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Proposed Rule Cover Sheet

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D-350 Juveniles in the Custody of Division of Youth Services (DYS)

MS Manual 01/01/2025~~04/29/2016~~

Juveniles committed to the custody of the Division of Youth Services may be detained in secure facilities or be placed for treatment in inpatient psychiatric facilities, inpatient medical facilities, residential treatment facilities, emergency shelters, therapeutic group homes or therapeutic foster care.

When juveniles in the custody of the Division of Youth Services are placed in juvenile detention centers and other facilities operated primarily for the detention of children who are determined to be delinquent, they are not eligible for a ~~Medicaid~~Health Care payment.

When juveniles in the custody of the Division of Youth Services are placed for treatment in inpatient psychiatric facilities, inpatient medical facilities, residential treatment facilities, emergency shelters, therapeutic group homes or therapeutic foster care, they are eligible for a ~~Medicaid~~Health Care payment under Medicaid or CHIP.

The Division of Youth Services (DYS) and the Division of County Operations have entered into an inter-agency agreement which permits DYS to process and approve ~~Medicaid~~Health Care eligibility through Medicaid and CHIP programs for ~~ARKids A and B for~~ DYS juveniles who have entered treatment facilities or have been released from DYS custody.

D-370 Inmates of Public Institutions

MS Manual 01/01/2025~~08/01/15~~

An inmate of a public institution is not eligible for ~~Medicaid~~Health Care payment. See exception- MS D-372.

Public institution means an institution that is the responsibility of a government unit or over which a governmental unit exercises administrative control.

"Public Institutions" include:

1. Institutions for ~~the~~ mental diseases which are hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.

2. Institutions for tuberculosis, which are primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis.

3. Correctional or holding facilities for individuals, who are prisoners, arrested, or detained pending dispositions of charges, or are being held under court order as material witness or juveniles. Correctional facilities include prisons, jails, juvenile detention centers and other facilities operated primarily for the detention of juvenile~~schildren~~ who are determined to be delinquent. Wilderness camps and boot camps are considered public institutions if a government unit has any degree of administration control.

If an individual in a public institution must be temporarily transferred to a medical treatment or evaluation facility, or if he/she is given temporary furlough, the individual is still considered to be under custody of the penal system and is not eligible for a ~~Medicaid~~Health Care payment. See exception at MS D-372.

An individual will be considered in a public institution until the indictment against the individual is dismissed, or until he/she is released from custody either as "not guilty" or for some other reason (bail, parole, pardon, suspended sentence, home release program, probation, etc.).

"Public institutions" do not include:

1. Inpatient psychiatric facilities for individuals under age 21 (22, if an inpatient on the 21st birthday) and over age 65.

2. Medical institutions which are organized to provide medical, nursing, and convalescent care, which have the professional staff, equipment and facilities to manage the medical, nursing and other health needs of patients in accordance with accepted standards, and which are authorized under State law to provide medical care. Medical institutions include hospitals and nursing facilities.

3. Intermediate care facilities for those individuals with intellectual disabilities which meet the standards under 42 CFR 483.440 (a) for providing active treatment for such individuals or individuals with related conditions.

4. Child-care institutions which are private, non-private, or public that accommodate no more than ~~twenty five~~twenty-five (25) juvenile~~schildren~~ and are licensed by the State or approved by the State agency responsible for licensing or approval of such institutions.

5. Therapeutic Group Homes, Residential Treatment facilities, Emergency Shelters and Therapeutic Foster Homes which meet facility and staffing requirements of the Minimum Licensing Standards for Child Welfare Agencies published by the Child Welfare Agency Review Board.

6. ~~Publically~~Publicly operated community residences that serve no more than 16 residents are facilities that provide some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. They cannot be on the grounds of or immediately adjacent to any large institution or multiple purpose complexes such as educational or vocational training institutions, correctional or holding facilities, or hospitals, nursing facilities or intermediate care facilities for individuals with intellectual disabilities.

D-371 Inmates Being Released from Custody

MS Manual 01/01/2025~~08/01/15~~

Individuals in the custody of the Arkansas Department of Correction (ADC), Arkansas Department of Community Correction (ADCC), county jail, city jail, juvenile detention facility or Division of Youth Services (DYS) will be allowed to submit an application for ~~Medicaid~~Health Care up to 45 days prior to the individual's scheduled release date. Applications will be submitted online

at ~~www.access.arkansas.gov,~~ https://access.arkansas.gov/Learn/Home or by paper application~~, DCO-151, Application for Health Coverage Single Adults, which will be submitted to the local DHS county office~~.

If eligible, ~~Medicaid~~Health Care will not start until the individual is released from custody. The authorized representative from the facility will notify DHS of the actual release date.

NOTE: Incarcerated individuals that are between the ages of 18 and 26 and are eligible under the Former Foster Care group, along with individuals that are ages 19-20 and are eligible for any Health Care program, must be allowed coverage during the 30-day period before release and the 30-day period after release.

D-372 Inmates Being Released for Inpatient Treatment

MS Manual 01/01/2025~~05/01/18~~

An individual in the custody of ADC, ADCC, or a local correctional facility who has been admitted and received treatment at an inpatient facility may be eligible for ~~Medicaid~~Health Care payment provided all eligibility requirements are met. Eligibility will be determined in accordance with MS Sections D, E and F. Only the inmate will be included in the ~~Medicaid~~Health Care household. The coverage period will begin on the hospital admission date and end on the hospital discharge date.

NOTE: Inmates may be approved for retroactive coverage 30 days prior to the date of application in the Adult Expansion Group, if eligible. Retroactive coverage for the Adult Expansion Group is date specific.

EXAMPLE: James applies for medical coverage on September 15. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of August 1. He is not eligible for retroactive coverage on this date because his bill is for August 1 and retroactive coverage can only begin August 16, thirty (30) days prior to the September 15 application date.

EXAMPLE: James applies for medical coverage on September 20. He asks for retroactive coverage for a medical bill with an inpatient hospital begin date of September 15. He is eligible for retroactive coverage on September 15, as this date is within the 30 days prior to the application date.

D-373 Suspension of Medicaid Coverage for an Inmate

MS Manual 01/01/2025~~05/01/18~~

The appropriate correctional facility will notify DHS when a Health Care ~~Medicaid~~ or Adult Expansion Group recipient enters the ADC, ADCC, the county jail, city jail, or a juvenile detention facility. When this notification is received, DHS will place that individual's Health Care~~Medicaid~~ coverage in suspended status for up to twelve (12) months from the initial approval or most recent renewal.

When an individual with suspended Health Care ~~Medicaid~~ eligibility receives eligible medical treatment off the grounds of the detention facility or is released from custody, the individual's case will be reopened~~reinstated~~ if the reopen~~reinstatement~~ date is within the twelve (12) month period from the individual's initial approval or most recent renewal. For those individuals receiving eligible treatment while off the correctional facility grounds, Health Care~~Medicaid~~ will be reopened~~re-instated~~ for a fixed eligibility period from the date of hospitalization to the date of hospital discharge. The case will be re-suspended following the fixed eligibility period.

D-374 Juveniles Entering Public Institutions

MS Manual 01/01/2025

When an "eligible juvenile" becomes an inmate of a public institution and is past their adjudication, they must be provided with coverage for the 30 days before and after their release. This coverage may be through a Medicaid or CHIP category, but must cover at minimum the following services:

- Physical and/or behavioral health screenings
- Diagnostic Services
- Case Management Services

Medicaid categories may cover other services for these members whereas CHIP categories will only cover these required services.

An "eligible juvenile" is any juvenile who meets the following criteria:

- Age 20 or younger or
- Ages between 18 and 26 AND eligible under the Former Foster Care group-See MS B-260 and
- Inmate of a public institution and was determined eligible for medical assistance immediately before or while an inmate of a public institution.
- Have been fully "adjudicated" which means they are officially sentenced.

Health Care coverage may not be terminated while the juvenile is an inmate of a public institution but must be placed in suspended status for up to twelve (12) months from the juvenile's last eligibility determination. A juvenile's suspended status will expire twelve (12) months from the date of the juvenile's last eligibility determination.

If the juvenile is returned to the same home that he or she left prior to entering the public institutions, and the Health Care case is still open with other members, the juvenile's coverage will be reopened. This case action will be treated as a change and a new application will not be required.

If the juvenile is returned to the same home that he or she left prior to entering the public institution and was the only Health Care eligible member in the home, the case will be reopened. If it is within the renewal period, a new application will not be required.

If the juvenile does not have a case in suspended status, an application will need to be provided to DHS to determine eligibility.

NOTE: Juveniles who fall under the age of 19 will still be eligible for the continuous eligibility (CE) rule if they were approved in a CE eligible category. (See policy MS A-230) Juveniles that are ages 19 and over, except for Former Foster Care Juveniles, will not fall under the CE rule. Former Foster Care Juveniles are an CE eligible category.

D-380 Juveniles~~Child(ren)~~ Entering Custody of Division of Youth Services (DYS)

MS Manual 01/01/2025~~04/29/16~~

The appropriate juvenile detention facility will notify the designated DYS staff when a ~~Medicaid~~Health Care recipient enters the facility. When this notification is received, DYS designated staff will place that child's ~~Medicaid~~Health Care coverage in suspended status for up to twelve (12) months from the initial approval or most recent renewal.

When a child with suspended ~~Medicaid~~Health Care eligibility receives eligible medical treatment off the grounds of the juvenile detention facility or is released from custody, the child's case will be reopened in their previous Medicaid or CHIP category~~reinstated~~ if the reopen~~reinstatement~~ date is within the twelve (12) month period from the individual's initial approval or most recent renewal. For those children receiving eligible treatment while off the correctional facility grounds, ~~Medicaid~~Health Care will be ~~re-instated~~reopened in their previous Medicaid or CHIP category for a fixed eligibility period from the date of hospitalization to the date of hospital discharge. The case will be re-suspended following the fixed eligibility period.

If the child is in the juvenile detention facility when a redetermination occurs, the case will be closed if it is a single person household or incarcerated juvenile is only member with coverage. If after the closure, the same individual requires overnight medical treatment off the correctional facility grounds, the juvenile detention center will submit a new application for the individual and once Medicaid or CHIP coverage is approved, the treatment stay will be approved for a fixed eligibility period and the case or coverage for the incarcerated juvenile will be placed in suspended status for a new twelve (12) month period.

D-381 Juveniles ~~Child(ren)~~ Released from DYS

MS Manual 01/01/2025~~04/29/16~~

~~Children who leave DYS custody with their case in suspended status will have their coverage reinstated on the date of their release. Upon receipt of the permanent date of discharge, the following procedures will be followed by DYS designated staff.~~

Juveniles under the care of DYS, who are eligible, ~~should~~must be provided with Medicaid or CHIP coverage for at least the 30 days before and after their release.

- If the juvenile ~~child~~ is returned to the same home that he or she left prior to entering DYS custody and the Health Care ~~Medicaid~~ case is still open with other children, the juvenile's~~child's~~ coverage will be reopened~~reinstated~~. This case action will be treated as a change and a new application will not be required.

- If the juvenile~~child~~ is returned to the same home that he or she left prior to entering DYS custody and was the only Health Care~~Medicaid~~ eligible juvenile ~~child~~ in the home, the case will be reopened. If it is within the renewal period, a new application will not be required.

- If the juvenile does not have a case in suspended status, DYS will determine eligibility into either a Medicaid or CHIP category~~-~~ for the juvenile while in the facility. This coverage will begin~~ing~~ 30 days prior to the juvenile's release date.

D-300 State Residency

D-381 Juveniles Released from DYS

~~**NOTE:** If the child is returned to a different home, an application will be needed to determine eligibility for the child in the new household. The application can be completed on line at www.access.arkansas.gov or the application can be turned in to the local county office.~~

D-500 Mandatory Assignment of Rights to Medical Support/Third Party Liabilities

MS Manual ~~05/01/18~~01/01/2025

As a condition of eligibility for Medicaid, recipients are required to assign their rights to Medical Support/Third Party Liability payments to the Department of Human Services. This means that any funds settlements or other payments made by or on behalf of third parties should be paid directly to the Arkansas Medicaid Program. In Arkansas, Third Party Liability payments are automatically assigned by state law.

The Medical Assistance Program is required by Federal and State Regulations to utilize all Third Party sources and to seek reimbursement for services which have been paid by both a Third Party and Medicaid.

Private insurance and Medicaid are complementary. A recipient's Medicaid eligibility, except for an ARKids B recipient, is not affected by having Third Party coverage (Re. MS F-180).

When a recipient has Third Party coverage in addition to Medicaid, which can be used for medical expenses, Third Party coverage must be utilized first. Medicaid will pay up to the Medicaid allowable charge. For example: A Medicaid recipient has insurance which paid 80%, or $80 of a $100 medical bill. The Medicaid allowable charge for the bill was only $60.00. A Medicaid payment was not due since the Medicaid allowable charge was less than the insurance payment. Third Party sources whose payments Medicaid will retrieve include private health insurance, automobile liability insurance where applicable, workmen's compensation, settlements for injuries, etc.

Tri-Care is considered to be a Third Party source. Whenever a Tri-Care beneficiary is also eligible for Medicaid, Tri-Care is in every instance the primary payer. This applies to all classes of Tri-Care beneficiaries, i.e., dependents of active duty members, retirees, dependents of retirees, dependents of deceased active duty members, and dependents of deceased retirees.

~~**NOTE:** The Third Party Liability policy does not apply to individuals enrolled in a private Qualified Health Plan through the Adult Expansion Group, however Assignment of Rights to Medical Support does apply.~~

TOC required

105.210 Medicaid Juvenile Re-entry Services 1-1-25

Medicaid Juvenile Re-entry Services are established to assist with the transition of juveniles who are leaving a carceral setting by furnishing active Medicaid coverage for developmental assessments, case planning, and case management to assist with necessary referrals for treatment and accessing resources to support the individual with obtaining successful outcomes.

Eligibility for the services may be activated for up to thirty (30) days prior to discharge from the carceral setting.

The services are furnished by providers who meet the participation requirements and enroll in Arkansas Medicaid. Services for juveniles preparing for re-entry to community settings will be coordinated by the court-ordered guardian or custodian of the juvenile.

Detailed information may be found on the **DMS website** in the **Targeted Case Management for Juveniles in Public Institutions provider manual**.

SECTION II – TARGETED CASE MANAGEMENT FOR JUVENILES IN PUBLIC INSTITUTIONS

CONTENTS

200.000 TARGETED CASE MANAGEMENT FOR JUVENILES IN PUBLIC INSTITUTIONS GENERAL INFORMATION

201.000 Scope and Eligibility for Targeted Case Management Services for Eligible Juveniles 1-1-25

A. "Eligible juveniles", as defined in section 5121 of the Consolidated Appropriations Act of 2023, includes children and youth who are incarcerated after adjudication and are:

1. Under twenty-one (21) years of age determined eligible in any Medicaid eligibility group; or

2. Between eighteen (18) and twenty-six (26) years of age and eligible for Medicaid under the mandatory former foster care eligibility group.

B. Targeted Case Management assists Eligible Juveniles in accessing all medical, social, educational, and other services appropriate to his or her needs with the goal of transitioning the Eligible Juvenile out of the carceral facility and into a stable home and community-based setting.

1. Targeted case management services for eligible juveniles in public institutions must be provided during the thirty (30) days prior to release (or not later than one (1) week, or as soon as practicable, after release) and for at least thirty (30) days following release.

2. See section 221.000 for information on extension of benefits beyond the thirty-day post-release period.

C. A targeted case manager may maintain a maximum active caseload of fifty (50) eligible juveniles at a time.

D. If a temporary situation arises based on a filled position becoming temporarily vacant and hiring for the position is in progress, a case manager may exceed the maximum of fifty (50) active cases for no more than sixty (60) consecutive days.

E. The maximum number of active cases during a temporary situation, as described above, may not exceed seventy (70).

201.100 Arkansas Medicaid Participation Requirements for Providers of Targeted Case Management for Juveniles in Public Institutions 1-1-25

Targeted case management (TCM) services providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual to be eligible to participate in the Arkansas Medicaid Program.

201.200 Participation Requirements for Individual, Rendering Providers of Targeted Case Management for Beneficiaries Who Are Eligible Juveniles in Public Institutions as Defined in Section 5121 of the Consolidated Appropriations Act of 2023 1-1-25

A. Providers of targeted case management services who serve beneficiaries who are eligible juveniles in public institutions as defined in section 5121 of the Consolidated Appropriations Act of 2023 must be:

1. Licensed in the state of Arkansas as one (1) of the following:

   a. A Licensed Clinical Social Worker;

   b. A registered nurse;

   c. A licensed practical nurse;

   d. A licensed social worker; or

   e. A licensed psychiatric technician nurse; or

2. Certified on the basis of a master's degree or higher by the Arkansas State Board of Education as a school guidance counselor, school psychology specialist, or special education supervisor.

B. A copy of the applicant's license or certification must accompany the provider application and Medicaid contract.

C. In addition, qualified targeted case management providers for eligible juveniles must:

1. Be enrolled with Arkansas Medicaid;

2. Have full access to all pertinent records concerning the incarcerated youth's needs for services, including records from all types of facilities in both the juvenile justice

system and adult criminal justice system, the Division of Youth Services, and the Division of Children and Family Services;

3. Have established referral systems and demonstrated linkages and referral ability with community resources required by eligible juveniles in public institutions;

4. Have a minimum of one (1) year of experience in providing all core elements of case management services to the target population;

5. Ensure quality services in accordance with state and federal requirements;

6. Have a financial management capacity and system that provides documentation of services and costs in conformity with generally accepted accounting principles; and

7. Have a capacity to document and maintain individual case records in accordance with state and federal requirements.

201.300 Participation Requirements for Group Providers of Targeted Case Management for Beneficiaries Who Are Eligible Juveniles in Public Institutions as defined in Section 5121 of the Consolidated Appropriations Act of 2023 1-1-25

If a case manager is a member of a group, each individual case manager and the group must both enroll according to the following criteria:

A. Each individual case manager within the group must enroll following the criteria established in Sections 201.100 and 201.200.

B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled case manager within the group.

201.400 Targeted Case Management Providers in Bordering and Non-Bordering States 1-1-25

The Arkansas Medicaid Targeted Case Management Program is limited to in-state providers only.

201.500 The Role of the Child Health Services (EPSDT) Program 1-1-25

A. The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth up to their twenty-first birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic, and treatment services delivered on a periodic basis.

B. As provided in section 5121 of the Consolidated Appropriations Act of 2023, TCM providers must provide eligible juveniles with any screening and diagnostic services that meet reasonable standards of medical and dental practice in accordance with EPSDT requirements:

1. In the thirty (30) days prior to release from a public institution; or

2. Within one (1) week or as soon as practicable after release from a public institution.

C. EPSDT treatment services are not required prior to release.

D. TCM providers are encouraged to refer to the EPSDT provider manual for additional information regarding covered services under EPSDT.

220.000 PROGRAM COVERAGE

220.100 Covered Case Management Services for Eligible Juveniles 1-1-25

The following are required case management services for Eligible Juveniles:

A. Comprehensive needs assessments, including for medical, educational, social, or other services.

1. This includes planning for any Medicaid-covered screening and diagnostic services that the juvenile may receive pre-release.

a. For eligible juveniles under twenty-one (21) years of age, these services will be provided in the same manner in which EPSDT services are provided for youth under age twenty-one (21) who are not incarcerated.

b. For eligible juveniles age twenty-one (21) and older, screening services will be covered when they are medically necessary to determine existence of a physical or behavioral health illness or condition as well as diagnostic services when a screening service indicates the need for further evaluation and when such diagnostic services are otherwise medically necessary.

B. Development of a person-centered care plan—including social, educational, and other underlying needs, such as developing safe decision-making skills or building relationships.

C. Referrals and related activities (e.g., scheduling initial post-release appointments, coordinating transition to PASSE services, as appropriate) to link individuals to needed services when in the community.

D. Monitoring and follow-up activities (e.g., follow-up with service providers) to ensure the care plan is implemented, including transfer of care if another case manager is to be involved upon release or after the mandatory thirty-day post-release service period.

220.200 Exclusions 1-1-25

Services that are not appropriate for targeted case management services and are not covered by the Arkansas Medicaid Program include without limitation:

A. The actual provision of services or treatment. Examples include without limitation:

1. Treatment for mental health, behavioral health, or chronic conditions;
2. Training in daily living skills;
3. Training in work skills, social skills, and/or exercise;
4. Grooming and other personal care services;
5. Training in housekeeping, laundry, cooking;
6. Transportation services (Arranging for transportation for a beneficiary is covered.);
7. Counseling and/or crisis intervention services;
8. Delivery of services or goods, such as wheelchairs, air conditioners, canes commodities, etc.; and
9. Inspection of services or goods, such as wheelchairs, wheelchair ramps, air conditioners, installation of air conditioners, commodities, etc.

B. Services that go beyond assisting individuals in gaining access to needed services. Examples include without limitation:

1. Supervisory activities, including supervisory duties required in other programs such as personal care and home health;
2. Paying bills and/or balancing the beneficiary's checkbook;

3. Delivering application forms, paperwork, evaluations and reports;
4. Observing a beneficiary receiving a service, e.g., physical therapy, speech therapy, classroom instruction;
5. Escorting beneficiaries to scheduled medical appointments;
6. Home visits to observe the beneficiary and family's interactions or the condition of the home for child or adult protection purposes;
7. Verifying Medicaid eligibility through telephone calls, AEVCS, or by any other means; and
8. Travel and/or waiting time.

C. Case management services that duplicate services provided by public agencies or private entities under other program authorities for the same purpose.

For example, targeted case management services provided to foster children that duplicate services provided by a public agency, such as home visits for purposes of reunification.

220.300 Documentation in Beneficiary Files 1-1-25

A. The targeted case manager must develop and maintain sufficient written documentation to support each service billed. Written description of services provided must emphasize how the goals and objectives of the service plan are being met or are not being met. All entries in a beneficiary's file must be signed and dated by the targeted case manager who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file.

B. Documentation must consist of, at a minimum, material that includes:

1. The beneficiary's name, date of birth, and Medicaid number;
2. The dates of any Child Health Services/EPSDT screens for Eligible Juveniles;
3. Documentation of the Service Plan meeting, including who was in attendance;
4. The Service Plan, and all subsequent updates, signed by the Eligible Juvenile and his or her legal guardian;
5. When applicable, a copy of the original and all updates of the beneficiary's individualized education plan (IEP);
6. The specific services rendered;
7. The type of service rendered: assessment, plan development, referrals and service management, and/or monitoring;
8. The type of contact: face to face or telephone;
9. The date and actual clock time for the service rendered. This must include the start time and the stop time for each TCM service;
10. The place of service (where the service took place: e.g., office, home);
11. The name of the provider agency, if applicable, and person providing the service;
12. The targeted case manager providing the service must initial each entry in the case file. If the process is automated and all records are computerized, no signature is required. However, there must be an agreement or process in place showing the responsible party for each entry;
13. Updates describing the nature and extent of the referral for services delivered;
14. Description of how TCM services are meeting beneficiary's Service Plan goals and objectives;

15. Progress notes on beneficiary's conditions, whether deteriorating or improving, and the reasons for the change.

    a. While the targeted case manager may not be considered a medical professional, progress notes are intended to describe a beneficiary's overall condition, including any changes since the last contact, the reason for the change, etc.

    b. This requirement is not asking the targeted case manager to diagnose, treat, or offer medical opinions. However, the targeted case manager must record information provided by the beneficiary or others on behalf of the beneficiary that pertains to the service plan goals and progress toward those goals; and

16. Documentation, as described above, is required each time a TCM function is provided for which Medicaid reimbursement will be requested.

220.400 Electronic Signatures 1-1-25

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

220.500 Requirements for Time Records and the Tickler System 1-1-25

A. Each TCM must maintain a tickler system for tracking purposes.

B. The tickler system must track and notify of the following activities:

1. Each active TCM beneficiary; and

2. Medicaid eligibility date.

C. It is the responsibility of the case manager to maintain a tickler system, as described above, for those beneficiaries in their specific caseload. However, the record keeping requirements and documentation requirements must be maintained in the beneficiary's file.

220.600 Description of Services 1-1-25

Sections 220.700 – 220.900 detail targeted case management services that must be provided by a targeted case management provider.

220.700 Assessment and Service Plan Development 1-1-25

A. Assessment is performed for the purpose of collecting information about the beneficiary's situation and functioning and to determine and identify the beneficiary's problems and needs.

B. The TCM assessment is a comprehensive assessment that includes medical, social, educational, and other services. It addresses all facets of the individual's everyday life in determining how any problem or need might be met and what services are available in the individual's community.

C. This component includes activities that focus on needs identification. Activities, at a minimum, include the assessment of an eligible beneficiary to determine the need for any medical, dental, behavioral, educational, social, or other services. Specific assessment activities include:

1. Taking beneficiary history;

2. Identifying the needs of the beneficiary;

3. Completing related documentation; and

4. Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the Medicaid-eligible beneficiary.

D. Service plan development builds on the information collected through the assessment phase and includes ensuring the active participation of the Medicaid-eligible beneficiary or their authorized representative. The goals and actions in the care plan must address medical, social, educational, and other services needed by the Medicaid-eligible beneficiary. Service plans must:

1. Be specific and explain each service needed by the beneficiary;
2. Include all services, regardless of payment source;
3. Include support services available to the beneficiary from family, community, church, or other support systems and what needs are met by these resources; and
4. Identify immediate, short-term, and long-term ongoing needs as well as a plan of action for how these needs/goals will be met.

E. The assessment and the service plan may be accomplished at the same time, during the same visit, or separately, but must occur face-to-face, in person.

220.800 Service Management/Referral and Linkage 1-1-25

A. This component includes activities that help link Medicaid eligible beneficiaries with medical, social, and educational providers and/or other programs and services that are capable of addressing identified needs and achieving goals specified in the service plan. This includes making referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, to help the eligible individual obtain needed services.

B. This component details functions and processes that include contacting service providers selected by the beneficiary and negotiation for the delivery of services identified in the service plan, including scheduling appointments for the eligible juvenile. Contacts with the beneficiary and/or professionals, caregivers, or other parties on behalf of the beneficiary may be a part of service management.

C. Targeted case managers are required to link eligible beneficiaries to needed EPSDT and other screenings and ensure the eligible beneficiary has access to needed services identified by those screenings.

220.900 Service Monitoring/Service Plan Updating 1-1-25

A. The service monitoring and service plan updating component includes activities and contacts that are necessary to ensure the TCM care plan is effectively implemented and adequately addresses the needs of the Eligible Juvenile.

B. The activities and contacts may be with the Eligible Juvenile, family members, providers, or other entities.

C. They must occur as frequently as necessary to help determine such things as:

1. Whether services are being furnished in accordance with the Eligible Juvenile's Service Plan;
2. The adequacy of the services in the Service Plan;
3. Whether progress is being made toward the goals and objectives of the Service Plan; and
4. Changes in the needs or status of the Eligible Juvenile.

D. Monitoring must include monthly contacts with service providers to verify that appropriate services are provided in accordance with the service plan and at least monthly contacts with the Eligible Juvenile to ensure that he or she participates in the service plan and is satisfied with services.

1. A monitoring contact with the beneficiary must be completed monthly. Required contacts with the service providers may be conducted through face-to-face contact or by telephone or video conference.

2. Documentation of monitoring contacts should be dated, signed by the targeted case manager, and filed in the eligible beneficiary's case record.

E. Each monitoring contact must include:

1. Reexamining the Eligible Juvenile's needs;

2. Identifying changes that have occurred since the previous monitoring contact;

3. Identifying hospitalizations or other extended absences from the home;

4. Updating the Service Plan, as needed;

5. Measuring the Eligible Juvenile's progress toward Service Plan goals;

6. Making additional referrals and linkages as needed to continue progress on Service Plan goals.

221.000 Benefit Limits 1-1-25

A. Targeted case management services will be covered on a per-member per-month basis for eligible juveniles who are within thirty (30) days of their scheduled date of release from a public institution following adjudication, and for at least thirty (30) days following release.

B. An extension of benefits can be requested if continued medically necessary services are needed beyond the thirty-day post-release period.

1. Extension of benefits requests must be sent to the DHS Utilization Review Section.

View or print current contact information.

2. For audit purposes, the extension of benefits must be in writing, placed in the beneficiary's file, and available for auditors.

230.000 REIMBURSEMENT

230.100 Method of Reimbursement 1-1-25

A. Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

B. Reimbursement for case management services is based on bundled unit billing. The provider will bill one (1) unit for the first thirty (30) days of service to the individual and one (1) unit for each thirty (30) days of service through the last thirty (30) days post-discharge.

DHS publishes the targeted case management fee schedule rates on its website.

C. Payment to all governmental and non-governmental providers is a uniform rate for these services unless otherwise approved in the state plan.

230.200 Rate Appeal Process 1-1-25

A. A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within twenty (20)

calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within twenty (20) calendar days of receipt of the request for review or the date of the Program/Provider conference.

B. When the provider disagrees with the decision made by the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The Rate Review Panel will include one (1) member of the Division of Medical Services, a targeted case management provider who serves eligible juveniles, and a member of the Department of Human Services (DHS) Management Staff who will serve as chairperson.

C. The request for review by the Rate Review Panel must be postmarked within fifteen (15) calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within fifteen (15) calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

240.100 Introduction to Billing 1-1-25

A. Targeted case management providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

B. Section III of this manual contains information about available options for electronic claim submission.

240.200 CMS-1500 Billing Procedures 1-1-25

240.300 Targeted Case Management Procedure Codes 1-1-25

View or print the procedure codes for targeted case management for eligible juveniles.

240.400 National Place of Service (POS) Codes 1-1-25

The national place of service code is used for both electronic and paper billing.

Place of Service	POS Codes
School	03
Prison/Correctional Facility	09
Office	11
Patient's Home	12
Other Locations	99

240.500 Billing Instructions — Paper Claims Only 1-1-25

A. Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. View a sample form CMS-1500.

B. Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

C. Forward completed claim forms to the Claims Department. View or print the Claims Department contact information.

Note: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

240.600 Completion of CMS-1500 Claim Form 1-1-25

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	

Field Name and Number	Instructions for Completion
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a and d are required. Name of the insured individual's employer and/or school.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.

Field Name and Number	Instructions for Completion
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for targeted case management services.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.

Field Name and Number	Instructions for Completion
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24.A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code .

Field Name and Number	Instructions for Completion
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

19. Case Management Services (continued)

E-1. Incarcerated Juveniles

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

- Reimbursement for case management services is based on bundled unit billing. The provider will bill one unit for the first thirty days of service to the individual and one unit for each thirty days of service through the last thirty days post discharge. Targeted case management fee schedule rates are published on the DHS website at: **fee schedules.** This bundled billing method and the resulting rate was developed through a combination of comparisons with public and proprietary industry data, existing Arkansas reimbursement, and rates for similar case management services delivered in other Medicaid programs across the country. The approach uses cost-based reimbursement principles, and the proposed rates reflect benchmarks of "reasonable costs" incurred by a typical provider, based on economic data from the Bureau of Labor Statistics, Occupational Employment and Wage Statistics (OEWS), Bureau of Labor Statistics, Costs for Employee Compensation Survey (CECS), and others.

Payment to all governmental and non-governmental providers is a uniform rate for these services unless otherwise approved in the state plan.

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Eligible juveniles as defined in §1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution **following adjudication,** and for at least 30 days following release.

Post Release TCM Period beyond 30 day post release minimum requirement:
☒ State will provide TCM beyond the 30-day post release requirement. **[explain]:**

An extension of benefits can be requested if continued medically necessary services are needed beyond the 30-day post release period.

Areas of State in which services will be provided (§1915(g)(1) of the Act):
☒ Entire state

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
☒ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management (TCM) services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

The periodic reassessment is conducted every (check all that apply):

- ☒ 1 month
- ☐ 3 months
- ☐ 6 months
- ☐ 12 months
- ☐ Other frequency **[explain]:** Click or tap here to enter text.

❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities are:
activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

- services are being furnished in accordance with the individual's care plan;
- services in the care plan are adequate; and
- changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Frequency of additional monitoring:
Specify the type and frequency of monitoring (check all that apply)
☒ Telephonic. Frequency: Monthly
☒ In-person. Frequency: Monthly
☐ Other **[explain]:** Click or tap here to enter text.

☒ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. For instance, a case manager might also work with state children and youth agencies for children who are involved with the foster care system.
(42 CFR 440.169(e))

☒ If another case manager is involved upon release or for case management after the 30-day post release mandatory service period, states should ensure a warm hand off to transition case management and support continuity of care of needed services that are documented in the person-centered care plan. A warm handoff should include a meeting between the eligible juvenile, and both the pre-release and post-release case manager. It also should include a review of the person-centered care plan and next steps to ensure continuity of case management and follow-up as the eligible juvenile transitions into the community.

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Targeted case management services are provided only through qualified providers. Qualified case management providers must meet the following criteria:

A. The provider must be enrolled with Arkansas Medicaid.
B. The provider must have full access to all pertinent records concerning the incarcerated youth's needs for services including records from all types of facilities in both the juvenile justice system and adult criminal justice system, Division of Youth Services, and Division of Children and Family Services.
C. The provider must have established referral systems and demonstrated linkages and referral ability with community resources required by the target population.
D. The provider must have a minimum of one year's experience in providing all core elements of case management services to the target populations.
E. The provider must ensure quality services in accordance with state and federal requirements.
F. The provider must have the financial management capacity and system that provides documentation of services and costs in conformity with generally accepted accounting principles.
G. The provider must have a capacity to document and maintain individual case records in accordance with state and federal requirements.

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Freedom of choice (42 CFR 441.18(a)(1)):

☒ The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services below.]

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TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

☒ The state assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plans.
- Delivery of TCM and the policies, procedures, and processes developed to support implementation of these provisions are built in consideration of the individuals release and will not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Payment (42 CFR 441.18(a)(4)):

☒ The state assures payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

☒ The state assures providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

☒ The state assures that case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

State Plan under Title XIX of the Social Security Act
State/Territory: Arkansas

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))
FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

☐ State has additional limitations **[Specify any additional limitations.]**
Click or tap here to enter text.

Mandatory Coverage for Eligible Juveniles who are Inmates of a Public Institution Post Adjudication of Charges

State/Territory: Arkansas

General assurances. State must indicate compliance with all four items below with a check.

☑ In accordance with section 1902(a)(84)(D) of the Social Security Act, the state has an internal operational plan and, in accordance with such plan, provides for the following for eligible juveniles as defined in 1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution following adjudication:

> ☑ In the 30 days prior to release (or not later than one week, or as soon as practicable, after release from the public institution), and in coordination with the public institution, any screenings and diagnostic services which meet reasonable standards of medical and dental practice, as determined by the state, or as otherwise indicated as medically necessary, in accordance with the Early and Periodic Screening, Diagnostic, and Treatment requirements, including a behavioral health screening or diagnostic service.
>
> ☑ In the 30 days prior to release and for at least 30 days following release, targeted case management services, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible, under the Medicaid state plan (or waiver of such plan).

☑ The state acknowledges that a correctional institution is considered a public institution and may include prisons, jails, detention facilities, or other penal settings (e.g., boot camps or wilderness camps).

Additional information provided (optional):

☐ No

☑ Yes [provide below]

The state may determine that it is not feasible to provide the required services during the pre-release period in certain carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g. unexpected release or short-term stays). The state will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the state determines that it is not feasible to provide for the required services during the pre-release period. This information is available to CMS upon request. Services will be provided post-release, including the mandatory 30-days of targeted case management, screening, and diagnostic services.

The state will maintain clear documentation in its internal operational plan indicating which carceral facility/facilities are furnishing required services during the pre-release period but not enrolling in or billing Medicaid. This information is available to CMS upon request.

CHIP Eligibility

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 25 - 0007

Incarcerated CHIP Beneficiaries — CS31

2102(d) and 2110(b)(7) of the SSA

Targeted Low-Income Children Who Become Incarcerated

☒ The state assures that it does not terminate eligibility for children enrolled in a separate CHIP because the child is an inmate of a public institution.

States may either suspend CHIP coverage or continue to provide CHIP state plan (or waiver of such plan) services otherwise not covered by the carceral facility to children who are incarcerated. States that elect to suspend CHIP coverage for the duration of a child's incarceration may implement a benefits or eligibility suspension.

The state elects to suspend CHIP coverage for the duration of a child's incarceration: Yes

If yes, then check an option below:

- (•) Benefits suspension
- ( ) Eligibility suspension

☒ The state assures that it redetermines eligibility for any child prior to their release if it has been longer than 12 months since the child's last redetermination and restores coverage for child health assistance to eligible children upon their release.

☒ Within the 30 days prior to release (or within one week of release, or as soon as practicable after release), the state assures that it provides eligible children with any screenings, diagnostic services, or case management services that would otherwise be available to children under the CHIP state plan (or waiver of such plan).

Additional information regarding implementation of mandatory provisions of section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023), including providing screenings, diagnostic services, or case management services:

The state may determine that it is not feasible to provide the required services during the pre-release period in certain carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g., unexpected release or short-term stays). The state will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the state determines that it is not

Under section 5122 of the CAA, 2023, states may consider otherwise eligible children who are inmates pending disposition of charges as eligible for CHIP and provide all services covered under the CHIP state plan.

☐ The state elects to provide all CHIP state plan benefits (or waiver of such plan) to eligible children who are inmates pending disposition of charges.

PRA Disclosure Statement

CHIP Eligibility

Children Determined Eligible for CHIP While Incarcerated

Generally, children who apply for CHIP when they are in a carceral facility are not eligible because of the eligibility exclusion for inmates of a public institution under section 2110(b) of the Act. However, section 2110(b)(7) of the Act provides an exception to this eligibility exclusion for children who are within 30 days prior to their release.

☒ The state assures that they will process any application submitted on behalf of a child and make an eligibility determination for child health assistance upon their release from the institution.

☒ Children who apply and are found eligible within 30 days prior to their release will be provided screening and diagnostic services, and case management services that are otherwise available under the CHIP state plan (or waiver of such plan).

PROPOSED

SPA # 13, Purpose of SPA:
The state is assuring that it covers age-appropriate vaccines and their administration, without cost sharing.

Proposed effective date: October 1, 2023

Proposed implementation date: October 1, 2023

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

SPA # 15 , Purpose of SPA:

The purpose of this SPA is to end the Healthy Smiles Managed Care waiver for dental services and transition the dental program to fee-for-services (FFS).

Proposed effective date: November 1, 2024

Proposed implementation date: November 1, 2024

SPA#16 (AR-25-0007), Purpose of SPA:

The purpose of this SPA is to add Targeted Case Management Services for Incarcerated Juveniles to the ARKids-B Sections of the CHIP state plan and to attest to the state's compliance with sections 2102(d) and 2110(b)(7) of the Consolidated Appropriations Act.

Proposed effective date: January 1, 2025

Proposed implementation date: September 1, 2025

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☐ No
☒ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

For children who are enrolled in the PASSE, the following services are carved-out of the model:

- Nonemergency Medical Transportation
- Dental Benefits
- School-based services provided by school employees
- Services provided to residents of a human development center, a skilled nursing facility, or an assisted living facility
- They are enrolled in ARChoices, Independent Choices, the 1915(c) Autism Waiver, or any successor to these programs.
- Pre-release services provided through carceral facilities for incarcerated youth consistent with section 2102 (d)(2)

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
☒ Capitation payment
Describe population served:

Those individuals who receive behavioral health and developmental disabilities services who are determined to meet the Tier II or Tier III level of need, unless they are residing in a Human Development Center, a skilled nursing facility, or an assisted living facility or they are enrolled in ARChoices, Independent Choices, the 1915(c) Autism Waiver, or a successor to one of these programs.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
☐ Capitation payment
☐ Other (please explain)

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

See page CS19

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility

The state's treatment of inmates of a public institution complies with sections 2102(d) and 2110(b)(7) of the Act as follows:

The state does not terminate eligibility for children enrolled in a separate CHIP because the child is an inmate of a public institution.

The state elects to suspend CHIP coverage for the duration of a child's incarceration. The state will use a benefits suspension.

The state redetermines eligibility for any child prior to their release if it has been longer than 12 months since the child's last redetermination and restores coverage for child health assistance to eligible children upon their release.

Within the 30 days prior to release (or within one week of release, or as soon as practicable after release), the state provides eligible children with any screenings, diagnostic services, or case management services that would otherwise be available to children under the CHIP state plan (or waiver of such plan).

The state will process any application submitted by or on behalf of a child and make an eligibility determination for child health assistance to provide all services available under the CHIP state plan (or waiver of such plan) upon their release from the institution.

Children applying for coverage who are within 30 days prior to their release and are found eligible for CHIP are provided screenings, diagnostic services, and case management services that are otherwise available under the CHIP state plan (or waiver of such plan).

The state may determine that it is not feasible to provide the required services during the pre-release period in certain carceral facilities (e.g., identified local jails, youth correctional facilities, and state prisons) and/or certain circumstances (e.g., unexpected release or short-term stays). The state will maintain clear documentation in its internal operational plan regarding each facility and/or circumstances where the state determines that it is not feasible to provide for the required services during the pre-release period.
This information is available to CMS upon request. Services will be provided post- release, including mandatory screening, and diagnostic services, and case management services consistent with coverage otherwise available under the CHIP state plan.

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4.[X] Coverage that includes benchmark coverage plus additional coverage.) Vision services (eye exam – one routine eye exam [refraction] every 12 months and eyeglasses – one pair every 12 months) and dental services (routine dental care & orthodontia) make up the additional benefit coverage to the Arkansas State and Public School Employees benchmark benefits. (See ATTACHMENT A for a copy of Arkansas State and Public School Employees benchmark benefits description). Beginning January 1, 2025, Targeted Case Management for Incarcerated Juveniles was added to the existing benefit coverage.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7.[ ] Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of

Physician
Podiatry
Prenatal Care
Prescription Drugs, CGMs, 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
Targeted Case Management for Incarcerated Juveniles
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).

6.2.1.[X] Inpatient services (Section 2110(a)(1))

6.2.2.[X] Outpatient services (Section 2110(a)(2))

6.2.3.[X] Physician services (Section 2110(a)(3))

6.2.4.[X] Surgical services (Section 2110(a)(4))

6.2.5.[X] Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6.[X] Prescription drugs (Section 2110(a)(6))

6.2.7.[X] Over-the-counter medications (Section 2110(a)(7))

6.2.8.[X] Laboratory and radiological services (Section 2110(a)(8))

6.2.9.[X] Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.20.[X] Case management services (Section 2110(a)(20))

Primary Care Case Management

Targeted Case Management for Incarcerated Juveniles

6.2.21. ☐ Care coordination services (Section 2110(a)(21))

6.2.22.[X] Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

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
Targeted Case Management for Incarcerated Juveniles**	None
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). Inclusion in the prescription drugs and diabetic supplies category requires a $5 co-pay rather than the DME $500 limitation per State Fiscal Year (SFY) July 1 – June 30, and the 10% coinsurance required for DME products. These products are reimbursable to both pharmacies and DME providers, and pricing methodology and billing processes have been aligned for both categories. Pharmacy and DME provider billing procedures for diabetic supplies would be aligned with the payment of a copay rather than ten percent (10%) coinsurance.
Only the traditional insulin pumps requiring a canula and tubing would have applicable 10 % coinsurance, as those will remain billed only through the DME benefit.

** For eligible incarcerated youth, copays are not required for pre-release services provided consistent with section 2102(d)(2) of the Act.

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.

8.2.3 Coinsurance or Copayments:

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all

Attachment G

FFY 2025 Budget – Targeted Case Management for CAA

CHIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	2025
State's enhanced FMAP rate	79.80%
Benefit Costs	
Insurance payments	$0.00
Managed care	$
per member/per month rate	$
Fee for Service	$15,969.60
Total Benefit Costs	$15,969.60
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	$
Cost of Proposed SPA Changes – Benefit	$15,969.60
Administration Costs	
Personnel	$0.00
General administration	$0.00
Contractors/Brokers	$0.00
Claims Processing	$0.00
Outreach/marketing costs	$0.00
Health Services Initiatives	$0.00
Other	$0.00
Total Administration Costs	$0.00
10% Administrative Cap	$0.00
Cost of Proposed SPA Changes	$15,969.60
Federal Share	$12,743.74
State Share	$3,225.86
Total Costs of Approved CHIP Plan	$15,969.60

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of County Operations
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 Health Care Coverage for Incarcerated Eligible Individuals

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	$23,044	General Revenue	$48,376
Federal Funds	$56,804	Federal Funds	$111,320
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 79,848.00	Total	$ 159,696.00

(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**
$ 23,044.00	$ 48,376.00

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
Health Care Coverage for Incarcerated, Eligible Individuals

Statement of Necessity

The Consolidated Appropriations Act (CAA) of 2023 mandates coverage requirements by all states to allow greater coverage to be offered to incarcerated youth. The Centers for Medicare and Medicaid (CMS) issued guidance following passage of the Act. To comply with the Act and CMS guidance, the Department of Human Services (DHS) will cover care coordination services for incarcerated youth under Medicaid.

The target group includes eligible juveniles transitioning to a community setting. Case management services will be available thirty (30) days prior to release and for at least thirty (30) days following release. Medicaid will reimburse targeted case management services, including referrals to care and services, available in the geographic region of the home or residence of the eligible juvenile. These updates are a joint endeavor between the Division of County Operations (DCO) and the Division of Medical Services (DMS).

Summary of Changes

DCO updates various sections of the Medical Services Policy Manual and creates a new section to implement the requirements contained in the CAA of 2023. DCO revises Sections D-350 *Juveniles in the Custody of Division of Youth Services (DYS)* and D-380 *Juveniles Entering Custody of Division of Youth Services (DYS)* to distinguish between Medicaid and CHIP categories of Health Care. DCO adds new language to Section D-371 *Inmates Being Released from Custody* to provide guidance regarding Health Care coverage for individuals of a certain age and eligibility status during a specific period of time surrounding their release from incarceration. Similarly, DCO adds new language to Section D-381 *Juveniles Released from DYS* to provide guidance regarding Health Care coverage for eligible juveniles during a specific period of time surrounding their release from the custody of DYS and to describe the method and timeframe in which DYS will determine Health Care coverage eligibility of juveniles in its custody.

DCO creates Section D-374 *Juveniles Entering Public Institutions* to provide guidance for those beneficiaries entering a public institution. The guidance addresses eligibility, minimum required services and other possible services, and coverage terms when moving between an institution and a home.

DCO makes global changes to the above sections, and for consistency sections 370, 372, and 373, to update terminology, including standardization of references to children as "juvenile(s)." DCO removes references to outdated forms or practices and corrects grammatical, spelling, or formatting errors or inconsistencies. Finally, a technical correction is made to Medical Services Policy Section D-500.

DMS updates Section I of the Arkansas Medicaid Provider Manuals to establish juvenile re-entry services that assist with the transition of juveniles who are leaving a carceral setting. The

services may be activated for up to thirty (30) days prior to discharge and provide active Medicaid coverage for developmental assessments, case planning, and case management to assist with necessary referrals for treatment and accessing resources to support the individual. The services are furnished by providers who meet the participation requirements and enroll in Arkansas Medicaid. Services for juveniles preparing for re-entry to community settings will be coordinated by the court-ordered guardian or custodian of the juvenile.

DMS also promulgates a new Targeted Case Management for Incarcerated Juveniles Provider Manual (to be designated 20 Code of Arkansas Rule Part 652). The manual defines scope and rules for coverage and reimbursement of required services.

Finally, DMS shall submit amendments to the Arkansas Medicaid State Plan and Children's Health Insurance Program (CHIP) State Plan. A Targeted Case Management state plan amendment (SPA) for Medicaid and for CHIP defines the specified population, qualified providers, and available coverage under targeted case management, and sets methods and standards for establishing payment rates. DMS also submits a template Attestation SPA under guidance from CMS regarding the mandatory coverage for eligible juveniles. The Centers for Medicare & Medicaid (CMS) created a CHIP Eligibility template for all states which also is part of this rule. CMS utilized its regulatory flexibility under 42 CFR 430.20(b)(3) to issue guidance stating that SPAs implementing Section 5121 of CAA will be approved effective January 1, 2025, regardless of when the SPA is submitted for review.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) 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 proposed effective date of the rule is April 1, 2026.

DHS promulgates rules to implement provisions contained in the Consolidated Appropriations Act (CAA) of 2023. The Act required states to provide certain coverage to eligible incarcerated youth. DHS will cover care coordination services for incarcerated youth under Medicaid. The target group includes eligible juveniles transitioning to a community setting. Case management services will be available thirty (30) days prior to release and for at least thirty (30) days following release. Medicaid will reimburse targeted case management services, including referrals to care and services, available in the geographic region of the home or residence of the eligible juvenile.

To implement coverage, the Division of County Operations (DCO) updates and adds language to the Medical Services Policy (MSP) Manual. The updates distinguish between Medicaid and CHIP categories of coverage and provide guidance regarding coverage for individuals of a certain age and eligibility status during a specific period of time surrounding their release from incarceration. New language provides guidance regarding coverage for eligible juveniles during a specific period of time surrounding their release from the custody of the Department of Youth Services (DYS), including the method and timeframe in which DYS will determine coverage eligibility. DCO also adds guidance for those entering a public institution to address eligibility, minimum required services and other services, and coverage terms when moving between an institution and a home. The applicable sections receive updates for consistent terminology, standardization of references to children as juveniles, removal of references to outdated forms or practices, and correction of grammar, spelling, and formatting errors or inconsistencies, and technical corrections as needed.

The Division of Medical Services (DMS) updates Section I of the Arkansas Medicaid Provider Manuals to establish juvenile re-entry services that assist with the transition of juveniles who are leaving a carceral setting. The services may be activated for up to thirty (30) days prior to discharge and provide active Medicaid coverage for developmental assessments, case planning, and case management to assist with necessary referrals for treatment and accessing resources to support the individual. The services are furnished by providers who meet the participation requirements and enroll in Arkansas Medicaid. Services for juveniles preparing for re-entry to community settings will be coordinated by the court-ordered guardian or custodian of the juvenile. DMS also promulgates a new Targeted Case Management for Incarcerated Juveniles Provider Manual. The manual defines scope and rules for coverage and reimbursement of required services.

Finally, DMS shall submit amendments to the Arkansas Medicaid State Plan and Children's Health Insurance Program (CHIP) State Plan. A Targeted Case Management state plan amendment (SPA) for Medicaid and for CHIP defines the specified population, qualified providers, and available coverage under targeted case management, and sets methods and

standards for establishing payment rates. DMS also submits a template Attestation SPA under guidance from CMS regarding the mandatory coverage for eligible juveniles. The Centers for Medicare & Medicaid (CMS) created a CHIP Eligibility template for all states which also is part of this rule. CMS utilized its regulatory flexibility under 42 CFR 430.20(b)(3) to issue guidance stating that SPAs implementing Section 5121 of CAA will be approved effective January 1, 2025, regardless of when the SPA is submitted for review.

The estimated financial impact is $79,848.00 (State $23,044.00; Federal $56,804.00) for State Fiscal Year (SFY) 2025 and $159,696.00 (State $48,376.00; Federal $111,320.00) for SFY 2026.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. 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. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428.

Public comments can 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 January 19, 2026. 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 online by remote access. Public comments may be submitted at the hearing. The details for attending the online public hearing appear at ar.gov/dhspublichearings.

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. **4502292178**

Mary Franklin, Director
Division of County Operations

Elizabeth Pitman, Director
Division of Medical Services