

DEPARTMENT OF HUMAN SERVICES, DIVISION OF COUNTY OPERATIONS AND DIVISION OF MEDICAL SERVICES

SUBJECT: Technical Corrections (20 CAR pts. 500, 570, 571, 610, 624, 642)

DESCRIPTION:

Statement of Necessity

The Department of Human Services promulgates technical corrections to various departmental rules. The updates involve the Division of County Operations (DCO) and the Division of Medical Services (DMS). The updates address needed clarification of Medicaid Provider Manuals, the Medical Services Policy Manual, the Arkansas Medicaid State Plan, and the Arkansas Children's Health Insurance Program (CHIP) State Plan. Several of the updates result from guidance or request from the Centers for Medicare & Medicaid Services (CMS), and other corrections involve updating links, codes, terminology, program names, and references, or clarifying existing processes with additional detail.

Summary of Updates

Medicaid Provider Manuals:

- a. Certified Nurse Midwife Provider Manual Section 204.200 is revised to update the hyperlink for the DHS Contracted Pharmacy Vendor.
- b. Hospital Provider Manual Section 272.160 is corrected by replacing an old billing code with reference to the National Uniform Billing Committee (NUBC) guidelines.
- c. Provider-Led Arkansas Shared Savings Entity (PASSE) Section 221.210 is revised to update the hyperlink for the DHS Contracted Pharmacy Vendor.

Medical Services Policy Manual Sections A, B, C and E:

- a. Revisions needed to make the rule consistent throughout all sections to mirror updates instituted in 2023 when the Limited Pregnant Woman and Full Pregnant Woman categories were combined into a single Pregnant Woman category.
- b. Clarification of eligibility rules based on CMS guidance regarding which coverage applies to certain infants when born such that eligibility must be determined in other programs based on regular eligibility rules.
- c. Clarification of newborn referral processes used for health care eligible mothers such that if eligibility cannot be determined, a transition form will be issued; if the transition form is returned and eligibility is determined for the infant, a new twelvemonth Continuous Eligibility period will begin.
- d. Clarification that CHIP coverage will continue for the infant for the remainder of the twelve-month period from the start of the coverage.
- e. Clarification that Newborn coverage may be closed by request from an adult member in the household.
- f. Clarification that paper and online application options apply to TEFRA services.
- g. Updates to current terminology, program names, and form references and titles.

Arkansas Medicaid State Plan:

- a. Technical Correction State Plan Amendment 23-0014 to correct a wording mistake in a prior approved Primary Care Case Management SPA.
- b. Assurance and Compliance Attestation State Plan Amendment 23-0027 requested by CMS that confirms and demonstrates DHS compliance with requirements of the Inflation Reduction Act and federal regulations regarding coverage of age-appropriate vaccines and their administration without cost sharing.
- c. Confirmation of Continuous Eligibility State Plan Amendment 24-0008 ensuring Arkansas maintains Twelve Month Continuous Coverage for children.

CHIP State Plan (“Healthy Moms, Healthy Babies”):

- a. Update to mirror new rate and claims process for prenatal, delivery, and postpartum professional services under Medicaid implemented July 1, 2025.
- b. Removed requirements for global methods of billing as all obstetric services became billable based on fee-for-service rates.

PUBLIC COMMENT: No public hearing was held on these rules. The public comment period expired on May 2, 2026. The agency indicated that it received no comments.

The proposed effective date is July 1, 2026.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total estimated cost to implement this rule is \$14,104 for the current fiscal year (\$4,272 in general revenue and \$9,832 in federal funds). The agency indicated that this rule will result in a cost reduction for the next fiscal year of \$135,896 (\$41,815 in general revenue and \$94,081 in federal funds). The total estimated cost by fiscal year to a state, county, or municipal government to implement this rule is \$4,272 for the current fiscal year, with a cost reduction for the next fiscal year of \$41,815.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements identical Acts 124 and 140 of 2025, sponsored by Representative Aaron Pilkington and Senator Missy Irvin, respectively. The Acts created the Healthy Moms, Healthy Babies Act and amended Arkansas law to improve maternal health outcomes in this state. The Acts required the Department of Human Services to adopt rules implementing Title 20, Chapter 77, Subchapter 29 of the Arkansas Code, regarding maternal health. *See* Act 124, § 3; Act 140, § 3.



**ARKANSAS
DEPARTMENT OF
HUMAN
SERVICES**

Office of Policy and Rules

P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

P: 501.320.6383 F: 501.404.4619

April 1, 2026

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Technical Corrections Rule

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT _____
 BOARD/COMMISSION _____
 BOARD/COMMISSION DIRECTOR _____
 CONTACT PERSON _____
 ADDRESS _____
 PHONE NO. _____ EMAIL _____
 NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING _____
 PRESENTER EMAIL(S) _____

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?

2. What is the subject of the proposed rule? _____
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes No

4. Is this rule being filed for permanent promulgation? Yes No

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire? _____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes No

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes No

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes No

If yes, please list the rules being repealed.

If no, please explain.

8. Is this a new rule? Yes No

Does this repeal an existing rule? Yes No

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes No

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes No

If yes, please provide the year of the act(s) and act number(s).

11. What is the reason for this proposed rule? Why is it necessary?

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

13. Will a public hearing be held on this proposed rule? Yes No

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. _____

15. What is the proposed effective date for this rule? _____

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes No

If yes, please explain.

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 July 1, 2026. The proposed rule estimates financial impact of \$14,104.00 for State Fiscal Year (SFY) 2026 and (-\$135,896.00) for SFY 2027.

The Department of Human Services promulgates technical corrections to various departmental rules. The updates address needed technical corrections of Medicaid Provider Manuals, the Medical Services Policy Manual, the Arkansas Medicaid State Plan, and the Arkansas Children's Health Insurance Program (CHIP) State Plan. Many of the updates result from guidance or request from the Centers for Medicare & Medicaid Services (CMS).

The Certified Nurse Midwife Provider Manual and the Provider-Led Arkansas Shared Savings Entity (PASSE) are revised to update the hyperlink for the DHS Contracted Pharmacy Vendor website. The Hospital Provider Manual is corrected by replacing an old billing code with reference to the National Uniform Billing Committee guidelines. The Arkansas Medicaid State Plan is corrected to update language in a prior approved Primary Care Case Management state plan amendment, to demonstrate compliance with the Inflation Reduction Act and federal regulations regarding coverage of age-appropriate vaccines and their administration without cost sharing, and to confirm twelve-month continuous coverage for children. The Arkansas CHIP State Plan is updated to mirror the new rate and claims process implemented July 1, 2025, for prenatal, delivery, and postpartum professional services under Medicaid, and to remove requirements for global methods of billing as all obstetric services are now billable based on fee-for-service rates.

The Medical Service Policy Manual Sections A, B, C, and E are revised for consistency and clarification. Revisions are needed to make the manual consistent throughout all sections to mirror updates instituted in 2023 when the Limited Pregnant Woman and Full Pregnant Woman categories were combined into a single Pregnant Woman category. Clarification is needed to eligibility rules based on CMS guidance regarding which coverage applies to certain infants when born such that eligibility must be determined in other programs based on regular eligibility rules. And clarification of the newborn referral processes used for health care eligible mothers is needed to state that if eligibility cannot be determined then a transition form will be issued; if the transition form is returned and eligibility is determined for the infant, a new twelve-month Continuous Eligibility period will begin. The manual is updated to clarify that CHIP coverage will continue for an infant for the remainder of the twelve-month period from the start of the coverage, and that newborn coverage may be closed by request from an adult member in the household. The manual is updated to clarify that paper and online application options apply to TEFRA services. Updates are made throughout the sections to updated current terminology, program names, and form references and titles.

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. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules.

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 May 2, 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.

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

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. **4502292178**

Mary Franklin, Director
Division of County Operations

Elizabeth Pitman, Director
Division of Medical Services

From: [Legal Ads](#)
To: [Renita Jones](#)
Cc: [Mac Golden](#); [Jack Tiner](#); [Lakeya Gipson](#); [Elaine Stafford](#)
Subject: Re: Full Run AD - (Rule #294) - Technical Corrections Rule
Date: Tuesday, March 31, 2026 2:42:08 PM
Attachments: [image001.png](#)

CAUTION: External Email

Scheduled for Fri 4/3, Sat 4/4, and Sun 4/5.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>
To: "Legal Ads" <legalads@arkansasonline.com>
Cc: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Monday, March 30, 2026 9:56:24 AM
Subject: Full Run AD - (Rule #294) - Technical Corrections Rule

Good morning,

Please Reply to this email using REPLY ALL.

Please run the attached ad in the Arkansas Democrat-Gazette on the following days:

- Friday April 3, 2026
- Saturday April 4, 2026
- Sunday April 5, 2026

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**

OPR, ATTN: Lakeya Gipson

P.O. Box 1437, Slot S295

Little Rock, AR 72203-8068

Lakeya.Gipson@dhs.arkansas.gov

Thank you,



Renita Jones

Rules and Regulations Coordinator

Arkansas Department of Human Services

Office of Policy and Rules

P: 501.320.3949

Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

From: [Renita Jones](#)
To: register@sos.arkansas.gov
Cc: [Renita Jones](#); [Mac Golden](#); [Jack Tiner](#); [JAMIE EWING](#); [Lakeya Gipson](#)
Subject: DHS/DMS/DCO - Proposed Filing - Technical Corrections (Rule #294)
Date: Wednesday, April 1, 2026 9:54:00 AM
Attachments: [Initial Filing - Sec of State - Rule #294.pdf](#)
[image001.png](#)

Good morning,

Please see attached for initial filing. The public notice will run:

Friday, April 3rd

Saturday, April 4h

Sunday, April 5th

The public comment period will end on May 2nd.

Thank you,



Renita Jones

Rules and Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.320.3949

Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT _____
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **EMAIL** _____

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

TITLE OF THIS RULE _____

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

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

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

If no, please explain:

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

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

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

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

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

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

Total _____

Next Fiscal Year

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

Total _____

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

Current Fiscal Year

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

Total _____

Next Fiscal Year

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

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

\$ _____

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.

Technical Corrections Rule

Statement of Necessity

The Department of Human Services promulgates technical corrections to various departmental rules. The updates involve the Division of County Operations (DCO) and the Division of Medical Services (DMS). The updates address needed clarification of Medicaid Provider Manuals, the Medical Services Policy Manual, the Arkansas Medicaid State Plan, and the Arkansas Children's Health Insurance Program (CHIP) State Plan. Several of the updates result from guidance or request from the Centers for Medicare & Medicaid Services (CMS), and other corrections involve updating links, codes, terminology, program names, and references, or clarifying existing processes with additional detail.

Summary of Updates

Medicaid Provider Manuals:

- a. Certified Nurse Midwife Provider Manual Section 204.200 is revised to update the hyperlink for the DHS Contracted Pharmacy Vendor.
- b. Hospital Provider Manual Section 272.160 is corrected by replacing an old billing code with reference to the National Uniform Billing Committee (NUBC) guidelines.
- c. Provider-Led Arkansas Shared Savings Entity (PASSE) Section 221.210 is revised to update the hyperlink for the DHS Contracted Pharmacy Vendor.

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- a. Revisions needed to make the rule consistent throughout all sections to mirror updates instituted in 2023 when the Limited Pregnant Woman and Full Pregnant Woman categories were combined into a single Pregnant Woman category.
- b. Clarification of eligibility rules based on CMS guidance regarding which coverage applies to certain infants when born such that eligibility must be determined in other programs based on regular eligibility rules.
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- d. Clarification that CHIP coverage will continue for the infant for the remainder of the twelve-month period from the start of the coverage.
- e. Clarification that Newborn coverage may be closed by request from an adult member in the household.
- f. Clarification that paper and online application options apply to TEFRA services.
- g. Updates to current terminology, program names, and form references and titles.

Arkansas Medicaid State Plan

- a. Technical Correction State Plan Amendment 23-0014 to correct a wording mistake in a prior approved Primary Care Case Management SPA.
- b. Assurance and Compliance Attestation State Plan Amendment 23-0027 requested by CMS that confirms and demonstrates DHS compliance with requirements of the Inflation Reduction Act and federal regulations regarding coverage of age-appropriate vaccines and their administration without cost sharing.
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CHIP State Plan (“Healthy Moms, Healthy Babies”)

- a. Update to mirror new rate and claims process for prenatal, delivery, and postpartum professional services under Medicaid implemented July 1, 2025.
- b. Removed requirements for global methods of billing as all obstetric services became billable based on fee-for-service rates.

TOC not required

204.200

Certified Nurse-Midwife's Role in the Prescription Drug Program

10-1-157-1-
26

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A certified nurse-midwife with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must refer to the ~~Arkansas Medicaid Pharmacy website at <https://arkansas.magellanrx.com/provider/documents>~~ **DHS Contracted Pharmacy Vendor website** to obtain the latest information regarding prescription drug coverage.

As additions or deletions by labelers are submitted to the state by the Centers for Medicare and Medicaid Services (CMS), the website is updated.

TOC not required

204.200

Certified Nurse-Midwife's Role in the Prescription Drug Program

7-1-26

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Prescribers must refer to the [DHS Contracted Pharmacy Vendor website](#) to obtain the latest information regarding prescription drug coverage.

As additions or deletions by labelers are submitted to the state by the Centers for Medicare and Medicaid Services (CMS), the website is updated.

TOC not required

272.160 **Outpatient Surgery**

40-13-037-
1-26

The procedure codes for outpatient surgical procedures are global codes which include all related non-physician services. Separate charges should not be billed for drugs, injection, supplies, room charges, etc. Laboratory, radiology, and machine tests charges may be billed separately. If more than one procedure is done, the more complex procedure should be coded. Do not use more than one surgical code per date of service. If the procedure is an emergency and a procedure is performed within the surgical code range, ~~the type of bill code must be 101~~ providers should bill using the appropriate Type of Bill per National Uniform Billing Committee (NUBC) guidelines.

TOC not required

272.160 Outpatient Surgery

7-1-26

The procedure codes for outpatient surgical procedures are global codes which include all related non-physician services. Separate charges should not be billed for drugs, injection, supplies, room charges, etc. Laboratory, radiology, and machine tests charges may be billed separately. If more than one procedure is done, the more complex procedure should be coded. Do not use more than one surgical code per date of service. If the procedure is an emergency and a procedure is performed within the surgical code range, providers should bill using the appropriate Type of Bill per National Uniform Billing Committee (NUBC) guidelines.

PROPOSED

TOC not required

221.210 Pharmacy Requirements

3-1-197-1-
26

The PASSE must use the most current version of the **Arkansas Preferred Drug List found at the DHS Contracted Pharmacy Vendor website** (<https://arkansas.magellanrx.com/provider/documents/>), which is subject to periodic changes. The PASSE must use the Medicaid PDL developed by DHS or its Agent and may not develop and use its own PDL.

Any prior authorization program for covered outpatient drugs must comply with the requirements defined under Section 1927 of the Social Security Act.

The PASSE Provider Agreement requires that:

- A. The PASSE provides coverage of covered outpatient drugs as defined in section 1927 of the Social Security Act, that meets the standards for such coverage imposed by section 1927 of the Social Security Act as if such standards applied directly to the PASSE.
- B. The PASSE reports drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927 of the Social Security Act, of which can be no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the MCO, PIHP, or PAHP. Specific timeframes and guidelines on submission of drug utilization data is contained within the PASSE Provider Agreement.
- C. The PASSE establishes procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from the reports required in Section 1927 of the Social Security Act when states do not require submission of managed care drug claims data from covered entities directly.
- D. The PASSE must operate a drug utilization review program that complies with the requirements described in Section 1927 of the Social Security Act and 42 CFR part 456, subpart K, as if such requirement applied to the PASSE instead of the State.

The PASSE must provide a detailed description of its drug utilization review program activities to the State on an annual basis as described in the PASSE Provider Agreement.

TOC not required

221.210 Pharmacy Requirements

7-1-26

The PASSE must use the most current version of the [Arkansas Preferred Drug List found at the DHS Contracted Pharmacy Vendor website](#), which is subject to periodic changes. The PASSE must use the Medicaid PDL developed by DHS or its Agent and may not develop and use its own PDL.

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The PASSE Provider Agreement requires that:

- A. The PASSE provides coverage of covered outpatient drugs as defined in section 1927 of the Social Security Act, that meets the standards for such coverage imposed by section 1927 of the Social Security Act as if such standards applied directly to the PASSE.
- B. The PASSE reports drug utilization data that is necessary for States to bill manufacturers for rebates in accordance with section 1927 of the Social Security Act, of which can be no later than 45 calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code of each covered outpatient drug dispensed or covered by the MCO, PIHP, or PAHP. Specific timeframes and guidelines on submission of drug utilization data is contained within the PASSE Provider Agreement.
- C. The PASSE establishes procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from the reports required in Section 1927 of the Social Security Act when states do not require submission of managed care drug claims data from covered entities directly.
- D. The PASSE must operate a drug utilization review program that complies with the requirements described in Section 1927 of the Social Security Act and 42 CFR part 456, subpart K, as if such requirement applied to the PASSE instead of the State.

The PASSE must provide a detailed description of its drug utilization review program activities to the State on an annual basis as described in the PASSE Provider Agreement.

MEDICAL SERVICES POLICY MANUAL, SECTION A

A-100 General Program Information

A-150 Quality Control Assurance

A-150 Quality Control Assurance

MS Manual ~~07/01/20~~ 07/01/26

As a condition of eligibility, all ~~Medicaid~~ Health Care recipients are required to cooperate with the Quality Assurance Control (QC) Unit during their review process.

A-160 Deleted Referral Process for Counties

MS Manual ~~07/01/20~~ 07/01/26

~~There are several standardized processes for hospitals/physicians to refer needy individuals to the County Office Department of Human Services. There are also several programs that receive referrals from the County Office. These processes and County Office responsibilities are described in the sections below.~~

A-161 Hospital/Physician Referral

MS Manual ~~07/01/20~~ 07/01/26

The hospital/physician should inform needy individuals of possible medical assistance available under the Department of Human Service's Health Care Medicaid Programs.

A-162 Hospital/Physician/Certified Nurse-Midwife Referral for Newborns

MS Manual ~~07/01/20~~ 07/01/26

Federal law mandates Medicaid Health Care coverage, that is covered through Medicaid funds, for the first 12 months from birth a period of 12 months for a newborn infant whose mother is certified for Health Care Medicaid at the birth of the ~~infant, or infant or~~ is determined Medicaid eligible after the birth for the birth month. The newborn is not required to reside with the mother during this period but must be an Arkansas resident. Refer to ([MSC-210](#)) for additional information on hospital/physician/certified nurse-midwife referral of a newborn.

NOTE: Newborn coverage for infants born to mothers under the Unborn category will not be explored and infant will need to be determined for eligibility under other Medicaid or CHIP categories, such as ARKIDS A or ARKIDS B, under regular program rules.

A-150 Quality Control

MS Manual 07/01/26

As a condition of eligibility, all Health Care recipients are required to cooperate with the Quality Control (QC) Unit during their review process.

A-160 Deleted

MS Manual 07/01/26

A-161 Hospital/Physician Referral


MS Manual 07/01/26

The hospital/physician should inform needy individuals of possible medical assistance available under the Department of Human Service's Health Care Programs.

A-162 Hospital/Physician/Certified Nurse-Midwife Referral for Newborns

MS Manual 07/01/26

Federal law mandates Health Care coverage, that is covered through Medicaid funds, for the first 12 months from birth for a newborn infant whose mother is certified for Health Care at the birth of the infant or is determined Medicaid eligible after the birth for the birth month. The newborn is not required to reside with the mother during this period but must be an Arkansas resident. Refer to ([MSC-210](#)) for additional information on hospital/physician/certified nurse-midwife referral of a newborn.

 **NOTE:** Newborn coverage for infants born to mothers under the Unborn category will not be explored and infant will need to be determined for eligibility under other Medicaid or CHIP categories, such as ARKIDS A or ARKIDS B, under regular program rules.

C-210 Newborn Referral Process

MS Manual ~~07/01/26~~07/01/20

Hospital and physician providers use the ~~DCO-0645~~, Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant ~~Health Care~~ ~~Medicaid~~ Coverage Form, to refer ~~children~~ ~~infants~~ who are born to ~~and will reside with their Medicaid~~ ~~Health Care (other than Unborn category of coverage)~~ eligible mothers following discharge from the hospital. The referring provider is requested to complete the ~~DCO-0645~~ Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Health Care and submit to DHS ~~and send it to the DHS County Office of the mother's residence~~ within five days of the ~~child's~~ ~~infant's~~ birth, when possible.

If the mother of the child is covered under the Unborn Child category, DHS will attempt to determine eligibility for Medicaid or CHIP using the Hospital/Physician/Certified Nurse-Midwife Referral. If enough information is not available to determine eligibility for the infant, a Healthcare Transition form will be sent. CHIP coverage will continue for the infant for the remainder of the 12 month period from the start of the Unborn coverage. If the Healthcare Transition form is returned and eligibility is determined for the infant, a new 12 month Continuous Eligibility period will begin.



NOTE: In the following situations, ~~the request for Newborn~~ coverage for the infant should be made ~~by completing an application. by paper on an Application for SNAP, Health Care and TEA Benefits form application a on a DCO-00040152, Application for Health Coverage, or online at access.arkansas.gov:~~

- If the mother of the child is not ~~Medicaid~~ eligible ~~for state Health Care~~ and has not made ~~an~~ application for ~~state Health Care~~ ~~Medicaid~~ to cover her pregnancy ~~or~~
- ~~If the mother of the child is approved under the Unborn Child category (refer to MS-B-220) or~~
- ~~If the infant will be living with someone else other than the biological mother following discharge from the hospital.~~

C-211 Newborn Referral Disposal Process

MS Manual ~~07/01/26~~07/01/20

Once an ~~infant is~~ ~~an~~ ~~Newborn~~ ~~is~~ eligible, the ~~infant~~ ~~newborn~~ will remain eligible until the last day of the month of the child's first birthday regardless of whether the mother continues to be eligible.

The only exceptions to a full year of coverage are:

MEDICAL SERVICES POLICY MANUAL, SECTION C

~~C-200 Alternative Application Processes~~

- If the child no longer resides in the State of Arkansas
- If the child dies during the 12-month coverage period
- If a request by an adult member of the household is made for the coverage to close

C-230 TEFRA Application Process

MS Manual ~~07/01/20~~ 07/01/26

P.L. 97-248

~~The TEFRA program may be applied for by completing the Department of Human Service's paper Application for SNAP, Health Care, and TEA benefits form or online at access.arkansas.gov. applications (DCO-9700) will be available at local DHS offices or by mail, through hospitals, including Arkansas Children's Hospital, and Federally Qualified Health Centers. Information will be available through the Division of Developmental Disabilities (DDS) Services Coordinators and Providers. Information will also be available on the DHS/DMS website.~~

To complete the eligibility determination, the following steps must be completed:

- The application must be made by an adult responsible for the care of the child.
- A DMS 2602, Physician's Assessment of Eligibility, must be completed by the child's physician to determine Medical Necessity and Appropriateness of Care.

If disability has not previously been established by the Social Security Administration, a Medical Review Team (MRT) disability review must be completed.

C-210 Newborn Referral Process

MS Manual 07/01/26

Hospital and physician providers use the, Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Health Care Coverage Form, to refer infants who are born to Health Care eligible mothers following discharge from the hospital. The referring provider is requested to complete the Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Health Care and submit to DHS within five days of the infant's birth, when possible.

If the mother of the child is covered under the Unborn Child category, DHS will attempt to determine eligibility for Medicaid or CHIP using the Hospital/Physician/Certified Nurse-Midwife Referral. If enough information is not available to determine eligibility for the infant, a Healthcare Transition form will be sent. CHIP coverage will continue for the infant for the remainder of the 12 month period from the start of the Unborn coverage. If the Healthcare Transition form is returned and eligibility is determined for the infant, a new 12 month Continuous Eligibility period will begin.



NOTE: In the following situations, the request for coverage for the infant should be made by completing an application.

- If the mother of the child is not eligible for state Health Care and has not made an application for state Health Care to cover her pregnancy

C-211 Newborn Referral Disposal Process

MS Manual 07/01/26

Once an infant is Newborn eligible, the infant will remain eligible until the last day of the month of the child's first birthday regardless of whether the mother continues to be eligible.

The only exceptions to a full year of coverage are:

- If the child no longer resides in the State of Arkansas
- If the child dies during the 12-month coverage period
- If a request by an adult member of the household is made for the coverage to close

MEDICAL SERVICES POLICY MANUAL, SECTION C

C-230 TEFRA Application Process

MS Manual 07/01/26

P.L. 97-248

The TEFRA program may be applied for by completing the Department of Human Service's paper Application for SNAP, Health Care, and TEA benefits form or online at access.arkansas.gov.

To complete the eligibility determination, the following steps must be completed:

- The application must be made by an adult responsible for the care of the child.
- A DMS 2602, Physician's Assessment of Eligibility, must be completed by the child's physician to determine Medical Necessity and Appropriateness of Care.

If disability has not previously been established by the Social Security Administration, a Medical Review Team (MRT) disability review must be completed.

PROPOSED

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-220 Families and Individuals Group (MAGI)

B-220 Newborns

MS Manual ~~01/01/22~~07/01/26

This group consists of newborns up to one (1) year of age whose mothers were Health Care eligible at the time of their births. Newborns in this group are guaranteed Health Care coverage for the first year of life regardless of income changes that may occur during that first year. Newborns receive the full range of Health Care services through Medicaid funds.

Although this group is considered part of the ARKids First group, Newborns also have a separate category of coverage to ensure no change in household circumstances affects their one-year of guaranteed coverage. At one (1) year of age, eligibility for ARKids First (A or B) is determined as for any other child ([See MS I-230](#)).

~~Newborns-Infants~~ born to pregnant women approved under the Unborn child category ([See MS B-250](#)) are ~~not also~~ eligible for the Newborn category and must be determined for eligibility in another Health Care category under normal eligibility rules. If infant is approved for Health Care coverage they will still be eligible for the Continuous Eligibility rules.

MEDICAL SERVICES POLICY MANUAL, SECTION B

B-220 Families and Individuals Group (MAGI)

B-220 Newborns

MS Manual 07/01/26

This group consists of newborns up to one (1) year of age whose mothers were Health Care eligible at the time of their births. Newborns in this group are guaranteed Health Care coverage for the first year of life regardless of income changes that may occur during that first year. Newborns receive the full range of Health Care services through Medicaid funds.

Although this group is considered part of the ARKids First group, Newborns also have a separate category of coverage to ensure no change in household circumstances affects their one-year of guaranteed coverage. At one (1) year of age, eligibility for ARKids First (A or B) is determined as for any other child ([See MS I-230](#)).

Infants born to pregnant women approved under the Unborn child category ([See MS B-250](#)) are not eligible for the Newborn category and must be determined for eligibility in another Health Care category under normal eligibility rules. If infant is approved for Health Care coverage they will still be eligible for the Continuous Eligibility rules.

MEDICAL SERVICES POLICY MANUAL, SECTION E

~~E-200 Determining Financial Eligibility Under the MAGI Methodology~~

E-20069 Determining Financial Eligibility Under the MAGI

E-268 The 5% Gross Income Disregard

MS Manual ~~08/01/18~~07/01/26

Each individual will be allowed a general gross income disregard in the amount of five percent (5%) of the Federal Poverty Level for the household size.

The five percent (5%) disregard will be applied only to the Families and Individuals category with the highest income level in which an individual could be eligible. For example, if an individual is not income eligible in the lowest income level group (e.g., Parents/Caretaker Relatives), the five percent (5%) disregard will be applied to the higher income group (e.g., Adult Expansion Group). However, if the individual is eligible in the higher income group without applying the five percent (5%) disregard, the disregard will not be applied.

When applied, the five percent (5%) disregard effectively raises the income limits for the applicable eligibility group by five percentage points. For example, the income limit for the Adult Expansion Group is one hundred thirty-three (133%) See [MS E-110](#). To apply the five percent (5%) disregard, add five percent (5%) to one hundred thirty-three percent (133%) to raise the income limit to one hundred thirty-eight percent (138%) of the Federal Poverty Level. The ~~Full Pregnant Women and~~ Parent Caretaker Relative ~~category categories~~ of assistance ~~are is~~ not eligible to receive the five percent (5%) disregard.

Application of the 5% Disregard in the ARKids First groups

The five percent (5%) disregard is applied to the ARKids A income limit only if the child who would otherwise be ineligible without the disregard is covered by a health insurance plan. Since eligibility in ARKids B is not available to a child with health insurance, ARKids A is the eligibility group with the highest income limit available to an insured child, and therefore, the five percent (5%) disregard can be allowed.

The five percent (5%) disregard is not applied to the ARKids A income limit if the child is uninsured and ineligible for ARKids A without application of the disregard. ARKids B is the eligibility group with the highest income limit for uninsured children, and therefore, the five percent (5%) disregard is applied only if needed to achieve ARKids B eligibility.

Refer to [MS F-180](#) for exceptions to health insurance coverage for ARKids B eligibility.

E-268 The 5% Gross Income Disregard

MS Manual 07/01/26

Each individual will be allowed a general gross income disregard in the amount of five percent (5%) of the Federal Poverty Level for the household size.

The five percent (5%) disregard will be applied only to the Families and Individuals category with the highest income level in which an individual could be eligible. For example, if an individual is not income eligible in the lowest income level group (e.g., Parents/Caretaker Relatives), the five percent (5%) disregard will be applied to the higher income group (e.g., Adult Expansion Group). However, if the individual is eligible in the higher income group without applying the five percent (5%) disregard, the disregard will not be applied.

When applied, the five percent (5%) disregard effectively raises the income limits for the applicable eligibility group by five percentage points. For example, the income limit for the Adult Expansion Group is one hundred thirty-three (133%) See [MS E-110](#). To apply the five percent (5%) disregard, add five percent (5%) to one hundred thirty-three percent (133%) to raise the income limit to one hundred thirty-eight percent (138%) of the Federal Poverty Level. The Parent Caretaker Relative category of assistance is not eligible to receive the five percent (5%) disregard.

Application of the 5% Disregard in the ARKids First groups

The five percent (5%) disregard is applied to the ARKids A income limit only if the child who would otherwise be ineligible without the disregard is covered by a health insurance plan. Since eligibility in ARKids B is not available to a child with health insurance, ARKids A is the eligibility group with the highest income limit available to an insured child, and therefore, the five percent (5%) disregard can be allowed.

The five percent (5%) disregard is not applied to the ARKids A income limit if the child is uninsured and ineligible for ARKids A without application of the disregard. ARKids B is the eligibility group with the highest income limit for uninsured children, and therefore, the five percent (5%) disregard is applied only if needed to achieve ARKids B eligibility.

Refer to [MS F-180](#) for exceptions to health insurance coverage for ARKids B eligibility.

SPA #23-0014

State: Arkansas

Citation Condition or Requirement

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)
1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
2. Pregnant Women	§435.116	X			Statewide	Required to enroll with a PCCM only if they need non-obstetrical services which require a PCP referral.
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	X			Statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X				Required only if deemed <u>medically frail and receiving</u> Traditional Medicaid
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			Statewide	

State: Arkansas

MARKK-UP

TN: 23-0014
Supersedes: 18-0013

Approved:
Effective: 07/01/2023

State: Arkansas

Citation Condition or Requirement

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)
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1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
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3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	X			Statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X				Required only if deemed medically frail
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			Statewide	

TN: 23-0014
 Supersedes: 18-0013

Approved:
 Effective: 07/01/2023

CHIP SPA

#23-0027

B. ARKids First Background and Development

In 1997, Arkansas' Governor, the Arkansas State legislature, the President and Congress were all addressing the issue of health care for vast numbers of uninsured children. Governor Mike Huckabee supported enabling state legislation and an appropriations bill in the 1997 legislative session that created and funded ARKids First, an 1115(a)-demonstration waiver. The Arkansas Legislature passed both bills and Governor Mike Huckabee signed both bills into law on March 10, 1997 Effective August 4, 2000, the 1115(a)-demonstration waiver was renamed ARKids-B.

Ray Hanley, then Director, Division of Medical Services (DMS), formed and chaired an ARKids First work group, composed of individuals from the Governor's Office (the Department of Human Services liaison), Arkansas Children's Hospital, Arkansas Department of Health, Catholic Social Services,

Arkansas Advocates for Children and Families, Easter Seals, Communities in School of Arkansas, Arkansas Chapter for American Academy of Pediatrics, Electronic Data Systems (Arkansas Medicaid's then fiscal agent), and various individuals in the Department of Human Services (DHS), including Tom Dalton, then Department Director. The first meeting was held February 7, 1997, one day after President Clinton announced his FFY '98 budget package that included a proposal to expand health insurance access for poor children in families that earn too much for Medicaid but not enough to afford private health insurance. Additional ARKids First meetings were held as needed. Most of the discussion and concerns involved eligibility factors and the benefit package.

The Arkansas legislation, though not as detailed, mirrors the CHIP legislation in its purpose, i.e., to provide health insurance coverage for uninsured children under age 19 whose family income is at or below 200% of the poverty level. The ARKids First program was designed as a CHIP program, but used the 1115(a) demonstration waiver process for implementation, since the CHIP legislation had not been passed at the time Arkansas' program was under development. The ARKids First 1115(a) demonstration waiver was approved by CMS on August 19, 1997 and implemented on September 1, 1997; only days after the CHIP legislation was signed by the President.

Arkansas developed the ARKids First Program with the thought that it would be able to roll the ARKids First 1115 demonstration waiver into a CHIP program. However, the State recognized that as the ARKids First demonstration waiver and the CHIP legislation were developing, they didn't make completely parallel steps. Therefore, ARKids First enrollees, who did not meet the definition of a CHIP targeted low-income child, would continue to receive their health care services through Title XIX federal funding. Children in ARKids First who met the definition

of a CHIP targeted low-income child would be able to receive their services through either Title XIX or Title XXI federal funding, at the discretion of the State. All of the ARKids First children would remain in the 1115(a) demonstration waiver regardless of the funding source. The children who did not meet the definition of a CHIP targeted low-income child were the children of state employees and the children who met the eligibility requirements for regular Title XIX Medicaid. In 2002, CMS instructed the State that parents or guardians of children who met eligibility for Title XIX Medicaid did not have the choice to have their children receive services through either Title XIX Medicaid or the Title XXI CHIP ARKids First 1115(a) demonstration waiver. Children found eligible for Title XIX Medicaid must receive services through the Title XIX Medicaid program. Effective August 4, 2000, the ARKids First program was separated into ARKids-A (regular children's Title XIX Medicaid program) and ARKids-B (1115(a) demonstration waiver Title XXI CHIP program), and ARKids First became an umbrella for these two programs.

The application form and the promotional materials for ARKids-A and ARKids-B identify the two programs as ARKids First. Applications may be made at the local DHS County Office, by mail, or through the internet, and a toll free number is available to clients. Applications in English or Spanish may be printed from the ARKids First website at www.arkidsfirst.com. Applications in other languages are available upon request.

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

Section 6. Coverage Requirements for Children's Health Insurance – ARKids-B Program

6.5-Vaccine coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the “unborn”) option under the State plan should also check box 6.5.3.

- 6.5.1- Vaccine coverage for targeted-low-income children. The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).
- 6.5.2- Vaccine coverage for targeted-low-income pregnant individuals. The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO # 23-003, issued June 27, 2023); (Section 2103(c)(12))
- 6.5.3- Vaccine coverage for from-conception-to-end-of-pregnancy population option. The State provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost-sharing, to benefit the unborn child.

Section 6. Coverage Requirements for Children's Health Insurance – Title XXI CHIP

- 6.2.27. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.5-Vaccine coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the “unborn”) option under the State plan should also check box 6.5.3.

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- 6.5.3- Vaccine coverage for from-conception-to-end-of-pregnancy population option. The State provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost- sharing, to benefit the unborn child.

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Arkansas Advocates for Children and Families, Easter Seals, Communities in School of Arkansas, Arkansas Chapter for American Academy of Pediatrics, Electronic Data Systems (Arkansas Medicaid's then fiscal agent), and various individuals in the Department of Human Services (DHS), including Tom Dalton, then Department Director. The first meeting was held February 7, 1997, one day after President Clinton announced his FFY '98 budget package that included a proposal to expand health insurance access for poor children in families that earn too much for Medicaid but not enough to afford private health insurance. Additional ARKids First meetings were held as needed. Most of the discussion and concerns involved eligibility factors and the benefit package.

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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

Section 6. Coverage Requirements for Children’s Health Insurance – ARKids-BProgram

6.5-Vaccine coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the “unborn”) option under the State plan should also check box 6.5.3.

- 6.5.1- Vaccine coverage for targeted-low-income children. The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).
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- 6.5.3- Vaccine coverage for from-conception-to-end-of-pregnancy population option. The State provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost-sharing, to benefit the unborn child.

Section 6. Coverage Requirements for Children’s Health Insurance – Title XXI CHIP

- 6.2.27. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

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- 6.5.1- Vaccine coverage for targeted-low-income children. The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).
- 6.5.2- Vaccine coverage for targeted-low-income pregnant individuals. The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO # 23-003, issued June 27, 2023); (Section 2103(c)(12))
- 6.5.3- Vaccine coverage for from-conception-to-end-of-pregnancy population option. The State provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost- sharing, to benefit the unborn child.

MAC PRO SPA

#24-0008

AR - Submission Package - AR2024MS0001O - (AR-24-0008) - Eligibility

[Summary](#) [Reviewable Units](#) [Versions](#) [Correspondence Log](#) [Approval Letter](#) [News](#) [Related Actions](#)

CMS-10434 OMB 0938-1188

Package Information

Package ID	AR2024MS0001O	Submission Type	Official
Program Name	N/A	State	AR
SPA ID	AR-24-0008	Region	Dallas, TX
Version Number	4	Package Status	Approved
Submitted By	Rosaura Page	Submission Date	2/28/2024
Package Disposition		Approval Date	4/5/2024 10:49 AM EDT

PROPOSED

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Eligibility | AR2024MS0001O | AR-24-0008

CMS-10434 OMB 0938-1188

The submission includes the following:

Administration

Eligibility

Income/Resource Methodologies

Income/Resource Standards

Mandatory Eligibility Groups

Optional Eligibility Groups

Non-Financial Eligibility

Eligibility and Enrollment Processes

Eligibility Process

Application

Presumptive Eligibility

Continuous Eligibility for Children

Reviewable Unit Name	Included in Another Submission Package	Source Type
Continuous Eligibility for Children		APPROVED
Continuous Eligibility for Pregnant Women and Extended Postpartum Coverage		

PROPOSED

Benefits and Payments

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Children

MEDICAID | Medicaid State Plan | Eligibility | AR2024MS0001O | AR-24-0008

Package Header

Package ID	AR2024MS0001O	SPA ID	AR-24-0008
Submission Type	Official	Initial Submission Date	2/28/2024
Approval Date	04/05/2024	Effective Date	1/1/2024
Superseded SPA ID	new		
	User-Entered		

The state provides continuous eligibility for children in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Hospitalized Children

The state provides Medicaid to a child eligible for and enrolled under the Infants and Children under Age 19 (42 CFR 435.118) eligibility group until the end of an inpatient stay for which inpatient services are covered, if the child:

1. Was receiving inpatient services covered by Medicaid on the date the child becomes ineligible under the eligibility group based on the child's age; and
2. Would remain eligible but for attaining such age.

B. Mandatory Continuous Eligibility for Children

The state provides continuous eligibility to all children under age 19 and that:

1. The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends the last day of the earlier of the following periods:

- a. The month that the child turns 19 years old;
- b. 7 months.

2. Continuous eligibility is provided to children eligible under all mandatory and optional eligibility groups (excluding Medically Needy) who would otherwise lose eligibility because of any change in circumstances, unless:

- a. The child dies;
- b. The child or the child's representative voluntarily requests a termination of the child's eligibility;
- c. The child ceases to be a resident of the state;
- d. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- e. The child attains the maximum age specified in B.

C. Additional Information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 4/10/2024 11:05 AM EDT



CHIP SPA

#25-0017

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Effective July 1, 2025, the state revised the rate and claims process for prenatal, delivery, and postpartum professional services under Medicaid pursuant to Acts 124 and 140 of 2025, known widely as “Healthy Moms, Healthy Babies”. The requirements for global method of billing were removed and all obstetric services became billable based on fee-for-service rates.

- Services that are determined by the physician as medically necessary as, if not provided, could complicate or endanger the eligible Unborn Child program’s beneficiary’s pregnancy.

E. Healthy Smiles Dental Managed Care Program

The Arkansas Department of Human Services transitioned the Medicaid dental program to a prepaid ambulatory health plan (PAHP) on January 1, 2018. Two vendors were selected to provide state-wide dental benefits:

- a. Delta Dental
- b. Managed Care of North America (MCNA)

In early December 2017, all Arkansas Medicaid and CHIP beneficiaries who are eligible for dental benefits were randomly and evenly assigned to one of the two dental managed care plans. Each plan sent a welcome packet to each member and the members were able to access plan providers starting January 1, 2018, for covered dental services. Both dental vendors will provide the same dental services that were covered under the Medicaid and CHIP fee-for-service program.

Effective November 1, 2024, Arkansas Department of Human Services transitioned the CHIP dental program to the previous fee-for-service arrangement for all covered dental services and is administered by Division of Medical Services.

F. Provider Led Arkansas Shared Savings Entity (PASSE)-MCO Model of care for client with high behavioral health or developmental disabilities service needs.

Effective February 1, 2018, Arkansas included the ARKids-B Title XXI CHIP program beneficiaries as part of its overall 1915(b) waiver implementing a Provider-Led Arkansas Shared Savings Entity (PASSE) Program. As of May 6, 2019, approximately 2,598 children who participate in ARKids-B were also enrolled in a PASSE. More ARKids-B eligible children will be mandatorily enrolled in a PASSE if they are determined to be a Tier 2 or Tier 3 on the Arkansas Independent Assessment (ARIA) for behavioral health or developmental disabilities services.

The PASSE program is an innovative approach to organizing and managing the

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The methods of establishing eligibility and continuing enrollment are the same as under Title XIX.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the in the citizenship status of the child. States electing this option should indicate so state plan. (42 CFR 457.355)

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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.[X] Other (Describe)

Conception through birth: For the Title XXI CHIP **Unborn Child program**, the State covers the same services that it covers in the Medicaid state plan for SIXTH OMNIBUS BUDGET RECONCILIATION ACT (SOBRA) pregnant women with the exception of sterilization or other family planning services. Services include prenatal services, delivery, sixty (60) day postpartum services and services for conditions that are determined by a physician as needed, as if not provided, could complicate and/or endanger the pregnancy. Postpartum coverage is through the end of the month in which the ~~60th~~ sixtieth day from the date of delivery falls. When one or more physicians in a group see the Unborn Child program beneficiary and at least two months of antepartum care were provided culminating in delivery or the beneficiary was continuously CHIP eligible for two or more months before delivery and on the delivery date, the global method of billing CHIP for postpartum services provided is used. When less than two months of antepartum care was provided to the Unborn Child program beneficiary or the beneficiary was not CHIP eligible for at least the last two months of the pregnancy, the antepartum/obstetrical care without delivery and the delivery and postpartum care can be billed to CHIP using the itemized billing method.

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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 services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the state plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a))

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