglect, it is also forwarded to the State Attorney General's Office for possible criminal investigation and to the Child

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

and/or Adult Abuse Registry, as appropriate.

Very serious complaints of abuse are immediately telephoned and faxed to the State Attorney General's Office, Medicaid Fraud Unit.

At the time the complaint is received the complainant is told that all complaints are investigated and that an acknowledgment of the receipt of the complaint will be mailed to him/her within a week.

All complaints are investigated. Health Care professionals who have completed training as specified by CMS investigate complaints concerning care and services in nursing facilities. When patient care services are in question the investigator is a Registered Nurse.

The visit to the involved facility is unannounced. Information gathered from the complainant may indicate that the visit should coincide with a particular time of day or week.

The investigators explain the purpose of the visit on entry into the facility. All reasonable care is taken not to divulge the identity of the complainant or resident in question.

The investigators use the appropriate survey report form and interpretative guidelines for the facility to conduct a partial survey focusing on the specific regulatory requirements related to the allegation(s). Appropriate samples of residents, rooms, records, services, etc., are reviewed as necessary to adequately assess compliance with applicable requirements. In cases involving allegations of substandard care, the institution's patterns of care, as well as the care furnished the individual(s) directly involved, is investigated. If, based on this initial assessment or other observations, significant problems are identified, the scope of the review is expanded as necessary.

Following the investigation the complaint status, substantiated or unsubstantiated, is determined and required notifications made. Required reports are prepared and forwarded according to State and federal regulations. If deficiencies are cited, a HCFA 2567 is forwarded to the facility for an appropriate plan of correction. Any subsequent certification actions depend on the nature of any deficiencies cited.

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Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

—2567 is forwarded to the facility for an appropriate plan of correction. Any subsequent certification actions depend on the nature of any deficiencies cited.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

A list of facilities to be surveyed for the month is prepared by the survey scheduler and given to each survey team. Each individual team completes a monthly calendar listing the dates assigned surveys, follow-ups and out-of-compliance visits will be made.

Teams and scheduling staff maintain strict confidentiality regarding the survey schedule. Staff without a need to know do not have access to the survey schedules.

The completed calendars (schedules) are returned to the schedule coordinator who tracks them. A copy is forwarded to the complaint coordinator.

Pharmacy, Life Safety Code and Dietary specialists either enter the facility with the team or approximately three days later. If the specialists do not meet with the team before the team enters they will not go into the facility unless they see the notice posted on the facility door that the survey team is present.

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Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

TRAINING
On-going training is conducted to enhance surveyor skills and increase consistency in the survey process. Training is conducted in specific survey areas such as pressure sores, infection control, trust funds, etc.

ON-SITE REVIEWS
On-site reviews are conducted periodically by supervisors to evaluate surveyor performance in following the survey process and evaluating compliance with state and federal regulations.

LOOK BEHIND REVIEWS
Look behind reviews are conducted periodically in nursing facilities by field supervisors to evaluate surveyor performance. The look behind is conducted the week following the surveyor exit from the facility. The supervisor is on-site at the facility and reviews per direct observations, interviews, and record review at least fifty per cent of the quality of care assessments and environmental quality assessments. Resident interviews are conducted regarding surveyor behavior.

REVIEWERS
Reviewers are employed to review each survey packet for completeness and accuracy. Reviewers evaluate deficiencies based on scope of finding and the severity of finding for the purpose of consistency in deficiency citations. This review results in an evaluation of the adequacy of surveyor documentation to support the deficiencies cited.

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Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

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The State has established statewide toll-free telephone numbers with 24-hour coverage to receive complaints of suspected abuse/neglect to children and adults, including residents of nursing facilities. In addition, Office of Long Term Care (OLTC) staff are available during normal business hours, and are on-call (through a State-wide beeper system) after-hours, to receive incident reports as specified under attachment 4.40-B. Incidents involving nursing facilities are referred to the Office of Long Term Care and the County Sheriff for investigation. If the alleged victim is a child, the Division of Children and Family Services is also involved in the investigation.

Upon receipt in the OLTC Complaints Section, the complaint report is typed on a standard report form, logged in, reviewed, categorized according to type of complaint (for example, abuse, neglect, resident rights; nursing; medications; etc.), and assigned a priority status according to federal regulations. Any required internal Departmental notifications are also made. These activities are accomplished within a day of the receipt of the complaint. If the complaint involves suspected abuse or neglect, it is also forwarded to the State Attorney General's Office for possible criminal investigation and to the Child and/or Adult Abuse Registry, as appropriate.

Very serious complaints of abuse are immediatley telephoned and FAXed to the State Attorney General's Office, Medicaid Fraud Unit.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

At the time the complaint is received the complainant is told that all complaints are investigated and that an acknowledgment of the receipt of a complaint will be mailed to him/her within a week.

All complaints are investigated. Health Care professionals who have completed training as specified by CMS investigate complaints concerning care and services in nursing facilities. When patient care services are in question the investigator is a Registered Nurse.

The visit to the involved facility is unannounced. Information gathered from the complainant may indicate that the visit should coincide with a particular time of day or week.

The investigators explain the purpose of the visit on entry into the facility. All reasonable care is taken not to divulge the identity of the complainant or resident in question.

The investigators use the appropriate survey report form and interpretative guidelines for the facility to conduct a partial survey focusing on the specific regulatory requirements related to the allegation(s). Appropriate samples of residents, rooms, records, services, etc., are reviewed as necessary to adequately assess compliance with applicable requirements. In cases involving allegations of substandard care, the institution's patterns of care, as well as the care furnished the individual(s) directly involved, is investigated. If, based on this initial assessment or other observations, significant problems are identified, the scope of the review is expanded as necessary.

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The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Following the investigation the complaint status, substantiated or unsubstantiated, is determined and required notifications made. Required reports are prepared and forwarded according to State and federal regulations. If deficiencies are cited, a HCFA 2567 is forwarded to the facility for an appropriate plan of correction. Any subsequent certification actions depend on the nature of any deficiencies cited.

The State conducts monitoring visits to facilities based on severity of problems or history of non-compliance.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

Methodology of Compliance Oversight Regarding False Claims Act

The State will ensure an entity's compliance with section 1902(a)(68) of the Act using the following methodology of compliance oversight:

(a) An entity as defined by section 1902(a)(68) of the Act must submit a Certification of Compliance with Employee Education About False Claims Recovery to the **Office of the Medicaid Inspector General (OMIG).**

OMIG will identify the entity or entities covered under 1902(a)(68) of the Act, which covers any entity receiving five million dollars or more for the federal fiscal year (FFY). The state plans to mail out the initial Certification request for calendar years 2007 and 2008 no later than May 31, 2008. The request will explain that compliance is mandatory. Identified entities will have one month (from the date the entity receives the Certification request) to comply with the request for calendar years 2007 and 2008.

The certification will not be specific to a single fiscal year. The certification is an attestation stating that the entity is in compliance with section 1902(a)(68). Following the initial determination for certification, the **OMIG** will review and compile any new information concerning any new entities meeting the threshold requirement for inclusion under this provision by December thirty-first (31) of each year. **OMIG** will then notify each entity of their responsibilities regarding false claims education. Entities will have one month thereafter to comply with the request. **OMIG** will validate the attestation on a sample basis each year. The false claims education requirement will be incorporated into **OMIG's** review program.

(b) This Certification will state that the entity:

(1) Has written policies that include detailed information about the False Claims Act and other provisions named in section 1902(a)(68)(A); and

(2) The policies include:

i. The entity's policies and procedures for detecting and preventing waste, fraud, and abuse; and
ii. A specific discussion of the laws described in the written policies; and
iii. A specific discussion of the rights of employees to be protected as whistleblowers; and

(3) The policies are readily available, in paper or electronic form, to all employees, contractors, or agents.

(4) The false Claims policy must be added to the provider's employee handbook if the provider has such a handbook. Employee handbooks will be reviewed for compliance as part of an audit by **OMIG.**

(5) Review for compliance will begin by **OMIG** staff July 1, 2008.

(c) As part of a **OMIG** Review, the **OMIG** will include additional procedures to ensure compliance with section 1902(a)(68). The procedures will include a review of the entity's written policies according to the terms of the Certification described in paragraph (b).

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Citation 1902(a)(68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries.

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

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health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

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(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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State/Territory: ARKANSAS

Citation
1902(a)(69) of the Act,
P.L. 109-171 (section 6034)

4.43 Cooperation with Medicaid Integrity Program Efforts.

The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

The Medicaid agency assures that it complies with § 1936 of the Act, and with determinations of the Secretary that are entitled to enforcement under 5 U.S.C. §706.

SUPERSEDES: NONE - NEW PAGE

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State/Territory: **ARKANSAS**

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

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Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

__X__ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

NONDISCRIMINATION Revised August 30, 1

Currently approved methods of administration under the civil rights requirements are on file in the Regional Office (submittal 469 dated 11-10-69).

Additional methods of administration will be developed to comply with Section 504 of the Rehabilitation Act of 1973 and the Regulations issued by the Department of Health, Education and Welfare (45 CFR Parts 80 and 84) as Federal guidelines are developed and published for program direction.

STATE Arkansas
DATE RECD 9-13-78
DATE APPD 12-21-78
PCC-11 78-4
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DEPARTMENT OF HUMAN SERVICES

Medical Assistance Program
Manual Of Cost Reimbursement Rules
For
Long Term Care Facilities

(July 1, 1999)
(Last Revised 08/01/2022)

Introduction

This manual is for use by providers, their accountants and the Department of Human Services in determining the allowable and reasonable cost of Long Term Care services furnished to Medicaid recipients. The manual contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Department of Human Services.

The Long Term Care Program is administered by the Division of Medical Services. The program herein adopted is in accordance with Federal Statute in the Social Security Act § 1902 (a) (13) (A) and Public Law 105-33. The applicable Federal Regulations begin at 42 Code of Federal Regulations § 430. Each Long Term Care Facility which has contractually agreed to participate in the Title XIX Program will adopt the procedures set forth in this manual and must file the required cost reports.

As interpretations and changes of this program are made, appropriate revisions of the manual will be furnished to each provider and interested party. Care should be taken to insure that revisions to the manual are promptly inserted.

Questions relating to this program or relating to the interpretation of any of the provisions included in this manual should be addressed to:

Department of Human Services
Division of Medical Services
P. O. Box 1437, Slot **S535**
Little Rock, AR 72203-1437

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Chapter 1 - Principles and Procedures

1-1 General Principles

All Long Term Care Facilities will be reimbursed according to the principles and procedures specified in these regulations. Allowable costs are those costs necessary and reasonable for performance of covered services required by Medicaid recipients.

A facility's direct and indirect allowable costs related to covered services will be considered in the findings and allocation of costs to the Medical Assistance Program for its eligible recipients. Total allowable, reasonable costs after removal of direct Medicare ancillary cost of a facility shall be apportioned on a per resident day basis between third-party payers and other residents so that the share borne by Medicaid under Title XIX is based upon actual services and costs related to Medical Assistance recipients.

Costs included in the per diem rate will be those necessary to be incurred by efficiently and economically operated facilities to comply with all requirements of participation in the Medicaid program.

1-2 Record Keeping

Providers are required to maintain adequate financial records and statistical data for proper determination of costs payable under the program. The cost report is to be based on financial and statistical records maintained by the facility. Cost information must be current, accurate and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, and original evidence of cost (purchase requisitions for supplies, invoices, paid checks, inventories, time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable costs. A provider must make available (within the state) all financial and statistical records to the Department or its representatives for the purpose of determining compliance with the provisions of this program. Providers who find it difficult to provide home office records at the audit or review site can at their option, reimburse the Department for all costs associated with the travel of Department employees or their representatives in accordance with state laws and rules for the reimbursement of travel for state employees.

The Financial and Statistical Report/Cost Report and Schedules sets forth information to be reported. The report must be prepared on the accrual basis of accounting in accordance with instructions for completion of the Cost Report. Government facilities have the option to use the cash basis of accounting for reporting.

All financial and statistical records, including cost reports, must be retained for a period of five years after submission to the Department.

1-3 Activities Not Related to Resident Care

If the provider conducts activities not related to resident care, additional accounts must be added to accommodate those activities.

1-4 Accrual and Cash Basis of Accounting

For non-governmental providers, the Financial and Statistical Report must be filed using information stated on the accrual method of accounting. The Chart of Accounts is designed to be used in a complete accrual accounting system.

Financial information stated on an accrual basis is essential to insure that the proper reimbursement is made to providers. The measurement of the cost of services performed must include all supplies, salaries, services and other expenses incurred, regardless of whether or not those items have been paid.

Many providers will find that the accounting for all transactions on a pure accrual basis may create undue workloads. Also, many providers account for their activities on a strict cash basis and they are satisfied with the management information produced from their existing system. Therefore, in lieu of accounting for all transactions on an accrual basis, the provider may maintain his records on a cash basis during the year and convert to an accrual basis at the beginning and end of the year for reporting purposes.

1-5 Chart of Accounts

The applicable Chart of Accounts shall be used by all Long Term Care Facilities participating in the Title XIX Program. Each Chart of Accounts provides for the basic classifications of all assets, liabilities, income and expense necessary for the preparation of the Cost Report. Providers may take some latitude in assigning account numbers but must maintain the basic Chart of Accounts.

1-6 Cost Reporting Requirements

All providers in operation under a valid Medicaid agreement for long term care services must file a Financial and Statistical Report (commonly referred to as a Cost Report or FSR). In addition to the annual reporting requirement nursing facilities will be required to submit a limited cost report containing direct care cost information for the period January 12, 2001 to June 30, 2001, in order that the direct care per diem can be rebased after this initial period. Nursing facilities that have been newly constructed or a newly enrolled provider that did not previously participate in Medicaid, will be required to prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation. This report is essential in establishing rates for a new provider. If the facility was not certified for Medicaid participation at date of first

opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition. Nursing Facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end the State Fiscal Year unless the cost reporting period would be less than three months of operation. Facilities that change ownership after April 1 of a State Fiscal Year would not submit a cost report from the date of initial operation to the end of the State Fiscal Year. Facilities changing ownership after April 1 of a State Fiscal Year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within **ninety (90)** days after the end of the reporting period. Under **sixteen (**16**)** Bed ICF/IID providers will report cost on a calendar year basis. The cost report will be due within **ninety (**90**)** days of the end of the reporting period. The Arkansas Health Center Nursing Facility and the **sixteen (**16**) bed** and over ICF/IID providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due **within sixty (60) days of the end of the reporting period**. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. **Nursing Facility cost r**eports are to be **electronically submitted through the LTC cost report web application** on or before the applicable due date. **ICF/IID reports are to be delivered, postmarked or electronically uploaded, to the web portal on or before the applicable due date.**

Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section 1-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the **Division of Medical Services** in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than **thirty (**30**)** days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,

2. Working trial balance and related working papers identifying the cost report line each account is included on,

3. Detailed depreciation schedule,

4. Any work papers used to compute adjustments made on the cost report,

5. A copy of any new or amended contracts for management services by a related party, home office or a third party which includes the basis used to allocate the costs to providers of the group and to non-provider activities, if applicable.

6. Copy of new or amended lease agreement if a leased facility.

When it is determined, upon initial review for completeness by the **Division of Medical Services**, that a cost report has been submitted without all required information, providers will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the
request for additional information will be allowed for the provider to submit the additional information. For cost reports which are submitted by an extended due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, the cost report will be subject to the penalty provisions for delinquent submission. An exception exists in the event that the due date (or extended due date when an extension has been granted) comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date (or extended due date if an extension has been granted) of the cost report.

D. Where to Submit

Nursing facility cost reports and additional information should be submitted through the LTC cost report web application. ICF/IID cost reports and additional information may be submitted to the address below or uploaded to the contractor's web portal.

Arkansas Department of Human Services
Division of Medical Services
P. O. Box 1437 - Slot **S535**
Little Rock, AR 72203-1437

E. Amended Cost Reports

Providers can submit amended cost reports to the Department up to **one hundred, eighty (**180**)** days after the close of the cost reporting period.

1-7 Desk Reviews

The Department will review all cost reports to verify that all facilities have submitted reports properly and in compliance with this manual. Providers will be notified in writing of the results of the desk review.

A provider's cost report can be adjusted for any errors or unallowable costs identified on a provider's cost report after the initial desk review has been completed up to the last day of the rate year for which rates are based on the adjusted cost report.

Financial and Statistical Reports, financial records, statistical records, and any other pertinent documents will be analyzed to verify that:

A. Cost reports are complete, accurate, and consistent with previous periods and in compliance with program policy.

B. The allowable costs are necessary, allocable, and reasonable for the performance of covered services required by Medicaid recipients.

C. The costs are authorized and are not prohibited under Federal and State laws and regulations.

D. The costs are accorded consistent treatment through the application of accounting principles and practices appropriate to the circumstances.

E. The costs are related to resident care.

F. The costs and statistics included in the Financial and Statistical Report are accurate and applicable to the current period.

G. The costs are net of all applicable credits.

1-8 Audits of Financial Records

The Department will provide for periodic audits of some or all cost reports and supporting records. The Department may also conduct limited reviews of cost data and/or client statistics reported in the cost reports.

The auditors will issue a report upon completion of each audit or review. The report will reflect cost and statistical information as submitted in the cost report and any adjustments the auditors recommend, such that the information complies with the criteria listed above. All audit reports will state the auditor's opinion as to whether, in all material respects, the cost information reported on the Schedule of Expenses (DHS 750, Form 5 or DOM 400, Form 6) and total actual resident days reported on the Statistical Data Schedule (DHS

750, Form 2 or DOM 400, Form 3), with audit adjustments, is presented fairly and in compliance with program policy and regulations.

1-9 Unauditable Situations

If a facility is unable or unwilling to provide necessary documentation to support the financial or statistical records contained in their cost report, the auditors will issue a "disclaimer" report signifying that the audit could not be accomplished. The Office of Long Term Care will advise the facility of the disclaimer in writing. A period of 90 days from the date of the letter of notification will be allowed to permit the facility to accumulate necessary documentation. A follow-up audit will be attempted upon expiration of the 90 day period or sooner if requested by the facility. If the audit can not be completed on the second attempt, the facility will be advised, in writing, that their agreement to participate in the Medicaid program will be terminated effective immediately. A period of 30 days from the date of such notification will be allowed to permit the orderly relocation of Medicaid recipients. The appeals procedures specified in Section 1-10 of this Manual are available to providers.

1-10 Appeal Procedures

A. Time Limit for Appeals

1. Any Long-Term Care Facility may appeal the facility's reimbursement rate, by submitting a written notice of appeal to the Director of the Department of Human Services within sixty-five (65) calendar days following the date of the notice from DHS regarding a final reimbursement rate. The appeal must clearly state the basis for appeal and must be accompanied by supporting documentation. If the facility wishes to utilize the "MEDIATION PROCESS" as contained in this section, it must so state in its written Notice of Appeal.

2. If an appeal is filed, the DHS Director or designee will appoint an independent hearing officer to hear the appeal. The hearing officer will schedule all appeals within sixty (60) calendar days of receipt of written notice of appeal by the Division and will notify the parties in writing of the hearing schedule. If the appealing facility states in its written Notice of Appeal that it wishes to utilize the "MEDIATION PROCESS" and the department agrees, then the time for the DHS Director or designee to appoint a Hearing Officer is waived. The appealing facility and the DHS Director or designee shall implement the mediation process within the sixty (60) days. Upon the termination of the mediation process, if any dispute stated in the notice of appeal remains unresolved,

the DHS Director or his designee will appoint the Independent Hearing Officer within sixty days of the termination. The hearing officer will set a discovery schedule if requested by either party. Either party may request a continuance for good cause. The hearing officer may grant a continuance for good cause upon motion of either party or on the hearing officer's own motion. The hearing officer will render a written decision within 30 days of the hearing and furnish a copy of the decision to the parties or their representatives.

Any objection requesting disqualification of the hearing officer upon allegations of personal interest or bias must be made in writing, supported by good faith affidavit, and submitted to the DHS Director at least fifteen days before the scheduled hearing. The DHS Director will consider the objection promptly and rule on it in a timely manner.

B. Administration of Appeal

1. The appellant may be present at the hearing, may be represented by counsel, and may call witnesses. DHS may appear by such officials as the Division may deem necessary, may be represented by counsel, and may call witnesses.

2. All testimony shall be under oath. Each party shall have the right to call and examine parties and witnesses; to introduce exhibits; to question opposing witnesses and parties on any matter relevant to the issue; and to rebut opposing evidence. The appellant shall have the burden of proving whatever facts it must establish to sustain its position by a preponderance of the evidence.

3. The Hearing Officer shall conduct himself in an impartial manner, and may question any party or witness at any time during the hearing.

C. Decisions

1. All decisions rendered shall be submitted by the Hearing Officer in writing to the Director, DHS, for his review and final determination. At his discretion and for good cause the Director shall have the right to reverse a Decision, or to return the issue to the Hearing Officer for further consideration or additional findings of law or fact. All decisions by the Hearing Officer and the Director shall contain findings of fact and law in accordance with applicable State and Federal laws and regulations. The final decision shall be rendered in writing to the appellant.

D. Mediation Process

1. If a long term care facility in its written Notice of Appeal states it desires to utilize the mediation process in attempt to resolve the dispute(s) between the facility and the DHS as stated in the notice of appeal, and the DHS agrees to the mediation process, then mediation shall be utilized to clarify, narrow or resolve the dispute(s). The DHS shall maintain a list of mediators supplied by the Arkansas Commission on Alternative Dispute Resolution Commission. The objective of the mediation process is to help each side in the dispute(s) understand the other's point of view, with a goal of narrowing, clarifying, or resolving issues in dispute. If the dispute(s) is/are resolved as a result of mediation, then a written statement signed by both parties will be filed with the DHS Director or his designee, shall substitute for a decision in the case, and shall not be appealable.

2. The Chief Counsel's Office of the Department of Human Services shall submit a list of available mediators from which a mediator agreed to by both parties will be selected. The mediator shall restrict his discussions to the designated representatives of the appealing facility and the designated representative of the Department. Designated representatives include each party's attorneys. The mediation shall not bind the parties. The mediation shall not add anything to the record except a final written agreement. The parties may add to the record, but only to the extent they both agree. The mediation shall not unduly delay the process of a case. Time limits for appointing a Hearing Officer and a decision shall be temporarily suspended during the mediation. The mediator shall insure the parties are continuing to work towards resolution of the dispute. The negotiations shall be confidential and shall not be communicated to any decision makers who may serve as future Hearing Officers. If the mediation fails to produce and agreement, or if mediation is not proceeding toward resolving the dispute, then the mediator or either party may so notify the DHS Director or his designee. The DHS Director or his designee will terminate the mediationm whereupon the appeal will proceed as outlined in this Section.

3. The appealing facility and the Department of Human Services shall equally share the cost of the mediator's fee.

1-11 Penalties for Failure to Comply with the Medicaid Long Term Care Program

A. By agreeing to participate in the Long Term Care program, providers must abide by these regulations. Participation in the program may be terminated should the provider:

1. Fail to keep and maintain auditable records.

2. Fail to disclose or make available to the Department, or its authorized agent, records concerning the operation of the facility, including home office records, if applicable.

3. Breach the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider's certifications set out on the Medicaid claim form.

4. Charge or attempt to charge Medicaid recipients for Medicaid covered services over and above that paid by the Department.

5. Rebate or accept a fee or portion of a fee or charge for a Medicaid resident referral.

6. Present, or cause to be presented, false information.

7. Submit, or cause to be submitted, false information for the purpose of obtaining greater compensation to which the provider is legally entitled.

In addition to the above listing of causes for termination, State or Federal laws or rules may create requirements, the violation of which may cause adverse action.

B. Arkansas Code 20-10-205 classifies violations relating to the administration of Long Term Care Facilities. Administrative and reporting requirements are classified as Class C and Class D Violations. A description of each follows:

Class C Violations: Providers who fail to comply with administrative and reporting requirements that do not directly threaten the health, safety, or welfare of a resident have committed a Class C Violation. Violations of this nature would include but are not limited to:

1. Failure to provide resident assessment instruments in accordance with the prescribed submission policy. The resident assessment instrument must be complete to be considered submitted.

2. Failure to maintain accurate census records in accordance with this Manual.

3. Failure to maintain accurate resident trust fund records in accordance with this Manual.

4. Submission on the facility's Cost Report as allowable, costs determined by the DHS audit staff to have been claimed under circumstances identical in all material respects to costs that have been disallowed by final desk review or audit. A desk review or audit is final if no timely appeal has been filed, or, if a timely appeal has been filed, there is a final appeal decision disallowing the cost. An appeal decision is final if no additional appeal is provided for by law, or if the time to file an additional appeal has expired. Any facility submitting as allowable costs, costs previously disallowed by a desk review or audit decision that is not final must identify each such cost and reference the pending appeal.

Class C Violations are subject to a civil money penalty to be set by the DHS Director or his designee, in an amount not to exceed five hundred dollars ($500.00) for a single violation. A single erroneous administrative or reporting practice will be considered a single violation regardless of the number of resident records affected by the practice.

Class D Violation: Failure to timely submit the Cost Report for Long Term Care Facilities. Cost Reports must be postmarked on or before the due date or the extended due date in order to avoid a penalty. The failure to timely submit a cost report shall be considered a separate Class D Violation during any month or part thereof of non-compliance.

Class D Violations are subject to a civil money penalty to be set by the Director, DHS, or his designee, in an amount not to exceed two hundred fifty dollars ($250.00) for each violation.

In addition to any civil money penalty which may be imposed, the Director of the OLTC is authorized after the first month of a Class D Violation to withhold any further reimbursement to the Long Term Care Facility until the Cost Report is received by the Office of Long Term Care.

Any violation repeated within six months subjects the facility to double civil money penalties up to a maximum of one thousand dollars ($1,000.00) per violation.

Assessment of civil money penalties does not limit the right of the OLTC to take such other action as may be authorized by law or regulation.

Providers violating this section may be referred to the Attorney General's office.

1-12 Overpayments and Underpayments

Administrative errors on the part of the Division or the Facilities may result in erroneous payments. These errors most commonly result from: failures to report a death, discharge, or transfer; system error in resident classification; and miscalculations of recipient incomes. Overpayments/Underpayments resulting from these errors will be corrected when discovered. Overpayments will be recouped by the Division and underpayments will be reimbursed to the Facility.

Chapter 2 - Payment Method

Federal law requires that states use published payment methodologies and justifications which specify comprehensively the methods and standards for making Medicaid provider payments to long term care facilities.

2-1 Assurance of Payment

Certified Title XIX Long Term Care Facilities furnishing services in accordance with all state and federal Medicaid laws and rules will be paid in accordance with rates established under the state Medicaid plan.

2-2 Acceptance of Payment

Participation in the Title XIX Program is limited to those Facilities which agree to accept the Medicaid payment as payment in full for all care services provided to Medicaid recipients.

2-3 Rate Limitations Based on Medicaid Rates

The purpose of this provision is to assure that the Medicaid program is not charged unfairly high rates as compared to other payers. To that end, Medicaid reimbursement is limited by the weighted average per diem rates charged to other payers. Specifically if a long-term care facility charges other long-term care payers less than 80% of the Medicaid rate for long-term care services, (except for those public facilities rendering long-term care services free of charge or at a nominal charge) then the weighted average Medicaid reimbursement will be reduced to no more than 125% of the facility's weighted average reimbursement. For purposes of applying this rule: (1) Weighted average per diem rates for other payers will be compared to the weighted average Medicaid per diem rates by fiscal year; (2) The 60 consecutive days after a Medicaid rate increase shall not be considered; and (3) No facility shall be required to make a retroactive rate adjustment.

2-4 Facility Class

The Department has established the following specific payment methods:

A. Nursing Facilities

1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four **(4)** major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four **(4)** separate components of cost: Direct Care, Indirect, Administrative and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative, and operating class rate. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a ceiling.

The ceiling shall be established at **one hundred five percent (**105%**)** of the allowable Medicaid direct care cost per diem incurred by the facility at the **ninetieth (**$90^{th)}$ percentile of arrayed Medicaid direct care facility cost.

The direct care component of the rate will rebase annually for the period July 1st to June 30th. An inflation index **(see Section A. 6.)** will be applied to the provider's direct care per diem cost to inflate cost from the cost reporting period to the rate period.

B. Indirect, Administrative, and Operating

The per diem payment for this component will be set at **one hundred ten percent (**110%**)** of the median indirect, administrative, and operating per diem cost adjusted for inflation using the inflation index (see Section A. **6**.) and paid as a class rate to all facilities. This per diem payment will be rebased **annually**.

C. Fair Market Rental

A fair rental system will be used to reimburse property costs. The fair rental system reduces the wide disparity in the cost of property payments for basically the same service therefore making this payment fairer to all participants in the program. The fair market rental system will be used in lieu of actual cost and/or lease payments on land, buildings, fixed equipment, and major movable equipment used in providing resident care. The fair rental payment for facilities that are leased from a related party will be calculated from the costs associated with the related party in conformity with related party regulations.

The payment for provider property cost will be calculated annually by adding the return on equity, facility rental factor, and the cost of ownership, and dividing the sum of these three components by the greater of the actual resident days or resident days calculated at the following occupancy levels. **The minimum occupancy percentage for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year shall be sixty percent (60%). Thereafter, the minimum occupancy percentage shall increase as indicted in the following table, up to a maximum of seventy-five percent (75%).**

Cost Report Period	Rate Period	% Occupancy
SFY 2022	**SFY 2023**	**60%**
SFY 2023	**SFY 2024**	**65%**
SFY 2024	**SFY 2025**	**70%**
SFY 2025	**SFY 2026**	**70%**
SFY 2026 & after	**SFY 2027 & after**	**75%**

Resident days at the minimum occupancy level are calculated as: *Total Licensed Beds x Number of Days in the Period x Minimum Occupancy Percentage.*

1. Return on Equity

   The return on equity portion of the fair market rental payment will be calculated by taking the Current Asset Value (CAV) of a facility less the ending loan balance on any loans used to finance fixed assets or major movable equipment, times the sum of the **average Moody's Seasoned Baa Corporate Bond Yield for the month of June in the applicable cost reporting period** plus **one and a half percent (**1.5%**)** as a risk premium. For purposes of calculating return on equity and determining allowable interest expense, allowable debt cannot exceed the facilities Current Asset Value. The maximum rate used for calculating return on equity will be **ten percent (**10%**)**.

   The Current Asset Value (CAV) of a facility is calculated by multiplying the number of beds in a facility by the Per Bed Valuation (PBV) less an aging index of **one percent (**1%**)** for each year of age, not to exceed a **fifty percent (**50%**)** reduction in PBV. A facility will be considered new the cost reporting period in which the facility is licensed. A facility will be considered one year old the following cost reporting period. The CAV of a facility will be recalculated and an appropriate adjustment to the per diem will be made when additional beds are placed in operation.

   Beginning with the CY 2023 rate year and based on the Base PBV for the SFY cost reporting period, the PBV methodology shall differentially apply PBV amounts according to the class of resident room where a licensed bed is located.

Class A Resident Room	
Criteria for Class A Room	**PBV Applicable to Each Licensed Bed in a Class A Room**
A private, single occupancy resident bedroom. Maximum of one licensed bed per room. Each Class A private room shall have an attached private bathroom, or an attached private bathroom shared with one adjoining private resident room. A Class A room must meet minimum space and other standards for private rooms and attached private bathrooms as set in Department regulations for a licensed SNF.	Base PBV (full PBV) for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year is $196,977. Updated annually as Base PBV is updated for increases in the construction index.
Class B Resident Room	
Criteria for Class B Room	**PBV Applicable to Each Licensed Bed in a Class B Room**
A semi-private, double occupancy resident bedroom. Maximum of two licensed beds per Class B room. Each Class B room shall have an attached private bathroom, or an attached private bathroom shared with one adjoining private or semi-private resident room. A Class B room must meet minimum space and other standards for semi-private rooms and attached private bathrooms as set in Department regulations for a licensed SNF.	Base PBV (full PBV) for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year is $140,594. Updated annually as Base PBV is updated for increases in the construction index.

Class C Resident Room	
Criteria for Class C Room	**PBV Applicable to Each Licensed Bed in a Class C Room**
A Class C room is any resident room that does not meet the criteria for a Class A room or Class B room. Maximum of two licensed beds per Class C room. For example, a Class C room includes any private or semi-private room lacking an attached private bathroom or where the occupants otherwise must rely on a communal bathroom(s) for toileting.	Fixed at the Per Bed Value in effect on June 30, 2022, with no annual update thereafter for the construction index.

The PBV will be adjusted annually thereafter to reflect changes in construction costs as indicated per the **Core Logic** Marshall **& Swift** Valuation Service. A percentage increase will be calculated by dividing the difference between the Comparative Cost Multipliers construction index for Little Rock, Arkansas, for the quarter ending January of the cost reporting period and January of the previous year. The annual adjustment percentage will be the lessor of the percentage as calculated above for building classes:1) Masonry Bearing Walls, 2) Wood Frame, or **five percent (5%)**.

Every five (5) years, the Division shall analyze and compare the annual updates made using the construction cost index and the actual total cost (including physical plant, fixed equipment, land acquisitions and land improvements) of new SNF construction in Arkansas during the same period. The Division shall rebase the base PBV if actual construction costs increased more than estimated by the construction index.

2. Facility Rental Factor

A facility rental factor will be paid for each facility. The rental factor is calculated by multiplying the CAV of the facility by **two and a half percent (**2.5%**)**.

3. Cost of Ownership

   The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums (including professional liability and property) as identified on the facility's cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in Section 3-2 J. 9.

4. Minor Equipment Purchases

   The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of **less than two thousand five hundred dollars ($2,500).** Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used **(i.e., direct care cost component or indirect, administrative, and operating component)**.

5. Renovations

   The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

Adjustments to the aging index will be rounded to a whole percentage. Percentages greater than or equal to .5 will be rounded up. Percentages less than .5 will be rounded down. A facility wishing to do major renovation to their facility must submit a plan for renovation to the Department of Human Services for review and approval to facilitate an adjustment to the provider's aging index. The duration of the renovation plan cannot exceed a three-year period. The plan shall include a detailed description of the renovation to be done along with the cost of the renovation. The Department will determine if the proposed renovation meets the requirements for major renovation.

The Department will approve or disapprove the renovation project within thirty days of receipt. The provider will then submit a detailed description of the actual work performed and a statement of the actual cost of the renovation upon completion of the project. Renovations that were not completed in compliance with the plan for renovation will not be considered. The Department will notify the provider of the adjustment to the facility aging index as a result of the major renovation. Under no circumstances will the aging index be reduced to less than zero.

6. Aging Index
   Age of provider beds for purposes of calculating the aging index were taken from surveys provided by the Arkansas Health Care Association as prepared by providers. The provider is responsible for the accuracy of the information provided. The provider may at any time be required to provide records validating this information. The aging index is subject to adjustment based upon review or audit.

D. Quality Assurance Fee

Act 635 of 2001 established the levy of a quality assurance fee on nursing facilities. The reimbursement rate paid nursing facilities will include a Quality Assurance Fee component. The Quality Assurance Fee component will be reimbursed at the amount established as the multiplier as defined in Act 635 for the date of service billed.

E. Emergency Generators

Act 1602 of 2001 requires nursing facilities to own and maintain emergency generators. This establishes an add-on payment for installing emergency generators applicable only to first time emergency generators installed in order to comply with act 1602 of 2001. Facilities that do not meet the requirement of existing facility as defined in Act 1602 will not receive any add-on payment

in addition to the facility's fair market rental payment. Add-on payments shall be made only for the periods that depreciation or lease expense for the cost of first time generator installations is allowable.

Facilities will be required to submit copies of invoices indicating generator cost and a copy of the financing arrangement if any for the emergency generator installation or a copy of the generator operating lease if any. Facilities that fail to provide this information by December 1, 2002 will not be paid the add-on for thirty days past the date of submission. Should the financing arrangement on the emergency generator change during the add-on period; the facility must provide revised financing information that will be used to calculate the add-on for the following calendar year.

Facilities will be paid an add-on to their per diems for installing emergency generators. The add-on payment will begin January 1, 2003 and will be adjusted each January 1 for the period the add-on is applicable. Using cost information supplied by the facility, the add-on will be calculated by dividing the sum of projected yearly depreciation and projected yearly interest expense or projected yearly lease expense by the greater of the actual resident days from the previous cost reporting period or resident days calculated at the minimum occupancy levels identified in section 2-4 A. 1. C. Fair Market Rental.

Depreciation will be calculated using the straight-line method assuming a useful life of ten years. Interest expense will be allowable and included in the add-on for emergency generators for a maximum period of five years. Interest expense and the associated debt instrument reimbursed under this provision will not be included in the fair market rental payment or any other component of the rate. Lease expense on emergency generator systems will only be allowable for a maximum period of ten years.

Change of ownership does not affect add-on payments. Facilities that change ownership while receiving a generator add-on payment will continue to receive the add-on for the remainder of the allowable period identified above using the original owner's projected expense.

2. Facility Payments – Interim Rates

An interim rate will be established at the beginning of each state fiscal year for each facility. The interim rate will be established by applying the inflation index to the actual per diem rate from the previous rate period. (For the period January 12, 2001 to June 30, 2001, an actual rate will be

calculated from cost reports submitted for the period July 1, 1999 to June 30, 2000. No initial interim rate is necessary because the methodology has been implemented the second half of the rate period and therefore actual rates have been calculated.) The interim rate is necessary to allow time for providers to complete cost reports and allow the Department adequate time to review the cost reports and calculate rates. After the actual per diem calculations occur providers will be paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate will provide for an average payment approximating providers actual per diem.

The following formula will be used to calculate the weighted per diem rate.

{(Actual Per Diem Rate x 12) - (Interim Rate x Months Used)}/ Months Remaining.

3. Provisional Rate

A provisional rate will be paid to a provider who:

A. Constructs a new facility; or
B. Enrolls as a Medicaid provider and has not previously participated in the Medicaid program.

The provisional rate will be established as follows.

A. The Direct Care per diem rate will be established at the inflation adjusted ceiling for that rate period.
B. The Indirect, Administrative, and Operating per diem will be the class rate as established for that rate period.
C. The Fair Market Rental Payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total

cost for all full year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components above by the required minimum occupancy. New facilities that have been constructed will use an occupancy rate of fifty percent when calculating the per diem for this component. Facilities that want to establish their provisional rate assuming a higher percent of occupancy can do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

Facilities who are placed on a provisional rate as detailed above must submit a six month cost report as required in section 1-6 of this manual. The provisional rate will be retroactively adjusted to the per diem calculated in the following manner.

A. The provider's direct care per diem rate will be calculated from the six month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods the applicable rate period will be considered the one that contains the majority of the days included in the six month report.

B. The Indirect, Administrative, and Operating per diem will continue to be the class rate as established in the provisional rate.

C. The amount identified as the sum of the components used in the original calculation (as adjusted for actual cost data if applicable) for the Fair Market Rental Payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that enroll as a Medicaid provider who have not previously participated or fifty percent occupancy for new facilities. After the initial six-month reporting period the Fair Market Rental payment will be calculated using a minimum occupancy factor as required in 2-4 A.1. C., for both new facilities and facilities that were not previously enrolled.

If either the provisional rate or the actual rate calculated from the six month cost report extend from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the direct care per diem. The administrative and operating per diem will be changed to the class rate for the latest rate period. The fair market rental per diem will be adjusted to reflect any change in the PBV for the latest rate period.

4. Rates for Facilities that Change of Ownership

   Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be **reimbursed the previous operator's rate as of the date of the change of ownership. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6.**

5. Terminating Facilities

   Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility.

6. Inflation Index

   For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket **Index as published by the Centers for Medicare and Medicaid Services. The Department will use the Four Quarter Moving Average Percent Change identified for the final quarter of the rate period.**

7. Adjustments to Provider Cost Reports

   Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than

an inquiry for additional information as a result of a desk review for **which provided** within required deadlines will only affect the per diem for that particular provider. Cost component ceilings for applicable cost components and the floor established for direct care will not be adjusted under these circumstances.

8. Cost Components:

For rate setting, facility allowable costs from desk reviewed facility cost reports for an annual period ending June 30, will be identified and grouped as: Direct Care; Indirect, Administrative, & Operating; Property Costs (Identified for informational purposes, the reimbursement rate for property costs will be determined by the Fair Market Rental method as outlined above in Item A. 1. C.); and Quality Assurance Fee.

a. Direct Care Expenses

The following expenses are classified as Direct Care.

Salaries-Aides
Salaries-Medication Assistants
Salaries-LPN's
Salaries-RNs
Salaries-Occupational Therapists
Salaries-Physical Therapists
Salaries-Speech Therapists
Salaries-Other Therapists
Salaries-Rehabilitation Nurse Aide
Salaries-Assistant Director of Nursing
Salaries-Director of Nursing
FICA-Direct Care
Group Health-Direct Care
Pensions-Direct Care
Unemployment Taxes-Direct Care
Uniform Allowance-Direct Care
Worker's Compensation-Direct Care
Other Fringe Benefits-Direct Care
Contract-Aides
Contract-Medication Assistants
Contract-LPN's
Contract-RN's
Training-Direct Care
Drugs, Over-the-Counter
Oxygen
Medical Supplies-Direct Care
Contract-Occupational Therapists
Contract-Physical Therapists
Contract-Speech Therapists

Contract-Other Therapists
Therapy Supplies
Consultant Fees-Nursing
Raw Food
Food Supplements
Incontinence Supplies

b. Indirect, Administrative, and Operating

The following expenses are classified as Indirect, Administrative & Operating.

Salaries-Administrator
Salaries-Assistant Administrator
Salaries-Dietary
Salaries-Housekeeping
Salaries-Laundry
Salaries-Maintenance
Salaries-Medical Records
Salaries-Other Administrative
Salaries-Owner or Owner/Administrator
Salaries-Activities
Salaries-Pharmacy
Salaries-Social Services
FICA- Indirect, Administrative, and Operating
Group Health- Indirect, Administrative, and Operating
Pensions- Indirect, Administrative, and Operating
Unemployment Taxes- Indirect, Administrative, and Operating
Uniform Allowance- Indirect, Administrative, and Operating
Worker's Compensation- Indirect, Administrative, and Operating
Other Fringe Benefits- Indirect, Administrative, and Operating
Barber & Beauty Expense-Allowable
Consultant Fees-Activities
Consultant Fees-Medical Director
Consultant Fees-Pharmacy
Consultant Fees-Social Worker
Consultant Fees-Therapists
Medical Transportation
Patient Activities
Supplies-Care Related
Other Care Related Costs
Contract-Dietary
Contract-Housekeeping
Contract-Laundry
Contract-Maintenance
Consultant Fees-Dietician

Consultant Fees-Medical Records
Accounting Fees
Advertising for Labor/Supplies
Amortization Expense-Non-Capital
Bank Service Charges
Board of Directors Fees
Data Processing Fees
Dietary Supplies
Depreciation Expense
Dues
Educational Seminars & Training
Housekeeping Supplies
Interest Expense-Non-Capital
Laundry Supplies
Legal Fees
Linen & Laundry Alternatives
Miscellaneous
Management Fees& Home Office Costs
Office Supplies & Subscriptions
Postage
Repairs & Maintenance
Taxes-Other
Telephone & Communications
Travel
Utilities
Criminal Backgrounds Check
Vehicle Depreciation
Vehicle Interest

c. Property

The following expenses are classified as property.

Insurance-Professional Liability
Amortization Expense-Capital
Depreciation
Interest Expense-Capital
Property Insurance
Property Taxes
Rent-Building
Rent Furniture & Equipment

d. Quality Assurance Fee

8. Non-State Public Nursing Facility Adjustment

~~Effective February 21, 2002, a non-state public nursing facility (that is, a public nursing facility that is not owned or operated by the State of Arkansas) shall qualify for a monthly reimbursement adjustment. The adjustment shall result in total payments to the public nursing facilities that are equal to but not in excess of the total of each individual facility's Medicare-related upper payment limit. The public nursing facility with the greatest number of Medicaid days by date of service from the previous state fiscal year will receive the adjustment. The adjustment shall be calculated as follows:~~

~~Once a year:~~
~~All Minimum Data Set (MDS) submissions for the previous state fiscal year for Medicaid residents by public nursing facility will be processed through the Medicare 44-group RUG classification system to attain the RUG score.~~
~~A report will be generated by facility identifying all prescription drugs, lab and x-ray paid by Medicaid for Medicaid residents. Total cost will be divided by twelve to derive a monthly amount.~~
~~A report will be generated by facility identifying Medicaid resident days for the previous fiscal year. Total days will be divided by twelve to derive a monthly amount.~~

1. ~~Monthly:~~
2. ~~The current Medicare rate associated with each RUG score will be assigned as if the resident were Medicare.~~
3. ~~An average rate will be calculated by facility from all rates determined above.~~
4. ~~The difference in a facility's average Medicare rate and the facility's Medicaid rate is calculated.~~
5. ~~This difference is multiplied by the number of monthly Medicaid resident days.~~
6. ~~The monthly amount of prescription drugs, lab and x-ray charges will be subtracted from the product calculated in step 4 by facility.~~
7. ~~The total UPL amount is the sum of the amounts calculated in step 5.~~
8. ~~Payment shall be made on a monthly basis by the fifteenth of the month.~~

Effective January 1, 2004, the Non-State Public Nursing Facility Adjustment is eliminated.

9. Home Style Facilities

A. Fair Market Rental Payment

Minimum occupancy rules **(as defined in Section 2-4 A. 1. C.)** for calculating the facility fair market rental payment will be calculated and applied separately for beds certified as Home Style. All other policy described in this Cost Manual regarding the calculation of a facility's fair market rental payment is applicable to Home Style Facility beds.

All costs associated with renovating or constructing beds for initial certification as Home Style shall not be considered a renovation as detailed in section 2-4, A. 1. C. 5. of this Cost Manual. Thereafter, Home Style beds are eligible for renovation adjustment as detailed in the Cost Manual.

A nursing facility participating in this program may certify less than **one hundred percent (**100%**)** of its beds as Home Style Facility beds. A facility may have a combination of traditional style nursing facility beds and Home Style Facility beds within a single licensed facility.

B. Cost Reporting

A facility or any part thereof, certified by the Office of Long Term Care as Home Style shall prepare and submit a Financial and Statistical Report/Cost Report. The cost report for Home Style beds will be identified as such by including the words Home Style at the end of the facility name **wherever** used. The cost report must be prepared in accordance with all reimbursement rules and reporting requirements detailed in **the** "Manual of Cost Reimbursement Rules." Combination facilities will be required to complete a separate cost report for both the traditional beds and beds certified as Home Style Facility beds. Whenever possible, costs that can be directly identified to either the traditional or Home Style beds must be included on the appropriate cost report. The department recognizes that certain costs **cannot** be directly identified and benefit both reporting entities. These shared costs

must be allocated between each of the benefiting entities. Any shared cost included in the calculation of the facility's fair market rental payment must be allocated based on the Current Asset Value (CAV). All other shared cost must be allocated based on resident days. The cost report for the Home Style portion of a combination facility will include forms 1, 2, 3, 4, 6, 7, 8, 9, 10, and 16. The cost report for the traditional beds in a combination facility must include all forms. The cost report for traditional beds in a combination facility will include aggregate information (includes both traditional and Home Style) on forms 5, 11, 12, 13, 14, and 15. These forms relate to the overall operation of the facility and cannot be allocated between traditional and Home Style.

The Cost Report for Home Style Beds will be used for the purpose of establishing a per diem rate for the facility's Home Style beds.

Full year cost reports for facilities certified entirely as Home Style Facilities will be included when calculating the direct care ceiling and the median for the indirect, administrative and operating component of the rate during the overall rate setting process. Full year cost reports for combination facilities will be combined into an aggregate per diem cost for both direct care and indirect, administrative and operating, and will be included in the overall rate setting process as well.

C. Staffing

Certified Nurse Assistant's (CNA) utilized in staffing Home Style beds are designated as universal workers within the Home Style concept. The universal worker performs CNA duties, and performs dietary, laundry, housekeeping and other services to meet the needs of residents. CNA duties are considered primary to other duties performed by the CNA, therefore the cost of salaries and fringe benefits for CNA's are considered direct care costs and are appropriately reported in Section 1 of Form 6 on the facility cost report.

D. Rate Setting

With the exceptions detailed above, the per diem rate for beds certified as Home Style beds will be established in the same manner as traditional beds.

B. Intermediate Care Facilities for Individuals with Intellectual Disabilities

1. 16 Bed & Over - State-Operated Facilities:

a. Effective January 1, 1994, the method of reimbursement for ICF/IID state-operated facilities certified as having more than 15 beds will be based on actual cost with provisions for retrospective adjustment semi-annually to ensure reimbursement of actual allowable, reasonable costs. Each facility will have an interim per diem rate established based on the most recent semi-annual cost report. This interim per diem rate will be adjusted retrospectively as a result of actual costs for that semi-annual cost reporting period. Rates established for this facility type shall be changed due to adjustments to the semi-annual cost reports resulting from provider corrections, desk reviews, or audits and will be retrospectively adjusted to the first day of the applicable cost report period. The reimbursement methodology for this type facility will be adjusted by submission of a State Plan amendment as warranted.

b. Provider Fee

Act 433 of 2009 established the levy of a provider fee on Intermediate Care Facilities for Individuals with Developmental Disabilities. The reimbursement rate paid 16 Bed & Over – State-Operated Facilities will include a Provider Fee component. The Provider Fee component will be reimbursed at the amount established as the multiplier for the date of service billed.

B. Intermediate Care Facilities for Individuals with Intellectual Disabilities - Continued

2. 16 Bed & Over - Private Facilities:

a. Reimbursement Methodology

Effective with dates of service on or after January 1, 1999, ICF/IID 16 bed and over facilities will be paid a prospective rate based on a combination of actual allowable cost for Direct Care & Care Related costs and a class rate up to a ceiling for Administrative and Operating costs. Effective the beginning of each state fiscal year, rates will be rebased or adjusted for inflation. The Department will in its sole discretion determine whether to rebase the rate or apply an inflationary adjustment.

b. Cost Categories

For rate setting, facility allowable costs from desk reviewed facility cost reports for an annual period determined by the Department, will be identified and grouped as Direct Care & Care Related or Administrative and Operating. Direct Care & Care Related include those expenses the facility incurs in providing care directly to the resident. Because these costs most directly affect the quality of care given a resident, the methodology includes as a component the actual allowable cost incurred for Direct Care & Care Related costs.

Administrative and Operating constitute the remainder of facility costs. Costs associated with Administrative and Operating are more directly controllable by the facility. The methodology includes as a component a class rate up to a ceiling to cover the costs for Administrative and Operating.

For rates effective January 1, 1999, desk reviewed facility cost reports for the period 1/1/97 through 6/30/97 and 71/97 through 12/31/97 were combined to establish the base year rates. Rebasing and cost reporting period for rebasing will be at the discretion of the Department. Should the Department decide to rebase, the most currently available desk reviewed cost reports will be used.

c. Rate Setting

Rates will be established in the following manner: An average per diem cost for Administrative and Operating will be calculated for the facility class. This will be accomplished by determining per diem cost for Administration & Operating for each facility by dividing the actual allowable cost for each facility by their total resident days, adding the individual facility per diem costs and dividing by the number of facilities within the facility class. A ceiling for Administrative and Operating will be set at 105% of the average. A facility will be paid at the lesser of the ceiling or their actual per diem cost plus 10% of the amount calculated as 105% of the average. A per diem cost will be calculated for each facility for Direct Care and Care Related costs. The per diem cost will be calculated by dividing the actual allowable cost for each facility by their total resident days. A facility's per diem cost for Direct Care and Care Related cost and Administrative & Operating cost will be combined to get a facility's total per diem. Once the total per diem by facility has been established, these rates will be adjusted for inflation from the base year to the rate year. In years that the rates are not rebased, existing rates will be adjusted for projected inflation. The Department will use the HCFA Input Price Index (market basket) – Nursing Facilities published quarterly for determining appropriate inflation rates. Facility rates will be rebased periodically at the Department's discretion.

d. Provider Fee

Act 433 of 2009 established the levy of a provider fee on Intermediate Care Facilities for Individuals with Developmental Disabilities. The reimbursement rate paid 16 Bed & Over – Private facilities will include a Provider Fee component. The Provider Fee component will be reimbursed at the amount established as the multiplier for the date of service billed.

e. Enhanced Care Add-On

The Department recognizes that the current rate structure limits the providers' ability to invest additional monies for the purpose of improving the quality of care. Additionally the recent increase in the minimum wage (an unfunded federal mandate) will make it difficult for providers to maintain current standards much less improve the quality of care. Therefore the Department will implement an enhanced care add-on in the amount of $10.54 per day. This enhanced payment will provide additional funds for

wage adjustments in the base salaries for new hires and incumbent salaries to address the increase of the federal minimum wage in July 2009. This will also directly increase benefits related to these salary increases such as FICA, LTD, Life insurance, retirement, etc. This add-on will also provide funding for additional initiatives to improve the quality of care. The following list of items identifies these additional initiatives.

1. Enhanced staff resources for staff development, nursing, psychological and other professional personnel
2. Enhanced maintenance cost due to the aging of the facilities
3. Enhanced direct care staff and increase in number of staff to meet increased needs of children with autism and other behavior needs in order to maintain a quality standard of care and insure the health and safety of all children being served
4. Enhanced Technology (Computers, teleconferencing, electronic files, electronic time keeping, etc.
5. Software for client programming, client data bases, billing etc.
6. Security cameras/lighting
7. Other items deemed appropriate in providing enhance care

The Enhanced Care Add-on is paid in addition to the rate components identified in paragraph a. and b. above.

f. Rate Justification

Modeling of this methodology produced estimates that each facility identified as efficient and economic (providers operating at or below the median of arrayed non-direct care costs) would receive payment equaling 100% (plus or minus 5%) of that facility's actual allowable cost. Cost coverage in the aggregate is equal to or less than 100% for ICF/IID facilities.

B. Intermediate Care Facilities for Individuals with Intellectual Disabilities – Continued

3. Under 16 Beds:

a. Small ICF/IID facilities certified as having 15 beds or fewer will be reimbursed on a prospective uniform class rate system. An inflationary adjustment, determined by the Division to be reasonable and adequate, will be applied to the existing rates and will be implemented by State Plan amendment as warranted by analysis of cost report data. Cost reports will be submitted annually for the preceding calendar year (January 1 – December 31) and will be reviewed prior to establishing new rates. The Division has established the per diem rate of $195.43 for dates of service beginning July 4, 2013.

b. Provider Fee

Act 433 of 2009 established the levy of a provider fee on Intermediate Care Facilities for Individuals with Developmental Disabilities. The reimbursement rate paid Under 16 Beds facilities will include a Provider Fee component. The Provider Fee component will be reimbursed at the amount established as the multiplier for the date of service billed.

The Provider Fee component is paid in addition to the rate identified in paragraph a. above.

c. Enhanced Care Add-On

The Department recognizes that the current class rate structure limits the providers' ability to invest additional monies for the purpose of improving the quality of care. Additionally the recent increase in the minimum wage (an unfunded federal mandate) will make it difficult for providers to maintain current standards much less improve the quality of care. Therefore the Department will implement an enhanced care add-on in the amount of $7.02 per day. This enhanced payment will provide additional funds for wage adjustments in the base salaries for new hires and incumbent salaries to address the increase of the federal minimum wage in July 2009. This will also directly increase benefits related to these salary increases such as FICA, LTD, Life insurance, retirement, etc. This add-on will also provide funding for additional initiatives

to improve the quality of care. The following list of items identifies these additional initiatives.

8. Enhanced staff resources for staff development, nursing, psychological and other professional personnel.
9. Enhanced therapy services to meet increasing behavior needs of the aging population being served
10. Enhanced maintenance, housekeeping staff
11. Enhanced direct care staff
12. Generators
13. Enhanced Technology (Computers, teleconferencing, electronic files, electronic time keeping, etc.
14. Software for client programming, client data bases, billing etc.
15. Security cameras/lighting
16. Other items deemed appropriate in providing enhanced care

The Enhanced Care Add-on is paid in addition to the rate components identified in paragraph a. and b. above.

d. Overpayment/Underpayments

Overpayment/underpayments resulting from Section 1-12 administrative errors shall be handled through the vendor payment by recouping overpayments and reimbursing underpayments.

C. SNF & ICF - Special Class – Arkansas Health Center Nursing Facility

1. Reimbursement Methodology

The Arkansas Health Center Nursing Facility will be reimbursed on an actual cost reimbursement system with provisions for retrospective adjustments to ensure reimbursement of actual allowable and reasonable costs. The facility will have an interim per diem rate established based on the most recent semi-annual cost report. This interim per diem rate will be adjusted retrospectively as a result of actual costs for that semi-annual cost reporting period. The per diem will be calculated by dividing actual allowable cost by resident days for the cost reporting period. The per diem rate shall be changed as a result of adjustments to the semi-annual cost reports resulting from provider corrections, desk reviews, or audits, and will be retrospectively adjusted to the first day of the applicable cost report period.

2. Overpayments/Underpayments

Overpayments/underpayments resulting from Section 1-12 administrative errors shall be handled through the vendor payment by recouping overpayments and reimbursing underpayments.

2-5 Mandatory Changes

The Department of Human Services acknowledges that State laws passed by the Arkansas General Assembly and administrative rules promulgated by the Division of Medical Services occasionally require the state's long term care facilities to incur costs which were not incurred prior to the adoption of the law or rule. DHS will assess the impact of newly required costs and, when warranted, seek additional reimbursement through the state and federal executive and legislative agencies. The Division of Medical Services will implement any available additional reimbursement, including appropriate retroactive payments, within the quarter following all necessary approvals, appropriation, and funding.

DHS will inform state and federal agencies proposing new nursing facility mandates of the projected costs, if any, of such mandates. If a proposed mandate would substantially increase costs without attendant state and federal funding, DHS will object to implementing the mandate without corresponding state and federal funding.

Chapter 3 - Allowable Costs

3-1 General Information

A. This chapter sets forth principles for determining the allowable costs for the facilities which:

1. Meet the definition of a Nursing Facility (NF) under 42 CFR Part 483, Subpart B, if licensed and certified as a NF.

2. Meet the definition of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) under 42 CFR Part 483, Subpart I, if licensed and certified as an ICF/IID.

3. Meet certification requirements to participate in the Medicaid program as a NF or ICF/IID.

4. Are primarily engaged in providing to residents:

a) skilled nursing care and related services for residents who require medical or nursing care,

b) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,
or

c) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

B. The Medicare Provider Reimbursement Manual (HCFA Publication 15-1) and the Federal regulations appropriate to the recognition of costs for facilities under the Medicare program are a supplement to this chapter. A facility shall use the Medicare Provider Reimbursement Manual and Federal regulations for the sole purpose of determining the allowability of a specific cost not determinable by reference to this manual. A facility may not use the Medicare Provider Reimbursement Manual or Federal regulations for a cost that is determined to be unallowable in this chapter. A facility may not use the Medicare Provider Reimbursement Manual or Federal regulations to alter the treatment of a cost provided for in this chapter.

C. Generally Accepted Accounting Principles (GAAP) as interpreted in the opinions of the American Institute of Certified Public Accountants (AICPA) and in the statements by the Financial Accounting Standards Board (FASB) are a supplement to this chapter. A facility shall use GAAP for cost issues which are not specifically addressed in this chapter, the Medicare Provider Reimbursement Manual, or Federal regulations. A facility may not use GAAP for a cost that is determined to be unallowable in either this chapter, the Medicare Provider Reimbursement Manual, or Federal regulations. A facility may not use GAAP to alter the treatment of a cost provided for in this chapter, the Medicare Provider Reimbursement Manual, or Federal regulations.

D. Allowable costs must be reported on a full accrual basis of accounting. If a facility maintains its internal records on a basis other than the accrual method, it will be necessary to convert to the accrual basis for cost reporting purposes. This does not apply to State owned facilities.

E. The Arkansas Department of Human Services (DHS) defines allowable and unallowable costs to identify expenses which are reasonable and necessary to provide recipient care to Medicaid recipients by an economical and efficient provider. The primary objective of the cost reporting process is to provide adequate data for the determination of fair and reasonable reimbursement rates to providers. To achieve that objective, DHS compiles a rate base consisting, if possible, only of allowable cost information. If DHS classifies a particular type of expense as unallowable for purposes of compiling a rate base, it does not mean that individual providers may not make expenditures of this type.

F. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

1. Allowable costs — Those expenses that are reasonable and necessary in the normal conduct of operations to provide recipient care in a facility.

a) Reasonable refers to the amount expended. The test of reasonableness is that the amount expended does not exceed the cost which would be incurred by a prudent business operator seeking to contain costs.

b) Necessary costs are those costs essential:

(1) to operate a long term care facility and deliver long term care in conformity with applicable federal, state, and local laws, rules, ordinances, and codes; and

(2) to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.

c) Normal conduct of operations relating to recipient care refers to otherwise allowable costs that include, but are not limited to, the following:

(1) expenses for facilities, materials, supplies, or services used by a facility solely for providing longterm recipient care. Whenever otherwise allowable costs are attributable partially to personal or other business interests and partially to facility recipient care, the latter portion may be allowed on a pro rata basis if the basis for allocation of expense for recipient care purposes is well-documented. This documentation includes the allocation methodology and appropriate logs necessary to support amount attributed to recipient care;

(2) allowable costs which result from arms-length transactions involving unrelated parties. In transactions involving related organizations, the allowable cost to the facility is the cost to the related party. Allowable costs in this regard are limited to the lesser of the actual purchase price to the related party, or usual and customary charges for comparable goods or services.

d) Allowable costs must be reported net of any applicable returns, allowances, discounts, and refunds.

2. Costs of Related Organizations — Costs for services or supplies furnished to the facility by related organizations are allowable at the cost to the related party to the extent that they are reasonable and necessary in the normal conduct of operations relating to recipient care in a facility and **do not exceed** those costs incurred by a prudent buyer. **Providers should treat the cost incurred by the related party as if they were incurred by the provider itself. Providers must supply a detail income statement from the related party entity so the proper cost report classification can be determined. If the cost to the related party would be classified as a direct care cost by the nursing facility, then the related cost must be claimed on a direct care line on the cost report. If the cost to related party would be classified as an indirect, administrative, and operating cost by the nursing facility, then the related party cost must be claimed on an indirect, administrative, and operating cost report line. If the cost to related party would be classified as a property cost by the nursing facility, then the related party cost must be claimed on a property cost report line.** Expenses for transactions with related

organizations should not exceed expenses for like items in arms' length transactions with other non-related organizations.

a) Related Organization — A related organization (includes individuals, partnerships, corporations, etc.) is one where the provider is associated or affiliated with, has common ownership, control, or common board members, or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

b) Common ownership — Common ownership exists when an entity, individual or individuals possess 5% or more ownership or equity in the provider and the institution or organization serving the provider.

c) Control — Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

d) Immediate Family Relationship - Immediate family members are related parties. Immediate family members include husband/wife, natural parent, child, sibling, adoptive child and adoptive parent, step-parent, step-child, step-sibling, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent, and grandchild.

e) Exception - An exception to the general rule applicable to related organizations exists where large quantities of goods and services are furnished to the general public by the related organization and sales to the facility represent no more than five percent of the gross receipts of the related organization. The facility must demonstrate to the satisfaction of the Department that all of the following criteria are met:

(1) The supplying organization is a bona fide separate organization;

(2) A substantial part of the supplying organization's business activity with the facility is transacted with other organizations not related to the facility and the supplier by common ownership and there is an open, competitive market for the type of services, supplies or facilities furnished by the organization;

(3) The services, supplies, or facilities are those commonly obtained by facilities from other organizations and are a necessary element of resident care.

(4) The charge to the facility is no more than the charge for such services, supplies, or facilities in the open, competitive market, and no more than the charge made by the organization, under comparable circumstances, to other customers for such services, supplies, or facilities.

f) The facility must furnish to the Department adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies, services, or facilities furnished to the facility. Such documentation must include an identification of the organization's total costs, and the basis for allocating direct and indirect costs to the facility and to other entities served.

g) Limitations on cost for related party transactions will not apply to the sale of one or more nursing facilities by a person to that person's child or children for money equal to the fair market value of the facility or facilities. All other regulations relating to the sale of a facility will apply.

3. Unallowable Costs — Those expenses that are not reasonable or necessary for the provision of recipient care in a facility, according to the criteria as specified in paragraph (1) of the subsection. Unallowable costs are not included in the rate base used for determining reimbursement rates.

4. Prudent Buyer Concept - Allowable costs may not exceed the cost that a prudent buyer would pay in the open market to obtain products or services.

5. Arms-Length Transaction - A voluntary transaction between a knowledgeable and willing buyer unrelated to the seller, with each acting for his or her own independent self-interest.

3-2 List of Allowable Costs

The following list of allowable costs is not all **inclusive but** serves as a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost. As discussed further in Section 3-4, certain income items will reduce allowable costs and be offset against the appropriate line items for salaries and wages or other service expenses. Except where specific exceptions are noted, the allowability of all costs is subject to the amounts being reasonable and to the other general principles specified in section 3-1 of this chapter.

A. Compensation of facility employees. This includes compensation for only those employees who provide services directly to the recipients or staff of individual facilities in the normal conduct of operations relating to recipient care: certified nurse aides; nurse aides in training; **medication assistants;** licensed practical nurses; graduate practical nurses; registered nurses; graduate nurses; other salaried direct care staff; occupational therapists; physical therapists; speech therapists; other therapists; activities
personnel; assistant director of nursing; director of nursing; pharmacy personnel; social services personnel; administrator; assistant administrator; food service personnel; housekeeping, laundry, and maintenance staff; medical records personnel; other administrative staff; accounting staff; and data processing

personnel. Compensation for employees related to the owners, partners, or stockholders of the facility are subject to the limitation established in Section 3-2 B. following. Compensation includes:

1. wages and salaries;

2. the employer's portion of payroll taxes and other mandatory insurance payments. Federal Insurance Contributions Act (FICA or Social Security), Unemployment Compensation Insurance, Workers' Compensation Insurance premiums and other payments mandated by Workers' Compensation laws, including self insurance payments, and payments direct to hospitals or physicians for treating minor injuries.

3. employee benefits. Employer-paid health, life, accident, and disability insurance for employees; uniform allowance and meals provided to employees as part of an employment contract; contributions to an employee retirement fund; and deferred compensation. The allowable portion of deferred compensation is limited to the dollar amount that an employer contributes during a cost reporting period. The expenses:

   a) must represent a clearly enumerated liability of the employer to individual employees;

   b) must be incurred as a benefit to employees who provide services to the recipients or staff of an individual facility; and

   c) must be offered to all full-time non-probationary employees on a equal basis in accordance with an employee benefit policy established in writing. Employers may offer different fringe benefits to different employee classes. Fringe benefits offered to only certain employees within the same employee class of the facility are considered discriminatory fringe benefits and are not allowable. Employee classes must be reasonably related to employee job duties and may not distinguish between persons similarly situated. Reasonable uniform allowances, and life insurance policies on key personnel as required to obtain a loan from an unrelated party, are exempt from this rule.

B. Compensation of owners, partners, or stockholders. NOTE: These provisions do not apply to corporations whose stock is publicly traded. Compensation will be included as an allowable cost to the extent that it represents reasonable remuneration for managerial, professional, and administrative services related to the operation of the facility and rendered in connection with resident care. Services rendered in connection with resident care include both direct and indirect activities in the provision and supervision of resident care, such as administration,

management, and supervision of the overall institution.

To be included as allowable cost, the compensation shall not exceed 150% of the median wage (excluding non-wage compensation) for comparable positions in facilities that do not have owner operators. Cost Reports from the previous reporting period will be used for setting the ceiling. The HCFA Market Basket projection of inflation will be used to adjust ceilings calculated from the cost reporting period to the rate setting period. Three peer groups will be established for this purpose: 1) Less than 75 licensed beds; 2) 75 to 149 licensed beds; and 3) 150 licensed beds or more. This ceiling is established based on a 40-hour workweek. Owner administrators working less than 40 hours per week must adjust allowable compensation accordingly.

C. Cost of contracted services. This means costs of services defined in 3-1.F.1. procured by contract.

D. Management fees paid to unrelated parties. The department considers management fees paid to unrelated parties as allowable only to the extent that such fees are reasonable and are in accordance with the other general requirements of section 3-1 of this chapter.

E. Management fees paid to related party organizations and other home office overhead expenses. These fees and expenses paid to a related organization may not exceed the actual cost of materials, supplies, or services provided to an individual facility. A facility that is owned, operated, or controlled by other individual(s) or organization(s) may report the allowable portion of costs for materials, supplies, and services provided to that facility. The allowable portion of such costs to a given facility is limited to those expenses that can be attributed to the individual establishment.

1. In multi-facility organizations where the clear separation of costs to individual facilities is not always possible, the allowable portion of actual costs for materials, supplies, and services may be allocated to individual facilities on a pro rata basis. The required allocation method for these costs is a bed day's basis. Providers who wish to use an alternative allocation methodology may do so by obtaining prior written approval from the Director of the Department of Human Services, or the Director’s designee, before implementation. Once a provider has chosen an alternative allocation method, and it has been approved, it must be consistently used in preparing subsequent cost reports.

2. In organizations with multiple levels of management, costs incurred at levels above the individual facility in Arkansas are allowable only if the costs were incurred in the provision of materials, supplies or services used by the facility staff in the conduct of normal operations relating to

recipient care. In addition, the facility will make available immediately upon request adequate documentation to demonstrate that the costs satisfy the following criteria:

a) The expense does not duplicate other expenses.

b) The expense is not incurred for personal or other activities not specifically related to the provision of long term care.

c) The expense does not exceed the amount that a prudent business operator seeking to contain costs would incur.

If at the time of the request, records are in active use or are located in a place which makes immediate access impossible or impractical, the facility must certify that fact in writing and deliver the records within 72 hours of the request.

3. Adequate documentation consists of all materials necessary to demonstrate the relationship of personnel, supplies, and services to the provision of recipient care. These materials may include, but are not limited to, accounting records, invoices, organizational charts, functional job descriptions, other written statements, and direct interviews with staff, as deemed necessary by DHS auditors to perform required tests of allowability.

4. A ceiling is established for compensation of owners, partners or stockholders or employees related to owners, partners, or stockholders, employed by a company managing multiple facilities. That ceiling is calculated as follows: For the first two nursing facilities, the ceiling is set at 150 percent of the median wage for non-related administrators for nursing facilities having 150 or more certified beds as provided in Section 3-2 B. For the third facility, the allowable cost is raised by 20 percent of the ceiling for two facilities. For each of the fourth and fifth facilities, the allowable cost is raised by 10 percent of the ceiling for two facilities. Thereafter, for each additional facility, the allowable cost is raised by 5 percent of the ceiling for two facilities. The total allowable cost for an employee must not exceed 200 percent of the ceiling for two facilities.

F. Cost to Provide routine services. Includes cost that will be incurred in all cost reporting categories. This section of the manual identifies items that are generally considered allowable cost and therefore must by furnished by the facility and does not address the proper category for cost reporting purposes. Please refer to the instructions for completing cost reports and the chart of accounts to assist in determining the classification of these items. (Items appearing in this listing that are required to be capitalized and depreciated as described in other sections of this Cost Manual should be treated accordingly. The cost of items that are rented or

leased must be reported on the cost report as equipment rental). Cost includes but is not limited to:

1. Urological, ostomy, and gastrostomy supplies not billable under Medicare Part B.

2. Intravenous (I.V.) or subcutaneous tray, connecting tubing and needles.

3. General medical supplies stocked on floor in gross supply and distributed in small quantities, including isopropyl alcohol, hydrogen peroxide, applicators, cotton balls, tongue depressors.

4. Items furnished routinely and relatively uniformly to all residents, such as water pitcher, glass and tray, wash basin, emesis basin, denture cups, bedpan, urinal, thermometer, and hospital type resident gowns.

5. First aid supplies, including small bandages, merthiolate, mercurochrome, hydrogen peroxide and ointments for minor cuts and abrasions, etc.

6. Enema supplies, including equipment, solutions and disposable enemas.

7. Douche supplies, including vaginal or perineal irrigation equipment, solutions and disposable douches.

8. Special dressings, including gauze, 4 x 4's ABD pads, surgical and micropore tape, telfa gauze, ace bandages, and cast materials.

9. Administration of oxygen, related equipment and medications including oxygen, oxygen concentrators, cannulas, mask, connecting tubing, IPPB, Pulmo-Aide, nebulizers, humidifiers and related respiratory therapy supplies and equipment.

10. Pressure relieving devices including, air or water mattresses or pads, fleece pads, foam pads and rings.

11. Disposable diapers and other incontinence items used as a means of caring for incontinent residents.

12. Special diets, salt and sugar substitutes, supplemental feedings, special dietary preparation, equipment required for preparing and dispensing tube and oral feedings, special feeding devices.

13. Daily hair grooming/shaving performed by a facility staff member. (Does not include service performed by licensed barber or beautician except as an employee of the facility).

14. Comb, brush, toothbrush, toothpaste, toothettes, lemon glycerin swabs, denture cream, razor, razor blades, soaps and breath fresheners, mouthwashes, deodorants, disposable facial tissues, sanitary napkins, and similar personal hygiene items. Residents who choose not to use the brand furnished by the facility must purchase their own items, and the costs of the items are not allowable costs.

15. Personal laundry services for residents (does not include dry cleaning).

16. Equipment required for dispensing medications, including needles, syringes, paper cups, medicine glasses.

17. Equipment required for simple tests and examinations, including sphygmomanometers, stethoscopes, clinitest, acetist, dextrostix, scales, glycometer.

18. Equipment required by the Arkansas Department of Human Services for licensure which is available for use by all residents. Includes trapeze bars and overhead frames, foot boards, bed rails, cradles, wheelchairs, geriatric chairs, foot stools, adjustable crutches, canes, walkers, bedside commode chairs, hot water bottles or heating pads, ice bags, sand bags, traction equipment.

19. Other equipment required to adequately care for residents including suction machines, connecting tubing, catheters, suture removal trays, airways, infusion arm boards, sun or heat lamps, chest or body restraints, slings.

20. Food and nonalcoholic beverages, dietary and food service supplies, and cooking utensils.

21. Housekeeping supplies, office supplies, and materials and supplies for the operation, maintenance, and repair of buildings, grounds, and equipment.

22. Equipment and supplies to meet the activity needs of residents as required by state and federal regulations including the needs of room bound residents.

G. Drugs.

1. All drugs furnished by a facility must be administered in conformity with a physician's written order or prescription.

2. Over-the-counter drugs (PRN or routine) not covered by the prescription drug program are allowable cost items. These include but are not limited to simple pain relievers, antacids, mouthwashes, simple laxatives and suppositories, simple cough syrups, antidiarrheal medications, insulin and insulin needles (regardless of frequency).

3. Herbal supplements and remedies are not allowable.

H. Cost of specialized rehabilitative services including physical, speech, occupational and mental health, in facilities provided by licensed therapist when such treatment is ordered by a physician. However, these costs will not include the direct cost of services reimbursed by Medicare Part A, Medicare Part B, or other third party payer."

I. Utilities. This includes electricity, natural gas, fuel oil, water, wastewater, garbage collection and telephone. The costs of staff personal calls and individualized resident telephone services including long distance are not allowable.

J. Property and Equipment Expenses. Note: Effective January 12, 2001 the reimbursement methodology for nursing facilities changed to a cost based facility specific rate which included a fair market rental component to reimburse for property and equipment cost in lieu of actual cost and/or lease payments. Allowability (or unallowability) of costs as described below will not affect nursing facility reimbursement rates. Nevertheless, nursing facilities must continue to report costs in the manner described below in order to continue to maintain historic cost records. Actual reimbursement to providers will be made in accordance with the rules established in Section 2-4 A. of this Manual of Cost Reimbursement Rules.

1. Amortization Expense – Costs associated with the origination of a loan allowable under this section will be allowable if amortized over the life of the loan. Costs associated with early retirement of a loan allowable under this section may be allowable. If the amount of the interest plus any unamortized origination fees or prepayment penalties do not exceed the maximum amount of allowable capital interest that would have been allowed had the debt not been paid off, then all of the interest and unamortized costs and other prepayment penalties can be claimed as part of the interest expense for the year. If the unamortized fees and prepayment penalties plus interest exceed the amount that would have been allowed then any excess can be carried forward and claimed for a period of up to five years so long as total interest expense and unamortized fees and prepayment penalties do not exceed the interest amount that would have been allowable under the previous financing arrangement.

2. Depreciation Expense - Depreciation on the facility's buildings, furniture, equipment, leasehold improvements and land improvements.

   Depreciation on capital assets, including assets for normal standby or emergency use in which the facility is the record title holder and which assets are used to provide covered services to Medical Assistance Recipients, will be allowable subject to the following conditions:

a) Generally accepted accounting principles incorporating the straight-line method of depreciation must be used. Accelerated methods of depreciation are not acceptable. Facilities must follow American Hospital Association Guidelines for Depreciation as the basis for calculation of straight-line depreciation. Capitalization is not required for minor equipment costing less than **two thousand five hundred dollars ($2,500) per item**. **Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used (i.e., direct care cost component or indirect, administrative, and operating component).** It is not required to deduct salvage value from the cost of the asset for the purpose of calculating depreciation. Component depreciation for physical structures is not acceptable.

Depreciation expense for the year of acquisition and the year of disposal can be computed by using: (1) the half-year method; or (2) the actual time method.

b) The method and procedure for computing depreciation must be applied from year-to-year on a consistent basis.

c) The assets shall be recorded at cost. Cost during the construction of an asset, such as architectural, consulting, and legal fees, interest, etc., must be capitalized as a part of the cost of the assets. When an asset is acquired by trade in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt

as consideration paid.

d) Leasehold improvements may be depreciated over the asset's useful life or the remaining life of the lease, whichever is less.

e) Losses realized from the reasonable disposal or transfer of depreciable assets are a reported cost. Gains realized from the disposal or transfer of depreciable assets are revenue adjustments to be deducted from depreciation costs.

f) As a basis for reporting depreciation on capital building construction or renovation costs exceeding $500,000, prior approval of the Arkansas Health Services Agency must be secured to meet the requirements of Section 1122 of Federal Social Security Act. If the prior approval is not obtained, no depreciation cost will be allowed for expenditures for such capital building construction or renovation, unless such approval is subsequently received, although operational costs will be considered as a regular expense.

g) Where purchase of a facility or improvements thereto are financed by tax exempt bonds, the acquired property, plant or equipment must be capitalized and depreciated over the life of the asset. The depreciation and not the installment payment is considered an allowable cost. The amortization of interest in accordance with the terms of the bond issue is an allowable cost. Where the principal amount of the bond issue was expended in whole or in part on capital assets which fail to meet the requirements above regarding eligibility for depreciation, the includable depreciation shall be proportionately reduced.

h) Fixed asset records shall be maintained. The records shall include: The depreciation method, a description; the date acquired; cost; depreciable cost; estimated useful life; depreciation for the year and accumulated depreciation. Salvage value is not required to be maintained.

i) A funded depreciation account for future replacement of assets must be maintained for depreciation allowed on assets obtained through federal or state funds or grants, e.g., legacy foundation grant, Hill-Burton grants, etc.

3. Interest expense includes interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the facility's land, buildings and/or furniture and equipment. Intra/Inter Company

transactions should be handled according to Generally Accepted Accounting Principles.

a) To be allowable under the Medicaid Program, interest must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of funds are required, identifiable in the provider's accounting records, related to the reporting period in which costs are incurred, necessary to the operation, maintenance, or acquisition of the provider's facilities, and be incurred for a purpose related to resident care.

b) Allowable interest expense on loans from a related party is limited to the maximum interest rate equal to the Prime Commercial Rate reported by the St. Louis Federal Reserve Bank.

c) Interest applying to mortgages on the property and plant of the facility will be included in allowable costs. Where a provider leases facilities from a related organization and the rental expense paid to the related organization is not allowable as cost, the mortgage interest paid by the related organization is allowable to the provider as cost, as are the other costs of ownership of the leased facility such as property insurance, depreciation, and real estate taxes.

d) Interest incurred at a rate not in excess of what a prudent borrower would have had to pay in the open market existing at the time the loan was made will be recognized. Allowable costs for interest may not exceed limitations set by any state or federal law or the law of the state in which the loan originated. Allowable costs for interest may not include penalties or late charges.

4. Cost of fire and casualty insurance on facility buildings and equipment.

5. Taxes levied on the facility's land, buildings, furniture and equipment.

6. Cost of leasing the facility's real property. The lease must classify as a true operating lease. (Any lease that transfers substantially all of the benefits and risks of ownership should be accounted for as the acquisition of an asset and the incurrence of an obligation by the lessee in accordance with generally accepted accounting principles.)

7. Cost of leasing the facility's furniture and equipment.

8. Sale and leaseback transactions will not be recognized for reimbursement purposes. Only those costs associated with the owner of record prior to the sale and leaseback transaction will be considered for reimbursement.

9. Cost of premiums for insuring the facility against injury and malpractice claims. The allowable insurance premium cost for nursing facilities (excluding Arkansas Health Center) is capped at $2,500 per licensed bed as of the end of the cost reporting period.

K. Transportation costs.

1. The per mile deduction for business travel fixed by the Internal Revenue Service may be claimed for each facility vehicle mile traveled for resident transportation or business use related to resident care, as established by mileage records. The cost of a vehicle provided to a key staff person for his or her use shall be included in the compensation for that individual.

2. If the facility acquires and maintains one or more vehicles designed and equipped to carry more than seven passengers, one or more vehicles equipped to transport residents that require wheelchairs for mobility, or the cost of a vehicle used exclusively for maintenance of the facility for which it is claimed, the facility may opt not to claim the Internal Revenue Service's rate per mile and instead claim reimbursement of the actual vehicle costs to provide resident transportation in that vehicle or vehicles to the extent such costs conform to Internal Revenue Service rules for vehicle business use.

3. The per mile rate allowable by the Arkansas Department of Finance and Administration to reimburse state employees for travel by private aircraft.

L. Business and professional association dues. These dues are limited to associations devoted exclusively to issues of recipient care.

M. Outside training costs. These costs are limited to direct costs (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the recipients or staff of individual facilities. To qualify as an allowable cost, the training must be:

1. located within the State of Arkansas or a contiguous state within 250 miles of the facility; and

2. related to recipient care; and

3. related to the employee's duties in the facility.

N. Costs incurred by members of the facility governing body to attend meetings at the facility or, if the governing body is responsible for more than one facility, at a location central to such facilities. Allowable costs are limited to a maximum of four meetings per calendar or facility fiscal year, are limited to meetings during

which facility management and operations related to resident care constitute the majority of business discussed, and may not exceed the amounts payable to members of state boards pursuant to Ark. Code Ann. ∋25-16-901 and Ark. Code Ann. ∋25-16-902 for travel to and attendance at state board meetings.

O. Interest expense on working capital loans: Working capital is defined as funds borrowed to meet the expenses of daily operations. Working capital interest expense is not allowable on loan amounts up to and including the amount of equity withdrawn from the facility during the six months preceding the working capital loan or during the term of the working capital loan. For purposes of this paragraph, equity withdrawals do not include withdrawals necessary to pay allowable facility salaries or withdrawals necessary to make federal and state tax payments. The allowance for federal and state taxes will be limited to no more than 30 percent of the net income reported on the most recent Form 5.

Amounts paid in excess of allowable salaries will be considered a withdrawal of equity. Net income must be adjusted for salaries in excess of allowable.

No working capital interest will be allowed when the facility has cash on hand equal to or greater than two months' operating expenses.

P. Costs determined by the DHS audit staff to have been claimed under circumstances identical in all material respects to costs that have been allowed by final appeal decision. An appeal decision is final if no additional appeal is provided for by law, or if the time to file an additional appeal has expired.

3-3 List of Unallowable Costs

The following list of unallowable costs is not all inclusive, but rather serves as a general guide and clarifies certain key expense areas. The absence of a particular item does not necessarily mean that it is an allowable cost. Except where specific exceptions are noted, the allowability of all costs is subject to the general principle specified in section 3-1 of this chapter.

A. Compensation in the form of salaries, benefits, or any form of perquisite provided to owners, partners, officers, directors, stockholders, employees, or others who do not provide services necessary to facility operations or recipient care;

B. Personal expenses not related to the provision of long-term recipient care in a facility;

C. Costs for a private duty nurse or sitter;

D. Forms of compensation that are not clearly enumerated as to dollar amount or which represent profit distributions;

E. Management fees paid to a related organization that exceed the actual cost of materials, supplies, or services;

F. Costs of advertising to the general public which are intended to attract residents to the facility (for example: advertising in the yellow pages of the telephone directory exceeding the advertisement that is free with a business line).

The cost of advertising related to classified advertisements for labor and supplies are allowable costs and should be included in the Administrative and Operating Expenses section;

G. Business expenses not related to the care of recipient or necessary for the operation of a long-term care facility. This includes all costs of business investment activities, stockholder and public relations activities, and farm and ranch operations;

H. Political contributions and lobbying expenses including any portion of professional or other association dues or fees which is used for these purposes;

I. Depreciation and amortization of unallowable costs. This includes amounts in excess of those resulting from the straight-line method, capitalized lease expenses in excess of actual lease payments, and amortization of goodwill or any excess above the actual value of physical assets at the time of purchase;

J. Amounts donated to charitable or other organizations;

K. Dues to all types of organizations and associations not related to facility resident care;

L. Entertainment expenses not related to resident care;

M. Cost of radios and television sets used in the residents' rooms, or cost of providing cable TV to residents' rooms;

N. Expense incurred for services provided in a facility but not related to long-term recipient care. This includes meals provided to others than recipients or facility employees as a part of an employment contract, nonmedical rentals, barber and beauty shop operations, canteens and gift shops, and vending machines;

O. Retainers, and honorariums;

P. Fines and penalties for violations of regulations, statutes, and ordinances of all types;

Q. Fund raising and promotional expenses;

R. Interest expenses on loans pertaining to unallowable items. Otherwise allowable interest expense on short-term indebtedness must be reduced or offset by interest income as specified in Section 3-4 of this Chapter;

S. Insurance premiums pertaining to items of unallowable cost;

T. Cost of life insurance on officers and key employees of the facility where the company is the direct or indirect beneficiary. The cost of premiums for term policies on the lives of key officers or employees will be allowable provided that securing such policies was a condition precedent to the provider's obtaining financing to improve resident facilities and when such condition is a customary business practice of the lender. However, these premiums will be considered allowable only to the extent that coverage equals the unpaid principal balance;

U. Costs associated with portions of a facility that are not licensed as a NF or ICF/IID. Costs must be allocated between licensed and unlicensed portions of a facility based upon objective measures;

V. Planning and evaluation expenses for the expansion of an existing facility or for new business opportunities. Expense will be capitalized and amortized on the records of the appropriate facility if actual construction occurs;

W. Costs of motor vehicles, except as allowed in 3-2.K;

X. Values assigned to the services of unpaid workers and volunteers;

Y. Costs of purchases from a related party which exceed the lesser of the original cost to the related party or fair market value;

Z. Out-of-state travel expenses, except as allowed in Section 3-2 M;

AA. Legal and other costs associated with litigation between the provider and the state or federal agencies administering the Medicaid program;

BB. Penalties and insufficient funds charges by banks;

CC. Undocumented cost;

DD. Federal, state, and local income taxes;

EE. Prescription drugs*;*

FF. Accounts receivable written off as uncollectable, including bad debts incurred from private pay residents, Medicare, or Medicaid recipients;

GG. Personal telephone service;

HH. Costs of owning, leasing or operating boats;

II. Costs of chaplaincy training programs;

JJ. Cosmetics;

KK. Barber and beautician services provided by personnel not employed within the facility;

LL. Dry cleaning services for residents.

MM. Salaries, wages, and benefits paid for undocumented or duplicated duties, services, and management activities.

NN. Interest related to the acquisition and retirement of treasury stock is not an allowable cost. Treasury stock is not an asset and should be carried on the balance sheet as a reduction of equity capital. All costs relating to the retirement of stock shall not be considered allowable. Transactions in stock or equity which benefit stockholders, partners, and ownership interest will not be recognized.

OO. Interest expense, finance charges, and service charges on loans, mortgages, and bond issues, where the proceeds of such loans, mortgages, and bond issues are used to acquire stock ownership of additional facilities are not allowable costs.

PP. Interest on proceeds from loans not necessary for facility operations or used for investments are not allowable costs.

3-4 Items That Will Reduce Allowable Costs

A. Interest income on unrestricted funds will reduce interest expense on all short-term debt not to exceed interest expense. Short-term debt will be defined as debt having a term of 48 months or less.

B. Grants, gifts, and income designated by the donor for specific operating expenses must be used as an offset to those specific operating expenses.

C. Recovery of insured loss.

D. The cost of the following items should be eliminated. In lieu of determining and eliminating costs, the related income may be used to offset costs.

1. Income from laundry and linen service.

2. Income from employee and guest meals.

3. Income from the sale of drugs to other than residents.

4. Income from the sale of medical and surgical supplies to other than residents.

5. Income from the sale of medical records and abstracts.

6. Income from space rented to employees and others.

7. Payment received from specialists.

8. Payments received from recipients for items not medically necessary to the recipient; i.e., tobacco, soft drinks, personal items, etc.

E. Rebates and refunds of expenses.

F. Trade, quantity, time, and other discounts on purchases.

3-5 Special Items to Meet Needs of Residents of ICF's/MR and the Arkansas Health Center Nursing Facility

A. In addition to those items listed in Section 3-2, the following items will be allowable costs for ICF's/MR and the Arkansas Health Center Nursing Facility:

1. Central medical supplies
2. Dental Services
3. Drugs and pharmacy
4. Medical services, general physician
5. Therapy: physical, occupational, psychiatric, psychological, and speech
6. All training and habilitation services whether provided in-house or through contractual arrangements (i.e. vocational training, sheltered workshop, or day activity center).

7. Actual costs of use of vehicles will be allowable to the extent that such costs meet the criteria set forth in Section 3-2.K.

B. In addition to the items listed above, the following items are allowable costs for the Arkansas Health Center Nursing Facility:

1. Actual costs of ambulance (escort services)
2. EEG and EKG services
3. Externs (residents serving internships)
4. Radiology

3-6 Direct Provider Payment Not Includable in Allowable Expenses

The direct costs of prescription drugs, physician, dental, dentures, podiatry, eye glasses, appliances, x-rays, laboratory, and any other materials or services for which benefits are offered by direct provider payment plans under Medical Assistance or Medicare Part B, CHAMPUS, Blue Cross-Blue Shield, various other insurers or third-party resources are not allowed.

3-7 Charges to Recipients, Relatives, or Recipient Representatives and Solicitations of Contributions from Medicaid Recipients

Facilities must not charge recipients, relatives, or recipient representatives for any item included in this manual as an allowable cost item. No provider participating in this program can solicit contributions, donations, or gifts directly from Medicaid recipients or family members. See 42 U.S.C. 1302a-7b (D), 42 U.S.C. 1396 (a) (g), 42 U.S.C. 447.15, 42 U.S.C. Part 1001, and 42 U.S.C. 1003.102 (b).

3-8 Point of Care Medication Management Software Applications (POCMM)

Effective November 1, 2007 software applications for medication management employing point of care technology is afforded special treatment for cost reporting periods beginning July 1, 2007. Characteristics of point of care technology include software applications installed on medication carts allowing point of care based medication management. The allowable cost of software and associated hardware (used exclusively for this application) required to operate a point of care software application will be treated as direct care cost for cost reporting purposes. All costs associated with the point of care application must continue to meet all allowable cost principles as defined in Chapter 3 including capitalization requirements. Chapter 4-A and Chapter 4-B of the state Manual of Cost Reimbursement Rules for Long Term Care Facilities dated July 1, 1999 include specific instructions on how these costs will be reported on provider cost reports.

Revisions: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

5.2 [Reserved]

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR Part 432,
Subpart B
AT-78-90

5.3 Training Programs; Subprofessional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

TN # 78-1
Supersedes
TN #

Approval Date 1/20/78 Effective Date 2/27/78

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AT-82-10(BPP)

State ARKANSAS

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

TN # 83-4
Supersedes
TN # 71-20

Approval Date 3/31/83 Effective Date 5/24/82

3/31/83
83-4

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State ARKANSAS

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☒ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☐ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: ARKANSAS

SECTION 7 - GENERAL PROVISIONS

Citation	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APP'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-52
A

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: ARKANSAS

Citation	7.2	Nondiscrimination
45 CFR Parts 80 and 84		In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

TN No. 91-52
Supersedes TN No. 79-03 Approval Date DEC 13 1991 Effective Date OCT - 1 1991

HCFA ID: 7982E

STATE Arkansas
DATE REC'D NOV 21 1991
DATE APPV'D DEC 13 1991
DATE EFF OCT - 1 1991
HCFA 179 91-52
A

Revision: HCFA-PM-91-4 (BPD) OMB No 0938-
1991

State/Territory: ARKANSAS

(RESERVED)

TN No. 92-21
Supersedes TN No. 91-52 Approval Date 5/18/92 Effective Date 4/8/92

HCFA ID: 7982E

STATE Arkansas
DATE REC'D 5-14-92
DATE APPV'D 5-18-92
DATE EFF 4-8-92
HCFA 179 92-21

A

DELEGATION OF AUTHORITY
BY DIRECTOR, DEPARTMENT OF HUMAN SERVICES
TO DIRECTOR, DIVISION OF MEDICAL SERVICES

I hereby delegate to the Director of the Division of Medical Services the authority vested in me to direct and manage the operations of all statewide programs falling within the scope of the Division of Medical Services.

The powers I specifically delegate are the following:

To administer all programs within the exclusive area of the Division of Medical Services.

Within the Division, to appoint personnel to approved positions, to supervise and direct personnel and personnel training, and to receive resignations. This may be subject to review and approved by the Office of the Director.

To plan the operations of the agency.

To represent the Division in liaison, negotiating and contracting with other public organizations within and without the State and with private persons and organizations; and to sign contracts so negotiated, all of which may be subject to review and approval by the Office of the Director as to legal form and as to availability of funds subsequent to the effective date of any contract to be signed.

To approve, and sign as appropriate, all documents and state plan revisions relating to the programs administered by the Division; and issuance of state plan revisions shall be subject to review and approval by the Office of the Director.

To approve, and sign as appropriate, fiscal reports of the Division, all of which may be subject to review and approval by the Office of the Director.

To act as spokesman for the Division in matters within the scope of Division responsibility.

Any or all of the above powers are subject to revocation upon written notice signed by me or by someone duly authorized by me.

Dated: 3/5/11

John Selig, Director
Department of Human Services

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991
Revised: April 1, 2011

State/Territory: ARKANSAS

Citation	7.4 State Governor's Review
42 CFR 430.12(b)	The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

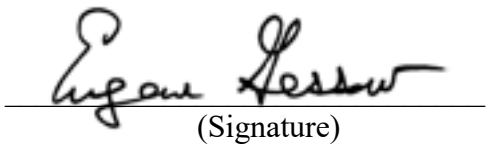
☐ Not applicable. The Governor –

☐ Does not wish to review any plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of Department of Human Services (Designated Single State Agency).

Date: April 4, 2011



(Signature)

Director
Division of Medical Services.
(Title)

MMDL SPA PAGES

State: Arkansas
Date Received: 9/23/13
Date Approved: 12/19/13
Date Effective: 1/1/14
Transmittal Number: 13-14

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies — S10

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size
- ○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☐ Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- ☐ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

Medicaid Eligibility

■ The age used for children with respect to 42 CFR 435.603(f)(3)(i) is:

◉ Age 19

○ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Arkansas
Date Received: 9/23/13
Date Approved: 12/19/13
Date Effective: 1/1/14
Transmittal Number: 13-14

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	97	X
+	2	183	X
+	3	229	X
+	4	270	X
+	5	309	X
+	6	345	X
+	7	378	X
+	8	408	X
+	9	436	X
+	10	441	X

Additional incremental amount
( ) Yes (•) No

Increment amount $

State: Arkansas
Date Received: 9/20/13
Date Approved: 12/10/13
Date Effective: 1/1/14
Transmittal Number: 13-15

The dollar amounts increase automatically each year
( ) Yes (•) No

Medicaid Eligibility

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	81	X
+	2	162	X
+	3	204	X
+	4	247	X
+	5	286	X
+	6	331	X
+	7	373	X
+	8	415	X
+	9	457	X
+	10	457	X

Additional incremental amount

( ) Yes (•) No

Increment amount $

State: Arkansas
Date Received: 9/20/13
Date Approved: 12/10/13
Date Effective: 1/1/14
Transmittal Number: 13-15

The dollar amounts increase automatically each year

( ) Yes (•) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	124	X
+	2	220	X
+	3	276	X
+	4	334	X
+	5	388	X
+	6	448	X
+	7	505	X
+	8	561	X
+	9	618	X
+	10	618	X

Additional incremental amount

○ Yes ◉ No

Increment amount $

State: Arkansas
Date Received: 9/20/13
Date Approved: 12/10/13
Date Effective: 1/1/14
Transmittal Number: 13-15

The dollar amounts increase automatically each year

○ Yes ◉ No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option 513a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

State: Arkansas
Date Received: 9/20/13
Date Approved: 12/10/13
Date Effective: 1/1/14
Transmittal Number: 13-15

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Arkansas
Date Received: 9/20/13
Date Approved: 12/10/13
Date Effective: 1/1/14
Transmittal Number: 13-15

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10.31.2014

Eligibility Groups - Mandatory Coverage Parents and Other Caretaker Relatives	State: Arkansas Date Received: 9/20/13 Date Approved: 12/10/13 Date Effective: 1/1/14 Transmittal Number: 13-15	S25
42 CFR 435.110 1902(a)(10)(A)(i)(I) 1931(b) and (d)		

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income standard

Medicaid Eligibility

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

○ A percentage of the federal poverty level: [ ] %

◉ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ Other dollar amount

■ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

○ Another income standard in-between the minimum and maximum standards allowed

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

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Medicaid Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
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Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19 **S30**

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19 -** Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

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○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 185% FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

○ The maximum income standard

◉ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

The amount of the income standard for infants under one is: 142 % FPL

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

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The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 142 % FPL.

■ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

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○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

◉ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 133% FPL

Enter the amount of the maximum income standard: 142 % FPL

■ Income standard chosen

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The state's income standard used for children age six through eighteen is:

(•) The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

( ) If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

( ) Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

[■] There is no resource test for this eligibility group.

[■] Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

( ) Yes (•) No

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PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
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Eligibility Groups - Mandatory Coverage
Adult Group **S32**

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

(•) Yes ( ) No

[■] **Adult Group** - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] Have attained age 19 but not age 65.

[■] Are not pregnant.

[■] Are not entitled to or enrolled for Part A or B Medicare benefits.

[■] Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

[■] Have household income at or below 133% FPL.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

[■] There is no resource test for this eligibility group.

[■] Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

(•) Under age 19, or

( ) A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

( ) Yes (•) No

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Medicaid Eligibility

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Eligibility Groups - Options for Coverage **Individuals above 133% FPL**	**S50**
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

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Eligibility Groups - Options for Coverage **Optional Coverage of Parents and Other Caretaker Relatives**	**S51**
42 CFR 435.220 1902(a)(10)(A)(ii)(I)	
Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220. ○ Yes ◉ No	

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Medicaid Eligibility

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Eligibility Groups - Options for Coverage **Reasonable Classification of Individuals under Age 21**	**S52**
42 CFR 435.222 1902(a)(10)(A)(ii)(I) 1902(a)(10)(A)(ii)(IV)	
Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

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Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance **S53**

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

( ) Under age 21
( ) Under age 20
( ) Under age 19
(•) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(•) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

( ) Yes (•) No

[■] There is no resource test for this eligibility group.

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Medicaid Eligibility

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Eligibility Groups - Options for Coverage **Optional Targeted Low Income Children**	**S54**
1902(a)(10)(A)(ii)(XIV) 42 CFR 435.229 and 435.4 1905(u)(2)(B)	
Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229. ○ Yes ◉ No	

PRA Disclosure Statement

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Eligibility Groups - Options for Coverage **Individuals with Tuberculosis**	**S55**
1902(a)(10)(A)(ii)(XII) 1902(z)	
Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. ○ Yes ◉ No	

PRA Disclosure Statement

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Eligibility Groups - Options for Coverage **Independent Foster Care Adolescents**	**S57**
42 CFR 435.226 1902(a)(10)(A)(ii)(XVII)	
Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226. ○ Yes ◉ No	

PRA Disclosure Statement

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Eligibility Groups - Options for Coverage **Individuals Eligible for Family Planning Services**	**S59**
1902(a)(10)(A)(ii)(XXI) 42 CFR 435.214	
Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214. ○ Yes ◉ No	

PRA Disclosure Statement

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State: Arkansas
Date Received: 9/20/13
Date Approved: 12/10/13
Date Effective: 1/1/14
Transmittal Number: 13-15

State: Arkansas
Date Received: 9/23/13
Date Approved: 12/20/13
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility **State Residency**	**SSB**

42 CFR 435.403

State Residency

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- ■ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - ■ Intends to reside in the state, including without a fixed address, or
  - ■ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ■ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- ■ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - ■ Residing in the state, with or without a fixed address, or
  - ■ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ■ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - ■ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - ■ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - ■ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- ■ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- ■ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ■ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- ■ IV-E eligible children living in the state, or

Medicaid Eligibility

☒ Otherwise meet the requirements of 42 CFR 435.403.

State: Arkansas
Date Received: 9/23/13
Date Approved: 12/20/13
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

(•) Yes ( ) No

[■] The state has interstate agreements with the following selected states:

[☒] Alabama	[☒] Illinois	[☒] Montana	[☒] Rhode Island
[☒] Alaska	[☒] Indiana	[☒] Nebraska	[☒] South Carolina
[☒] Arizona	[☒] Iowa	[☒] Nevada	[☒] South Dakota
[☒] Arkansas	[☒] Kansas	[☒] New Hampshire	[☒] Tennessee
[☒] California	[☒] Kentucky	[☒] New Jersey	[☒] Texas
[☒] Colorado	[☒] Louisiana	[☒] New Mexico	[☒] Utah
[☒] Connecticut	[☒] Maine	[☐] New York	[☒] Vermont
[☒] Delaware	[☒] Maryland	[☒] North Carolina	[☒] Virginia
[☒] District of Columbia	[☒] Massachusetts	[☒] North Dakota	[☒] Washington
[☒] Florida	[☒] Michigan	[☒] Ohio	[☒] West Virginia
[☒] Georgia	[☒] Minnesota	[☒] Oklahoma	[☒] Wisconsin
[☒] Hawaii	[☒] Mississippi	[☒] Oregon	[☐] Wyoming
[☒] Idaho	[☒] Missouri	[☒] Pennsylvania	

[■] The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- [☒] Are IV-E eligible
- [☐] Are in the state only for the purpose of attending school
- [☐] Are out of the state only for the purpose of attending school
- [☐] Retain addresses in both states
- [☐] Other type of individual

State: Arkansas
Date Received: 9/23/13
Date Approved: 12/20/13
Date Effective: 1/1/14
Transmittal Number: 13-17

The state has a policy related to individuals in the state only to attend school.

(•) Yes ( ) No

Provide a description of the policy:

An individual aged 18-22 and a full-time student at an Arkansas school, is not a resident of Arkansas if: a) Neither parent lives in Arkansas, b) The student is claimed as a tax dependent by someone in a state other than Arkansas, and c) The student is applying on his or her own behalf.

[■] Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

Medicaid Eligibility

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

○ Yes ◉ No

PRA Disclosure Statement

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State: Arkansas
Date Received: 9/23/13
Date Approved: 12/20/13
Date Effective: 1/1/14
Transmittal Number: 13-17

Medicaid Eligibility

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 17 - 0007

Non-Financial Eligibility Citizenship and Non-Citizen Eligibility	S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

State: Arkansas
Date Received: 1 August, 2017
Date Approved: 26 October, 2017
Effective Date: 1 January, 2018
Transmittal Number: 17-007

Citizenship and Non-Citizen Eligibility

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

■ The state provides Medicaid eligibility to otherwise eligible individuals:

■ Who are citizens or nationals of the United States; and

■ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

■ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

◉ Yes ○ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

○ Yes ◉ No

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

◉ Yes ○ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

(•) Yes ( ) No

☒ Pregnant women

☒ Individuals under age 21:

( ) Individuals under age 21

( ) Individuals under age 20

(•) Individuals under age 19

State: Arkansas
Date Received: 1 August, 2017
Date Approved: 26 October, 2017
Effective Date: 1 January, 2018
Transmittal Number: 17-007

■ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

■ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

   ■ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

   ■ Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   ■ Granted employment authorization under 8 CFR 274a.12(c);

   ■ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   ■ Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   ■ Granted Deferred Action status;

   ■ Granted an administrative stay of removal under 8 CFR 241;

   ■ Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

   ■ Has been granted employment authorization; or

   ■ Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

■ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;

■ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

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V.20160722

State: Arkansas
Date Received: 1 August, 2017
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Medicaid Eligibility

State: Arkansas
Date Received: 9/23/13
Date Approved: 12/20/13
Date Effective: 10/1/13
Transmittal Number: 13-19

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements
Eligibility Process — **S94**

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☒ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

State: Arkansas
Date Received: 9/23/13
Date Approved: 12/20/13
Date Effective: 10/1/13
Transmittal Number: 13-19

Indicate the other electronic means below:

	Name of Method	Description	
+	On-line	www.access.arkansas.gov	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

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Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The state relies on monographs developed by its designated utilization management contractor to assess whether a hospital's triage protocols are sufficiently effective to ensure the correct level of treatment is determined. Because emergency department services are part of the overall retrospective review process, if non-emergency services are billed at the higher emergency level incorrectly, the entire service would be recouped and the emergency department could bill Medicaid for the non-emergency level and be paid the amount minus the cost share. They would not be allowed to charge the beneficiary for the cost share because the hospital is responsible for the error in claims processing.

Cost Sharing for Drugs

The state charges cost sharing for drugs.	Yes
The state has established differential cost sharing for preferred and non-preferred drugs.	Yes

- ■ The state identifies which drugs are considered to be non-preferred.
- ☑ The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

Cost sharing requirements are published in the provider manuals and a hyperlink is used to send the provider to the coinciding table housing the amount of the cost share, which is also published on the Arkansas Medicaid Website. Division of Provider Services and Quality Assurance (DPSQA) maintains the Choices in
Living Resource Center, where Arkansas citizens can call for assistance, including telephone information and brochures for the Workers with Disabilities program. Various brochures are available at the DHS website:
https://humanservices.arkansas.gov/, and are distributed throughout the state in the county offices where the

Division of County Operations are housed.

PRA Disclosure Statement

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V.20160722

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Categorically Needy Individuals	G2a
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals.	No

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional): Workers with Disabilities, Interim Alternative Benefits Plan, and Transitional Medicaid

Eligibility Group(s) Included: 1902(a)(10)(A)(ii)(XV); 1902(a)(10)(A)(i)(VIII); and 408(a)(11)(A), 1902(a)(52), 1902(e)(1), 1925, 1931(c)(2)

Incomes Greater than 20% TO Incomes Less than or Equal to

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physician visit (including PCP/specialist/audiologist/podiatrist visit, excluding preventive service	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Other Practitioner Office Visit (Nurse, Physician Assistant)	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Federally Qualified Health Center (FQHC)	4.70	$	Encounter	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rural Health Clinic	4.70	$	Encounter	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Ambulatory Surgical Center	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Chiropractor	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Generics	4.70	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Preferred Brand Drugs	4.70	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Non-Preferred Brand Drugs	9.40	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Specialty Drugs (i.e., High-Cost)	9.40	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	X-rays and Diagnostic Imaging	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Imaging (CT/Pet Scans, MRIs)	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Laboratory Outpatient and Professional Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Allergy Testing	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Non-Emergency Use of the Emergency Department	9.40	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Urgent Care Centers or Facilities	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Durable Medical Equipment	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Prosthetic Devices	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Orthotic Appliances	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Mental/Behavioral Health and SUD Outpatient Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rehabilitative Occupational Therapy	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rehabilitative Speech Therapy	4.70	$	Visit		Remove

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Rehabilitative Physical Therapy	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Outpatient Rehabilitation Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Habilitation Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Outpatient Surgery Physician/Surgical Services	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Chemotherapy	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Radiation	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Infusion Therapy	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Accidental Dental	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Home health Care Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. No

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Add Population

PRA Disclosure Statement

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - ☐ Other procedure

Additional description of procedures used is provided below (optional):

To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

- [x] The MMIS system flags recipients who are exempt
- [ ] The Eligibility and Enrollment System flags recipients who are exempt
- [ ] The Medicaid card indicates if beneficiary is exempt
- [ ] The Eligibility Verification System notifies providers when a beneficiary is exempt
- [ ] Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

- [x] The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

- [x] The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

- [x] Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

The percentage of family income used for the aggregate limit is:

- (•) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

☑ The state calculates family income for the purpose of the aggregate limit on the following basis:

◉ Quarterly

○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

☑ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☐ Other process:

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The DHS eligibility system identifies and sends notice to beneficiaries of the initial aggregate family limit when applicable. The MMIS system sends beneficiary letters regarding incurred cost sharing and when the family limit has been met. The provider is notified via the eligibility verification system and upon explanation of benefits when limit has been met.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

The state uses its standard Medicaid fair hearing process.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The MMIS system stops deducting the cost sharing amount once met. The provider is required to refund any cost sharing it has collected upon notification via MMIS that cost sharing was met.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Beneficiaries may notify their local eligibility office of changes in circumstances adversely affecting their family aggregate limit.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).	No

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

State Name: Arkansas Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Arkansas Newly Eligible Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Mandatory	Remove

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Arkansas will provide access to the Alternative Benefit Plan (ABP) through two mechanisms: premium assistance to support coverage from Qualified Health Plans (QHPs) offered in the individual market and through fee-for-service Medicaid.

Arkansas has received approval under 1115 of the Social Security Act to implement the Arkansas Health and Opportunity For Me (ARHOME) program. Under the ARHOME demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group established under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to support the purchase of coverage from QHPs offered in the individual market through the Marketplace

Arkansas will also offer benefits described in this ABP State Plan Amendment through the fee-for-service delivery system. The State will offer two types of fee for service ABP plans: an ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan and an ABP that covers the Essential Health Benefits provided by QHPs (EHB-equivalent ABP). Individuals who are eligible for coverage under ARHOME will receive the EHB-equivalent ABP through fee-for-service temporarily prior to the effective date of their QHP coverage. Exempt populations will have the option of receiving the ABP that offers approved Arkansas state plan benefits or the EHB-equivalent ABP.

PRA Disclosure Statement

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V.20181119

Alternative Benefit Plan

State Name: Arkansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☐ Other

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

The State will provide a notice informing individuals of their eligibility under the Section 1902(a)(10)(A)(i)(VIII) eligibility group once they have been determined eligible by the State's eligibility system. Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP coverage is effective, the process for accessing supplemental services, the grievance and appeals process, and accessing other ABP delivery mechanisms for those eligible.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the eligibility application process, a member who answers "yes" to the following questions will be considered medically frail or eligible for Medicaid through another Aid Category: "Do you have a disability? Or are you blind? Do you live in a medical facility or nursing home? What type of facility is this? Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?" Individuals screened as medically frail will be enrolled in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan and will be provided with a Choice Counseling notice that will inform them about their benefit plan options.

The Choice Counseling notice will inform medically frail clients of their right to choose the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP and will describe the differences between the two. The notice will also include a toll-free number that individuals can call to make their selection. If an affirmative selection is not made, the individual will remain in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan.

Medically frail clients with a serious mental illness or a substance use disorder who assess as a Tier 2 or Tier 3 on the independent assessment will be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program.

All individuals not screened as medically frail based on their responses on the integrated application for assistance will receive a general Medicaid eligibility notice. That eligibility notice will include information about an individual’s ability to identify as medically frail at a later time. The notice will define a medically frail individual as a person who has a physical or behavioral health condition that limits what he or she is able to do (like bathing, dressing, daily chores, etc.), a person who lives in a medical facility or nursing home, a person who has a serious mental illness, a person who has a long-term problem with drugs or alcohol, a person with intellectual or developmental disabilities, or a person with some other serious health condition. The document will inform all enrollees that they may screen for medically frailty at any time and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information.

Individuals identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in a QHP but can choose to opt into a QHP. Individuals identified as AI/AN will receive a Choice Counseling notice that will inform them of their right to choose between a QHP and the EHB-equivalent ABP and will describe the differences between the two. The notice will also include a link to a webpage and a toll-free number that individuals can use to make their selection. If an affirmative selection is not made, the individual will remain in the EHB-equivalent ABP.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Alternative Benefit Plan

Where will the information be documented? (Check all that apply)

- ☒ In the eligibility system.
- ☐ In the hard copy of the case record.
- ☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

- ☒ Copy of correspondence sent to the individual.
- ☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- ☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

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V.20160722

Alternative Benefit Plan

State Name: Arkansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

Enrollment Assurances - Mandatory Participants ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

The state will review to ensure the person is newly eligible under section 1902(a)(10)(A)(i)(VIII) and is not in any of the following eligibility categories at the time of application: children, adults eligible for the Parent/Caretaker Relative aid category, blind or disabled, terminally ill hospice patients, pregnant women, individuals living in an institution who are required to contribute all but a minimum amount of their income toward the cost of their care, individuals eligible for medical assistance for long-term care services described in Section 1917(c)(1)(C) of the Social Security Act, individuals infected with tuberculosis, individuals covered by Medicaid only for the treatment of an emergency medical condition, individuals determined Medicaid eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical care, foster children, or former foster children.

☒ Self-identification

Describe:

Individuals will be identified as medically frail through one of two mechanisms: (1) the individual responds “yes” to any of the following questions on the integrated application for assistance: "Do you have a disability? Or are you blind? Do you live in a medical facility or nursing home? What type of facility is this? Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc?” or (2) at any time after the application process, the individual requests to be rescreened for medically frail status. The Division of Medical Services will also monitor rescreening requests to ensure policies and processes for medically frail identification continue to identify appropriate beneficiaries.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☐ Review of claims data
- ☒ Self-identification
- ☒ Review at the time of eligibility redetermination
- ☒ Provider identification
- ☒ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

The medical frailty screening process is a part of the integrated application for assistance, completed at the time of initial eligibility determination. Individuals will be provided with the opportunity to self-identify as medically frail. Those who self-identify as medically frail will have the option of receiving either the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP.

DHS will rely on carriers and providers to assist DHS in identifying individuals with emerging medical needs that lead to a need for transition to the Medicaid program during the plan year.

An ARHOME enrollee can notify the DHS at any time to be rescreened for medically frail status.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Once individuals have been rescreened as medically frail, they will be sent a notice informing them of their exempt status. This notice will inform them of their right to choose between the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP. The notice will outline the differences in the benefit offerings and will provide information on the process for enrolling in either the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP. The notice will also include a toll-free number that individuals may call to make their selection. If an affirmative selection is not made, the individual will be placed in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan.

Arkansas Medicaid has developed a process for making transitions to medically frail status after initial application for eligibility. As a part of this process, DHS will rely on carriers to monitor claims so that DHS and carriers may identify individuals with emerging

medical needs that indicate a possible need for transition fee for service delivery system.

An ARHOME enrollee can notify DHS at any time to request a rescreening to determine whether they are medically frail. Additionally, rescreening requests will be monitored to ensure policies and processes for medically frail identification continue to identify beneficiaries in need of services that are not available from the qualified health plans.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

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V.20160722

Alternative Benefit Plan

State Name: Arkansas Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Arkansas's base benchmark plan is composed of benefits offered through the HMO Partners Inc. Open Access POS 13262AR001. For individuals receiving the ABP through a Qualified Health Plan (QHP), ARHOME,the State will provide supplemental services that are required for the ABP but not covered by QHPs—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services. For beneficiaries under age 21 receiving the ABP through a QHP, Medicaid will provide supplemental coverage for EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them of how to access the supplemental benefits. Since the QHPs must cover all Essential Health Benefits (EHBs), Arkansas provides supplemental coverage for only a small number of EPSDT benefits, such as pediatric vision and dental services.

QHP enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC and/or RHC.

If family planning services are accessed at a facility that the QHP considers to be an out-of-network provider, the State's fee-for-service delivery system will cover those services.

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: HMO Partners, Inc. - Small Group Gold 1000-1

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Arkansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

No

Other Information Related to Cost Sharing Requirements (optional):

The State will use cost-sharing as described in the cost sharing section of the State Plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Alternative Benefit Plan

State Name: Arkansas Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0030

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Arkansas's EHB base benchmark plan is composed of benefits offered through the HMO Partners, Inc. - Small Group Gold 1000-1 and the CHIP plans for pediatric dental and vision. The State will provide through its fee-for-service Medicaid program supplemental benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and, for beneficiaries up to age 21 receiving the ABP through Qualified Health Plans (QHPs) under Arkansas's 1115 demonstration waiver, Arkansas Medicaid will provide supplemental coverage for EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them of how to access the supplemental benefits. Since the QHPs must cover all EHBs, we anticipate that Arkansas will provide supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.
For benefits provided by Qualified Health Plans, the state also authorizes benefit packages substantially equivalent/actuarially equivalent to the benefit package articulated in this document".

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Practitioner Office Visit (Nurse, PA, etc)
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Includes but not limited to Nurse or Physician Assistants. An APN may not be able to perform certain services that a practitioner would subject to the Arkansas scope of practice and appropriate licensure requirements.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Facility Fee (Ambulatory Surgery Ctr).
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: See www.healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Outpatient Surgery Physician/Surgical Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: See https://www.healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Hospice Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

In accordance with section 2302 of the Affordable Care Act, individuals under the age of 21, will receive hospice care concurrently with curative care. For individuals over age 21, individuals will not receive curative care concurrent with hospice services. Hospice care is multi-disciplinary and may include case management.

Remove

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:

Infusion Therapy

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:

Renal Dialysis/Hemodialysis

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Allergy Treatment

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Dental Surgery for Accidents

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: For non diseased teeth.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Oral Surgery

Source: Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This benefit is in the CHIP Pediatric dental benefit.

Benefit Provided:
Outpatient Surgery

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Chemotherapy

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

Benefit Provided: Cochlear Implants

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: Lifetime maximum of one per ear.

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Diabetic Supplies

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided: Urgent Care Centers or Facilities
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Coverage is the same for In Network and Out of Network

Benefit Provided: Emergency Room Services
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Coverage is the same for In Network and Out of Network

Benefit Provided: Emergency Transportation/Ambulance
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: Ground $1000 per trip. Air $5000 per trip.
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

While there is an amount limit per trip, there is no annual or lifetime limit or limit on number of services.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: Inpatient Hospital Services (e.g., Hospital Stay)
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Transplants
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Certain transplants are allowed and some require prior authorization. Not needed for kidney and cornea.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Treatment of infertility, including prescription drugs, is not a covered benefit. Infertility testing is a covered benefit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Collapse All ☐

☑ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient Services

Source: Base Benchmark Federal Employees

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The initial diagnostic services is not subject to pre-authorizion but treatment plans may be subject to pre-authorization.

Remove

Benefit Provided: Mental/Behavioral Health Inpatient Services

Source: Base Benchmark Federal Employees

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: The treating facility must be a hospital

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark Federal Employees

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

The initial diagnostic services is not subject to pre-authorizion but treatment plans may be subject to pre-authorization.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Must have treatment plan pre-approved.

Benefit Provided:

Substance Abuse Disorder Inpatient Services

Source:

Base Benchmark Federal Employees

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

The treating facility must be a hospital.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

☑ 6. Essential Health Benefit: Prescription drugs

☐ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Prior authorization applies only to drugs not on the formulary and specialty drugs. New prescription medications approved by the FDA are not covered under the evidence of coverage unless or until the medication is placed on the formulary.

Alternative Benefit Plan

☑ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Home Health Care Services

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 50 visits per member per contract year.

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Skilled Nursing Facility

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: Limited to 60 days per member per contract year

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Outpatient Rehabilitation Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 30 aggregate visits per member per contract year.

Scope Limit:

All therapies (speech, occupational, physical and chiropractic) combined in the limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient Therapy. Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Member per Contract Year.

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required if costs exceed $5,000. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Single replacement of eyeglasses or contacts within the first 6 months following cataract surgery is covered.

Benefit Provided: Inpatient Rehabilitative

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 60 days per member per contract year.

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Habilitation (Developmental Services)

Source: Base Benchmark Small Group

Remove

Alternative Benefit Plan

Authorization:	Provider Qualifications:
Prior Authorization	State Plan & Public Employee/Commercial Plan
Amount Limit:	**Duration Limit:**
None	180 visits per contract year

Scope Limit:

Habilitation services are available to all individuals meeting the medical necessity criteria, not just those with an intellectual or developmental disability.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Outpatient Diagnostic Test (X-Ray and Lab Work)
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Advanced Diagnostic Imaging CT Scan, PET, MRI
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventative Care/Screening/Immunization

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 1 visit per year

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Diabetic Education Management

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: $250 per program

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For individuals receiving coverage through the Arkansas Health and Opportunity for Me (ARHOME) program, QHP benefits are supplemented using fee-for-service Medicaid.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

☐ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: Non-Emergency Medical Transportation

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit: Authorization above the 8 legs may be exceeded through a prior authorization process. The 8 leg limit does not apply to individuals determined to be medically frail.

Other:

Other 1937 Benefit Provided: PASSE-1915(i)

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: PASSE services are provided only to Medicaid clients with a Tier 2 or Tier 3 Behavioral Health Independent Assessment

Other: See Attachment 3.1-i PASSE program.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

All beneficiaries up to age 21 will receive the full range of EPSDT benefits. For beneficiaries up to age 21 receiving the ABP through Qualified Health Plans (QHPs) under Arkansas's 1115 waiver, Arkansas Medicaid will provide supplemental coverage for any EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them of how to access the wrapped benefits. Since the QHPs must cover all EHBs, we anticipate that Arkansas will provide supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services. For beneficiaries up to age 21 receiving the ABP through fee-for-service Medicaid, the beneficiaries will access all benefits, including the full range of EPSDT benefits, through fee-for-service Medicaid.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

State Name: Arkansas Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- ☒ Managed care.
  - ☐ Managed Care Organizations (MCO).
  - ☐ Prepaid Inpatient Health Plans (PIHP).
  - ☐ Prepaid Ambulatory Health Plans (PAHP).
  - ☒ Primary Care Case Management (PCCM).
- ☒ Fee-for-service.
- ☒ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

All ARHOME beneficiaries who are medically frail, and are not enrolled in a PASSE, will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medically frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Feb 28, 2019

Describe program below:

Through the PCCM program, beneficiaries choose a primary care provider (PCP), who, through an on-going provider/beneficiary relationship, coordinates health care services, including referrals for necessary specialty services, physician's services, hospital care and other services. The PCCM provider assists enrollees with locating medical services and coordinates and monitors their enrollees prescribed medical and rehabilitation services. This program reimburses the PCP a case management fee provided on a per beneficiary per month basis. All ARHOME beneficiaries who are medically frail, and are not enrolled in a PASSE, will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medially frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

#type# Procurement or Selection Method

Indicate the method used to select #type#s:

○ Competitive procurement method (RFP, RFA).

◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PCCMs:

All PCP-qualified physicians and clinics must enroll as PCPs with some exceptions.

Other PCCM-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. No

PCCM service delivery is provided on less than a statewide basis. No

PCCM Payments

Specify how payment for services is handled:

◉ Per member/per month case management fee paid to PCCM provider.

○ Other:

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Arkansas Medicaid will provide individuals who are exempt from the ABP delivered through a QHP with a notice that informs individuals that they may choose between the EHB-equivalent ABP that is operated through fee-for-service or the ABP that is the Medicaid State plan (which in Arkansas is the standard Medicaid benefit package).

All ARHOME beneficiaries who are medically frail will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medically frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

Individuals receiving the EHB-equivalent ABP while awaiting QHP enrollment will not be required to enroll with a Medicaid PCCM provider. Arkansas regulations require QHPs to follow the requirements of the Arkansas Patient Centered Medical Home (PCMH) model or develop their own PCMH standards.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Other Service Delivery Model

Name of service delivery system:

Premium Assistance for QHPs for ARHOME SECTION 1115(a) demonstration

Provide a narrative description of the model:

Under the ARHOME SECTION 1115(a) demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group under the state plan, to support the purchase of coverage from QHPs offered in the individual market through the Marketplace. ARHOME QHP beneficiaries will receive the ABP through a QHP.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Alternative Benefit Plan

State Name: Arkansas Attachment 3.1-L- OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 64 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 64 with incomes between the established monthly eligibility income levels for the Parent/Caretaker/Relative Aid Category (currently $124 per month for a one-person household) and 133% FPL who are not enrolled in Medicare (ARHOME beneficiaries). ARHOME beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP available in their region. The state will use the authority granted under its Arkansas Health and Opportunity for Me Section 1115 Demonstration to provide for the payment of premiums.

The State will provide through its fee for service (FFS) ABP Medicaid program supplemental services that are required for the ABP but not covered by QHPs—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) for beneficiaries under age 21 receiving the ABP through QHPs, Medicaid will provide supplemental EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them about how to access the supplemental services.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

General Assurances	ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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V.20130807

MACPRO SPA PAGES

AR - Submission Package - AR2017MS0006O - (AR-17-0015) - Administration

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | AR2017MS0006O | AR-17-0015

CMS-10434 OMB 0938-1188

Package Header

Package ID	AR2017MS0006O	**SPA ID**	AR-17-0015
Submission Type	Official	**Initial Submission Date**	11/27/2017
Approval Date	2/9/2018	**Effective Date**	1/1/2018
Superseded SPA ID	AR-15-0002		

User-Entered

A. Single State Agency

1. State Name: Arkansas

☑ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency:

Arkansas Department of Human Services

4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created
Certificate from AR Attorney Gen Office Identifying Single State Agency	10/27/2017 3:00 PM EDT

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

☐ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

◉ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

- ☐ a. The single state agency supervises the administration through counties or local government entities.
- ☐ b. The single state agency supervises the administration through other state agencies. The other state agency implements the state plan through counties and local government entities.
- ☑ c. Another state agency administers a portion of the state plan through a waiver under the Intergovernmental Cooperation Act of 1968.

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D. Additional information (optional)

None

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12), which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of: improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Programs, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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AR - Submission Package - AR2017MS0006O - (AR-17-0015) - Administration

Medicaid State Plan Administration

Organization

Intergovernmental Cooperation Act Waivers

MEDICAID | Medicaid State Plan | Administration | AR2017MS0006O | AR-17-0015

CMS-10434 OMB 0938-1188

Package Header

Package ID	AR2017MS0006O	**SPA ID**	AR-17-0015
Submission Type	Official	**Initial Submission Date**	11/27/2017
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Superseded SPA ID	AR-15-0002		
	User-Entered		

A. Intergovernmental Cooperation Act Waivers

The state has the following Intergovernmental Cooperation Act Waivers:

View Waiver Arkansas Insurance Department

1. Name of state agency to which responsibility is delegated:

Arkansas Insurance Department

2. Date waiver granted:

12/18/2013

3. The type of responsibility delegated is (check all that apply):

- [x] a. Conducting fair hearings
- [ ] b. Other

4. The scope of the delegation (i.e. all fair hearings) includes:

For Private Option enrollees only, the Arkansas Department of Human Services intends to delegate to the Arkansas Insurance Department the final administrative adjudication of appeals regarding covered services, including appeals related to medical necessity and scope and duration. An interagency agreement or memorandum of agreement between the Arkansas Insurance Department and the Arkansas Department of Human Services will assure that final administrative adjudications conducted by the Arkansas Insurance Department comply with all requirements for due process and the hearing rights afforded Medicaid applicants and beneficiaries and comply with state and federal Medicaid laws, rules, and regulations. The Arkansas Department of Human Services retains oversight of the State Plan and will establish a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by the Arkansas Insurance Department.

5. Methods for coordinating responsibilities between the agencies include:

- [x] a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.
- [x] b. The Medicaid agency has established a process to monitor the entire appeals process, including the quality and accuracy of the hearing decisions made by the delegated entity.
- [x] c. The Medicaid agency informs every applicant and beneficiary in writing of the fair hearing process and how to directly contact and obtain information from the Medicaid agency.
- [x] d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.
- [x] e.The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:
  - [x] i. A written agreement between the agencies.
  - [ ] ii. State statutory and/or regulatory provisions.

6. The single state agency has established a review process whereby the agency reviews fair hearing decisions made by the delegated entity.

- (•) Yes

☐ No

☑ The Medicaid agency only reviews fair hearing decisions issued by the delegated entity with respect to the proper application of federal and state law regulations and policies. The review process is conducted by an impartial official not involved in the initial determination.

7. Additional methods for coordinating responsibilities among the agencies (optional):

The Arkansas Department of Human Services will enter into a written memorandum of understanding with the Arkansas Insurance Department (that will be made available to the Secretary of Human Services upon request) that will include the following provisions: (1) the relationships and respective responsibilities of both entities to effectuate coverage fair hearings; (2) quality control and oversight by the Medicaid agency, including reporting requirements needed to facilitate control and oversight; and (3) assurances that the Arkansas Insurance Department will: (a) comply with all federal and state Medicaid laws, regulations and policies; (b) and prohibit conflicts of interest and improper incentives; and (c) ensure privacy and confidentiality safeguards. AID will ensure that every beneficiary is informed, in writing, of the appeals process and how to contact AID and how to obtain information about appeals from that agency.

Intergovernmental Cooperation Act Waivers

MEDICAID | Medicaid State Plan | Administration | AR2017MS0006O | AR-17-0015

Package Header

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B. Additional information (optional)

None

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12), which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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AR - Submission Package - AR2017MS0006O - (AR-17-0015) - Administration

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID : Medicaid State Plan | Administration | AR2017MS0006O | AR-17-0015

CMS-10434 OMB 0938-1188

Package Header

Package ID	AR2017MS0006O	**SPA ID**	AR-17-0015
Submission Type	Official	**Initial Submission Date**	11/27/2017
Approval Date	2/9/2018	**Effective Date**	1/1/2018
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User Entered

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- [x] a. The Medicaid agency
- [ ] b. Delegated governmental agency

2. The entity or entities that conduct determinations of eligibility based on age, blindness, and disability are:

- [x] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [ ] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [x] iii. The Social Security Administration determines Medicaid eligibility for SSI beneficiaries
  - [ ] iv. Other

3. Assurances:

- [x] a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- [x] b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- [x] c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- [x] d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | AR2017M50006O | AR-17-0015

Package Header

Package ID	AR2017M50006O	**SPA ID**	AR-17-0015
Submission Type	Official	**Initial Submission Date**	11/27/2017
Approval Date	2/9/2018	**Effective Date**	1/1/2018
Superseded SPA ID	AR-15-0002		

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B. Fair Hearings (including any delegations)

- [x] The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.
- [x] The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

   - [x] a. Medicaid agency
   - [ ] b. State agency to which fair hearing authority is delegated under an Intergovernmental Cooperation Act waiver.
   - [ ] d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

   - [x] All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | AR2017MS0006O | AR-17-0015

Package Header

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C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

None

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12), which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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AR - Submission Package - AR2017MS0006O - (AR-17-0015) - Administration

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | AR2017MS0006O | AR-17-0015

CMS-10434 OMB 0938-1188

Package Header

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User-Entered

A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

- a. A stand-alone agency, separate from every other state agency
- b. Also the Title IV-A (TANF) agency
- c. Also the state health department
- d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

Arkansas Department of Human Services' Division of County Operations perform the administrative function of Medicaid eligibility determinations for all Medicaid eligible groups

b. Fair Hearings (including expedited fair hearings)

Arkansas Department of Human Services' Office of Policy and Legal Services.
Arkansas Department of Human Services delegates to the Arkansas Insurance Department the final administrative adjudication of appeals regarding covered services, including appeals related to medical necessity and scope and duration as it relates to Marketplace insurance carriers providing services to individuals for whom premiums are paid to the Marketplace insurance carriers through the Arkansas Department of Human Services' Division of Medical Services' 1115 (a) Arkansas Works (aka Private Option) waiver. An interagency agreement between the Arkansas Insurance Department and the Arkansas Department of Human Services will assure that final administrative adjudications conducted by the Arkansas Insurance Department comply with all requirements for due process and the hearing rights afforded Medicaid applicants and beneficiaries and comply with State and Federal Medicaid laws, rules, and regulations. The Arkansas Department of Human Services retains oversight of the State Plan and will establish a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by the Arkansas Insurance Department. The Arkansas Department of Human Services will enter into a written memorandum of understanding with the Arkansas Insurance Department that will include the following provisions: 1) the relationships and respective responsibilities of both entities to effectuate coverage of hearings; 2) quality control and oversight by the Medicaid agency, including reporting requirements needed to facilitate control and oversight; and 3) assurances that the Arkansas Insurance Department will: (a) comply with all State and Federal Medicaid laws, regulations and polices; (b) and prohibit conflicts of interest and improper incentives; and (c) ensure privacy and confidentiality safeguards. The Arkansas Insurance Department will ensure that every beneficiary is informed, in writing, of the appeals process and how to contact the Arkansas Insurance Department and how to obtain information about appeals from that agency.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

Arkansas Department of Human Services' Division of Medical Services' Medical Services section

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

Arkansas Department of Human Services' Division of Medial Services' Office of Policy Development 1) coordinates the DHS policy agenda; 2) inticipates State and Federal policy changes, new demographic trends or proposed program changes and their effects; 3) facilitates cross-division projects or opportunities of importance; and 4) creates strategies to improve data use and analysis.

e. Administration, including budget, legal counsel

Arkansas Department of Human Service (authorized single state agency to administer the title XIX Medicaid Program)' Division of Medical Services; Arkansas Department of Human Services (DHS)' Office of Chief Counsel, respectively; Arkansas Office of Finance and Administration. The Director of the Department of

Human services is charged with the responsibility of providing leadership to all divisions within the Department. The Director of the DHS Division of Medical Services is responsible for the formulation and implementation of medical services policy and payment of claims. All administrative authority over the Medicaid program is within the DHS Division of Medical Services, with the DHS Division of County Operations performing the administrative function of Medicaid eligibility determination for all Medicaid eligible groups. The DHS O e of Policy and Legal Services is responsible for all appeals and fair hearings conducted on behalf of Medicaid applicants and beneficiaries. Appeals of adverse Arkansas Works (aka Private Option) 1115 waiver eligibility determinations and beneficiary appeals concerning wrap-around services are conducted by the DHS O e of Appeals and Hearings, an office within the Arkansas Department of Human Services, Office of Policy and Legal Services. This appeals entity will enter final administrative adjudications concerning: 1) eligibility to participate in the Arkansas Works (aka Private Option) 1115 waiver; and 2) appeals brought by Arkansas Works (aka Private Option) beneficiaries regarding Arkansas Works (aka Private Option) 1115 waiver wrap-around Medicaid services. The O e of Finance and Administration (OFA) supports the programs within the Department of Human Services by providing financial and administrative management in the areas of human resources, contract support and accounting.

f. Financial management, including processing of provider claims and other health care financing

Arkansas Department of Human Services' Division of Medical Services' Program Budgeting and Analysis, Financial Activities, Third Party Liability and Estate Recovery Contract Oversight and MMIS fiscal, management and information contract agent

g. Systems administration, including MMIS, eligibility systems

Arkansas Department of Human Services' Division of Medical Services' MMIS fiscal, management and information contract agent

h. Other functions, e.g., TPL, utilization management (optional)

Arkansas Department of Human Services' Division of Medical Services' Program and Administrative Support, O e of Long Term Care, Health Care Innovation, Provider Reimbursement

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created	
Organizational Charts for Arkansas Dept of Human Services & Div of Medical Services	11/27/2017 12:53 PM EST	

Package Header

Package ID	AR2017M50006O	**SPA ID**	AR-17-0015
Submission Type	Official	**Initial Submission Date**	11/27/2017
Approval Date	2/9/2018	**Effective Date**	1/1/2018
Superseded SPA ID	AR-15-0002		

User-Entered

B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
The Social Security Administration	Performs the functions of determining Medicaid eligibility for SSI beneficiaries

Package Header

Package ID	AR2017MS0006O	**SPA ID**	AR-17-0015
Submission Type	Official	**Initial Submission Date**	11/27/2017
Approval Date	2/9/2018	**Effective Date**	1/1/2018
Superseded SPA ID	AR-15-0002		

User-Entered

E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

- Yes
- No

Organization and Administration

MEDICAID | Medicaid State Plan | Administration | AR2017M50006O | AR-17-0015

Package Header

Package ID AR2017M50006O
SPA ID AR-17-0015
Submission Type Official
Initial Submission Date 11/27/2017
Approval Date 2/9/2018
Effective Date 1/1/2018
Superseded SPA ID AR-15-0002

User-Entered

F. Additional information (optional)

None

PRA Disclosure Statement. Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12), which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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AR - Submission Package - AR2017MS0006O - (AR-17-0015) - Administration

Medicaid State Plan Administration

Organization

Single State Agency Assurances

MEDICAID | Medicaid State Plan | Administration | AR2017MS0006O | AR-17-0015

CMS-10434 OMB 0938-1188

Package Header

Package ID	AR2017MS0006O	**SPA ID**	AR-17-0015
Submission Type	Official	**Initial Submission Date**	11/27/2017
Approval Date	2/9/2018	**Effective Date**	1/1/2018
Superseded SPA ID	AR-15-0002		
	User-Entered		

A. Assurances

- [x] 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- [x] 2. All requirements of 42 CFR 431.10 are met.
- [x] 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- [x] 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- [x] 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- [x] 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

None

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12) which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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AR - Submission Package - AR2022MS0001O - (AR-22-0027) - Eligibility

Medicaid State Plan Eligibility

Income/Resource Methodologies

Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability

MEDICAID | Medicaid State Plan | Eligibility | AR2022MS0001O | AR-22-0027

CMS 10434 OMB 0938-1188

Package Header

Package ID	AR2022MS0001O	**SPA ID**	AR-22-0027
Submission Type	Official	**Initial Submission Date**	12/13/2022
Approval Date	1/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	New		
	User Entered		

A. Eligibility Determinations of Individuals Who Are Age 65 or Older or Who Have Blindness or a Disability

Eligibility determinations of individuals who are age 65 or older or who have blindness or a disability are based on one of the following:

◉ 1. SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

○ 2. State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

○ 3. State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

B. Additional information (optional)

PRA Disclosure Statement. Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12), which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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AR - Submission Package - AR2022MS0001O - (AR-22-0027) - Eligibility

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | AR2022MS0001O | AR-22-0027

Women who are pregnant or post-partum, with household income at or below a standard established by the state

CMS-10434 OMB 0938-1188

Package Header

Package ID	AR2022MS0001O	**SPA ID**	AR-22-0027
Submission Type	Official	**Initial Submission Date**	12/13/2022
Approval Date	1/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	AR -13-0015		

User-Entered

The state covers the mandatory pregnant women group in accordance with the following provisions:

A. Characteristics

1. Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

2. Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 C.F.R. 435.110.

◉ Yes

○ No

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

The state uses the following income standard for this group:

FPL 209.00%

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | AR2022MS0001O | AR-22-0027

Package Header

Package ID	AR2022MS0001O	**SPA ID**	AR-22-0027
Submission Type	Official	**Initial Submission Date**	12/13/2022
Approval Date	1/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	AR -13-0015		

User-Entered

D. Benefits for Pregnant Women

Benefits for individuals in this eligibility group consist of the following:

- (●) 1. All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- ( ) 2. Pregnant women whose income exceeds the income limit specified for full coverage of pregnant women receive only pregnancy-related services.

Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | AR2022MS0001O | AR-22-0027

Package Header

Package ID	AR2022MS0001O	**SPA ID**	AR-22-0027
Submission Type	Official	**Initial Submission Date**	12/13/2022
Approval Date	1/13/2023	**Effective Date**	1/1/2023
Superseded SPA ID	AR -13-0015		

User Entered

E. Basis for Pregnant Women Income Standard

1. Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

- Yes
- No

b. The minimum income standard for this eligibility group is 133% FPL.

2. Maximum income standard

- a. The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

b. The state's maximum income standard for this eligibility group is:

- i. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(i)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(i)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ii. The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(i)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(i)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- iii. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- iv. The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- v. 185% FPL

c. The amount of the maximum income standard is: **FPL** 209.00%

G. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12), which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally-identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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AR - Submission Package - AR2024MS0001O - (AR-24-0008) - Eligibility

CMS-10434 OMB 0938-1188

Package Information

Package ID	AR2024MS0001O	**Submission Type**	Official
Program Name	N/A	**State**	AR
SPA ID	AR-24-0008	**Region**	Dallas, TX
Version Number	4	**Package Status**	Approved
Submitted By	Rosaura Page	**Submission Date**	2/28/2024
Package Disposition		**Approval Date**	4/5/2024 10:49 AM EDT

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | AR2024MS0001O | AR-24-0008

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [x] Eligibility
  - [ ] Income/Resource Methodologies
  - [ ] Income/Resource Standards
  - [ ] Mandatory Eligibility Groups
  - [ ] Optional Eligibility Groups
  - [ ] Non-Financial Eligibility
  - [x] Eligibility and Enrollment Processes
    - [ ] Eligibility Process
    - [ ] Application
    - [ ] Presumptive Eligibility
    - [x] Continuous Eligibility for Children

Reviewable Unit Name	Included in Another Submission Package	Source Type
Continuous Eligibility for Children		APPROVED

    - [ ] Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage
- [ ] Benefits and Payments

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Children

MEDICAID | Medicaid State Plan | Eligibility | AR2024MS0001O | AR-24-0008

Package Header

Package ID	AR2024MS0001O	**SPA ID**	AR-24-0008
Submission Type	Official	**Initial Submission Date**	2/28/2024
Approval Date	04/05/2024	**Effective Date**	1/1/2024
Superseded SPA ID	new		
	User-Entered		

The state provides continuous eligibility for children in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Hospitalized Children

The state provides Medicaid to a child eligible for and enrolled under the Infants and Children under Age 19 (42 CFR 435.118) eligibility group until the end of an inpatient stay for which inpatient services are covered, if the child:

1. Was receiving inpatient services covered by Medicaid on the date the child becomes ineligible under the eligibility group based on the child's age; and

2. Would remain eligible but for attaining such age.

B. Mandatory Continuous Eligibility for Children

The state provides continuous eligibility to all children under age 19 and that:

1. The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends the last day of the earlier of the following periods:

a. The month that the child turns 19 years old;

b. 12 months.

2. Continuous eligibility is provided to children eligible under all mandatory and optional eligibility groups (excluding Medically Needy) who would otherwise lose eligibility because of any change in circumstances, unless:

a. The child dies;

b. The child or the child's representative voluntarily requests a termination of the child's eligibility;

c. The child ceases to be a resident of the state;

d. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

e. The child attains the maximum age specified in B.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid State Plan Administration

General Administration

Reporting

Package Header

Package ID	AR2024MS0002O	**SPA ID**	AR-24-0013
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	10/1/2024
Superseded SPA ID	New		
	User-Entered		

A. General Reporting

The agency submits all reports in the form and with the content required by the Secretary and complies with any provisions that the Secretary finds necessary to verify and assure the correctness of all reports.

☒ 1. The agency assures that all requirements of 42 CFR 431.16 are met.

B. Annual Reporting on the Child and Adult Core Sets

☒ 1. The agency assures that all requirements of 42 CFR 437.10 through 437.15 are met.

☒ 2. The agency reports annually, by December 31, on:

a. All measures on the Child Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

b. All behavioral health measures on the Adult Core Set that are identified by the Secretary pursuant to 42 CFR 437.10.

C. Additional Information (optional)

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [x] Eligibility
  - [ ] Income/Resource Methodologies
  - [x] Income/Resource Standards
    - [ ] AFDC Income Standards
    - [x] Medically Needy Income Level

Reviewable Unit Name	Included in Another Submission Package	Source Type
Medically Needy Income Level	(	APPROVED

    - [x] Handling of Excess Income (Spenddown)

Reviewable Unit Name	Included in Another Submission Package	Source Type
Handling of Excess Income (Spenddown)	(	APPROVED

    - [x] Medically Needy Resource Level

Reviewable Unit Name	Included in Another Submission Package	Source Type
Medically Needy Resource Level	(	APPROVED

  - [x] Mandatory Eligibility Groups

Reviewable Unit Name	Included in Another Submission Package	Source Type
Mandatory Eligibility Groups	(	APPROVED

  - [x] Optional Eligibility Groups

Reviewable Unit Name	Included in Another Submission Package	Source Type
Optional Eligibility Groups	(	APPROVED

  - [ ] Non-Financial Eligibility

☐ Eligibility and Enrollment Processes

☐ Benefits and Payments

- [ ] Service delivery
- [ ] Other issue

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Package Header

Package ID AR2025MS0001O
SPA ID AR-26-0009
Submission Type Official
Initial Submission Date 4/20/2026
Approval Date 07/14/2026
Effective Date 8/1/2026
Superseded SPA ID AR 91-56
User-Entered

A. Income Level Used

1. The state employs a single income level for the medically needy.

2. The income level varies based on differences between shelter costs in urban and rural areas.

- (○) Yes
- (●) No

3. The level used is:

Household size	Standard
1	$108.33
2	$216.66
3	$275.00
4	$333.33

The state uses an additional incremental amount for larger household sizes.

- (●) Yes
- (○) No

Incremental Amount:

$58.33

The dollar amounts increase automatically each year

- (○) Yes
- (●) No

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Package Header

Package ID	AR2025MS0001O	**SPA ID**	AR-26-0009
Submission Type	Official	**Initial Submission Date**	4/20/2026
Approval Date	07/14/2026	**Effective Date**	8/1/2026
Superseded SPA ID	AR 91-56		
	User-Entered		

B. Basis for Income Level

1. Minimum Income Level

The minimum income level for this eligibility group is the lower of the state's July 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.

2. Maximum Income Level

The maximum income level for this eligibility group is 133 1/3 percent of the higher of the state's 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Package Header

Package ID	AR2025MS0001O	**SPA ID**	AR-26-0009
Submission Type	Official	**Initial Submission Date**	4/20/2026
Approval Date	07/14/2026	**Effective Date**	8/1/2026
Superseded SPA ID	AR 91-56		
	User-Entered		

C. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Package Header

Package ID	AR2025MS0001O	**SPA ID**	AR-26-0009
Submission Type	Official	**Initial Submission Date**	4/20/2026
Approval Date	07/14/2026	**Effective Date**	8/1/2026
Superseded SPA ID	AR 91-56; AR-91-57		
	User-Entered		

If countable income exceeds the income standard, the state must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party, in accordance with 42 CFR 435.831 and 42 CFR 435.121.

A. Budget Periods

Income in excess of the appropriate income standard is considered available for payment of medical or remedial care expenses in budget periods that do not exceed six months.

1. In determining income eligibility, countable income is reduced by the amount of incurred medical or remedial care expenses during the budget period specified below:

- (•) a. One budget period of:
  - ( ) i. 6 months
  - ( ) ii. 5 months
  - ( ) iii. 4 months
  - (•) iv. 3 months
  - ( ) v. 2 months
  - ( ) vi. 1 month
- ( ) b. More than one budget period, as described below:

2. The state includes part or all of the retroactive period in the budget period.

- (•) Yes
- ( ) No

Handling of Excess Income (Spenddown)

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Superseded SPA ID	AR 91-56; AR-91-57		
	User-Entered		

B. Types of Eligible Expenses

1. In determining incurred expenses to be deducted from income, the state includes:

a. Medicare, Medicaid, and other health insurance premiums and enrollment fees.

b. Cost sharing, including copayments, coinsurance, and deductibles, imposed by Medicare, Medicaid or other health insurance.

c. Expenses for necessary medical and remedial services recognized by state law but not included in the state plan.

d. Expenses for necessary medical and remedial services included in the state plan, including those that exceed limitations on the amount, duration, and scope of services.

2. The state also includes medical institutional expenses projected to the end of the budget period at the Medicaid reimbursement rate.

- (•) Yes
- ( ) No

3. Incurred expenses subject to payment by a third party are not deducted unless the third party is a public program (other than Medicaid) of a state and the program is financed by the state.

Handling of Excess Income (Spenddown)

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C. Timeframe of Deduction of Expenses

In determining incurred expenses to be deducted from income, the state deducts:

1. For retroactive budget periods and a budget period that includes both retroactive and prospective budget, the state deducts:

a. Eligible expenses incurred during the budget period, whether paid or unpaid.

b. Payments made during the budget period on eligible expenses incurred at any time prior to the budget period, if not previously deducted in establishing eligibility.

c. Unpaid eligible expenses, which have not been deducted previously in establishing eligibility, and were incurred:

- (•) i. At any time prior to the budget period.
- ( ) ii. Prior to the third month before the month of application, but no earlier than:
- ( ) iii. No earlier than the third month before the month of application.

2. For prospective budget period(s), the state deducts:

a. Eligible expenses incurred during the budget period, whether paid or unpaid.

b. Payments made during the budget period on eligible expenses incurred at any time prior to the budget period, if not previously deducted in establishing eligibility.

c. Unpaid eligible expenses that are carried over from the prior budget period and have not been deducted previously in establishing eligibility.

Handling of Excess Income (Spenddown)

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D. Order of Deduction of Expenses

Incurred medical or remedial care expenses are deducted in the following order:

- ○ 1. By the type of service, in the following order:
  - a. Premiums, deductibles, coinsurance and co-payments.
  - b. Expenses for necessary medical or remedial care services that are recognized under state law but not included in the State Plan.
  - c. Expenses for necessary medical or remedial care services that are included in the state Plan that exceed agency limitations on amount, duration, or scope of services.
  - d. Expenses for necessary medical or remedial care services that are included in the state Plan that are within the agency limitations on amount, duration, or scope of services.
- ◉ 2. In chronological order by the date of the service, or the date cost sharing payments are due.
- ○ 3. In chronological order by the date the bill is submitted to the state by the individual.

Handling of Excess Income (Spenddown)

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E. Reasonable Limitations

The state sets reasonable limits on the amount to be deducted for expenses.

- ○ Yes
- ◉ No

Handling of Excess Income (Spenddown)

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	User-Entered		

F. Spenddown Payments Made by Individuals

The state permits individuals to pay-in their spenddown liability.

- ○ Yes
- ◉ No

Handling of Excess Income (Spenddown)

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G. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Resource Level

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A. Medically Needy Resource Level Structure

1. The state employs a single resource level for the medically needy.

2. The resource level is equal to or higher than the lowest resource standard used under the most closely related cash assistance program.

Medically Needy Resource Level

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B. Resource Level Used

The level used is:

Household size	Standard
1	$2000.00
2	$3000.00

The state uses an additional incremental amount for larger household sizes.

(•) Yes
( ) No

Incremental Amount:

$100.00

Medically Needy Resource Level

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C. Additional Information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

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System-Derived

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☑	☐	○	CONVERTED
Parents and Other Caretaker Relatives		☑	☐	○	CONVERTED
Pregnant Women		☑	☐	○	APPROVED
Deemed Newborns		☑	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☑	☐	○	NEW
Former Foster Care Children		☑	☐	○	APPROVED
Transitional Medical Assistance		☑	☐	○	NEW
Extended Medicaid due to Spousal Support Collections		☑	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries		☑	☐	○	NEW
Closed Eligibility Groups		☑	☐	○	NEW
Individuals Deemed To Be Receiving SSI		☑	☐	○	NEW
Working Individuals under 1619(b)		☑	☐	○	NEW
Qualified Medicare Beneficiaries		☑	☑	○	APPROVED
Qualified Disabled and Working Individuals		☑	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Specified Low Income Medicare Beneficiaries		☑	☑	○	APPROVED
Qualifying Individuals		☑	☑	○	APPROVED

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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	System-Derived		

B. The state elects the Adult Group, described at 42 CFR 435.119.

(•) Yes ( ) No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group		☑	☐	◯	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Individuals with income equal to or less than 100% of the FPL, who are entitled to Medicare Part A, and who qualify for Medicare cost-sharing.

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	User-Entered		

The state covers the mandatory qualified Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are entitled to hospital insurance benefits under part A of title XVIII (Medicare Part A), including individuals who have purchased a premium to enroll in Part A.

2. Have income and resources at or below the standard for this group.

Qualified Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes

( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Non-Home Income Producing Property	Non-Home income producing property, such as mineral and timer rights, rented farm land, and rented dwellings, will continue to be excluded from resources if it meets the pre-5/1/90 SSI $6000/6% rules, which was terminated by Section 8014 of OBRA 1989.
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).

Qualified Medicare Beneficiaries

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C. Income Standard Used

The amount of the income standard for this group is 100% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment of co-insurance and deductibles for Medicare Parts A, B and C and payment for the premiums for Medicare Parts A and B.

Medical assistance begins the first day of the month following the month in which the individual is determined to qualify for this eligibility group.

Qualified Medicare Beneficiaries

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Individuals with income above 100% and below 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

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The state covers the mandatory specified low income Medicare beneficiaries group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.

2. Have income below the income standard and resources at or below the resource standard for this group.

Specified Low Income Medicare Beneficiaries

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B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes

( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).
Non-Home Income Producing Property	Non-Home income producing property, such as mineral and timer rights, rented farm land, and rented dwellings, will continue to be excluded from resources if it meets the pre-5/1/90 SSI $6000/6% rules, which was terminated by Section 8014 of OBRA 1989.

Specified Low Income Medicare Beneficiaries

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C. Income Standard Used

Family income must be above 100% FPL and below 120% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Specified Low Income Medicare Beneficiaries

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Qualifying Individuals

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Individuals with income at or above 120% and below 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.

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The state covers the mandatory qualifying individuals group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet all of the following criteria:

1. Would qualify as Qualified Medicare Beneficiaries (described in section 1905(p)(1) of the Act), except that their income exceeds the income level for that eligibility group.

2. Are not otherwise eligible for Medicaid under the state plan.

3. Have income below the income standard and resources at or below the resource standard for this group.

Qualifying Individuals

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B. Financial Methodologies

1. SSI methodologies are used in calculating household income. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes

( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).
Non-Home Income Producing Property	Non-Home income producing property, such as mineral and timer rights, rented farm land, and rented dwellings, will continue to be excluded from resources if it meets the pre-5/1/90 SSI $6000/6% rules, which was terminated by Section 8014 of OBRA 1989.

Qualifying Individuals

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C. Income Standard Used

Family income must be at or above 120% FPL and below 135% FPL.

D. Resource Standard Used

The resource standard is the same used to determine eligibility for the Medicare Part D full-benefit low-income subsidy (LIS) (but without regard to the life insurance policy exclusion applied in LIS resource eligibility determinations). This standard is three times the SSI resource standard, adjusted annually in accordance with the consumer price index.

E. Medical Assistance Provided

Medical assistance is limited to payment for Medicare Part B premiums.

Qualifying Individuals

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Optional Eligibility Groups

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	System-Derived		

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives		☐	☐	○	NEW
Reasonable Classifications of Individuals under Age 21		☐	☐	○	NEW
Children with Non-IV-E Adoption Assistance		☑	☐	○	CONVERTED
Independent Foster Care Adolescents		☐	☐	○	NEW
Optional Targeted Low Income Children		☐	☐	○	NEW
Individuals above 133% FPL under Age 65		☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer		☐	☐	○	NEW
Individuals Eligible for Family Planning Services		☐	☐	○	NEW
Individuals with Tuberculosis		☐	☐	○	NEW
Individuals Electing COBRA Continuation Coverage		☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance		☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for Cash Except for Institutionalization		☑	☑	○	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☑	☐	○	NEW
Optional State Supplement Beneficiaries		☐	☐	○	NEW
Individuals in Institutions Eligible under a Special Income Level		☑	☑	○	APPROVED
PACE Participants		☑	☐	○	NEW
Individuals Receiving Hospice		☐	☐	○	NEW
Children under Age 19 with a Disability		☐	☐	○	NEW
Age and Disability-Related Poverty Level		☑	☑	○	APPROVED
Work Incentives		☐	☐	○	NEW
Ticket to Work Basic		☑	☐	○	APPROVED
Ticket to Work Medical Improvements		☐	☐	○	NEW
Family Opportunity Act Children with a Disability		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	●	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	○	NEW

Optional Eligibility Groups

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B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women		☑	☑	○	APPROVED
Medically Needy Children under Age 18		☑	☑	○	APPROVED

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973		☑	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21		☑	☑	○	APPROVED
Medically Needy Parents and Other Caretaker Relatives		☑	☑	○	APPROVED

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability		☑	☑	○	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Individuals who would be eligible for federal cash assistance or an optional state supplement, except for institutionalization.

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Superseded SPA ID	AR 00-07; AR 91-56		
	User-Entered		

The state covers the optional Individuals Eligible for Cash Except for Institutionalization eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are in a medical institution.

2. Would meet the eligibility requirements for at least one of the following cash assistance programs, but for the lower income standards used to determine eligibility for institutionalized individuals:

- [x] a. SSI
- [ ] b. Optional State Supplement
- [x] c. AFDC

Individuals Eligible for Cash Except for Institutionalization

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	User-Entered		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (•) Yes
- ( ) No

Individuals Eligible for Cash Except for Institutionalization

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C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. In calculating household income and resources for populations for which AFDC is the most closely related program, the following methodology(ies) are used:

- ○ a. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- ◉ b. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable income.

- ◉ Yes
- ○ No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

4. Less restrictive methodologies are used in calculating countable resources.

- ◉ Yes
- ○ No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the “Ticket to Work-Basic” reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).
Non-Home Income Producing Property	Non-Home income producing property, such as mineral and timer rights, rented farm land, and rented dwellings, will continue to be excluded from resources if it meets the pre-5/1/90 SSI $6000/6% rules, which was terminated by Section 8014 of OBRA 1989.

Individuals Eligible for Cash Except for Institutionalization

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	User-Entered		

D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for Cash Except for Institutionalization

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Individuals who are in medical institutions for at least 30 consecutive days who are eligible under a special income level.

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The state covers Individuals in Institutions Eligible under a Special Income Level in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Have been in a medical institution for at least 30 consecutive days.

2. Have income at or below a standard described in section D.

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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B.Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- ○ Yes
- ◉ No

2. The state covers the following populations:

- ☑ a. Individuals age 65 or older
- ☑ b. Individuals who have blindness
- ☑ c. Individuals who have a disability
- ☐ d. Pregnant women
- ☐ e. All Individuals under age 21, or a lower age
- ☐ f. Reasonable classifications of children.

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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C. Financial Methodologies

1. In calculating household income, the methodologies of the most closely related cash assistance program are used, except that disregards are not applied.

2. In calculating household resources, the methodologies of the most closely related cash assistance program are used Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☑ Real property not otherwise excluded is disregarded.

Description of disregard:

For aged, blind and disabled individuals, Non-Home Income Producing Property, such as mineral and timber rights, rented farmland, and rented dwellings, will be disregarded if it meets the pre-5/1/90 SSI $6000/6% rule, which was terminated by Section 8014 of OBRA, 1989.

☑ The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.

☑ Resources set aside in Independence/Freedom accounts

Description:

Independence Accounts established during an individual's eligibility in the eligibility group described in section 1902(a)(10)(A)(ii)(XV) of the Act, approved as an Independence Account by the state, and held separate from other resources, shall be disregarded. Accounts that may be designated as Independence Accounts include assets such as a savings accounts and retirement accounts (including retirement or pension accounts through an employer). Once approved by the state, an individual is permitted to fund their Independence Account with their earned income. An Independence Account may be the individual's retirement account through an employer.

The disregard shall apply only to amounts contributed to Independence Accounts during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the accounts are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. The individual must continue to allow the state regular monitoring of the account and/or reporting on deposits, withdrawals, and other information deemed necessary by the state for the proper administration of the disregard. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).

☑ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Individuals in Institutions Eligible under a Special Income Level

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D. Income Standard Used

The income standard for this group is:

- (•) 1. 300% of the SSI Federal Benefit Rate (FBR) for an individual
- ( ) 2. Other lower income level

Individuals in Institutions Eligible under a Special Income Level

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E.Resource Standard Used

The resource standard for this group is the one used for the most closely-related cash assistance program.

Individuals in Institutions Eligible under a Special Income Level

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F.Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Individuals who are age 65 or older or who have a disability, with income no higher than 100% FPL.

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The state covers the optional Age and Disability-Related Poverty Level eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Meet at least one of the following condition(s):

   a. Are age 65 or older; or

   b. Have a disability.

2. Have income and resources at or below the standard for this group.

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (•) Yes
- ( ) No

Age and Disability- Related Poverty Level

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	User-Entered		

C. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- (•) Yes
- ( ) No

a. The state uses the same less restrictive income methodologies for all individuals covered.

- (•) Yes
- ( ) No

The less restrictive income methodologies are:

- [x] Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

3. Less restrictive methodologies are used in calculating countable resources.

- (•) Yes
- ( ) No

a. The state uses the same less restrictive resource methodologies for all individuals covered.

- (•) Yes
- ( ) No

The less restrictive resource methodologies are:

- [x] General resource disregard:

Name of disregard:	Description:
QMB Matching Resource Level	Disregard the difference between $2,000.00 for individuals and $3,000.00 for couples, and the QMB resource limit for individuals and couples; thereby effectively setting the resource limit at the QMB resource level.

- [x] A specified type of resource is disregarded:

Name of resource type:	Description:
Non-Home Income Producing Property	Non-Home income producing property, such as mineral and timer rights, rented farm land, and rented dwellings, will continue to be excluded from resources if it meets the pre-5/1/90 SSI $6000/6% rules, which was terminated by Section 8014 of OBRA 1989.

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the “Ticket to Work-Basic” reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).

Age and Disability- Related Poverty Level

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D. Income Standard Used

The income standard for this eligibility group is:

- (•) 1. 100% FPL
- ( ) 2. A lower percent of the FPL:

Age and Disability- Related Poverty Level

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	User-Entered		

E. Resource Standard Used

The resource standard used is:

- (•) 1. The resource limit for the SSI program; or
- ( ) 2. The resource limit used in the state's medically needy program, if higher.

Age and Disability- Related Poverty Level

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Pregnant Women

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Woman who are pregnant or post-partum who would qualify under the state's Pregnant Women eligibility group, except for income.

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The state covers the Medically Needy Pregnant Women eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are pregnant or post-partum, as defined in 42 CFR 435.4.

2. Would qualify under the Pregnant Women eligibility group, except for income.

3. Are not otherwise eligible for categorically needy coverage under the state plan.

4. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Pregnant Women

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B. Financial Methodologies

1. The financial methodology used is:

(•) a. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

( ) b. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes

( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).

Medically Needy Pregnant Women

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C. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

D. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

E. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Pregnant Women

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Children under Age 18

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Children under age 18 who would qualify under the state's categorically needy eligibility groups, except for income.

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The state covers the Medically Needy Children under Age 18 eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 18.

2. Would qualify as categorically needy, except for income.

3. Are not otherwise eligible for categorically needy coverage under the state plan.

4. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Children under Age 18

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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B. Financial Methodologies

1. The financial methodology used is:

(•) a. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

( ) b. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes

( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).

Medically Needy Children under Age 18

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C. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

D. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

E. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Children under Age 18

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F. Additional Information (optional)

Medically Needy Children under Age 18

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Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Reasonable Classifications of Individuals under Age 21

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

One or more reasonable classifications of individuals under age 21 who do not qualify as categorically needy.

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The state covers the optional Medically Needy Reasonable Classifications of Individuals under Age 21 eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 21, or a lower age, as specified in section C.

2. Would not qualify under the Medically Needy Children under Age 18 eligibility group (42 CFR 435.301)

3. Are not otherwise eligible for categorically needy coverage under the state plan.

4. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Reasonable Classifications of Individuals under Age 21

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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Approval Date	07/14/2026	**Effective Date**	8/1/2026
Superseded SPA ID	AR 00-07		
	User-Entered		

B. Individuals Covered

The state covers the following populations:

- [x] 1. All children under a specified age limit:
  - ( ) i. Under age 21
  - ( ) ii. Under age 20
  - (•) iii. Under age 19
- [ ] 2. Reasonable classifications of children

Medically Needy Reasonable Classifications of Individuals under Age 21

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C. Financial Methodologies

1. The state uses the same financial methodology for all individuals covered.

(•) Yes
( ) No

2. The financial methodology used is:

(•) a. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
( ) b. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable income.

(•) Yes
( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

4. Less restrictive methodologies are used in calculating countable resources.

(•) Yes
( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).

Medically Needy Reasonable Classifications of Individuals under Age 21

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D. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

E. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

F. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Reasonable Classifications of Individuals under Age 21

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G. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Parents and Other Caretaker Relatives

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Parents and other caretaker relatives of dependent children who do not qualify as categorically needy.

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The state covers the optional Medically Needy Parents and Other Caretaker Relatives eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Meet the definition of parent or caretaker relative, as described in the mandatory Parents and Other Caretaker Relatives eligibility group.

2. Are not otherwise eligible for categorically needy coverage under the state plan.

3. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Parents and Other Caretaker Relatives

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B. Financial Methodologies

1. The financial methodology used is:

(•) a. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

( ) b. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

(•) Yes

( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

3. Less restrictive methodologies are used in calculating countable resources.

(•) Yes

( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).

Medically Needy Parents and Other Caretaker Relatives

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C. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

D. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

E. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Parents and Other Caretaker Relatives

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F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

Individuals who are age 65 or older or who have blindness or a disability who do not qualify as categorically needy.

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The state covers the optional Medically Needy Populations Based on Age, Blindness or Disability eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1.Meet at least one of the following:

a. Are age 65 or older;

b. Have blindness; or

c. Have a disability.

2. Are not otherwise eligible for categorically needy coverage under the state plan.

3. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | AR2025MS0001O | AR-26-0009

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B. Individuals Covered

The state covers the following populations:

- [x] 1. Individuals age 65 or older
- [x] 2. Individuals with blindness
- [x] 3. Individuals who have a disability

Medically Needy Populations Based on Age, Blindness or Disability

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C. Financial Methodologies

1. The state uses the same financial methodology for all individuals covered.

(•) Yes
( ) No

2. The financial methodology used is:

a. SSI methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b. Less restrictive methodologies are used in calculating countable income.

(•) Yes ( ) No

The less restrictive income methodologies are:

☑ Census Bureau wages are disregarded.

Description of disregard:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

c. Less restrictive methodologies are used in calculating countable resources.

(•) Yes ( ) No

The less restrictive resource methodologies are:

☑ A specified type of resource is disregarded:

Name of resource type:	Description:
Independence account established during Ticket to Work basic eligibility	Independence Accounts established under the terms of the resource disregard described in the "Ticket to Work-Basic" reviewable unit shall be disregarded. The disregard shall apply only to amounts contributed to the account during the individual' s enrollment in the section 1902(a)(10)(A)(ii)(XV) eligibility group and any interest and earnings accrued by the account during and subsequent to such enrollment. No additional deposits into the account are permitted once the individual is no longer enrolled in the eligibility group described at section 1902(a)(10)(ii)(XV) of the Act. Actions involving the accounts are subject to standard eligibility rules relating to resources (e. g., a transfer from the account for less than fair market value would be subject to transfer-of-asset rules).
Non-Home Income Producing Property	Non-Home income producing property, such as mineral and timer rights, rented farm land, and rented dwellings, will continue to be excluded from resources if it meets the pre-5/1/90 SSI $6000/6% rules, which was terminated by Section 8014 of OBRA 1989.

Medically Needy Populations Based on Age, Blindness or Disability

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D. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

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E. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

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F. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Populations Based on Age, Blindness or Disability

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G. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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