ARMedicaid

ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS PROVIDER MEDICAID UPDATE

Q2 SFY 2027
(October–December 2026)







What's New for Arkansas Medicaid Providers

- New Official Notices
- New Provider Manual Updates
- New RA Messages

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ConnectCare Provider Fax Request Transition

Effective **October 30, 2026**, ConnectCare will no longer accept faxed provider assignment requests from Primary Care Providers (PCP). After this date, provider-requested PCP changes and assignments must be submitted through the ConnectCare Online Portal.

Why this change is happening

Faxed requests require additional manual steps, including tracking, review, and follow-up. Moving requests to the ConnectCare Online Provider Portal will help reduce delays, prevent duplicate work, and support clearer ownership of provider requests.

What providers need to do

Enroll in and begin using the ConnectCare Online Provider Portal for provider-requested PCP changes and assignments.

Submit requests through the portal before the **October 30, 2026**, transition date to avoid processing interruptions.

Important date

October 30, 2026: Faxed provider assignment requests will no longer be accepted. Requests must be submitted through the ConnectCare Online Provider Portal.

PCP change form requests submitted via the ConnectCare Online Provider Portal cannot exceed 90-day retroactive assignment date requests. PCP selection/change forms with a PCP assignment request date farther back than 90 days will need to be securely emailed to your AFMC Provider Relations Outreach Specialist and they will work with ConnectCare to determine if the backdated assignment request can be made.

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Credentialing and Billing Changes for Physician Assistants

Effective November 1, 2026, the Arkansas Department of Human Services, pursuant to State Plan Amendment 26-0010, will allow Physician Assistants (PAs) to enroll as Medicaid providers and bill Medicaid for approved covered services. PAs will also be able to enroll as Primary Care Providers (PCPs).

Enrollment

Changes to provider type and specialty designations will be implemented for PA providers effective November 1, 2026. The following information is provided to transition active, enrolled providers as seamlessly as possible and to streamline the enrollment process for potential applicants.

Current Status	New Mapping (Automatic)	Enrollment/ Revalidation Required?	Key Action
Active Type 95, **NV** who previously enrolled as Type **12, NV**	**12, NV**	Revalidate as Type **12, NV**	Enrollment in the PCCM program will be completed during revalidation by submitting: • DMS-2608 PCP Agreement • DMS-831 EPSDT Program Agreement • Form DMS-9980, Supervising Provider Information **IF Opting Out** of the PCCM program, Provider Enrollment requires notification via a letter submitted during revalidation.
Active Type **95, NV** who **did not** previously enroll as Type **12, NV**	None	Enroll as Type **12, NV**	Complete online enrollment application and submit required documents for provider type **12, NV**
Not enrolled	None	New enrollment	Complete online enrollment application and submit required documents for provider type **12, NV**

Enrollment and training materials are now available and should be shared broadly with prospective providers and stakeholders. These resources provide information on provider enrollment requirements, documentation standards, approved services, and key implementation timelines. If you have questions about or need enrollment assistance, please reach out to the Gainwell provider help desk at 1-800-457-4454.

Enrollment and training materials can be accessed at **the following links**:

- Arkansas Medicaid Provider Enrollment
- Resources | Arkansas Medicaid Management Information System
- Webinars | Arkansas Medicaid Management Information System

New providers will be contacted by AFMC MMIS representatives and can assist providers with enrollment, training and needed resources.

Key Information for Physician Assistant Providers

- Physician Assistant must have at least one (1) supervising physician.
- Supervising physician(s) must be actively enrolled with Arkansas Medicaid.
- Physician Assistant must have an NPI.

Billing and Rendering Services

Providers billing for or rendering services need to refer to the following Physician Assistant documents:

- Physician Assistant Provider Manual
- Procedure Code Table for Physician Assistants.
- Fee Schedule for Physician Assistants.

Providers are to bill within the scope of their practice.

Providers are encouraged to reach out to their AFMC MMIS representative with any billing questions.

Maternal Health Providers

Arkansas Medicaid is pleased to announce that Doulas, Lactation Consultants, and Lactation Counselors can enroll as a Medicaid provider effective September 1, 2026. This initiative supports our statewide maternal health initiative and strengthens access to high-quality perinatal and lactation support services.

Enrollment and training materials are now available and should be shared broadly with prospective providers and stakeholders. These resources provide information on provider enrollment requirements, documentation standards, approved services, and key implementation timelines.

Enrollment and training materials can be accessed at the following links:

- Resources | Arkansas Medicaid Management Information System
- Webinars | Arkansas Medicaid Management Information System
- Maternal Health Providers - Arkansas Department of Human Services

Key Information for Lactation Consultants and Lactation Counselors

- Lactation Consultants must hold a certification from the International Board of Lactation Consultant Examiners.
- Lactation Counselors must hold a certification from either the International Breastfeeding Institute OR the Academy of Lactation Policy and Practice.
- Lactation Counselors must have a supervising provider (physician or another approved clinician).
- Must have an NPI.

Key Information for Doulas

- Must hold certification from the Arkansas Department of Health.
- Certification details and processes are available on the ADH website.

ARHOME Open Enrollment and 2027 Changes

ARHOME health plan options are changing for 2027. Providers can help affected beneficiaries understand their coverage transition, complete open enrollment, and prepare for the new Community Engagement and Work Requirement.

Centene is exiting ARHOME effective December 31, 2026.

Centene Departure and Enrollment Dates

- October 15–December 15, 2026: Open Enrollment period for affected beneficiaries to select a 2027 Arkansas Blue Cross and Blue Shield plan.
- **December 31, 2026: Centene—also known as Ambetter, QCA, and QualChoice—will leave the ARHOME program at the end of 2026.**
- January 1, 2027: New plan coverage takes effect. Beneficiaries who do not choose a plan by December 15 will be automatically assigned to a Blue Cross plan, so coverage does not lapse.
- 30-day change period: Beneficiaries who are automatically assigned may change their plan within 30 days.

How Providers Can Help

Beneficiaries currently enrolled in a Centene plan must transition to Arkansas Blue Cross and Blue Shield for 2027. Beneficiaries already enrolled in a Blue Cross plan do not need to take action; their coverage will continue.

Please encourage affected beneficiaries to: Watch for official DHS communications; sign in to Access Arkansas and update their address, phone number, and email; and select a plan between October 15 and December 15, 2026, if they want to make their preferred choice. For more information about enrollment, visit ARHOME Open Enrollment - Arkansas Department of Human Services

ARHOME Outreach Toolkit

DHS offers a comprehensive ARHOME Outreach Toolkit to help providers explain the Community Engagement and Work Requirement beginning January 1, 2027. Unless exempt, ARHOME beneficiaries ages 19–64 must work, volunteer, attend school or training, or combine qualifying activities for at least 80 hours per month to maintain coverage. The toolkit includes up-to-date FAQs, provider-specific letters, email, and text templates, flyers, posters, customizable social media and waiting-room graphics, and videos. Download and share these materials in patient communications, waiting rooms, websites, social media, and community outreach. ARHOME Outreach Toolkit

New Process for Requesting Prior Authorizations for Surgical Procedures

To support the addition of new Extension of Benefit requests for Doula and Lactation Services, Arkansas Medicaid has created a dedicated Prior Authorization (PA) process type for Surgical Procedures. Separating Surgical Procedure reviews from Professional Services will streamline submission and review processes, improve efficiency, and support future Medicaid program enhancements.

Effective September 1, 2026, the Arkansas Department of Human Services implemented the Surgical Procedures process type. Providers submitting prior authorization requests for surgical procedures must transition from using the Professional Services process type to the new Surgical Procedures process type.

Key Changes

PA Process Type 126 – Professional Services

Beginning September 1, 2026, the Professional Services process type will be used exclusively for:

- Extension of Benefit requests
- Maternity Health Extensions

PA Process Type 136 – Surgical Procedures

Beginning September 1, 2026, the Surgical Procedures process type will be used for:

- All new prior authorization requests related to surgical procedures

Provider Impact

Providers should be aware of the following requirements:

- Extension of Benefit requests will continue to be submitted under PA Process Type 126 – Professional Services.
- Effective September 1, 2026, all new prior authorization requests for surgical procedures must be submitted under PA Process Type 136 – Surgical Procedures.
- Requests submitted under an incorrect PA process type may result in processing delays.

Prior Authorization Submission

The PA submission process has not changed. Providers will continue to request authorization from the Arkansas Foundation for Medical Care as they would have prior to these changes being implemented.

Limitation Restrictions Removed for Non-Stress Tests and Ultrasounds

Effective September 1, 2026, Arkansas Department of Human Services has removed the limitation restriction for Non-Stress Tests and Ultrasounds. Providers must maintain documentation supporting the necessity of these services. All claims are subject to retrospective review and recoupment. For the list of errors that no longer apply to the applicable procedure codes refer to ON-039-26.

Substance Abuse Residential Treatment Provided in an Inpatient Hospital Setting

Effective July 1, 2026, Arkansas Medicaid began covering and reimbursing qualifying Substance Abuse Residential Treatment Services for individuals under 21 years of age provided in an inpatient hospital setting. To support this change, the Department of Human Services (DHS) implemented new provider enrollment, prior authorization, and claims processing requirements for hospitals billing these services.

Coverage and reimbursement policies described in this notice are effective for dates of service on and after July 1, 2026. Functionality to enroll under Specialty SU and submit prior authorization requests through the Arkansas Medicaid Provider Portal became available September 1 , 2026. Services provided on or after July 1, 2026, may be authorized and billed in accordance with guidance outlined in this notice once Provider Portal functionality becomes available.

Arkansas Medicaid allows providers to enroll under Specialty SU, obtain prior authorization, and submit claims retroactively for covered Substance Residential Treatment Services for individuals under 21 years of age furnished on or after July 1, 2026. These activities may be completed beginning September 1, 2026 when the necessary Provider Portal functionality becomes available.

Action Required Beginning September 1, 2026

Hospitals that intend to provide and bill for inpatient Substance Abuse Residential Treatment Services for individuals under 21 years of age for dates of service on or after July 1, 2026, must:

- Enroll under Provider Type 05, Specialty SU.
- Obtain prior authorization for all admissions.
- Bill claims using Revenue Code 156.
- Ensure claims are supported by an approved prior authorization.

Details on enrollment and prior authorization requirements, and claims processing are outlined in the official notice Substance Abuse Residential Treatment Provided in an Inpatient Hospital Setting

Prior Authorization Changes for Inpatient Stay

The Arkansas Department of Human Services (DHS) has revised the prior authorization (PA) requirements for inpatient hospital stays.

Effective September 1, 2026, for dates of service on or after September 1, 2026, Arkansas Medicaid covers up to seven (7) inpatient days without a prior authorization requirement.

- Inpatient stays of seven (7) days or less do not require prior authorization.
- If a beneficiary remains hospitalized beyond the seventh day, a prior authorization is required for the eighth (8th) day and all subsequent days.
- This change replaces the previous policy that required prior authorization beginning on the fifth (5th) day of an inpatient stay.

Example of when an inpatient PA is needed: If a beneficiary is admitted on September 10, 2026, and remains hospitalized through September 16, 2026, no prior authorization is required for days 1—7. If the beneficiary remains hospitalized on September 17, 2026 (day 8), prior authorization is required beginning with day 8 and for all subsequent approved inpatient days.

Critical Access Hospitals (CAHs)

There are no changes to the certification requirements for Critical Access Hospitals (CAHs).

- CAHs must continue to obtain prior authorization for inpatient stays that exceed four (4) days (96 hours).

Rehabilitation Hospitals

There are no changes to the certification requirements for Rehabilitation Hospitals.

- Rehabilitation Hospitals must obtain prior authorization for inpatient stays that exceed ten (10) days. Please refer to the official notice (ON-013-25): https://humanservices.arkansas.gov/wp-content/uploads/ON-013-25.docx

Transfers Between Hospitals

There are no changes to the prior authorization requirements for beneficiaries who are transferred from one hospital to another.

- When a patient is transferred to a different hospital, the inpatient stay must continue to be certified under the receiving provider in accordance with existing policy.

Prior Authorization Submission

The PA submission process has not changed. Providers will continue to request authorization from the Arkansas Foundation for Medical Care as they would have prior to these changes being implemented.

Inpatient Hospitals – Criteria for Rehabilitation Services Provided in Acute Care Setting

Effective for dates of service starting 9/1/2026, the Arkansas Department of Human Services has expanded coverage for Revenue Code 158 (REHAB/WARD) to all inpatient hospitals (provider type 05). Revenue Code 158 will be reimbursed at the same hospital-specific prospective per diem rates used for rehabilitative hospitals when only rehabilitative services are provided in an acute care setting. These rates are subject to an upper limit with no cost settlement. Please reference ON-044-26.

AFMC has published clinical guidelines on the MCG Transparency Portal. Instructions for accessing all guidelines are provided below. Rehabilitation guidelines apply to both adult and pediatric populations. Acute Hospital Care guidelines are organized by Adult, Pediatric, and Surgical. Both acute care and rehabilitation guidelines address admission criteria and length of stay.

Recovery Facility Care (RFC) - Inpatient Rehabilitation Facility (Acute Rehabilitation)

These guidelines are organized by condition and begin with I. Typical sections include: Criteria; Clinical Indications for Acute Rehabilitation; Estimated Stay; Care Alternatives (when present); Length of Stay; Treatment; Care Coordination; Rationale; CMS Coverage Guidelines; and References. Use recovery facility guidelines only when the patient has **no acute hospital care needs.**

Inpatient & Surgical Care (ISC)

These guidelines are organized into M = Adult Medical Care; P = Pediatric Care; and S = Surgical Care. Use the Clinical Indications section to determine whether the patient has acute care needs that would qualify for an acute hospital admission. If these indications apply to the patient's condition, the hospital stay is considered acute hospital care rather than rehabilitation.

EPSDT

Claims for beneficiaries under 21 years of age are reviewed on a case-by-case basis under EPSDT. MCG criteria still inform the review; they do not replace the EPSDT medical-necessity standard (services needed to correct or ameliorate the child's condition).

Providers needing to request an extension of inpatient stays per AFMC will follow the Medicaid Utilization Management Program (MUMP) process. Please reference ON-042-26

How to access the guidelines

Complete this sequence **every time** you open the guidelines. Access is session-based and not saved.

1. Go to the Clinical Guidelines page.
2. Select Click here to access the MCG care guidelines**.**
3. Review the terms and conditions, check **Accept Terms and Conditions**, then select **Accept and Proceed.**
4. Enter your first and last name.
5. Choose the category that best describes your role or interest, then select **Next**.
6. Choose your verification method, enter the required information, then select **Next**.
7. Retrieve the access code sent by that method.
8. Enter the access code and select **Next**.
9. Open **Inpatient & Surgical Care** or **Recovery Facility Care**, then open the guideline for the condition.

Providers will continue to request authorization from the Arkansas Foundation for Medical Care as they would have prior to these changes being implemented.

Physical and Occupational Therapy Coverage for Adults in a Clinic Setting

Pursuant to ACT 103 of 2025, the Department of Human Services has expanded coverage for Physical and Occupational Therapy for adults in a clinic setting effective 7/1/2026.

- Therapy providers are to use their same Medicaid (MCD) provider ID as they currently are using.
- Coverage will include the following services rendered in an office or clinic setting:
  - A maximum of 2 Occupational Therapy Evaluations per member per state fiscal year;
  - A maximum of 2 Physical Therapy Evaluations per member per state fiscal year.
  - A maximum of 12 Occupational Therapy (OT) and/or Physical Therapy (PT) visits combined per member per state fiscal year.

    An extension of benefits may be requested through AFMC using process type 126 (Professional Services). Please refer to Sections 220.100, 220.200, and 220.300 in the Rehabilitative Occupational Therapy and Physical Therapy Services provider manual for the extension of benefits process.
  - Services rendered by an OT and PT on the same day will count as 2 visits.
  - Providers will be able to view a member's therapy usage via the portal under the Service Limit section for 5109 (12 ADULT THERAPY PROCEDURES PER SFY)
  - Notes for Extension of Benefits:
    - Requests for extension of benefits are considered only after a claim is filed and is denied because the member's benefit limits are exhausted.
    - Submit a copy of the Medical Assistance Remittance (RA) and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.
    - Requests for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.
    - Additional information such as the clinical note and all applicable documentation should be included to support the request. Please refer to Section(s) 204.200 in the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services provider manual.
    - Other information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

      Note: The limit audit 5109 will not be in the system until later in July 2026. A RA message will be sent to notify providers when the audit is in the system. Claims analysis will be done once the audit is in place.

Additional details can be found in the REVISED: Physical and Occupational Therapy Coverage for Adults in a Clinic Setting official notice.

CSSP Enhanced Provider Webinar Recording Now Available

The Arkansas Department of Human Services (DHS) recently hosted training webinars for Community Support System Provider (CSSP) Enhanced providers. If you were unable to attend or would like to review the information presented, a recording of the webinar is now available.

The training was designed specifically for CSSP Enhanced providers delivering services in:

- Therapeutic Communities
- Residential Community Reintegration Programs (RCRPs)

The webinar provides important information and guidance for providers delivering CSSP Enhanced services and offers an opportunity to review program expectations, updates, and key operational information shared by DHS.

Watch the Recorded Webinar

Providers can access the webinar recording here.

Who Should Watch?

This recording is recommended for:

- CSSP Enhanced providers serving Therapeutic Communities
- CSSP Enhanced providers serving Residential Community Reintegration Programs
- Administrative and clinical staff involved in delivering or overseeing CSSP Enhanced services
- New staff members who would benefit from reviewing the training content

DHS encourages all applicable providers and staff to take advantage of this on-demand training opportunity to ensure they remain informed about requirements and expectations related to CSSP Enhanced services.

Dental Rate Increase for Services Provided to Children, Adults with Intellectual or Developmental Disabilities, and for Services Provided by Oral Surgeons

Arkansas Medicaid has updated reimbursement rates for certain dental services provided to children, and to adults with intellectual or developmental disabilities (IDD), and for certain services provided by oral surgeons. Pursuant to Act 1025 of 2025, the updated rates are retroactively effective for dates of service beginning September 1, 2025.

Arkansas Medicaid will perform claims analysis for services provided to children and for services provided by oral surgeons to retroactively adjust eligible claims dating back to September 1, 2025. Providers should review the official notice containing the referenced procedure codes and rates for complete billing details.

The rate increase for adults with IDD applies to eligible dental services rendered to adults who meet the statutory definition of IDD under Arkansas Code Annotated § 20-48-101(4). Most eligible adults have already been identified in the Medicaid billing system. In the Arkansas Medicaid Provider Portal, open the beneficiary's eligibility record and navigate to Other Details > Plan. For a beneficiary identified with IDD, the plan information will display "Intellectual and Developmental Disability."

Arkansas Medicaid will perform claims analysis and retroactively adjust eligible adult IDD dental claims dating back to September 1, 2025, at a future date. Providers should review the official notice containing the referenced procedure codes and rates for complete billing details.

Dental Sedation Rate Updates for D9245 and D9248

Arkansas Medicaid has updated reimbursement rates for dental sedation procedure codes D9245 and D9248 pursuant to Act 1025 of 2025. The updated rate for D9245, administration of moderate enteral sedation, is retroactively effective for dates of service beginning January 1, 2026. Although CMS terminated D9248, non-IV sedation, effective December 31, 2025, the

code is eligible for the increased rate for dates of service from September 1 through December 31, 2025. Arkansas Medicaid will conduct claims analysis for the affected dates of service. Official notice and procedure-code information: https://humanservices.arkansas.gov/wp-content/uploads/ON-030-26.docx

Rate Details for Providers

Dental providers should review the procedure-code details, reimbursement rate, and applicable service dates below. Use the appropriate code for the date of service and monitor future communications regarding claims analysis or adjustments.

Proc	Description	Contract	Rate	Rate Effective
D9245	ADMIN MOD SEDATION-ENTERAL	DENTC	$191.57	1/1/2026
D9248	SEDATION (NON-IV)	DENTC	$191.57	9/1/2025 - 12/31/2025

Important Reminder: Rebilling Required for Dental Claims Submitted at Previous Fee Schedule Rates

The Arkansas Medicaid dental rate increase became effective July 1, 2026, and the associated mass adjustment process has been completed, with only a small number of isolated issues currently being resolved by technical teams.

Please note that all claims submitted on or after July 1, 2026, are processed using standard system logic, which reimburses the lower of the billed amount or the Medicaid-allowed amount. As a result, claims submitted using rates from the previous fee schedule will be paid at those lower billed amounts.

What Providers Need to Know

- If you submitted claims on or after July 1, 2026, using rates from the previous dental fee schedule, those claims will be paid at the lower billed rate.
- To receive reimbursement at the updated dental fee schedule rate, providers must rebill those claims using the current rates.
- This payment outcome is a result of standard system processing logic designed to ensure billing accuracy and is not related to the dental rate increase itself.
- We encourage providers to review claims submitted on or after July 1, 2026, and rebill any claims that were submitted using rates from the previous fee schedule to ensure appropriate reimbursement.

What's New for Arkansas Medicaid Providers

Official notices posted from July 1, 2026 – September 30, 2026. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

Title	Posted Date	Category
Electronic Visit Verification for Home Health (EVV)	9/30/2026	EVV
Updated Coverage for Procedure Codes J2789 and 0402T	9/30/2026	Procedure Codes
2027 ICD10-CM/PCS Revisions Effective 10/1/2026	9/29/2026	Procedure Codes
Anesthesia Coverage for PWUCH Members	9/22/2026	Procedure Codes
Electronic Visit Verification (EVV) Compliance Threshold Updates	9/1/2026	Billing Instruction
Medicaid Enrollment and Coverage for Doulas and Lactation Consultants/Lactation Counselors	9/1/2026	Billing Instruction
2027 NUBC/UB04 Changes	8/31/2026	Billing Instruction
Substance Abuse Residential Treatment Provided in an Inpatient Hospital Setting	8/31/2026	Prior Authorizations
Inpatient Hospitals – Criteria for Rehabilitation Services Provided in Acute Care Setting	8/28/2026	Billing Instruction
New Process for Requesting Prior Authorizations for Surgical Procedures	8/28/2026	Prior Authorizations
Updates to Skin Substitute Procedures	8/27/2026	Procedure Codes
Dental Rate Increase Retro Effective 9/1/2025 for Services Rendered to Individuals with Developmental Disabilities (IDD)	8/27/2026	Procedure Codes
Purchase of Blood Pressure Monitor and Cuff Covered for High-Risk Pregnancies and Postpartum	8/26/2026	Procedure Codes
Limitation Restrictions Removed for Non-Stress Tests and Ultrasounds	8/26/2026	Procedure Codes
Coverage Added for Remote Patient Monitoring	8/26/2026	Procedure Codes
REVISED: Continuous Glucose Monitor (CGM) Systems and Supplies – Effective 9/1/2026	8/25/2026	Procedure Codes
Prior Authorization Changes for Inpatient Stay	8/25/2026	Prior Authorizations
Medicaid Billing Guidelines for Ambulance Service when Member has Medicare or Medicare Advantage	8/25/2026	Billing Instruction
Inpatient Hospitals Reimbursed for Revenue Code 158	8/25/2026	Revenue Codes
Skin Substitution Code Changes	8/21/2026	Prior Authorizations
Updated Coverage for Procedure Codes J1434 and J2468	8/20/2026	Procedure Codes
Procedure Code 69200 Covered Under Audiology Contract	8/20/2026	Procedure Codes

Title	Posted Date	Category
Coverage for Procedure Codes 0479T and 0480T	8/19/2026	Procedure Codes
Additional Medicaid Utilization Management Program (MUMP) Days Submitted on a Reconsideration Request	8/14/2026	Prior Authorizations
2026 Quarter 3 Healthcare Common Procedure Coding System Level II (HCPCS) Code and Current Procedural Terminology (CPT) Code Conversion	8/3/2026	Procedure Codes
REVISED: Physical and Occupational Therapy Coverage for Adults in a Clinic Setting	7/31/2026	Billing Instruction
Expedited Prior Authorization (PA) Submission	7/23/2026	Prior Authorizations
Dental Rate Increase for D9245 and D9248	7/16/2026	Rate Increase
Obstetrics (OB) Services Billing Changes (Global) for PWUCH Members	7/10/2026	Procedure Codes
Revised Respiratory Syncytial Virus (RSV) Vaccine/Monoclonal Procedures Rate Update	07/06/2026	Procedure Codes
REVISED Dental Rate Increase Retro Effective 9/1/2025	07/02/2026	Procedure Codes

SAVE THE DATE!

2026 ARKANSAS MEDICAID EDUCATIONAL CONFERENCE

FOR PHYSICIANS, NURSES, OFFICE MANAGERS, BILLERS AND HOSPITALS

December 8, 2026

NORTH LITTLE ROCK EVENT CENTER

IN-PERSON AND VIRTUAL EVENT

REGISTRATION LINK COMING SOON

afmc.org/medicon

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Patient-Centered Medical Home (PCMH) Enrollment

Enroll now for the 2027 AR Medicaid Performance Period

Open Enrollment: October 1, 2026 – November 13, 2026

PCMH Enrollment Eligibility

All four of these requirements must be met to be eligible for enrollment as a PCMH

- The Provider entity must be one of the following:
  - An individual Primary Care Physician (PCP) (Medicaid Provider Types 01, 03, or 58)
  - A physician group of Primary Care Providers who are affiliated with a common group Medicaid identification number (Provider Types 02 or 04)
  - A Rural Health Clinic (Medicaid Provider Type 29) as defined by the Rural Health Clinic Provider Manual, Section 201.000
- The practice must include PCPs enrolled in the ConnectCare Primary Care Case Management program
- The practice may not participate in the PCCM Shared Savings Program established under AR Act 1453 of 2013
- The practice must have at least 125 attributed beneficiaries at the time of enrollment

PCMH 12-month activities - Due by Dec. 31, 2026

241.00 Activities Tracked for Practice Support (PBPM Care Coordination Payment)

Activities for the 2026 Performance Period

All PCMHs must complete the following activities, complete the required attestations, and submit supporting documentation in the Quality Care Insight (QCI) provider portal by 12/31/2026 to be eligible for PBPM care coordination payments.

Activity	12-month
N. Care Plans for High Priority Beneficiaries	✓
O. Identify Focus Area for Improvement-Follow Up	✓

Activity N: Care Plans for High-Priority Beneficiaries

Activity N Deadline: 12/31/2026 Care Plans for High Priority Beneficiaries

Develop care plans for at least 80% of high-priority patients. Care plans and/or notes contained in the medical record must include the following elements:

1. Documentation of the patient's appropriate problem list

2. The problem list should include any active, significant clinical condition (chronic and/or acute).

3. Each related visit encounter should include a list of current problems (chronic and/or acute).

4. Assessment of progress to date

5. Documentation and assessment of each problem (stability or change of condition)

6. Each problem noted in the problem list must have an assessment as well as a status of the problem/diagnosis in the plan or in the note.

   For example, "diabetes well controlled based on HbA1c 6.7 and per patient's compliance with prescribed medication" is sufficient.

7. If a problem noted in the problem list is no longer an active problem, a status such as "resolved" should be indicated.

8. If a specialist follows the patient, the most recent findings should be documented, if available, including name of specialist.

9. Plan of Care

- The documentation should include a specific plan of care related to the problem.

  For example, "continue Lisinopril 5mg daily", "ordering labs", "referral to OT/PT for evaluation and treatment", "continue therapy sessions", "prescribed Vyvanse 30 mg daily", are acceptable.

  - Instruction for follow-up
  - The documentation should include the timing of future follow-up visits (related to the problem).
  - If multiples problems are addressed, a single clearly defined future visit (return to clinic date) is acceptable.

    For example, "return to office in 6 months" is acceptable; "return if no improvement or as needed" is not acceptable.
    - If problems/conditions are followed by a specialist, the timing of the follow-up visit with the specialists should be noted.
      For example, "follow up with endocrinologist in 6 months" is acceptable; "follow up with endocrinologist" is not acceptable.

10. A minimum of two care plans should be completed within a 12-month period and submitted for validation review.

11. Documented update to the care plan, which would include active problems

12. For new patients: initial care plan and one update (in person or phone call).

13. For established patients: one care plan update must be completed by a face-to-face visit, and one update may be completed via a phone call.

14. Addendums to the care plans are acceptable if completed within a reasonable period of no more than two weeks after the care plan has been created or updated.

15. Indicate if at least 80% of the top 10% of high-priority patients have a first and second care plan in the medical record. Each attested care plan includes all required elements listed in number 1.

16. For validation audit, 20% of the top 10% of high-priority patients will be randomly selected for review of care plans. To pass this activity, at least 80% of the care plans must include all the required elements listed in number 1.

17. PCMHs that successfully pass two consecutive years of care plan validation audits without going into remediation will be eligible for a "Fast Track" audit.

18. The Fast Track audit includes:

- Sample audit of five care plans
- Sample audits will be conducted at the same time as regular care plan validation audits and for the same performance period
- The PCMH must successfully pass the audit with at least an 80% total score. The scoring methodology will remain the same for the sample audit.
- If the practice passes the Fast Track audit, no further care plan audit will be required for the performance period.
- If a practice fails the sample Fast Track audit, care plan validation will revert to the standard audit process and the PCMH will be required to submit the full 20% of care plans randomly selected for high-priority patients with a first and second care plan.
- If the PCMH passes the secondary audit, the PCMH will remain in good standing and will be eligible for the Fast Track audit in the upcoming performance period.
- If PCMH does not meet the 80% target for the secondary audit, the PCMH will be required to follow the remediation process as stated in Section 242.000 of the 2019-2026 PCMH Provider Manual and will not be eligible for the Fast Track audit for the upcoming year.

19. Scoring methodology:

- Each element of the care plan will be scored accordingly, with a total of eight possible points per High Priority Patient (HPP). The scoring methodology is the same for a regular care plan audit and a Fast Track audit.

Care Plan Element	Point Value (Care Plan 1)	Point Value (Care Plan 2)	Total Possible Points per HPP
Problem list	1	1	2
Assessment of problems	1	1	2
Plan of Care	1	1	2
Instruction for follow up	1	1	2
Total possible points per HPP	4	4	8

20. Practices must document completion of this activity via the QCI portal.

Activity O: Identified Focus Area for Improvement Follow Up from Activity B



1. Attest that the PCMHs has been actively participating in a quality improvement strategy related to the focus area of improvement identified in Activity B.

2. Through the QCI portal describe if these goals were met and list successes and/or challenges the practice may have faced this performance period.

Click here for Table of Contents 2026 PCMH Program Policy Addendum

The 2027 PCMH Program Policy Addendum is Now Available

The 2027 Patient-Centered Medical Home (PCMH) Program Policy Addendum is now available on the PCMH website – 2027 PCMH Program Policy Addendum. Providers participating in the PCMH Program are encouraged to review the addendum to familiarize themselves with program requirements, policies, and expectations for the 2027 program year.

Please review the 2027 PCMH Program Policy Addendum to ensure your practice is prepared for the upcoming program year.

Provider Relations Outreach Specialists Information Sheet

1020 W. 4th St., Suite 400 • Little Rock, AR 72201 • **Toll free: 1-877-650-2362** • **Transportation Helpline: 1-888-987-1200**

AFMC OUTREACH SPECIALISTS

Refer to the map and the color key below to find your representative.

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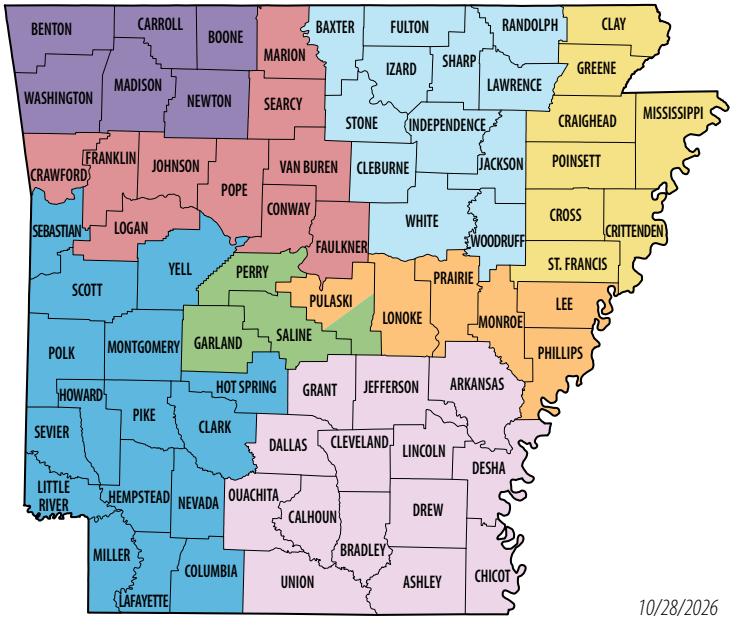
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10/28/2026

GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

Gainwell Provider Assistance Center

ELECTRONIC DATA INTERCHANGE (EDI), PROVIDER ASSISTANCE CENTER (PAC), AND PROVIDER ENROLLMENT

In-state toll free **800-457-4454**
Local and out-of-state **501-376-2211**
Monday through Friday 8 a.m. until 5:00 p.m.

ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

ARMedicaid

CONNECTCARE - BENEFICIARY SERVICES

- Complaints
- Demographic updates
- Eligibility/Medicaid coverage/ Medicaid card
- Find a doctor/PCP assignment
- Other resources

• Toll free **800-275-1131**

MEDICAID FRAUD CONTROL UNIT (PROVIDERS)

• Central Arkansas..... **501-682-8349**

VOICE RESPONSE SYSTEM - PCP ASSIGNMENT

• Toll free **800-805-1512**

PCMH QUESTIONS.....**PCMH@afmc.org**

MEDICAID PHARMACY VENDOR: PRIME THERAPEUTICS MANAGEMENT, LLC

• PDL Call Center **800-424-7895**
ar.primetherapeutics.com

THIRD PARTY LIABILITY

• Local..... **501-537-1070**
• Fax **501-682-1644**

DHS Division of Medical Services,
TPL Unit • P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

IN THIS ISSUE OF ARMedicaid

ARKANSAS PROVIDER MEDICAID UPDATE

Q2 SFY 2027
(October–December 2026)

- ARHOME Open Enrollment & 2027 Eligibility
- ConnectCare Fax Request Changes
- Dental Rate Updates
- Inpatient Rehabilitation Criteria
- Non-Stress Tests & Ultrasound Limit Changes
- Maternal Health Providers
- Adult PT/OT Clinic Coverage
- Inpatient Substance Abuse Treatment

Additional resources can be found at www.afmc.org/providerrelations

- Educational Outreach Updates
- PCP Update Packets/Archived PCP Update Packets
- Webinars

If you have any questions or if you would like additional information regarding any Medicaid topic, please contact the AFMC Provider Relations team:

- ProviderRelations@afmc.org
- 501-212-8686