ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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Name of Rule Hospital Reimbursement for Long Acting Reversible Contraceptives (LARCs)

Newspaper Name Arkansas Democrat Gazette

Date of Publishing September 23, 2023

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Location and Time of Public Meeting October 4,2023 at 11:30 am by Zoom:https://us02web.zoom.us/j/84641394854 Webinar ID: 846 4139 4854

TOC not required

292.551 Family Planning Services For Beneficiaries

~~2-1-22~~1-1-24

Family planning services are covered for beneficiaries in full coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in Section 292.552.

A. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.

B. The following procedure table explains family planning procedure codes payable to physicians. These codes require modifier FP except for hospital-based physicians. (See Sections D, E and F below for codes payable to hospital-based physicians.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations.

**This procedure requires special billing instructions. Refer to Section 292.553.

***Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider.

¤This procedure code is not to be billed with an FP modifier but should follow the anesthesia billing protocol as seen in Sections 272.100, 292.440 through 292.442 and 292.444 through 292.447.

C. The following procedure code table explains the family planning visit services payable to physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

D. The following procedure code table explains the codes that are payable to hospital-based physicians.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations; however, these procedure codes are not allowable for Aid Category 69.

**This procedure requires special billing instructions. Refer to Section 292.553.

E. The following procedure code table explains the family planning visit services payable to the hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

F. Effective 1/1/2024,- providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, ~~**see LARC billing combinations for billing codessee**~~ **LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. See ~~**see**~~ **LARC billing combinations for billing codes**.
4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

G. The following procedure code table explains the pathology procedure code payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 292.552**.

TOC not required

214.330 Family Planning Coverage Information

~~1-15-16~~1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.

C. Nurse practitioners desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age.

D. Nurse practitioners preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Physicians
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians
8. Certified Nurse-Midwives

E. Effective 1/1/2024, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.

3. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. ~~See s~~**See LARC billing combinations for billing codes**.

4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

TOC not required

215.200 Family Planning Coverage Information

~~10-1-15~~1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, certified nurse-midwives, clinics, and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family Planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 215.200 through 215.260 of this manual for service descriptions and coverage information.

C. Certified nurse-midwives desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 215.210 through 215.260, to Medicaid beneficiaries of childbearing age.

D. Certified nurse-midwives preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners
4. Rural Health Clinics.
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians

E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for

the LARC device, if provided by the Physician. ~~See s~~**See LARC billing combinations for billing codes**.

4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 215.200-215.260.

TOC not required

216.000 Family Planning

~~10-1-15~~1-1-24

States participating in the Medicaid Program are required to cover family planning services. Arkansas Medicaid covers family planning services in a variety of settings, including hospitals. See Sections 216.100-216.110, 216.130-216.132, 216.515 and 216.540-216.550 for Family Planning Information.

Effective 1/1/2024~~,~~ providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

A. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).

B. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.

C. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. See **~~see~~ LARC billing combinations for billing codes**.

D. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

1. Inpatient Hospital Services (continued)

Long-Acting Reversible Contraceptives (LARC)

Effective for claims with dates of service on or after January 1, 2024, all acute care hospitals will be reimbursed in addition to the per diem rates for Food and Drug Administration approved Long-Acting Reversible Contraceptives (LARCs) to include the IUD and contraceptive implants, and insertion and removal. LARC reimbursement will be the same as found in Attachment 4.19-B page 1v.

RULES SUBMITTED FOR REPEAL

Rule #1: DDS Policy 1088 – Burial Insurance

Rule #2: DDS Policy 2001 – Building and Contents Insurance Claims

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	Burial Insurance	1088

1. **Purpose**: The purpose of this policy is to ensure that burial insurance is offered to any person residing in a Human Development Center (HDC) and to ensure that affected DDS community providers are informed about the existence of burial insurance when an individual moves from an HDC to the community.

2. **Scope**: This policy applies to all employees of DDS.

3. **Definitions**:

A. Burial Insurance – An insurance policy purchased by or for an individual specifically for the purpose of providing funds for burial expenses.

B. Consent – Written permission from the decision-maker approving the purchase of a specific benefit amount of burial insurance.

C. Designated staff member – The employee of an HDC who has been specified by the HDC administrator to perform tasks related to burial insurance.

D. Decision-maker – The individual with the legal authority to consent to or refuse the expenditure of funds. This may be an adult individual receiving services, the parent(s) of a minor child receiving services, or an adult individual's legal guardian.

4. **Procedures**:

A. Prior to or upon admission, the designated staff member will request from the individual, the parent(s), a responsible party, or the legal guardian copies of any burial and/or life insurance policies that are in effect for the individual being admitted.

B. Prior to or upon admission, a designated staff member will discuss with the decision maker burial insurance options that are available.

C. If the decision maker decides to purchase burial insurance, the designated staff member will obtain written consent to purchase burial insurance for the individual and will notify the funeral home chosen by the decision maker. Refusal of burial insurance by the decision maker will also be documented.

D. The cost of the burial insurance will be the responsibility of the decision-maker.

Policy Type	Subject of Policy	Policy No.
Administrative	Burial Insurance	1088

E. Information about burial insurance will be presented to the decision maker at least annually, if burial insurance appears to be warranted and the purchase of burial insurance has previously been refused.

F. The funeral home that sells the burial insurance will normally be named as the beneficiary. If the funeral home that sold the policy will not be the funeral home to conduct the burial, and a transfer of benefits from the former funeral home to the latter is not an option, the designated staff member will ask the decision maker to name another beneficiary.

G. Upon the discharge of an individual from an HDC, the designated staff member will provide information for the continuation of burial insurance to the decision maker, the individual's DDS Service Specialist, and to the DDS community provider who will be providing the individual's services.

5. **Record Keeping**:

Written consent forms for the purchase of burial insurance will be completed and placed in the individual's Master File within 15 days of admission or at the time of signing if the burial insurance is purchased at a later date. Copies of all policies will be maintained in the Master File.

Reviewed: Arkansas Legislative Council Administrative (Rules and Regulations) Subcommittee _____ 2003

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Fiscal	Building and Contents Insurance Claims	2001

1. Purpose. This policy has been prepared to explain the real property insurance claim responsibility of the Department of Human Services Division of Developmental Disabilities Services.

2. Scope. This policy concerns all business managers of Developmental Disabilities Services and other interested parties. The DDS Director/designee(s) has responsibility for ensuring compliance.

3. Agency Responsibility. DDS will carry real property insurance on State buildings and certain of their contents held in trust by the DDS Board.

4. Procedural Additions. Procedures for making insurance claims against real property damage are kept in and disseminated by Department of Human Services – Division of Management Services.

REPEAL-EO 23-02

Replacement Notation: This Policy replaces DDS Deputy Director's Office Policy Number 1001 effective October 17, 1979.

Effective Date: March 15, 1993 Sheet 1 of 1

References: Board Action December 15, 1979

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE _____

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 no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$139,554	General Revenue	$279,107
Federal Funds	$1,255,984	Federal Funds	$2,511,967
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 1,395,537.00	Total	$ 2,791,075.00

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

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

6. What is the total estimated cost by fiscal year to a state, county, or 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**
$ 139,554.00	$ 279,107.00

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;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(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;

(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;

(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;

(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

(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.

FINANCIAL IMPACT STATEMENT ADDENDUM

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;

Act 581 of 2023 requires Medicaid to allow separate reimbursement of long-acting reversible contraceptives for hospitalized Medicaid beneficiaries immediately after birth of a child or during postpartum.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

According to findings of ACT 581 of 2023, long-acting reversible contraceptives are cost-prohibitive for providers of healthcare services when provided at the same time as other services rendered at time of birth or during the postpartum eligibility period.

(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;

Allowing separate reimbursement of LARCs removes barriers and provides access to effective family planning services for women of child-bearing age.

(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;

None

(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;

None

(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

N/A

(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 policies for opportunities to reduce and control cost.

Statement of Necessity and Rule Summary
[Hospital Reimbursement for Long-Acting Reversible Contraceptives]

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

The Long-Acting Reversible Contraceptive (LARC) rule is necessary to comply with Act 581 of 2023 which allows separate reimbursement of long-acting reversible contraceptives for hospitalized Medicaid beneficiaries immediately after birth of a child or during postpartum. Thus, it is necessary to update the appropriate Medicaid provider manuals and state plan to furnish information to providers regarding the rules required to claim reimbursement.

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

Physician Manual: Section 292.551 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Nurse Practitioner Manual: Section 214.330 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Certified Nurse Midwife Manual: Section 215.200 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Hospital Manual: Section 216.000 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Medicaid state plan: Amended attachment 4.19-A, Page 11ddd, to establish the reimbursement method for the LARC device and insertion when the beneficiary is a hospital inpatient.

Repeals pursuant to the Governor's Executive Order 23-02:

1. DDS Policy 1088 – Burial Insurance, and
2. DDS Policy 2001 – Building and Contents Insurance Claims.

NOTICE OF RULE MAKING

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

The Director of the Division of Medical Services amends Section 292.551 of the Physician Manual, Section 214.330 of the Nurse Practitioner Manual, Section 215.200 of the Certified Nurse Midwife Manual, Section 216.000 of the Hospital Manual, and the Medicaid State Plan to comply with Act 581 of the 94th General Assembly. The proposed effective date is January 1, 2024. Act 581 directs the Arkansas Medicaid Program to reimburse a healthcare provider for providing long-acting reversible contraception immediately after childbirth and during postpartum. The proposed rule estimates a financial impact of $1,395,537 ($1,255,984 of which is federal funds) for state fiscal year (SYF) 2024 and $2,791,075 ($2,511,967 of which is federal funds) for SYF 2025.

Pursuant to the Governor's Executive Order 23-02, DHS repeals the following two rules as part of this promulgation: (1) DDS Policy 1088 – Burial Insurance, and (2) DDS Policy 2001 – Building and Contents Insurance Claims.

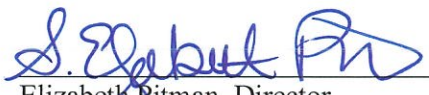
The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state.

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 October 22, 2023. 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 October 4th at 11:30 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/84641394854. The webinar ID is 846 4139 4854. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone 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 501-534-4138.

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. 4502172997



Elizabeth Pitman, Director
Division of Medical Services