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Proposed Rule Cover Sheet

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TOC required

214.210 ~~General~~ Advanced Practice Registered Nurse (APRN) ~~Practitioner~~ Services Benefit Limits

~~7-1-15-16~~1-~~20~~22

A. ~~For beneficiaries aged~~clients ~~twenty-one~~ 21 ~~years of age~~ and older, services provided ~~in~~ by ~~an~~ Advanced Practice Registered ~~N~~ nurse ~~(~~APRN~~)~~ in the APRN's ~~practitioner's~~ office, ~~a~~ patient's ~~client's~~ home or nursing home are limited to 12 ~~sixteen (16)~~ visits per ~~S~~state ~~F~~fiscal ~~Y~~year ~~(SFY/July 1 through June 30)~~ ~~when the APRN is enrolled in the Medicaid Primary Care Physician (PCP) program.~~For clients twenty-one (21) years of age or older, APRN services provided in a physician office, a patient's home, or nursing home are limited to 12 visits per state fiscal year (SFY) (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). If the client is assigned to a provider enrolled in the PCCM, the limit is sixteen (16) visits.

The following services are counted toward the ~~12 sixteen (16) visits per S~~state ~~F~~fiscal ~~Y~~year ~~(SFY/July 1 to June 30) limit established for the Nurse Practitioner~~Primary Care ~~Physician P~~~~program~~Service Benefit Visit Limits established for the state fiscal year:

~~1. Services of Primary Care Physicians in the office, client's home, or nursing facility.~~

~~2. Services of Advanced Practice Registered Nurses (APRNs) who are enrolled in the PCP program in the office, home, or nursing facility.~~

A. Advanced nurse practitioner services~~.~~

B. Physician services in the office, patient's home or nursing facility~~.~~

C. Rural health clinic (RHC) encounters~~.~~

D. Medical services ~~provided~~ furnished by a dentist~~.~~

E. Medical services furnished by an optometrist~~.~~

F. Certified nurse-midwife services~~.~~

G. Federally Qualified Health Center (FQHC) encounters

The established benefit limit does not apply to ~~individuals~~ clients under age twenty-one (21).

Global obstetric fees are not counted against the sixteen (16)~~12~~-visit limit. Itemized obstetric office visits are not counted in the limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

~~B. For clients twenty-one (21) years of age and older, services provided by an Advanced Practice Registered Nurse (APRN) not enrolled in the Medicaid Primary Care Physician (PCP) program in their office, a client's home, or nursing home are limited to twelve (12) visits per State Fiscal Year (SFY/July 1 through June 30).~~

~~1. The following services are counted toward the twelve (12) visits per SFY limit established for the Advanced Practice Registered Nurse (APRN) not enrolled in the PCP program when furnished in the office, client's home, or nursing facility.~~

~~2. Specialty physician services in the office, client's home, or nursing facility.~~

~~3. Rural health clinic (RHC) encounters.~~

~~4. Medical services provided by a dentist.~~

5. Medical services furnished by an optometrist.

6. Any combination of the five (5) service provider types.

The established benefit limit does not apply to clients under age twenty-one (21).

Global obstetric fees are not counted against the twelve (12) visit limit. Itemized obstetric office visits are not counted in the limit.

Extensions of the benefit limit will be considered services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

225.000 Outpatient Hospital Benefit Limit

7~~1~~-1-~~20~~22~~0~~

Medicaid-eligible ~~beneficiaries~~ clients age twenty-one (21) and older are limited to a total of twelve (12) outpatient hospital visits a year. This benefit limit includes outpatient hospital services provided in an acute care, general, or a rehabilitative hospital. This yearly limit is based on the State Fiscal Year (SFY/July 1 through June 30).

A. Outpatient hospital services include the following:

1. Non-emergency professional visits in the outpatient hospital and related physician services.
2. Outpatient hospital therapy and treatment services and related physician services.

B. Extension of benefits will be considered for ~~patients~~ clients based on medical necessity.

C. The Arkansas Medicaid Program automatically extends the outpatient hospital visit benefit for certain primary diagnoses. Those diagnoses are:

1. Malignant neoplasm (**View ICD Codes.**)
2. HIV infection and AIDS (**View ICD Codes.**)
3. Renal failure (**View ICD Codes.**)
4. Pregnancy (**View ICD Codes.**)
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

D. When a Medicaid eligible ~~beneficiary's~~ client's primary diagnosis is one (1) of those listed above and the Medicaid eligible ~~beneficiary~~ client's has exhausted the Medicaid established benefit limit for outpatient hospital services and related physician services, the provider does not have to file for an extension of the benefit limit.

E. All outpatient hospital services for ~~beneficiaries~~ clients under age twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program are not benefit limited.

F. Emergency and surgical physician services provided in an outpatient hospital setting are not benefit limited.

226.000 Physician Services Benefit Limit

7~~1~~-1-~~20~~22~~0~~

~~1.~~ **Primary Care Physician Program**

A. ~~Primary Care~~ Physician ~~(PCP) services in a physician's office, patient's~~ client's ~~home, or nursing home for beneficiaries~~ clients ~~aged twenty-one (21)~~ years of age ~~or older are limited to twelve~~ sixteen (1~~6~~2) visits per ~~S~~state ~~F~~fiscal ~~Y~~year (SFY/July 1 through June 30). ~~Beneficiaries~~ Clients ~~under age twenty-one (21)~~ years of age ~~in the Child Health Services/Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.~~For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home or nursing home are limited to 12 visits per state fiscal year (July 1 through June 30) unless the client is assigned to provider enrolled in the Primary Care Case Management Program (PCCM). If the client is assigned to a provider who is enrolled in the PCCM the limit is sixteen (16) visits.

Clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the ~~sixteen~~twelve (1~~6~~2) visits ~~per state fiscal year limit established for the~~ Primary Care ~~Physician Program~~service benefit limits:

1. Services of ~~Primary Care~~ Physicians ~~services~~ in the office, ~~patient's~~ client's home, or nursing facility.
2. ~~Rural health clinic (RHC) encounters~~Services of Advanced Practice Registered Nurses (APRN) who are enrolled in the PCP Program in the office, client's home, or ~~nursing facility.~~Medical services provided by a dentist.
3. Medical services furnished by an optometrist.
4. Certified nurse-midwife services.
5. Advanced nurse practitioner services.
6. Rural health clinic (RHC) encounters.

~~3. Medical services provided by a dentist.~~

~~4. Medical services furnished by an optometrist.~~

~~5. Certified nurse-midwife services.~~

~~6. Advanced nurse practitioner services.~~

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of the~~is~~ manual for procedures on obtaining extension of benefits for Primary Care P~~p~~hysician (PCP) services.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant neoplasm (**View ICD Codes.**).
2. HIV infection or AIDS (**View ICD Codes.**).
3. Renal failure (**View ICD Codes.**).
4. Pregnancy* (**View ICD Codes.**).
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

When a Medicaid ~~beneficiary's~~ client's primary diagnosis is one (1) of those listed above and the ~~beneficiary~~ client has exhausted the Medicaid established benefit for physician services, ~~specialty physician services,~~ outpatient hospital services, or laboratory and X-ray services, a request for extension of benefits is not required.

*OB ultrasounds and fetal non-stress tests are not exempt from Extension of Benefits. ~~-~~See Section 292.673 for additional coverage information.

~~2. **Specialty Physician Services**~~

~~A. Specialty Physician services in a physician's office, patient's client's home, or nursing home for beneficiaries clients aged twenty-one (21) years of age or older are limited to twelve (12) visits per Sstate Ffiscal Yyear (SFY/July 1 through June 30). Beneficiaries Clients under age twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.~~

~~The following services are counted toward the twelve (12) visits per Sstate Ffiscal Yyear limit established for the Physician Specialty Physician Program:~~

~~1. Specialty Physician services in the office, patient's client's home, or nursing facility.~~

~~2. Rural health clinic (RHC) encounters.~~

~~3. Medical services provided by a dentist.~~

~~4. Medical services furnished provided by an optometrist.~~

5. Certified nurse midwife services.

56. Services of an Advanced Practice Registered Nnurse (APRN) practitioner servicesnot enrolled in the PCP program.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of this the manual for procedures on obtaining extension of benefits for Specialty Pphysician services.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant neoplasm (**View ICD Codes.**).

2. HIV infection or AIDS (**View ICD Codes.**).

3. Renal failure (**View ICD Codes.**).

4. Pregnancy* (**View ICD Codes.**).

5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

When a Medicaid beneficiary's client's primary diagnosis is one (1) of those listed above and the beneficiary client has exhausted the Medicaid established benefit for Specialty Pphysician Sservices, outpatient hospital services, or laboratory and X-ray services, a request for extension of benefits is not required.

***OB ultrasounds and fetal non-stress tests are not exempt from Extension of Benefits. See Section 292.673 for additional coverage information.**

257.000 Tobacco Cessation Products and Counseling Services

8-1-2171-1-202022

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without Pprior Aauthorization (PA) to eligible Medicaid beneficiariesclients. Additional information can be found on the **designated Pharmacy Vendor websiteDHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

A. Physician providers may participate by prescribing covered tobacco cessation products. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products and subject to be within U.S. Food and Drug Administration prescribing guidelines.

B. Counseling by the prescriber is required to obtain initial Pprior Aauthorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the patientclient. The prescriber must retain the counseling checklist in the patient client records for audit. **View or Print the Arkansas Be Well Referral Form.**

C. Counseling procedures do not count against the twelve (12) visit limits alloweds per Sstate Ffiscal Yyear (SFY/July 1 to June 30), but they are limited to no more than two (2) 15 (fifteen) minute units and two (2) thirty (30) minute units for a maximum allowable of four (4) units per SFY.

D. Counseling sessions can be billed in addition to an office visit or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit. These sessions do not require a Primary Care Physician (PCP) referral.

E. If the beneficiary client is under the age of eighteen (18) years oldof age, and the parent or /legal guardian smokes, he or shethe parent or legal guardian can be counseled as well, and the visit billed under the minor's beneficiary client's Medicaid number. The provider

cannot prescribe medications for the parent or legal guardian under the ~~child's~~ minor client's Medicaid number. ~~-~~A parent or ~~/~~legal guardian session will count towards the four (4) counseling sessions limit described in S~~s~~ection C above.

F. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

G. Arkansas Medicaid 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.

H. Refer to Section 292.900 for procedure codes and billing instructions.

~~**292.682 Non-Emergency Services**~~ ~~**7-1-07**~~**1-1-2022**

~~**View or printg the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center Services.**~~

~~Procedure code **T1015**, modifier **U1**, should be billed for a non-emergency physician visit in the emergency department. Procedure code **T1015**, modifier **U1**, requires PCP referral. This procedure code is subject to the non-emergency outpatient hospital benefit limit of 12 visits per state fiscal year (SFY).~~

~~Physicians must use procedure code **T1015**, modifier **U2**, **Physician Outpatient Clinic Services** for outpatient hospital visits. This service requires a PCP referral. Procedure codes **T1015**, modifier **U1**, and **T1015**, modifier **U2**, are subject to the benefit limit of 12 visits per SFY for non-emergency professional visits to an outpatient hospital for patients clients age 21 and over.~~

~~To reimburse emergency department physicians for determining emergent or non-emergent patient client status, Medicaid established covers a physician assessment fee. The pProcedure code **T1015**for, **Physician Assessment in Outpatient Hospital** is payable for beneficiaries clients enrolled with a Primary Care Physician (PCP). The procedure code does not require PCP referral. The procedure code does not count against the beneficiary's client's benefit limits, but the beneficiary client must be enrolled with a PCP. It is for use when the beneficiary client is not admitted for inpatient or outpatient treatment.~~

292.740 Psychotherapy ~~**10-13-03**~~**1-1-2022**

The psychotherapy procedures covered under the Physician Program are allowed as a covered service when provided by the physician or when provided by a qualified practitioner who by State licensure is authorized to provide psychotherapy services. When a practitioner other than the physician provides the services, the services must be under the direct supervision of the physician billing for the service. For the purposes of psychotherapy services only, the term "direct supervision" means the following:

A. The person who is performing the service must be: (1) a paid employee of the physician (the physician who is billing the Medicaid Program). A W-4 Form must be on file in the physician's office or (2) a subcontractor of the physician (the physician who is billing the Medicaid Program). A contract between the physician and the subcontractor must be on file in the physician's office and

B. The physician must monitor and be responsible for the quality of work performed by the employee or subcontractor under ~~his~~ "direct supervision." The physician must be

immediately available to ~~provide assistance~~assist and ~~direction~~ direct throughout the time the service is being performed.

Psychotherapy Services must be provided by a physician rendering psychotherapy in their~~his/her~~ office, the hospital or the nursing home. Psychotherapy codes can~~may~~ not be billed in conjunction with an office visit, a hospital visit or inpatient psychiatric facility visit and can~~may~~ not be billed when services are performed in a ~~community mental health clinic~~outpatient behavioral health facility. Only one (1) psychotherapy visit per day is allowed in the physician's office, the hospital or nursing home. Psychotherapy Services provided by a psychiatrist will count against the twelve (12) visits per State Fiscal Year ~~p~~Specialty Physician~~service~~ benefit limit. Record Review is not covered.

TOC not required

171.100 PCP-Qualified Physicians and Single-Entity Providers

~~9-15-09~~71-1-22

A. Primary Care Physician (PCP)-qualified physicians are those whose sole or primary specialty is

1. Family practice
2. General practice
3. Internal medicine
4. Pediatrics and adolescent medicine
5. Obstetrics and gynecology

B. Obstetricians and gynecologists may choose whether to be PCPs.

All other PCP-qualified physicians and clinics must enroll as PCPs, except for physicians who certify in writing that they are employed exclusively by ~~an Area Health Education Center (AHEC),~~a University of Arkansas Medical School (UAMS) Regional Program, a Federally Qualified Health Center (FQHC), a Medical College Physicians Group, or a hospital (i.e., they are "hospitalists" and they practice exclusively in a hospital).

C. Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed in part A above.

D. Advanced Practice Registered Nurses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.

E. PCP-qualified clinics and health centers (single-entity PCPs) are

1. ~~AHECs~~UAMS Regional Programs
2. FQHCs
3. The family practice and internal medicine clinics at the University of Arkansas for Medical Sciences

171.630 Nurse Practitioners and Physician Assistants in Rural Health Clinics (RHCs)

~~7-1-05~~71-1-22

Advanced Practice Registered Nurses (APRN) may function as Primary Care Providers at the performing provider level.

~~Licensed~~ Registered N~~n~~urse P~~p~~ractitioners (RNP) or licensed P~~p~~hysician A~~a~~ssistants (PA) employed by a Medicaid-enrolled RHC (Rural Health Clinic) provider may not function as Primary Care Physician (PCP) substitutes, but they may provide primary care for a PCP's enrollees, with certain restrictions.

A. The PCP affiliated with the RHC must issue a standing referral, authorizing primary care services to be furnished

1. To the PCP's client enrollees
2. By registered nurse practitioners and physician assistants
3. In and/or on behalf of the RHC

B. Registered Nurse P~~p~~ractitioners (RNP) and P~~p~~hysician A~~a~~ssistants (PA) may not make referrals for medical services except for pharmacy services per established protocol.

C. The PCP must maintain a supervisory relationship with the Registered Nurse Practitioners (RNP) and Physician Assistants (PA).

220.000 Benefit Limits 9-1-20

A. ~~A.~~ Arkansas Medicaid ~~beneficiaries~~ clients aged twenty-one (21) and older are limited to ~~twelve (12)~~sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30)~~.~~ when the client is assigned to a provider enrolled in the Primary Care Case Management (PCCM) program. For clients who are not assigned to a provider enrolled in the PCCM program, the core service encounters will set at twelve. The following services are counted toward the per SFY benefit limit:

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient's home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; and
7. Advanced practice registered nurse services.

B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:

1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for beneficiaries of all ages.
2. Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.
3. Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.
4. Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis (**View ICD OUD Codes**) and rendered by a MAT specialty prescriber.

C~~B~~. Medicaid beneficiaries under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

218.100 RHC Encounter Benefit Limits 7~~9~~-1-22~~0~~

A. ~~There is no RHC encounter benefit limit for~~ Medicaid ~~beneficiaries~~ clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a RHC encounter benefit limit.

B. A benefit limit of ~~twelve~~ sixteen (16~~2~~) ~~visits~~ encounters per state fiscal year (SFY), July 1 through June 30, has been established for ~~beneficiaries~~ clients aged twenty-one (21) and older who are assign4ed to a provider enrolled in the Primary Care Case Management (PCCM) program. If the client is not assigned to a provider enrolled in the PCCM, the service limit will set at twelve.~~-~~ The following services are counted toward the ~~twelve (12)~~ visits per SFY encounter benefit limit:

1. Physician visits in the office, patient's home, or nursing facility;
2. Certified nurse-midwife visits;
3. RHC encounters;
4. Medical services provided by a dentist;
5. Medical services provided by an optometrist;~~ and~~
6. Advanced ~~nurse practitioner~~practice registered nurse services; and~~.~~
7. Federally Qualified Health Center (FQHC) encounters.

Global obstetric fees are not counted against the ~~12 visit~~ service encounter limit. Itemized obstetric office visits are counted in the limit.

The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis and rendered by a qualified X-DEA waivered provider. (**View ICD OUD Codes**).

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

218.300 Extension of Benefits 7~~10~~-1-~~15~~22

RHC encounters count toward the ~~12 visits per SFY benefit limit~~service benefit limits per state fiscal year. Arkansas Medicaid considers, upon written request, extending the RHC benefit for reasons of medical necessity.

A. Extensions of family planning benefits are not available.

B. Extensions of the RHC core service encounter benefit are automatic for certain diagnoses. The following diagnoses do not require a benefit extension request.

1. Malignant neoplasm **(View ICD codes.)**
2. HIV infection and AIDS **(View ICD codes.)**
3. Renal failure **(View ICD codes.)**

2.b. Rural Health Clinic Services

Rural health clinic services are limited to ~~twelve (12)~~sixteen (16) visits a year for ~~beneficiaries age~~clients twenty-one (21) years of age and older, when the client is assigned to a provider enrolled in the Primary Care Case Management (PCCM) program. This yearly limit is based on the State Fiscal Year (July I through June 30). If the client is not assigned to a provider enrolled in the PCCM program the service limit will set at 12. 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 and certified nurse midwife services, Federally Qualified Health Center (FQHC) encounters, and advanced practice registered nurse services ~~when they are enrolled in the primary care case management program (PCCM)~~, or a combination of the seven. ~~Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. 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, e~~Extensions of the service benefit limit will be ~~provided~~ available if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the service ~~12~~ ~~visit~~ limit.** ~~Beneficiaries~~ Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

1. Physicians' services including required physician supervisory services of nurse practitioners and physician assistants;

2. Services and supplies furnished as an incident to a physician's professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's 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 physician assistants, nurse practitioners, nurse midwives, and specialized nurse practitioners;

6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and

7. 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 rendered by an X-DEA waivered provider as 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).

~~Effective for claims with dates of service on or after July 1, 1995, federally~~ Federally qualified health center (FQHC) services are limited to ~~twelve (12)~~sixteen (16) encounters per ~~beneficiary~~client, per State Fiscal Year (July 1 through June 30) for ~~beneficiaries~~ clients age **twenty-one** (21) and older when the client is assigned ~~older~~to a provider within the PCCM program. If the client is not assigned to a provider enrolled in the PCCM program the service limit will set at 12. 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 (RHC) encounters, and advanced practice registered nurse services, or a combination of the seven. For federally qualified health center core services beyond the ~~12~~ service ~~visit~~ limit, extensions will be ~~provided~~ 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 rendered by an X-DEA waivered provider as part of a Medication Assisted Treatment plan.

5. a. Physicians' services, whether furnished in the office, the ~~beneficiary's~~ client's home, a hospital, a skilled nursing facility, or elsewhere

(1) ~~Physicians' services in a physician's office, patient's home or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and older.~~**For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, or nursing home are limited to 12 visits per state fiscal year (SFY) (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). If the client is assigned to a physician or (APRN) who is enrolled in the PCCM, the limit is sixteen (16) visits.**

(a) Benefit Limit Details

~~The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and advanced practice nurse or registered nurse practitioner services or a combination of the six. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.~~

~~Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.~~

The benefit limit will be considered in conjunction with the benefit limit established for Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services **and advanced practice nurse or registered nurse practitioner services or a combination of the seven**. For services beyond the established visit limit, extensions 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 (21) in the Child Health Services (EPSDT) Program are not benefit limited.

Certain services, specified in the appropriate provider manual, are not counted toward the limit.

(b) Extensions

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.

(i) The following diagnoses are considered to be 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.

(~~2~~) **(iii)** 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.

(~~3~~**iv**) Surgical procedures ~~**that**~~ which are generally considered to be elective require **p~~P~~**rior **a~~A~~**authorization from the Utilization Review Section.

(~~4~~**)(v)** Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

(iv~~6~~) Organ transplants are covered as described in Attachment 3.1-E.

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 recipient under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be provided if medically necessary for recipients 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 beneficiaries age 21 and 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, certified nurse midwife services and advanced practice nurse or registered nurse practitioner or a combination of the six. 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 12 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 (APRN)~~Practitioners and Registered Nurse Practitioners~~

~~Office medical services provided by an advanced nurse practitioner and registered nurse practitioner are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and over.~~ For clients twenty-one (21) years of age or older, services provided in a nurse practitioner's office, a patient's home or nursing home are limited to 12 visits per state fiscal year (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM) as a Medicaid Primary Care Provider. If the client is assigned to a provider enrolled in the PCCM, the limit is sixteen (16) visits.

The benefit limit will be in conjunction with the benefit limit established for physicians' services, Rural Health Clinic (RHC), medical services furnished by a dentist, office medical services furnished by an optomestrist, ~~rural health clinic services,~~ certified nurse midwife services and federally qualified health center (FQHC) ~~advanced practice nurse or registered nurse practitioner~~ or a combination of the seven~~six~~. For services beyond the established ~~twelve (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. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

2.b. Rural Health Clinic Services

Rural health clinic services are limited to ~~twelve (12)~~sixteen (16) visits a year for ~~beneficiaries~~ clients age twenty-one (21) and older who are assigned to a provider ~~when the client is assigned to a provider~~ enrolled in the Primary Care Case Management (PCCM) program.~~.~~ This yearly limit is based on the State Fiscal Year (July I through June 30). If the client is not assigned to a provider enrolled in the PCCM program the service limit will set at 12. The benefit limit ~~will~~ for those who are not assigned to a PCCM provider will be set at twelve (12) visits per SFY. Rural Health Clinic visits 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, ~~and~~ certified nurse midwife services, Federally Qualified Health Center (FQHC) encounters, and advanced practice registered nurse services or registered nurse practitioner services ~~,~~or a combination of the seven. ~~when they are enrolled in the Primary Care Case Management (PCCM) program~~. ~~Beneficiaries will be allowed twelve (12) visits per State Fiscal Year for rural health clinic services, physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or a combination of the five. 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,~~ Benefit limit extensions will be ~~provided~~ available if medically necessary. **Certain services, specified in the appropriate provider manual, are not counted toward the ~~12~~ service ~~visit~~ limit.** ~~Beneficiaries~~ Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

Rural Health Clinic core services are defined as follows:

1. Physicians' services including required physician supervisory services of nurse practitioners and physician assistants;

2. Services and supplies furnished as an incident to a physician's professional services;

   Services and supplies "incident to" the professional services of physicians, physician assistants and/or nurse practitioners are those which are commonly furnished in connection with these professional services, are generally furnished in the physician's 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 physician assistants, nurse practitioners; nurse midwives; and specialized nurse practitioners;

6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and

7. 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 rendered by an X-DEA waivered provider as 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).

~~Effective for claims with dates of service on or after July 1, 1995, f~~Federally qualified health center (FQHC) services are limited to ~~twelve (12)~~sixteen (16) encounters per ~~beneficiary~~client, per State Fiscal Year (July 1 through June 30) for ~~beneficiaries~~ clients age **twenty-one** (21) and older when the client is assigned to a provider enrolled in the Primary Care Case Management (PCCM) program. If the client is not assigned to a provider enrolled in the PCCM program the service limit will set at twelve~~12~~. 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 (RHC) encounters, and advanced practice registered nurse or registered nurse practitioner services, or a combination of the seven. ~~For federally qualified health center core services beyond the 12-visit limit,~~ Benefit extensions will be ~~provided~~ available if medically necessary. ~~Beneficiaries~~ 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 rendered by an X-DEA waivered provider as part of a Medication Assisted 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

(i) 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: ☐ No limitations [X] 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:

Face-to-face tobacco cessation counseling services are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per state fiscal year.

4.e. Prescription drugs for treatment of opioid use disorder

a. Oral preferred prescription drugs (preferred on the PDL) used for treatment of opioid use disorder require no prior authorization and do not count against the monthly prescription limits when prescribed by an X-DEA waivered provider as part of a Medication Assisted Treatment plan.

~~5.a. Physicians' services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere~~

~~(1) Physicians' services in a physician's office, patient's home, or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age twenty-one (21) and older.~~

5. a. Physicians' Services ~~(Continued)~~

For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, or nursing home are limited to 12 visits per state fiscal year (July 1 through June 30) unless the client is assigned to a provider enrolled in the Primary Care Case Management Program (PCCM) as a Medicaid Primary Care Provider. If the client is assigned to a provider enrolled in the PCCM, the limit is sixteen (16) visits.

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurse or registered nurse practitioners' services. Rural Health Clinic (RHC), medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and federally qualified health center (FQHC), or a combination of the seven. For services beyond the established visit limit, extensions will be available if medically necessary. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

Certain services, specified in the appropriate provider manual, are not counted toward the limit.

~~(a) Benefit Limit Details~~

~~The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic services, medical services furnished by a dentist, 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. Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.~~

~~Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit.~~

~~(b) Extensions~~

~~For services beyond the 12 visit limit, extensions will be provided if medically necessary~~.

~~(i)~~ **(1)** The following diagnoses are considered to be categorically medically necessary and are exempt from benefit extension requirements: Malignant neoplasm; HIV infection and renal failure.

~~(ii)~~ (2) ~~Additionally~~, P~~p~~hysicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(3~~2~~) 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~~3~~) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

(5~~4~~) Desensitization injections - Refer to Attachment 3.1-A, Item 4.b. (12).

~~(6~~5~~)~~ Organ transplants are covered as described in Attachment 3.1-E.

(7~~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.

(8~~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.

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 recipients under 21 years of age in the Child Health Services (EPSDT) Program. Extensions of the benefit limit will be provided if medically necessary for recipients 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 beneficiaries age 21 and 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, certified nurse midwife and services provided by an advanced practice nurse or registered nurse practitioner or a combination of the six. 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 12 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 ~~Practitioners and Registered Nurse Practitioners~~

~~Office medical services provided by an advanced nurse practitioner and registered nurse practitioner are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for beneficiaries age 21 and 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, certified nurse midwife services and advanced practice nurse or registered nurse practitioner or a combination of the six. 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 12 visit limit. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.~~For client's twenty-one (21) years of age or older, services provided in a nurse practitioner's office, a patient's home, or nursing home are limited to twelve (12) visits per state fiscal year (July 1 through June 30) unless the client is assigned to a provider enrolled in the PCCM, the limit is sixteen (16) visits. If the client is not assigned to a provider enrolled in the PCCM, the limit is set at twelve (12) visits per state fiscal year.

The benefit limit will be in conjunction with the benefit limit established for physicians' services, Rural

Health Clinic (RHC), medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, and federally qualified health center (FQHC) 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.

State of Arkansas *As Engrossed: H2/24/21 S3/17/21*
93rd General Assembly **A Bill**
Regular Session, 2021 HOUSE BILL 1254

By: Representatives Wardlaw, M. Gray, Dotson
By: Senator K. Hammer

For An Act To Be Entitled

AN ACT TO AUTHORIZE THE ARKANSAS MEDICAID PROGRAM TO RECOGNIZE AN ADVANCED PRACTICE REGISTERED NURSE AS A PRIMARY CARE PROVIDER; AND FOR OTHER PURPOSES.

Subtitle

TO AUTHORIZE THE ARKANSAS MEDICAID PROGRAM TO RECOGNIZE AN ADVANCED PRACTICE REGISTERED NURSE AS A PRIMARY CARE PROVIDER.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is amended to add an additional section to read as follows:

20-77-140. Primary care provider for Arkansas Medicaid Program — Advanced practice registered nurse.

(a)(1) The Arkansas Medicaid Program shall recognize an advanced practice registered nurse licensed by the Arkansas State Board of Nursing for all purposes as a primary care provider authorized to carry out the duties of a primary care case *manager, except as provided under subdivision (a)(3) of this section.*

(2) Purposes under subdivision (a)(1) of this section include without limitation:

(A) Being recognized as the initial healthcare provider in the Arkansas Medicaid Program;

(B) Performing initial diagnosis;

(C) Acting as the team leader of family practice professionals and the patient-centered medical home;

(D) Maintaining the medical records of a patient;

(E) Ordering laboratory tests and records management as needed for patient care;

(F) Providing preventive and periodic examinations within primary care;

(G) Referring a patient to a physician, a specialist, or a hospital when necessary; and

(H) Treating a patient within the scope of practice and *licensure of an advanced practice registered nurse.*

(3) Purposes under subdivision (a)(1) of this section does not include owning a patient-centered medical home.

(b) The program shall reimburse an advanced practice registered nurse:

(1) Not less than the current reimbursement rate for services performed within the scope of practice and licensure of the advanced practice registered *nurse; and*

(2) One hundred percent (100%) of the physician reimbursement rate for all out-of-pocket costs incurred by the advanced practice registered nurse such as the costs of laboratory tests, X-rays, and any additional tests ordered or conducted by the advanced practice registered *nurse.*

(c) A healthcare insurance policy in which the premiums are paid directly or indirectly by the program also shall recognize and reimburse an advanced practice registered nurse under subsections (a) and (b) of this section.

(d) This section does not increase the scope of practice or licensure of an advanced practice registered nurse.

/s/Wardlaw

APPROVED: 4/5/21

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** 501-682-8155 **EMAIL:** Jason.callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE PCP Visits and Act 569 of 2021

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;
   N/A

   (b) The reason for adoption of the more costly rule;
   N/A

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;
   N/A

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.
   N/A

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds	$0	Cash Funds	$0
Special Revenue	$0	Special Revenue	$0
Other (Identify)	$0	Other (Identify)	$0
Total	$0	Total	$0

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$120,603	General Revenue	$241,206
Federal Funds	$304,354	Federal Funds	$608,709
Cash Funds	$0	Cash Funds	$0
Special Revenue	$0	Special Revenue	$0
Other (Identify)	$0	Other (Identify)	$0
Total	$424,957	Total	$849,915

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

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 120,603	$ 241,206

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose; **A revision of the Medicaid State Plan and Rules is necessary to increase state fiscal year service visit limits from twelve (12) to sixteen (16) for Medicaid adult clients who are assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). The revision allows APRNs to enroll as a Primary Care Physician per Act 569 of 2021.**

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute**; The agency seeks to improve access to primary care services by including APRNs in its program and to eliminate administrative burden by increasing the service visit limit per year. Act 569 of 2021 requires Medicaid to allow APRNs to enroll as PCPs.**

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs; **The changes described above will improve access to primary healthcare for adults. They will encourage primary providers to see Medicaid clients by reducing administrative burden and financial risk of seeing patients by increasing yearly coverage before requiring a records review to establish medical need for extended benefits.**

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **No less costly alternatives were identified.**

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; **No alternatives are proposed at this time.**

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

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives. **The Agency monitors State and Federal rules and regulations for opportunities to reduce and control cost.**

Statement of Necessity and Rule Summary

PCP Visits and Act 569 of 2021

Statement of Necessity & Rule Summary

Beginning with date of service July 1, 2022 and after, this Rule will increase the number of service benefit visits for Medicaid clients who are assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). The limit is being increased from twelve (12) visits to sixteen (16) visits per State Fiscal Year (SFY). Each SFY runs from July 1 through June 30.

The Rule implements the requirements of Act 569 of 2021. Act 569 designates Advanced Practice Registered Nurses (APRN) as PCPs when enrolled in the PCCM Program. Under Ark. Code Ann. §17-87-302, APRN includes the following nurse types: Certified Nurse Practitioner (CNP); Certified Registered Nurse Anesthetist (CRNA); Certified Nurse Midwife (CNM); and Clinical Nurse Specialist (CNS).

Summary of Changes

Medicaid is updating Section I of all provider manuals, along with Section II of the Physician, Nurse Practitioner, Federally Qualified Health Center (FQHC), and Rural Health Clinic (RHC) provider manuals. Other updates clarify APRNs may enroll as a PCP.

Amendments to the SPA mirror the updated provider manual changes.

Please attach additional documents if necessary:

-Act 569

-Amendments to Provider Manuals and Arkansas Medicaid SPA

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed ruleunder one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76- 201, 20-77-107, and 25-10-129.

Effective July 1, 2022:

The Director of the Division of Medical Services (DMS) amends the Medicaid State Plan, Section I for all manuals, section II for the Physician, Nurse Practitioner, Federally Qualified Health Center (FQHC), and Rural Health Clinic (RHC) manuals. The changes increase the State Fiscal Year service visit limit from twelve to sixteen for clients twenty-one years of age and older who are assigned to a provider enrolled in the Primary Care Case Management Program (PCCM). DMS implements Act 569 of the 93rd General Assembly for APRNs to enroll as PCPs.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **March 14, 2022**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on **March 8, 2022** at **10:00** a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at **https://us02web.zoom.us/j/89821809485**. The webinar ID is **898 2180 9485**. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or internationalphone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502035775

Elizabeth Pitman, Director
Division of Medical Services