ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Isaac Linam E-mail isaac.linam@dhs.arkansas.gov Phone 501-320-6570

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: ARKids-4-18, Domiciliary Care-1-18, Section I-5-18, Section III-4-18, and State Plan Amendment #2019-001

Intended Effective Date (Check One)		**Date**
☐ Emergency (ACA 25-15-204)	Legal Notice Published	August 18, 2019
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	September 16, 2019
☑ Other December 01, 2019 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	November 15, 2019
	Adopted by State Agency	December 01, 2019

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Lisa Teague	lisa.teague@dhs.arkansas.gov	11/19/19
Contact Person	**E-mail Address**	**Date**

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Janet Mann
Signature

501-320-6270 janet.mann@dhs.arkansas.gov
Phone Number **E-mail Address**

Director
Title

11/19/19
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Office of Rules Promulgation

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Domiciliary Care**

EFFECTIVE DATE: **December 1, 2019**

SUBJECT: **Provider Manual Update Transmittal DOMCARE-1-18**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
ALL	—	—	—

Explanation of Updates

The Domiciliary Care manual is being removed.

This update transmittal memorandum indicates which sections of your provider manual have been revised. Electronic versions of provider manuals available from the Arkansas Medicaid website have changes incorporated. See Section I for instructions on updating a paper copy of the manual.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and out-of-state at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Janet Mann
Director

TOC not required

221.200 Exclusions 12-1-19

Services Not Covered for ARKids First-B Beneficiaries:

Adult Developmental Day Treatment (ADDT)

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code **92567**, when the diagnosis is within the ICD range. (**View ICD codes**.)

Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Diapers, Underpads and Incontinence Supplies

Early Intervention Day Treatment (EIDT)

End Stage Renal Disease Services

Hearing Aids

Hospice

Hyperalimentation

Non-Emergency Transportation

Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitation Therapy for Chemical Dependency

Rehabilitative Services for Children

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

Targeted Case Management

Ventilator Services

TOC not required

103.200 Optional Services 12-1-19

Program	Coverage
Adult Behavioral Health Services for Community Independence	18 or older
Adult Developmental Day Treatment (ADDT)	Pre-School and Age 18 or Older
Ambulatory Surgical Center	All Ages
Audiological	Under Age 21
Certified Registered Nurse Anesthetist (CRNA)	All Ages
Chiropractic Services	All Ages
Dental Services	Under Age 21
Developmental Rehabilitation Services	Under Age 3
Durable Medical Equipment	All Ages
Early Intervention Day Treatment (EIDT)	Under Age 21
End-Stage Renal Disease (ESRD) Facility Services	All Ages
Hearing Aid Services	Under Age 21
Hospice	All Ages
Hyperalimentation	All Ages
IndependentChoices (Self-Directed Personal Assistance)	Age 18 or Older
Inpatient Psychiatric Services	Under Age 21
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	All Ages
Medical Supplies	All Ages
Nursing Facility	Under Age 21
Occupational, Physical and Speech-Language Therapy	Under Age 21
Orthotic Appliances	All Ages
Outpatient Behavioral Health Services	All Ages
PACE (Program of All-Inclusive Care for the Elderly) (*Participants must meet additional medical and non-medical criteria in addition to age eligibility.)	Age 55 or older*
Personal Care	All Ages
Podiatrist	All Ages
Portable X-Ray	All Ages
Prescription Drugs	All Ages
Private Duty Nursing Services (High Technology, Non-Ventilator Dependent, EPSDT Program)	Under Age 21

Program	Coverage
Private Duty Nursing Services (Non-Ventilator Dependent Beneficiaries Age 21 or Older)	Age 21 or Older
Private Duty Nursing Services (Ventilator-Dependent)	All Ages
Prosthetic Devices	All Ages
Rehabilitative Hospital and Extended Rehabilitative Hospital Services	All Ages
Rehabilitative Services for Persons with Physical Disabilities (RSPD)	Under Age 21
Rehabilitative Services for Youth and Children	Under Age 21
Respiratory Care	Under Age 21
School-Based Mental Health Services	Under Age 21
Targeted Case Management for Beneficiaries of DDS Children's Services (Title V Agency)	Under Age 21
Targeted Case Management for DDS Children's Services (Title V Agency) who are SSI Beneficiaries and TEFRA Waiver Participants	Under Age 16
Targeted Case Management for Beneficiaries Age 21 or Under with a Developmental Disability	Age 21 or Under
Targeted Case Management for Beneficiaries Age 22 or Older with a Developmental Disability	Age 22 or Older
Targeted Case Management for Beneficiaries in the Child Health Services (EPSDT) Program	Under Age 21
Targeted Case Management for Beneficiaries in the Division of Children and Family Services	Under Age 21
Targeted Case Management for Beneficiaries in the Division of Youth Services	Under Age 21
Targeted Case Management for Beneficiaries Age 60 or Older	Age 60 or Older
Targeted Case Management for Pregnant Women	Pregnant Women - All Ages
Ventilator Equipment	All Ages
Visual Care	All Ages

124.230 Working Disabled 12-1-19

The Working Disabled category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are ages 16 through 64, with a disability as defined by Supplemental Security Income (SSI) criteria and who meet the income and resource criteria may be eligible in this category.

There are two levels of cost sharing in this aid category, depending on the individual's income:

A. Regular Medicaid cost sharing.

Beneficiaries with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy, inpatient hospital and prescription services for eyeglasses). They are designated in the system as "WD RegCO."

B. New cost sharing requirements.

Beneficiaries with gross income equal to or greater than 100% FPL have cost sharing for more services and are designated in the system as “WD NewCo”.

The cost sharing amounts for the “WD NewCo” eligibles are listed in the chart below:

Program Services	**New Co-Payment***
Adult Developmental Day Treatment Services	$10 per day
ARChoices Waiver Services	None
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Chiropractor	$10 per visit
Dental	$10 per visit (no co-pay on EPSDT dental screens)
Diapers, Underpads and Incontinence Supplies	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Early Intervention Day Treatment	$10 per day
Emergency Department: Emergency Services	$10 per visit
Emergency Department: Non-emergency Services	$10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals ages 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital’s Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None

Program Services	New Co-Payment*
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the facility's Medicaid per diem for the first Medicaid-covered day
Outpatient Behavioral Health	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals ages 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of the first covered day's Medicaid inpatient per diem
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate per unit
Occupational Therapy (Age 21 and older have limited coverage**)	$10 per visit
Physical Therapy (Age 21 and older have limited coverage**)	$10 per visit
Speech-Language Therapy (Age 21 and older have limited coverage**)	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Visual Care	$10 per visit

*** Exception:** Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD beneficiaries (Aid Category 10) who temporarily enter a nursing home and continue to meet WD eligibility criteria will be exempt from the co-payments listed above.

**** Exception:** This service is NOT covered for individuals within the Occupational, Physical and Speech-Language Therapy Program for individuals ages 21 and older.

NOTE: Providers must consult the appropriate provider manual to determine coverage and benefits.

172.100 Services not Requiring a PCP Referral 12-1-19

The services listed in this section do not require a PCP referral.

A. Adult Developmental Day Treatment (ADDT) core services

B. ARChoices waiver services

C. Anesthesia services, excluding outpatient pain management

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP)

E. Chiropractic Services

F. Dental services

G. Developmental Disabilities Services Community and Employment Support

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS

I. Emergency services in an acute care hospital emergency department, including emergency physician services

J. Family Planning services

K. Gynecological care

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner.
2. Rehabilitative Services for Youth and Children (RSYC) Program.

N. Obstetric (antepartum, delivery and postpartum) services.

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement.
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications.
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider.

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye

Q. Optometry services

R. Pharmacy services

S. Physician services for inpatients in an acute care hospital. This includes:

1. Direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and

2. Indirect care (pathology, interpretation of X-rays, etc.)

T. 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.

U. Physician visits (except consultations) in the outpatient departments of acute care hospitals:

1. Medicaid will cover these services without a PCP referral only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations.

2. Consultations require PCP referral.

V. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCP referral only:

1. If the Medicaid beneficiary is enrolled with a PCP and

2. The services are within applicable benefit limitations.

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services

X. Transportation (emergency and non-emergency) to Medicaid-covered services

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity, or would create unnecessary hardship.

TOC not required

332.000 Patients With Joint Medicare-Medicaid Coverage 12-1-19

The following provider types accept Medicare-Medicaid Crossovers: Ambulatory Surgical Center, Chiropractic, Clinics, Dental, Family Planning, Federally Qualified Health Center, Health Department, Hearing Services, Hemodialysis, Home Health, Hospital, Hyperalimentation, Independent Laboratory, Independent Radiology, Inpatient Psychiatric Services for Under Age 21, Nurse Practitioner, Nursing Home, Occupational, Physical and Speech-Language Therapy Services, Physician, Podiatrist, Prosthetics, Rehabilitation Center, Rural Health Clinic Services, Transportation, Ventilator Equipment and Visual Care.

Claim filing procedures for these provider types are in Sections 332.100 through 332.300.

There will be a co-payment for Medicaid-covered services, as listed below, for WD eligibles, whose gross income is equal to greater than 100% of the Federal Poverty Level.

PROGRAM SERVICES	**"New" COPAYMENT**
Adult Developmental Day Treatment	**$10 per day**
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiology Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Chiropractor	$10 per visit
Dental (very limited benefits for individuals age 21 and over)	$10 per visit (no co-pay on EPSDT dental screens)
Diapers, Underpads and Incontinence Supplies	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Early Intervention Day Treatment (not covered for age 21 and over)	**$10 per day**
Emergency Department Services: Emergency Services Non-emergency	$10 per visit $10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (not available for individuals over age 21)	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals age 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient Outpatient	25% of 1st inpatient day (Medicaid per diem) $10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per visit
Medical Supplies	None

State: Arkansas
Date Received: 14 August, 2019
Date Approved: 31 October, 2019
Effective Date: 1 December, 2019
Transmittal Number: 19-0001

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.

State: Arkansas
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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.

State: Arkansas
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Citation	Condition or Requirement

4. 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
CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs 42 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 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
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, deliver and postpartum) services
Pharmacy
Physician Services for inpatients acute care.
Transportation

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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) 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.

(5) 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.

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Hearing Aid Services	Under Age 21
Hospice	All Ages
Hyperalimentation	All Ages
IndependentChoices (Self-Directed Personal Assistance)	Age 18 or Older
Inpatient Psychiatric Services	Under Age 21
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	All Ages
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Audiological Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Chiropractor	$10 per visit
Dental	$10 per visit (no co-pay on EPSDT dental screens)
Diapers, Underpads and Incontinence Supplies	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Early Intervention Day Treatment	$10 per day
Emergency Department: Emergency Services	$10 per visit
Emergency Department: Non-emergency Services	$10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals ages 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital’s Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None

Program Services	New Co-Payment*
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the facility's Medicaid per diem for the first Medicaid-covered day
Outpatient Behavioral Health	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals ages 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of the first covered day's Medicaid inpatient per diem
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate per unit
Occupational Therapy (Age 21 and older have limited coverage**)	$10 per visit
Physical Therapy (Age 21 and older have limited coverage**)	$10 per visit
Speech-Language Therapy (Age 21 and older have limited coverage**)	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Visual Care	$10 per visit

*** Exception:** Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD beneficiaries (Aid Category 10) who temporarily enter a nursing home and continue to meet WD eligibility criteria will be exempt from the co-payments listed above.

**** Exception:** This service is NOT covered for individuals within the Occupational, Physical and Speech-Language Therapy Program for individuals ages 21 and older.

NOTE: Providers must consult the appropriate provider manual to determine coverage and benefits.

172.100 Services not Requiring a PCP Referral 12-1-19

The services listed in this section do not require a PCP referral.

A. Adult Developmental Day Treatment (ADDT) core services

B. ARChoices waiver services

C. Anesthesia services, excluding outpatient pain management

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP)

E. Chiropractic Services

F. Dental services

G. Developmental Disabilities Services Community and Employment Support

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS

I. Emergency services in an acute care hospital emergency department, including emergency physician services

J. Family Planning services

K. Gynecological care

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner.
2. Rehabilitative Services for Youth and Children (RSYC) Program.

N. Obstetric (antepartum, delivery and postpartum) services.

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement.
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications.
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider.

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye

Q. Optometry services

R. Pharmacy services

S. Physician services for inpatients in an acute care hospital. This includes:

1. Direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and

2. Indirect care (pathology, interpretation of X-rays, etc.)

T. 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.

U. Physician visits (except consultations) in the outpatient departments of acute care hospitals:

1. Medicaid will cover these services without a PCP referral only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations.

2. Consultations require PCP referral.

V. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCP referral only:

1. If the Medicaid beneficiary is enrolled with a PCP and

2. The services are within applicable benefit limitations.

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services

X. Transportation (emergency and non-emergency) to Medicaid-covered services

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity, or would create unnecessary hardship.

TOC not required

332.000 Patients With Joint Medicare-Medicaid Coverage 12-1-19

The following provider types accept Medicare-Medicaid Crossovers: Ambulatory Surgical Center, Chiropractic, Clinics, Dental, Family Planning, Federally Qualified Health Center, Health Department, Hearing Services, Hemodialysis, Home Health, Hospital, Hyperalimentation, Independent Laboratory, Independent Radiology, Inpatient Psychiatric Services for Under Age 21, Nurse Practitioner, Nursing Home, Occupational, Physical and Speech-Language Therapy Services, Physician, Podiatrist, Prosthetics, Rehabilitation Center, Rural Health Clinic Services, Transportation, Ventilator Equipment and Visual Care.

Claim filing procedures for these provider types are in Sections 332.100 through 332.300.

There will be a co-payment for Medicaid-covered services, as listed below, for WD eligibles, whose gross income is equal to greater than 100% of the Federal Poverty Level.

PROGRAM SERVICES	**"New" COPAYMENT**
Adult Developmental Day Treatment	**$10 per day**
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiology Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Chiropractor	$10 per visit
Dental (very limited benefits for individuals age 21 and over)	$10 per visit (no co-pay on EPSDT dental screens)
Diapers, Underpads and Incontinence Supplies	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Early Intervention Day Treatment (not covered for age 21 and over)	**$10 per day**
Emergency Department Services: Emergency Services Non-emergency	$10 per visit $10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (not available for individuals over age 21)	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals age 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient Outpatient	25% of 1st inpatient day (Medicaid per diem) $10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per visit
Medical Supplies	None

State: Arkansas
Date Received: 14 August, 2019
Date Approved: 31 October, 2019
Effective Date: 1 December, 2019
Transmittal Number: 19-0001

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.

State: Arkansas
Date Received: 14 August, 2019
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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.

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Citation	Condition or Requirement

4. 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
CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs 42 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 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
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, deliver and postpartum) services
Pharmacy
Physician Services for inpatients acute care.
Transportation

State: Arkansas
Date Received: 14 August, 2019
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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) 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.

(5) 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.

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