Statement of Necessity and Rule Summary
ARKids-4-18, Domiciliary Care-1-18, Section I-5-18, Section III-4-18, and
State Plan Amendment #2019-001

Why is this change necessary? Please provide the circumstances that necessitate the change.

A Domiciliary Care claims report dated 12/5/18 indicated that Medicaid does not have any active providers currently enrolled. Because this optional program is not routinely used through Medicaid, the Division of Medical Services (DMS) has determined that it should be removed from the Arkansas Medicaid State Plan and all corresponding rules, regulations and policy rescinded as of 12/1/19.

What is the change? Please provide a summary of the change.

The proposed effective date for these rules is 12/1/19. The rules revisions will be as follows:

- Remove the optional Domiciliary Care service from the Arkansas Medicaid State Plan
- Remove the optional Domiciliary Care service from Sections I and III of all Arkansas Medicaid manuals (these sections appear in every Arkansas Medicaid manual)
- Remove the optional Domiciliary Care service from the ARKids Manual
- Repeal the Domiciliary Care Manual in its entirety
- Updating program names

TOC not required

103.200 Optional Services

~~1-1-16~~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
~~Child Health Management Services (CHMS)~~	~~Under Age 21~~
Chiropractic Services	All Ages
Dental Services	Under Age 21
~~Developmental Day Treatment Clinic Services (DDTCS)~~	~~Pre-School and Age 18 or Older~~
Developmental Rehabilitation Services	Under Age 3
~~Domiciliary Care~~	~~All Ages~~
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
~~Licensed Mental Health Practitioner~~	~~Under Age 21~~
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*

Program	Coverage
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
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 Mental Illness (RSPMI)~~	~~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

~~1-1-16~~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
~~Child Health Management Services~~	~~$10 per day~~
Chiropractor	$10 per visit
Dental	$10 per visit (no co-pay on EPSDT dental screens)
~~Developmental Disability Treatment Center Services~~	~~$10 per day~~
Diapers, Underpads and Incontinence Supplies	None
~~Domiciliary Care~~	~~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

Program Services	New Co-Payment*
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
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

Program Services	New Co-Payment*
	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

~~5-1-18~~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

~~B~~C. Anesthesia services, excluding outpatient pain management

~~C~~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)

~~D~~E. Chiropractic Services

~~E~~F. Dental services

~~F~~G. Developmental Disabilities Services Community and Employment Support~~DDS Alternative Community Services (ACS) Waiver services~~

~~G. Developmental Day Treatment Clinic Services (DDTCS) core services~~

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

~~I. Domiciliary care~~

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

~~K~~J. Family Planning services

~~L~~K. Gynecological care

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

~~N~~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 persons with mental illness (RSPMI Program) ages 21 or older, or for specified procedures for persons under age 21 as listed in the RSPMI provider manual, Section 216.000.~~
3. ~~—~~Rehabilitative Services for Youth and Children (RSYC) Program.

~~O~~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.

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

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

~~R~~Q. Optometry services

~~S~~R. Pharmacy services

~~T~~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.)

~~U~~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.

~~V~~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.

~~W~~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.

~~X~~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

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

~~Z~~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.