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 Continuous Glucose Monitors and Diabetic Supplies Coverage

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TOC not required

221.100 ARKids First-B Medical Care Benefits

~~2-1-22~~5-1-24

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code****, when the diagnosis is within the ICD range (View ICD codes.))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	$10 per visit
Chiropractor	Medical Necessity	PCP Referral	$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	$10 per visit
Durable Medical Equipment	Medical Necessity $500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	$10 per visit
Assessment	Medical Necessity	None	$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30)	PCP Referral	$10 per visit
Hospital, Inpatient	Medical Necessity	PA on stays over 4 days if age 1 or over	10% of first inpatient day
Hospital, Outpatient	Medical Necessity	PCP referral	$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	$10 per visit
Medical Supplies	Medical Necessity Benefit of $125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding $125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	PCP Referral PA on treatment services	$10 per visit
School-Based Mental Health	Medical Necessity	PA Required (See Section 250.000 of the School-Based Mental Health provider manual.)	$10 per visit
Nurse Practitioner	Medical Necessity	PCP Referral	$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	$10 per visit
Podiatry	Medical Necessity	PCP Referral	$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs Diabetic Supplies	Medical Necessity	Prescription	Up to $5 per prescription (Must use generic, if available)***
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None
Rural Health Clinic	Medical Necessity	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Speech-Language Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	$10 per visit
Occupational Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Physical Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of $5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to $5.00 per prescription. For billing information to include Continuous Glucose Monitors (CGM), CGM supplies, patch or tubeless insulin pumps, blood glucose monitors (BGMs), and glucose testing supplies see the **DHS contracted Pharmacy Vendor's website**.

****View or print the procedure codes for ARKids First-B procedures and services.

TOC not required

242.150 Home Health Medical Supplies

~~2-1-22~~5-1-24

The following Health Care Procedural Coding System (HCPCS) codes must be used when billing the Arkansas Medicaid Program for medical supplies. Providers must use the current HCPCS Book for code descriptions.

View or print the procedure codes for Home Health services.

Listed below are medical supplies that require special billing or need prior authorization. These items are listed with the HCPCS codes and require modifiers. The asterisk denotes these items and the required modifiers.

A. *Home Blood Glucose Supplies~~-~~ - Available to all beneficiaries~~ - Pregnant Women Only, All Ages~~

~~Codes must be billed either electronically or on paper with modifier NU for beneficiaries of all ages. When a second modifier is listed, that modifier must be used in conjunction with the NU modifier.~~

B. **Gradient Compression Stocking (Jobst Stocking), All Ages

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. Before supplying the items, the Jobst stocking must be prior authorized by AFMC. **View or print form DMS-679A and instructions for completion.** Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stocking and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy.

Code must be manually priced.

Code requires a prior authorization (PA). See Section 221.000.

Code requires prior authorization (PA); see Section 221.000. Code is manually priced and is covered for beneficiaries ages 0-20 years of age.

C. ***Food Thickeners, All Ages

Food thickeners, including “Thick-it”, “Simple Thick”, “Thick and Easy” and “Thick and Clear” are not subjected to the medical supply benefit limit.

The modifier **NU** must be used with the code found in this section and when food thickeners are administered enterally, the modifier **“BA”** must be used in conjunction with the code.

When food thickeners are billed, total units are to be calculated to the nearest full ounce. Partial units may be rounded up. When a date span is billed, the product cannot be billed until the end date of the span has elapsed.

The maximum number of units allowed for food thickeners is 16 units per date of service.

The following HCPCS codes usage must match the Arkansas Medicaid code description and use of modifier(s).

~~*The following HCPCS codes and modifiers are covered only for pregnant women.~~

TOC not required

212.000 Exclusions

~~8-1-21~~5-1-24

A. Products manufactured by non-rebating pharmaceutical companies.

B. Effective January 1, 2006, the Medicaid agency will not cover any drug covered by Medicare Part D for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

C. The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid beneficiaries under § 1927 (d) of the Social Security Act, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses; with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR § 423.104 (f) (1) (ii) (A),to full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

The following excluded drugs are set forth on the **DHS Contracted Pharmacy Vendor website.**

1. Select agents when used for weight gain
2. Select agents when used for the symptomatic relief of cough and colds
3. Select prescription vitamins and mineral products, except prenatal vitamins and fluoride
4. Select nonprescription drugs
5. ~~Select agents when used to promote smoking cessation~~

D. Medical accessories are not covered under the Arkansas Medicaid Pharmacy Program. Typical examples of medical accessories are atomizers, nebulizers, hot water bottles, fountain syringes, ice bags and caps, urinals, bedpans, ~~glucose monitoring devices and supplies,~~ cotton, gauze and bandages, wheelchairs, crutches, braces, supports, diapers, and nutritional products.

216.100 Medical Supplies for Long-Term Care Facility Residents

~~10-13-03~~5-1-24

A pharmacy often supplies items that are not covered under the Arkansas Medicaid Program to Medicaid eligibles in a long-term care facility. Under the cost-related reimbursement system in which long-term care (LTC) facilities are reimbursed, many of these items are the financial responsibility of the facility; therefore, the patient or the patient's family should not be billed for these items. The facility must furnish the following items to Medicaid beneficiaries:

A. First aid supplies (e.g., small bandages, merthiolate, mercurochrome, hydrogen peroxide, ointments for minor cuts and abrasions);

B. Dietary supplies (e.g., salt and sugar substitutes, supplemental feedings, equipment for preparing and dispensing tube feedings);

C. Items normally stocked by the facility in gross supply and distributed in small quantities (e.g., alcohol, hydrogen peroxide, applicators, cotton balls, tongue depressors);

D. All over-the-counter drugs and glucose monitors and supplies;

E. Enemas and douches—including equipment and solution (also disposables);

F. Catheters;

G. Special dressings (e.g., gauze, 4-by-4s, ABD pads, surgical and micropore tape, telfa gauze, ace bandages);

H. Colostomy drainage bags and

I. Equipment required for simple tests such as clinitest, acetest and dextrostix.

216.101 Medical Supplies Covered as a Pharmacy Benefit ~~1~~5-1-24

The pharmacy National Council for Prescription Drug Program (NCPDP) benefit for the Arkansas Medicaid pharmacy program covers continuous glucose monitors (CGMs) and other diabetic supplies. This coverage would include CGMs and supplies, patch type insulin pumps and supplies, and blood glucose monitors (BGMs) and supplies.

A. Medicaid beneficiaries are eligible for diabetic supplies processed as a pharmacy claim submission by pharmacies or DME providers and the provider (DME or pharmacy) will be reimbursed at the Wholesale Acquisition Cost (WAC) plus the applicable professional dispensing fee.

B. Traditional insulin pumps requiring tubing and cannula type supplies will remain processed as a medical benefit.

C. Beneficiaries with Medicare Part B benefits will continue to be serviced under the Durable Medical Equipment (DME) program.

D. For coverage details concerning prior authorization requirements and preferred product list see the **DHS Pharmacy Vendor's website** for specific information.

TOC required

212.206 ~~(DME)~~ Home Blood Glucose Monitor and Supplies, ~~Pregnant Women Only,~~ All Ages

~~8-1-05~~5-1-24

~~Arkansas Medicaid covers the home blood glucose monitor for pregnant women of all ages. Prior authorization is not required for use of this device.~~

A. ~~Patient Eligibility~~

~~1. Pregestational diabetes. Women on an oral hypoglycemic or insulin when the pregnancy is diagnosed.~~

~~2. Women that are being followed by a physician for elevated fasting hyperglycemia, but not on an oral hypoglycemic or insulin when the pregnancy is diagnosed.~~

~~3. Women demonstrating glucose intolerance during the pregnancy as demonstrated by an elevated three-hour glucose tolerance test.~~

Effective 4/1/2024, Medicaid beneficiaries are eligible for diabetic and blood sugar testing supplies processed as a pharmacy claim submission by pharmacies or DME providers. Home blood sugar meters and supplies (strips, lancets, calibration solution, etc.) are available without a prior authorization. **See the DHS Pharmacy Vendor's website for specific information for coverage details**.

B. ~~Criteria for glucose intolerance~~

~~1. Demonstration of an elevated one-hour glucose tolerance test of greater than 140 mg/deciliter on a non-fasting value.~~

~~2. Elevation of two or more values on a three-hour glucose tolerance test above the accepted cut-off points of:~~

~~a. Fasting, less than 105~~

~~b. One-hour, less than 190~~

~~c. Two-hour, less than 165~~

~~d. Three-hour, less than 145~~Beneficiaries with Medicare Part B benefits continue to be serviced under the durable medical equipment (DME) program.

212.207 ~~(DME)~~ Insulin Pump and Supplies, All Ages

~~8-1-21~~5-1-24

Insulin pumps and supplies are covered by Arkansas Medicaid for beneficiaries of all ages. Effective 4/1/2024, patch or tubeless insulin pumps are processed as a pharmacy claim submission by pharmacies or DME providers while traditional insulin pumps requiring tubing and cannula type supplies remain processed as a medical claim. Beneficiaries with Medicare Part B benefits continue to be serviced for all of their needs under the DME program.

Prior authorization is required for the insulin pump. A prescription and proof of medical necessity are required. The patient must be educated on the use of the pump, but the education is not a covered service.

Insulin is covered through the prescription drug program.

The following criteria will be utilized in evaluating the need for the insulin pump:

A. Insulin-dependent diabetes that is difficult to control.

B. Fluctuation in blood sugars causing both high and low blood sugars in a patient on at least three (3), if not four (4), injections per day.

C. Beneficiary's motivation level in controlling diabetes and willingness to do frequent blood glucose monitoring.

D. Beneficiary's ability to learn how to use the pump effectively. This will have to be evaluated and documented by a professional with experience in the use of the pump.

E. Determination of the beneficiary's suitability to use the pump should be made by a diabetes specialist or endocrinologist.

F. Beneficiaries not included in one (1) of these categories will be considered on an individual basis.

Prior authorization requests for ~~the~~ traditional insulin pumps and supplies (cannula, tubing) must be submitted on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

When submitting prior authorization requests for the patch or tubeless insulin pumps see the **DHS Pharmacy Vendor's website** for specific information for coverage details.

212.208 Continuous Glucose Monitors

~~1-1-22~~5-1-24

A. ~~The Arkansas Medicaid Program provides coverage for a continuous glucose monitor (CGM) for the treatment of a Medicaid client if the client has:~~Effective 4/1/2024, continuous glucose monitors (CGMs) are processed as a pharmacy claim submission by pharmacies or DME providers. Beneficiaries must meet the following criteria for coverage:

1. Either:
   a. A presence of type 1 diabetes or any other type of diabetes with the use of insulin ~~more than two (2) times daily~~; or
   b. A presence of type 1 diabetes or any other type of diabetes with evidence of Level 2 or Level 3 hypoglycemia; or
   c. Diagnosis of glycogen storage disease type 1a; or
   d. Use of an insulin pump; and
2. Regular follow-up with a healthcare provider at a minimum every six (6) months to assess for ongoing benefit.
3. **See the DHS Pharmacy Vendor's website** for specific information for coverage details.

B. Definition. As used in this section, "continuous glucose monitor" means an instrument or device, including repair and replacement parts, that:

1. Is designed and offered for the purpose of aiding an individual with diabetes;
2. Automatically estimates blood glucose levels, also called blood sugar, throughout the day and night;~~Measures glucose levels at set intervals by means of a small electrode placed under the skin and held in place by an adhesive; and~~
3. Is generally not useful to an individual who has not been diagnosed with diabetes.

~~C. Additional requirements are set out in Section 242.113.~~Beneficiaries with Medicare Part B benefits continue to be serviced under the DME program.

242.112 Home Blood Glucose Monitor and Supplies – Pregnant Women Only, All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **NU** for individuals of all ages. When a second modifier is listed, that modifier must be used in conjunction with the **NU** modifier.

Modifiers in the section are indicated by the headings M1 and M2. Prior authorization is indicated by the heading PA.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.113 Continuous Glucose Monitors 1-1-22

A. A Continuous Glucose Monitor (CGM) is covered by Arkansas Medicaid as set out in Section 212.208 of this provider manual.

B. The correct procedure codes and modifiers are found in the following link:

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

C. A prior authorization (PA) is required for a CGM. Requests for prior authorization must be submitted to DHS or its designated vendor. **View or print contact information for how to submit the request**. Requests must be made on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* (**View or print form DMS-679A and instructions for completion.**)

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(5) Aerochamber Device

Effective for dates of service on or after October 1, 1997, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX (Medicaid) maximum established was based on a 1997 survey of Durable Medical Equipment (DME) providers. The information obtained in the survey indicated there is only one major manufacturer and distributor of the aerochamber devices (with or without mask) to providers enrolled in the Arkansas Medicaid Program. It was determined the aerochamber devices are sold to each provider for the same price. As a result, the current Title XIX (Medicaid) maximum for the aerochamber devices (with or without mask) was established based on the actual manufacturer=s list prices. Thereafter, adjustments will be made based on the consumer price index factor to be implemented at the beginning of the appropriate State Fiscal Year, July 1.

(6) Specialized Wheelchairs, Seating and Rehab Items

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. Effective for claims with dates of service on or after May 1, 1995, the Title XIX (Medicaid) maximums were established utilizing the manufacturer's current published suggested retail price less 15%. The 15% is the median of Oklahoma Medicaid which is currently retail less 12% and Texas Medicaid which is currently retail less 18%. Effective for claims with dates of service on or after September 1, 1995, the following Kaye Products, procedure codes Z2059, Z2060, Z2061 and Z2062, are reimbursed at the manufacturer's current published suggested retail price. The State Agency and affected provider association representatives will review the rates annually and negotiate any adjustments.

(7) DME/Continuous Glucose Monitors.

Procedure Codes and Rates.

A. **Rates. Effective for dates of service on or after January 1, 2022, reimbursement for Continuous Glucose Monitors (CGM) and related supplies is based on the Medicare non-rural rate for the State of Arkansas (effective as of July 28, 2021, and subject to change when Medicare rates are adjusted) for the allowable procedure codes. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.**

~~A.~~B. **Effective for dates of service on or after April 1, 2024, reimbursement for Continuous Glucose Monitors (CGM) and related Diabetic Supplies including patch type insulin pumps is based on Wholesale Acquisition Cost (WAC) plus applicable professional dispensing fee. Traditional insulin pumps will**

remain at the Medicare non-rural rate as stated in A. above.

SPA # 14, Purpose of SPA:

The purpose of this SPA is to improve access to continuous glucose monitors (CGMs) through pharmacy claim submission processing for reimbursement to pharmacies and DME providers. Beneficiaries eligible for CGMs include those with Type 1 diabetes or any other type of diabetes with either insulin use or evidence of level 2 or level 3 hypoglycemia, or beneficiaries diagnosed with glycogen storage disease type 1a. Patch type insulin pumps, blood glucose monitors (BGMs) and testing supplies will be covered in the same manner. Coverage is being extended to comply with Arkansas Act 393 of 2023.

Proposed effective date: April 1, 2024
Proposed implementation date: April 1, 2024

6.2 The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

ARKids-B Program

The Title XXI CHIP ARKids-B program's benefit package includes inpatient and outpatient hospital services, physician, surgical and medical services, laboratory and x-ray services, well baby care, including age-appropriate immunizations. Enrollees in ARKids-B are not eligible for the full range of Medicaid State Plan services. The chart below provides a description of the coverage and the amount, duration, and scope of services covered in certain services included in the ARKids-B benefit package, as well as any exclusions or limitations. The services checked below in the pre-print are included in the ARKids-B benefit package.

Ambulance (Emergency Only)
Ambulatory Surgical Center
Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9)
Certified Nurse Midwife
Chiropractor
Dental Care (routine dental care & orthodontia)
Durable Medical Equipment (DME) (Limited to $500 per State Fiscal Year (SFY) July 1 – June 30)
Emergency Dept. Services (Emergent, non-emergent, assessment)
Family Planning
Federally Qualified Health Center (FQHC)
Home Health (10 visits per SFY (July 1 – June 30))

Hospital, Inpatient
Hospital, Outpatient
Inpatient Psychiatric Hospital & Psychiatric Residential Treatment Facility
Immunizations (All per protocol)
Laboratory & X-Ray
Medical Supplies (Limited to $125/month unless benefit extension is approved)
Mental & Behavioral Health, Outpatient
School-Based Mental Health
Nurse Practitioner
Physician
Podiatry

Prenatal Care
Prescription Drugs and diabetic supplies
Preventive Health Screenings (All per protocol)
Rural Health Clinic
Speech Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved
Physical Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved
Occupational Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved
Substance Abuse Treatment Services (SATS), Outpatient
Vision (Eye exam – One routine eye exam (refraction) every 12 months Eyeglasses) – One pair every 12 months

*The Prescription Drugs and diabetic supplies category includes prescription drugs, Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution).

CHIP Title XXI CHIP ARKids-B Program

8.2 Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1 ☐ Premiums:

8.2.2 ☐ Deductibles:

8.2.3 [X] Coinsurance or copayments:Co-payments and co-insurance apply for all services with the exception of immunizations, preventive health screenings, family planning, and prenatal care. The Title XXI CHIP ARKids-B schedule of co-payments and co-insurance is outlined in the following table. The annual cumulative cost-sharing maximum cannot exceed 5% of the ARKids-B beneficiary's family's income.

Benefits/Limits	Co-Pay/Co-Insurance
Ambulance (Emergency Only)	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9)	None
Certified Nurse Midwife	$10 per visit
Chiropractor	$10 per visit
Dental Care (routine dental care & orthodontia)	$10 per visit
Durable Medical Equipment (DME) (Limited to $500 per State Fiscal Year (SFY) July 1 – June 30)	10% of Medicaid allowed per DME item
Emergency Dept. Services (Emergent, non-emergent, assessment)	$10 per visit
Family Planning	None
Federally Qualified Health Center (FQHC)	$10 per visit
Home Health (10 visits per SFY (July 1 – June 30))	$10 per visit
Hospital, Inpatient	10% of first inpatient day
Hospital, Outpatient	$10 per visit
Inpatient Psychiatric Hospital & Psychiatric Residential Treatment Facility	10% of first inpatient day
Immunizations (All per protocol)	None
Laboratory & X-Ray	$10 per visit
Medical Supplies (Limited to $125/month unless benefit extension is approved	None
Mental & Behavioral Health, Outpatient	$10 per visit
School-Based Mental Health	$10 per visit
Nurse Practitioner	$10 per visit
Physician	$10 per visit
Podiatry	$10 per visit
Prenatal Care	None
Prescription Drugs and diabetic supplies*	$5 per prescription (Must use generic, if available)
Preventive Health Screenings (All per protocol)	None
Rural Health Clinic	$10 per visit

Speech Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is	
approved Therapy – Four 15 minute units/day unless benefit extension is approved	$10 per visit
Physical Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved	$10 per visit
Occupational Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved	$10 per visit
Substance Abuse Treatment Services (SATS), outpatient	$10 per visit
Vision (Eye exam, Eyeglasses)	$10 per visit No co-pay for eyeglasses

*The Prescription Drugs and diabetic supplies category includes prescription drugs, Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution).

During the Federal COVID-19 public health emergency, cost sharing shall be waived for any in vitro diagnostic product described in section 2103(c)(10) of the Social Security Act and any other COVID-19 testing-related services regardless of setting type. In addition, the state will waive copayments for COVID treatment.

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 Continuous Glucose Monitors and Diabetic Supplies Coverage

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	$84,013	General Revenue	$59,805
Federal Funds	$216,034	Federal Funds	$153,784
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 300,047.00	Total	$ 213,589.00

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

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	

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**
$ 84,013.00	$ 59,805.00

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.

Statement of Necessity and Rule Summary
Continuous Glucose Monitors and Diabetic Supplies Coverage

Statement of Necessity

The Division of Medical Services (DMS) revises the Arkansas Medicaid state plan and corresponding provider manuals to comply with Act 393 of 2023. The Act requires Arkansas Medicaid to cover continuous glucose monitors (CGMs) as a pharmacy benefit. It also mandates pharmacy coverage of CGMs for certain individuals with diabetes allowing for blood glucose levels to be monitored at set intervals without finger sticks. Eligible beneficiaries include those with Type 1 diabetes or any other type of diabetes with either insulin use or evidence of level 2 or level 3 hypoglycemia, or beneficiaries diagnosed with glycogen storage disease type 1a. While reviewing the financial impact, it was determined that blood glucose monitors (BGMs) and other diabetic supplies should be added to the rule to streamline administrative procedures and to increase access to care for beneficiaries.

Note: This rule began promulgation in October 2023. A public comment period ran from October 14, 2023, to November 12, 2023. DHS reviewed all public comments received and in response revises the rule and publishes it for a second public comment period with the responsive changes incorporated into the rule.

Summary

The following provider manuals and state plan amendment (spa) pages will be updated in compliance with the Act and for the other reasons stated above.

Medicaid Provider Manuals

ARKids First B –

- Section 221.100 – Deleted "Continuous Glucose Meters (CGM) and CGM supplies" and added "Including diabetic supplies". Added the statement "For billing information to include Continuous Glucose Monitors (CGM), CGM supplies, patch or tubeless insulin pumps, blood glucose monitors (BGMs), and glucose testing supplies see the **DHS contracted Pharmacy Vendor's website**."

Home Health-

- Section 242.150 – Changed Bullet A to state that Home Blood Glucose supplies include all beneficiaries. Deleted HCPCS code information for Home Blood Glucose supplies.

Pharmacy –

- Section 212.000 – Deleted "glucose monitoring devices and supplies"
- Section 216.100 – Added "and glucose monitors and supplies" to bullet point D. Deleted "Glucose home monitors with supplies" from bullet point J.
- Section 216.101 – Added new section concerning Medical Supplies Covered as a Pharmacy Benefit.

Prosthetics –

- Section 212.206 – Changed the title of the section from "(DME) Home Blood Glucose Monitor, Pregnant Women Only, All Ages" to "Home Blood Glucose Monitor and Supplies All Ages". Deleted all previous information and added the statement " "Effective 4/1/2024, Medicaid beneficiaries are eligible for diabetic and blood sugar testing supplies processed as a pharmacy claim submission by pharmacies or DME providers . Home blood sugar meters and supplies (strips, lancets, calibration solution, etc.) are available without a prior authorization. See the DHS Pharmacy Vendor's website for specific information for coverage details."
- Section 212.207 – Deleted "DME" from the title. Added the statement "Effective 4/1/2024, patch or tubeless insulin pumps are covered as a pharmacy claim submission while traditional insulin pumps requiring tubing and cannula type supplies remain processed as a medical claim. Beneficiaries with Medicare Part B benefits continue to be serviced for all of their needs under the DME program." Also added the statement "When submitting prior authorization requests for the patch or tubeless insulin pumps see the **DHS Pharmacy Vendor's website** for specific information for coverage details."
- Section 212.208 – Bullet point A – deleted "The Arkansas Medicaid Program provides coverage for a continuous glucose monitor (CGM) for the treatment of a Medicaid client if the client has:" and added "Effective 4/1/2024, continuous glucose monitors (CGMs) are covered as a pharmacy claim submission by pharmacies or DME providers. Beneficiaries must meet the following criteria for coverage:" Changed number 1 under this bullet point to remove "more than two times daily" and added #3 to state "See the **DHS Pharmacy Vendor's website** for specific information for coverage details, ´. Deleted bullet point C which stated "Additional requirements are set out in Section 242.113". Added the statement" Beneficiaries with Medicare Part B benefits continue to be serviced under the DME program."
- Section 242.112 – deleted in its entirety.
- Section 242.113 – deleted in its entirety.

Medicaid State Plan:

Page 4.19-B 2g

- Added 7B.
  "Effective for dates of service on or after April 1, 2024, reimbursement for Continuous Glucose Monitors (CGM) and related supplies including patch type insulin pumps is based on wholesale acquisition cost (WAC) plus applicable professional dispensing fee. Traditional insulin pumps will remain at the Medicare non-rural rate as stated in A. above."

Arkansas Child Health Plan Under Title XXI Of The Social Security Act Children's Health Insurance Program (CHIP SPA)

- SPA # 14 adds the statement " The purpose of this SPA is to improve access to continuous glucose monitors (CGMs) through pharmacy claim submission processing for reimbursement to pharmacies and DME providers. Beneficiaries eligible for CGMs include those with Type 1 diabetes or any other type of diabetes with either insulin use

or evidence of level 2 or level 3 hypoglycemia, or beneficiaries diagnosed with glycogen storage disease type 1a. Patch type insulin pumps, blood glucose monitors (BGMs) and testing supplies will be covered in the same manner. Coverage is being extended to comply with Arkansas Act 393 of 2023."

- Section 6.2 – adds "and diabetic supplies" to the Prescription Drugs section in the chart. Also adds the statement "*The Prescription Drugs and diabetic supplies category includes prescription drugs, Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution).
- Section 8.2 - *The Prescription Drugs and diabetic supplies category includes prescription drugs, Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution).

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: §§ 25-10-129, 20-76-201, and 20-77-107.

The Director of the Division of Medical Services (DMS) amends the Arkansas Medicaid State Plan, the Arkansas Children's Health Insurance Program (CHIP) State Plan, and corresponding Medicaid Provider Manuals to implement Act 393 of 2023 of the 94th General Assembly. The Act requires Arkansas Medicaid to cover continuous glucose monitors (CGMs) as a pharmacy benefit and mandates pharmacy coverage of CGMs for certain individuals with diabetes allowing for blood glucose levels to be monitored at set intervals without finger sticks. Eligible beneficiaries include those with Type 1 diabetes or any other type of diabetes with either insulin use or evidence of level 2 or level 3 hypoglycemia, or beneficiaries diagnosed with glycogen storage disease type 1a. Blood glucose monitors (BGMs) and other diabetic supplies are added to streamline administrative procedures and to increase access to care for beneficiaries.

To effectuate the above, DMS amends the following Medicaid Provider Manuals: ARKids First B (§221.100), Home Health (§242.150), Pharmacy (§§212, 216.100, and 216.101), and Prosthetics (§§212.206 and 212.207). Those sections of relevant manuals were updated to explain coverage for the expanded group of beneficiaries and supplies by pharmacies and DME providers as required by the Act. The revisions specify which claims are processed as a medical claim or a pharmacy claim.

DMS amends the Medicaid State Plan and CHIP state plan to establish reimbursement effective for dates of service on or after April 1, 2024. Specifically, reimbursement for CGM and related supplies, including patch type insulin pumps, will be based on wholesale acquisition cost (WAC) plus applicable professional dispensing fee. Traditional insulin pumps will remain at the Medicare non-rural rate. The CHIP state plan updates include comparable revisions to those outlined above. The updates include explanation of eligible beneficiaries, covered supplies with the addition of diabetic supplies to the prescription drugs category which ensures coverage for prescription drugs, CGMs with CGM supplies, patch type insulin pumps, and BGMs with blood glucose testing supplies.

The projected annual cost of this change for state fiscal year (SFY) 2024 is $300,047.00 (of which $216,034.00 is federal funds) and for SFY 2025 is $213,589.00 (of which $153,784.00 is federal funds).

Pursuant to the Governor's Executive Order 23-02, DHS repeals the following two rules as part of this promulgation: (1) DDS Policy 3018 – Reporting of Denial of Access to Services, and (2) DDS Policy 3018 – Mortality Review of Deaths of Persons Receiving Alternative Community Services Waiver Services.

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 March 04, 2024. 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 will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at (501) 320-6428. 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. 4502172997

Elizabeth Pitman, Director
Division of Medical Services

RULES SUBMITTED FOR REPEAL

Rule #1:

DDS Policy 3018 – Reporting of Denial of Access to Services

Rule #2:

DDS Policy 3018 – Mortality Review of Deaths of Persons Receiving Alternative Community Services Waiver Services

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

Policy Type	Subject of Policy	Policy No.
Service	Reporting of Denial of Access to Services	3018

1. Purpose. This policy has been established to ensure compliance with the Americans with Disabilities Act (ADA) PL 101-336; 42 USC 12101 et. seq. This policy establishes reporting requirements and processing criteria for denial of access to services to eligible or qualifying persons with developmental disabilities.

2. Scope. This policy applies to all Division of Developmental Disabilities Services (DDS) programs and services and their employees.

3. Definitions.

A. ADA – Americans with Disabilities Act (PL 101-336; 42 USC 12101 et. seq.). The purpose of the act is to prohibit discrimination against people with disabilities in employment, transportation, public accommodation, communications, and activities of state and local government.

Section 302 – Prohibits persons who own, lease, operate public accommodations from discriminating on the basis of a disability.

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B. Eligibility Criteria – See Act 513 of 1981 and DDS Interpretive Guidelines in making service eligibility determination. Eligibility Criteria should identify those persons who are eligible to receive services.

C. Program and Services – The operation of the Department of Human Services – Division of Developmental Disabilities Services Community Programs and Services licensed, or funded wholly or in part by the Division of Developmental Disabilities.

D. Public Accommodation – Includes health care providers, offices, hospitals, other service establishments, private schools, or other places of education; and social service center establishments.

References: Public Law 101-356 of 1990; Ark. Statute 20-48-101.

Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council; November 4, 1993.

E. Discrimination includes:

1. The establishment of eligibility criteria that tend to screen out applicants with disabilities unless it is shown that the criteria is necessary for the delivery of services;

2. A failure to make reasonable modifications in the policies, practices, or procedures to accommodate people with disabilities unless it can be demonstrated that such modifications would require fundamental alterations to the provider's service;

3. Failure to provide auxiliary aids for persons with disabilities unless it can be demonstrated the provision of aids would fundamentally alter the nature of the provider's services or would result in an undue burden;

4. A failure to remove architectural barriers and communications barriers where removal is readily achievable.

F. Reasonable Accommodation – Any change in the work environment (program) or in the way things are ordinarily done (why the program is operated) that results in equal employment opportunity (equal access to services) for an individual with a disability.

Example: Making existing facilities used by service recipients readily accessible to, and usable by, an individual with a disability. Acquiring or modifying equipment or devices.

G. Undue Burden – An action that is excessively costly, extensive, substantial, or disruptive, or that would fundamentally alter the nature or operation.

Factors: Nature and cost of the accommodation in relation to the size, the financial resources, the nature and structure of employer's operation.

Impact of the accommodation on the facility providing the accommodation.

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4. Access. DDS shall have access to the premises and records of programs and services at all times for the purpose of reviewing compliance with this policy and applicable licensure standards.

5. Development of Program Procedures.

A. Each DDS Program and Service shall develop and implement uniform procedures for access to services and conforming to the guidelines set forth herein and in accordance with ADA. Each service provider shall refer the applicant, who has been denied services, to another service provider. Uniform procedures shall be implemented by promulgation of licensing standards, policy and directives.

B. DDS Programs and Services shall develop procedures for documenting and reporting denial of access to services to designated DDS Staff.

C. A copy of each DDS Program's procedures will be submitted to DDS Licensure Staff for approval.

D. For the purpose of this policy, implementation shall include communication to managers, supervisors, and responsible persons (within a community program) regarding the duties and obligations imposed by this policy.

6. Reporting Requirements. Denial of access to services shall be reported verbally within twenty-four (24) hours to DDS Client Services (682-8677) and written confirmation submitted to DDS Licensure within three (3) working days of occurrence. (See Form ADA-1.)

The report shall include at least the following:

1. Name of program
2. Full name of individual
3. Date of birth
4. Sex
5. Race
6. Social Security Number
7. County of Residence
8. Name, address and telephone number of individual or parent/guardian (if applicable)

9. Date of application
10. Name of all services requested
11. Name of service requested and denied
12. Specific reason for denial of access to service
    a. Undue burden
    b. Fundamental change to a program
13. Where the individual was referred
14. Results of the referral (s)

7. Outcome. Verified failure to adhere to this policy could jeopardize the licensure or contract status of a program or service.

8. Appeal. Should a Program/Service Director disagree with a decision made, he/she may appeal that decision by following procedures outlined in DDS Policy # 1076.

9. Departmental Contact.

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David Fray, Director
Developmental Disabilities Services
Department of Human Services
P.O. Box 1437, Slot 2500
Little Rock, Arkansas 72203-1437

Telephone Number: (501) 682-8665

Policy Type	Subject of Policy	Policy No.
Administration	Mortality Review of Deaths of Persons Receiving Alternative Community Services Waiver Services	3018

INTRODUCTION

The Alternative Community Services (ACS) Mortality Review is an integral part of the Continuous Quality Improvement process for the Division of Developmental Disabilities Services (DDS). The mortality review is a process that entails a review of the specific circumstances of the death of an individual by at least one of two committees as well as a review of cumulative data regarding information on all deaths occurring within specific periods.

The review is not investigative in nature. Rather, the purpose is to facilitate Continuous Quality Improvement by gathering information to identify systemic issues that may benefit from scrutiny and analysis in order to make system improvement and to provide opportunities for organizational learning.

I. Purpose

The purpose of the review is to identify issues and trends related to deaths of Alternative Community Services Waiver service recipients in order to improve Division and Provider practices by:

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1. Identifying social, health and systems strengths and weaknesses as they impact circumstances leading to death,
2. Recommending changes in procedures, resources and service delivery systems that impact circumstances leading to death,
3. Influencing the development of policies and laws regarding provision of ACS Waiver services, and
4. Gathering data about deaths among individuals with developmental disabilities, such as cause of death and demographic information so that the DDS may aggregate data over time to identify and analyze trends.

II. Intent

The intent of the review is to facilitate a better understanding of factors contributing to deaths and to develop enhanced strategies for addressing preventable deaths, developing recommendations for appropriate care, and, ultimately, to prevent the occurrence of future preventable deaths.

III. Definitions

Division – The Division of Developmental Disabilities Services, Department of Human Services.

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Expected Death – A death that is natural or a death that is medically determined, based on a death certificate and supporting documentation, to have resulted solely from a diagnosed degenerative condition or similar circumstance or a death that occurs as the result of an undiagnosed condition resulting from an explained condition, such as the aging process.

Full Review – A review of the death of an individual in which no identifying information regarding the decedent or the Provider is available for consideration by the Mortality Review Committee.

Mortality Review Committee – A group, made up of individuals identified in Section VIII of this document, who conduct a Full Review of all deaths designated as unexplained or unexpected, as well as some deaths designated as expected.

Mortality Review Coordinator – The individual responsible for gathering specific information regarding deaths of persons receiving ACS Waiver services and for coordinating meetings of the Review Team and Mortality Review Committee.

Preliminary Review – A review of the death of an individual in which all identifying information regarding the decedent and the Provider is available for consideration by the Review Team. The purpose of the review is to determine the designation of the death as unexpected, unexplained or expected.

Provider – The entity licensed or certified by DDS providing services to the individual whose death is under review.

Record – The written or electronic file containing information pertaining to the individual, including relevant facts, dates, and actions taken related to the individual, and contacts made and the results of those contacts.

Review Team – A group, made up of specified individuals who conduct a Preliminary Review of the deaths of all persons receiving ACS Waiver services.

Reviewable Death – The death of a person who is receiving waiver services, whose waiver status is in abeyance, or whose waiver status had been closed within 60 days prior to their death.

Unexpected death – A death that occurs as the result of an accident, an undiagnosed condition, suicide, homicide or suspected maltreatment, abuse, or neglect.

Unexplained death – A death in which the cause of death noted on a person's death certificate is not supported by documentation found in the person's medical history and other documentation on file with the Provider, the DDS Waiver Section, or other source.

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IV. Preliminary Review

During the Preliminary Review, the Review Team will analyze the information regarding a reviewable death that the Mortality Review Coordinator has provided to them in order to determine if they will designate the death expected, unexpected, or unexplained. The Team may also recommend that the Mortality Review Committee review a death designated as expected. All members must be present in order for the Team to convene to review any death.

The Mortality Review Committee must conduct reviews of all deaths considered by the Review Team to be unexpected or unexplained, as determined by their Preliminary Review.

The Review Team will consist of the following individuals:

1. DDS Assistant Director for Quality Assurance,
2. DDS Licensure and Certification Administrator,
3. DDS Children's Services Registered Nurse,
4. DDS Mortality Review Coordinator,
5. DDS Medical Director, (available for telephone consultation, as needed), and
6. Representative from the Provider or Providers of ACS Waiver services for the person whose death is under review (optional, at the discretion of the Provider and non-voting).

The Review Team will hold Preliminary Review meetings at least quarterly to review and analyze the information referenced above. The Mortality Review Coordinator will present a brief written and verbal description of the facts and circumstances surrounding the death. Members of the team will take into consideration all information presented to make a determination regarding how to categorize the death and whether the Mortality Review Committee should review it.

Members of the Review Team may request additional information and delay assigning a designation until after receipt and review of that information.

V. Review Disposition

The Review Team must reach a unanimous decision regarding the designation and the recommendation for review by the Mortality Review Committee. If the team cannot reach a unanimous decision, then the Mortality Review Committee must review the death.

The Team may request that the DDS Investigations Unit conduct an investigation of the circumstances of the death. In such case, the Team must refer the death to the Mortality Review Committee for review.

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VI. Mortality Review Committee – Objectives and Tasks

The Mortality Review Committee provides a forum to ensure that relevant information is shared and available to determine why an individual has died and to understand better all the contributing factors leading to a death. The benefits of sharing information and clearly understanding Division and Provider responsibilities can make the process worthwhile even if new information does not surface at a review.

1. The Mortality Review Committee conducts reviews by discussing each death individually. The review should include a discussion of the following:

    a. The circumstances surrounding the death,
    b. Identification of the primary risk factors involved in the death,
    c. The appropriateness and coordination of care as planned, delivered, and overseen by the ACS Waiver Provider, up to and at the time of the person's death,
    d. Issues that arose near the time of the person's death which were under the control of an ACS Waiver Provider that may require further review for quality improvement,
    e. Best practices in the delivery of services, and,
    f. If, and the degree to which, the death was believed to be preventable.

2. The Mortality Review Committee will review information on all deaths that occurred over a specified period. The purpose of the review of the aggregated data will be to identify any patterns or trends. The Committee will review information regarding at least the following:

    a. Age
    b. Gender
    c. Residence
    d. Place of death
    e. Cause of death as designated on the Death Certificate

VII. Review Disposition

Prior to moving to review of the next death, all Committee members should express confidence that they understood all information as presented or ask for further clarification. The Mortality Review Committee will provide disposition as follows:

1. Close review
2. Hold for additional review, due to the following:

a. The Committee requests that the Mortality Review Coordinator obtain additional information from a Provider or other source,
b. Final findings from the medical examiner are not available, if an autopsy was performed, and
c. Any other reason deemed acceptable by the Committee.

VIII. Mortality Review Committee Membership

The circumstances involved in most deaths are multidimensional. As a result, the responsibility for review should not rest in any one profession. The membership of the Committee must include representatives of agencies or stakeholder groups, who may, based on their individual professional experience and knowledge, address the complex dimensions of a death. The Mortality Review Committee membership must include the following individuals or representatives of the following departments, agencies or organizations:

1. DDPA Member, who is also a certified ACS Waiver Provider (2 positions),
2. The Arkansas Waiver Association (2 positions),
3. Waiver Service Recipient or Family Member of a Waiver Service recipient (2 positions),
4. DDS Director's Office designee,
5. DDS Licensure and Certification Administrator,
6. DDS Ombudsman,
7. DDS Medical Director,
8. DMS Quality Assurance,
9. DDS Registered Nurse,
10. DDS Waiver Services Administrative Staff,
11. Member-At-Large who is not a member of any organization represented by positions 1 or 2, and
12. Representative from the Arkansas protection and advocacy agency

The Committee may designate ad hoc members when they need additional information or expertise.

IX. Mortality Review Committee Organization

The Committee will elect a chairperson and vice chairperson, who are not DHS staff, who serve in that role for a period of at least 1 year.

1. Persons in positions 1, 2 and 3 as described above, will serve three-year terms. Initial members will draw lots to determine initial term length so that term expiration is staggered.

2. By unanimous approval of those attending the meeting, the Committee membership may dismiss a member for repeated failure to attend Committee meetings.
3. The Committee will meet as determined by the Committee, but no less than quarterly if there are deaths that have been determined to require review.

X. Role of the Mortality Review Committee Members

The role of Mortality Review Committee members should be flexible in order to meet the needs of the particular issue under review. The Committee should recognize and utilize the individual abilities of each member in order to enhance the Committee's effectiveness. Each member should:

1. Contribute information from his or her expertise and experience,
2. Provide definitions of professional terminology,
3. Understand and apply Division procedures and policies,
4. Understand and explain the legal responsibilities, such as mandated reporting, or limitations of his or her profession,
5. Be aware and acknowledge that the Mortality Review Committee is not an investigative body,
6. Review all death review reports and participate in the decision to approve submission of the report, and
7. Review aggregated data regarding deaths in order to identify patterns or trends.

All Mortality Review Committee members must have a clear understanding of their own and other professional and individual roles and responsibilities in their community's response to the death of a service recipient. In addition, Committee members should be aware of and respect the expertise and resources offered by each profession and individual who is a part of the Committee.

XI. ACS Waiver Provider Responsibilities

The ACS Waiver Provider Executive Director of the program providing service to the person whose death is under review or designee will:

1. Submit initial required materials and any other additional materials as requested by the DDS Mortality Review Coordinator, and
2. Send knowledgeable staff, at their discretion, to the Preliminary Review meeting.

XII. Mortality Review Coordinator Responsibilities

The Mortality Review Coordinator will attend all Preliminary Review and Mortality Review

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Committee meetings and will facilitate by providing necessary information and following up on any requests made by Review Team or Mortality Review Committee members. He will retrieve all written information from each Review Team or Mortality Review Committee member at the close of each meeting. He will either destroy all documents or retain the documents in a secure manner until the next meeting, depending on the disposition of the review.

The DDS Mortality Review Coordinator or designee will gather information concerning the facts and circumstances surrounding all reported deaths, utilizing a standard process. The Coordinator will obtain the information according to the following time frames:

1. The Mortality Review Coordinator will request information from the Provider no sooner than 14 calendar days after receipt of the notice of a death.
2. The Mortality Review Coordinator will request that the Provider respond to the request by providing the information within 20 calendar days from the date the Provider received the request from DDS.

The Mortality Review Coordinator will compile the following information for analysis by members of the Review Team:

1. The Face Sheet from the Provider record,
2. A printout from the Incident Reporting Information System (IRIS) or, if unavailable, then a copy of the Incident Report of a death submitted by the Provider,
3. A summary prepared by the Provider for the exclusive use of the Mortality Review Committee, describing the events leading up to the death of the individual to include, at the discretion of the Provider, a suggested classification of the death, using one of the three categories included in the Mortality Review policy,
4. The most recent Individualized Program Plan, including any Behavior plan,
5. Daily case notes from Direct Care staff for the previous month,
6. Case manager notes for the last 6 months,
7. A list of current medications, if not on the Face Sheet,
8. Current diagnosis, if not on the Face Sheet,
9. The most recent (within one month) and pertinent records contained in the Provider file from physicians, nursing staff and hospitals. (If the Review Team determines that records from these entities are essential in determining antecedent causes of death, the DDS Mortality Review Coordinator will attempt to obtain these records directly from the appropriate entity),
10. Verification of any Guardianship or Power of Attorney,
11. The most recent physical examination (within one year), if available,
12. Behavior and Incident Reports for three months prior to the death,
13. Death certificate (obtained by the DDS Mortality Review Coordinator) and
14. A written summary of the events surrounding the death.

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When the Mortality Review Coordinator has compiled the necessary information listed above, he will place the death on the schedule for review at the next quarterly Preliminary Review meeting. The Coordinator will:

1. Prepare a packet of information comprised of the documents listed in Section XII for distribution at the time of the meeting,
2. Notify Review Team members of the date, time and location of the meeting, and
3. Notify the Provider or Providers of services to the decedent that they may, at their discretion, attend the Preliminary Review.

If the Review Team makes a recommendation for review by the Mortality Review Committee, the Mortality Review Coordinator will:

1. Place the review on the Mortality Review Committee schedule,
2. Prepare a packet of information, comprised of pertinent information gathered for the Preliminary Review as well as any other information obtained subsequent to that review,
3. Ensure that the packet of information contains no information that might identify the Provider of the decedent, and
4. Make the packet of information available to each member of the Mortality Review Committee at least 10 calendar days in advance of the meeting date.

If the Review Team makes a recommendation not to refer for review by the Mortality Review Committee, the Mortality Review Coordinator will notify the Provider in writing that the review has been completed.

The Mortality Review Coordinator will, on a quarterly basis:

1. Prepare and submit to the DDS Licensure and Certification Administrator a list of all deaths determined not to meet the requirements for review, and
2. Ensure that the list contains a summary of the facts that supported the recommendation not to review, and
3. Prepare a quarterly report that summarizes data detailed in Section VI, 2 regarding each death that occurred during that quarter.

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XIII. DDS Responsibilities

DDS will ensure that:

1. The DDS Quality Assurance Section will provide staff for Review Team and Mortality Review Committee support activities, such as making copies of materials, scheduling meetings and preparing reports,
2. The DDS Licensure and Certification Administrator will submit a list of all deaths not reviewed by the Mortality Review Committee to the DDS Director for final approval of the recommendation not to review, and
3. If the Director overturns a decision, the Mortality Review Coordinator will place the death on the agenda for review at the next scheduled Mortality Review Committee meeting.
4. The Annual Report produced by the Committee is distributed as appropriate and posted on the DHS website.

XIV. Mortality Review Reporting

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The Committee shall prepare an annual report that describes and summarizes any findings or issues and contains any recommendations suggested by the Committee. It shall address as appropriate, the issues described in Section I of this document. It shall contain an annual summary of the quarterly data gathered during the year.

The report should address any trend identified by the Committee as well as the identification of any prevention activities proposed because of any review. The report should contain recommendations regarding specific actions, such as:

1. Revision of Provider or Division policy or forms,
2. Development of new Provider or Division policy to address systemic issues discovered in the review process,
3. Training, either on a statewide or individual Provider basis,
4. Facilitation of best practice, including new risk-prevention practices, through dissemination of recommendations for development of or modification to Provider policies, or
5. Issuance of a statewide safety alert.

The Mortality Review Coordinator will distribute a copy of the Mortality Review Committee's Annual Report to the DHS Director's office and to the Director of the Department of Developmental Disabilities Services.

Policy Type	Subject of Policy	Policy No.
Administration	Mortality Review of Deaths of Persons Receiving Alternative Community Services Waiver Services	3018

Recipients of the report should consider all recommendations made by the Mortality Review Committee and take appropriate action as deemed necessary. In the determination of what may be deemed necessary action, DHS representatives will be mindful that the purpose of the Review Committee is to gather information to identify systemic issues that may benefit from scrutiny and analysis in order to make system improvements. In the event that any sanction of a Provider is necessary, the DDS Licensure and Certification Unit will determine and issue the sanction, in accordance with applicable policies and procedures.

The Mortality Review Committee will review any Department of Human Services or DDS policy change or other action taken by the Department or Division in response to the Committee's recommendations. If requested, the Committee will review ACS Waiver Community Provider policy changes or other actions taken by the Provider in response to Mortality Review Committee recommendations.

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