ARMedicaid
ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS PHYSICIAN MEDICAID UPDATE

Q3 SFY 2024
(January–March 2024)

What's New for Arkansas Medicaid Providers

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

Independent Assessments (IA) & Referral Process

Behavioral Health (BH) Independent Assessments are needed for mental health, substance abuse, home and community based and residential services.

Who Needs a Referral

- Any youth who is receiving outpatient counseling services for a mental health or substance use disorder and is not responding to treatment.
- Any youth identified as in need of home and community based or residential services to treat a mental health or substance use disorder.

Referral Process — Who Can Refer?

- Independent Assessment referrals are initiated by behavioral health service providers identifying a beneficiary who may require services in addition to behavioral health counseling services and medication management. This includes mental health and substance abuse residential treatment. Requests for the assessment are transmitted from the provider to Acentra, the AR Medicaid Quality Improvement Organization vendor.
- Acentra accepts the request in their provider portal, finalizes a referral after confirming Medicaid eligibility, and provides notification to the requesting entity that the referral has been transmitted.
- Primary Care Provider (PCP) – Beginning in 2024 the beneficiary's AR Medicaid PCP can initiate a referral for an Independent Assessment.
- Providers can send expedited requests for individuals who are in crisis or who do not have a behavioral health diagnosis in the Medicaid system.
- AR Medicaid beneficiaries who are receiving services in a psychiatric acute hospital setting receive an automatic referral and the time-of-service authorization by Acentra.

Portal Registration – Submit Independent Assessment Referrals

- Click on the following link to fill out the electronic registration form – https://arwebportal.eqhs.com/providerportal/providerregistration.aspx/Arkansas

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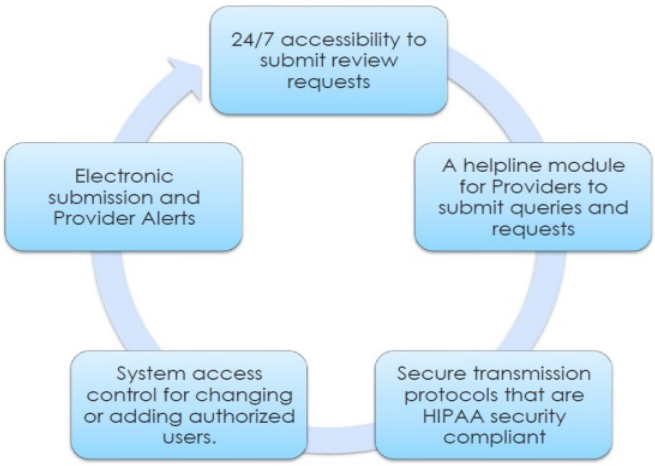
- Check your email inbox for a confirmation email and follow the instructions to activate your new Provider Portal account.

Provider Portal Accounts

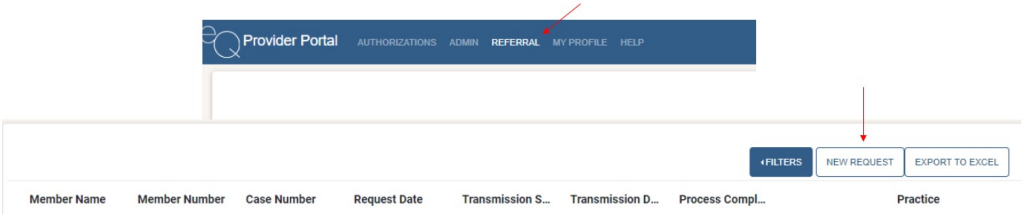
- The first person who registers with a Medicaid Provider ID will be the portal Account Administrator.
- The account administrator will have the ability to create additional user accounts, deactivate accounts, and send password reset emails.
- One person can be the account administrator over several accounts if a facility has multiple Medicaid IDs for different providers/locations.
- Passwords MUST contain a capital letter, lowercase letter, numbers, special character (#,@,!) and be at least 8 characters long.
- The provider ID used must be the correct ID for the claims associated with that provider type.

Overview of Portal



Referral Request and Status Check

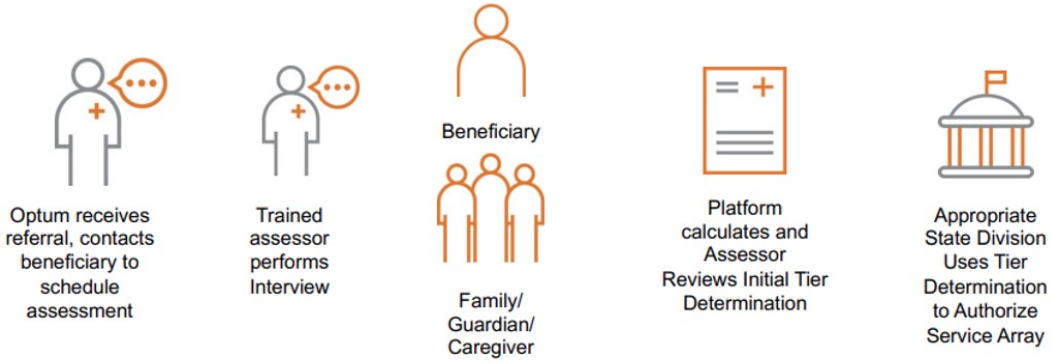
- Providers can view the status of an Independent Assessment by clicking on the "referral" option on the top menu.
- New referral requests are created by clicking on the "referral" option on the top menu and then clicking on "new request" within the referral page.
- Information required for the referral:
  - Beneficiary
  - Ordering Provider (you)
  - Beneficiary Demographics



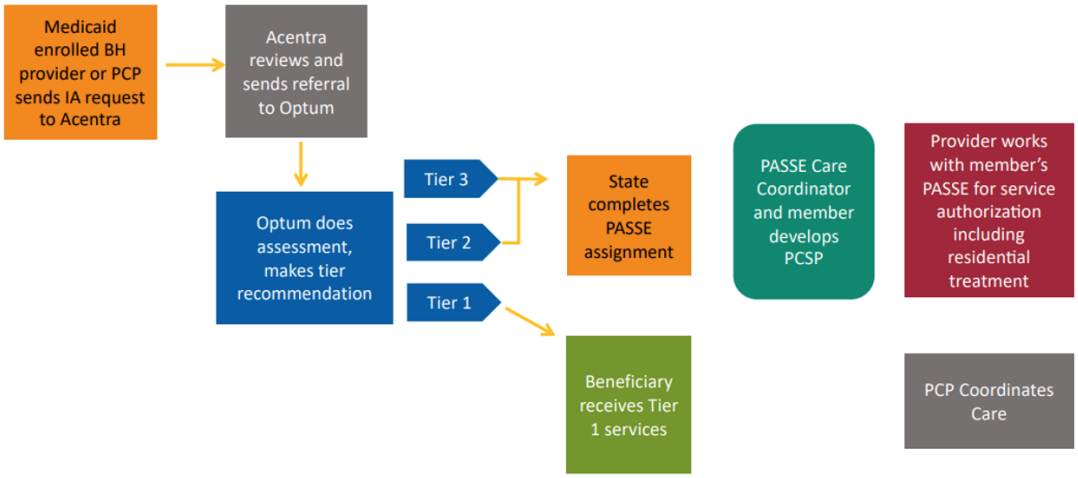
Once logging into eQSuite®, you will be directed to the home page, we call the "dashboard" On the dashboard, you will see PAs, referrals, and all administrative functions.

- **Authorizations:** Serves as a "home" button, bringing you back to the dashboard, when clicked on from any page in the portal.
- **Admin:** Only visible for those listed as "administrators" for their facility. All administrative functions can be found here.
- **Referral:** PCPS and BH providers, who require Independent Assessments from Aria/ Optum, can view their beneficiary assessment status.
- **My Profile:** Where you can access and edit your information that is tied to your specific login.
- **Help:** Access our Provider Support Portal to submit and check status of help tickets.

Assessment Process



Behavioral Health Independent Assessment Workflow



Resources and Education

- Webinar Power Point Trainings - https://ar.eqhs.com/Provider-Education-Resources/Webinar-Power-Point-Trainings
- Submitting a PA or Referral – https://ar.eqhs.com/Provider-Education-Resources/Provider-User-Guides
- Video Tutorials – https://ar.eqhs.com/Provider-Education-Resources/Video-Tutorials
- PowerPoint Trainings – https://ar.eqhs.com/Provider-Education-Resources/Webinar-Power-Point-Trainings

For more information, please review the Arkansas Medicaid manual for Arkansas Independent Assessment (ARIA) - ARIA_II.doc (live.com). ■

Process Changes for Early Intervention Day Treatment (EIDT) Services for Children

Updates for Medicaid primary care providers (PCPs) on: (1) an upcoming change in the process for prescribing Early Intervention Day Treatment (EIDT) services to children with intellectual and developmental disabilities, and (2) the implementation of a new billable pediatric developmental screen procedure code.

EIDT Referrals

Early Intervention Day Treatment (EIDT) facilities provide a clinic-based array of all-inclusive evaluation, therapeutic, developmental, and preventative services to children with significant intellectual and developmental disabilities for up to eight (8) hours a day. EIDT services include:

- Day habilitative services in areas of cognition, communication, social/emotional, motor, and adaptive, self-care skill acquisition, and activities to reinforce skills learned in occupational, physical or speech-language therapy
- Occupational therapy services
- Physical therapy services
- Speech-language pathology services
- Nursing services for medically fragile children

The current EIDT eligibility process, outlined in the References, will change April 1, 2024.**

PCP Developmental Screen

Starting April 1, 2024, the child's PCP will administer and analyze the required developmental screen for initial EIDT eligibility determination purposes, rather than an outside vendor. A list of validated screening tools can be found in the Screening Tool Finder in the American Academy of Pediatrics "Screening Technical Assistance and Resource (STAR) Center at this link: https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/.*

Please note: A PCP administered developmental screen is not a prerequisite to demonstrate continued eligibility for children already receiving EIDT services. It is only required when determining a child's initial eligibility for EIDT services.

Starting January 1, 2024, procedure code 96110 will be billable at a rate of $8.80 per screen by PCPs for the administration and analysis of this required initial developmental screen (see the next section for additional information concerning procedure code 96110).

Form DMS-642 Evaluation Referral (ER)

If, after reviewing the results of the developmental screen and conducting other relevant medical surveillance and diagnostic activities, the PCP believes that the child should be referred to an EIDT program for evaluation, the PCP will complete and sign a DMS-642 ER, which is the new EIDT specific evaluation referral form. The developmental screen must have been administered by the PCP within the twelve (12) months preceding the date of the child's initial DMS-642 ER to meet the requirement.

Form DMS-642-Treatment Plan (TP)

If the results of those evaluations ordered on the DMS-642 ER demonstrate the child is eligible for EIDT services, then the child's PCP may prescribe the medically necessary amount of EIDT services using a new EIDT treatment prescription form DMS-642 TP. The EIDT Medicaid manual can be reviewed in its entirety at the following link: EIDT_II.doc (live.com).

Please note: Evaluation referrals and prescriptions for standalone (i.e. not at EIDT) occupational therapy, physical therapy, and speech-language pathology services will continue to be completed using the DMS-640.

Billable Developmental Screens

Starting January 1, 2024, procedure code 96110 will be billable at a rate of $8.80 per screen as part of an initiative to encourage universal screening that will enhance early identification of developmental needs in children and increase the quality of referrals for specialized services. PCPs must use a validated developmental screening tool recommended by the American Academy of Pediatrics. A list of validated screening tools can be found in the Screening Tool Finder in the American Academy of Pediatrics "Screening Technical Assistance and Resource (STAR) Center at this link: https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/.

PCP's will be allowed to bill procedure code 96110 as follows:

- One (1) unit before twelve (12) months of age;
- Two (2) units (but no more than one per year) between the ages of thirteen (13) to forty-eight (48) months; and
- Starting April 1, 2024, one (1) unit between the ages of forty-eight (48) to sixty (60) months.

PCPs are encouraged to administer additional development screens to children in accordance with Bright Futures/American Academy of Pediatrics Periodicity Schedule (or as needed to evaluate developmental concerns) regardless of whether the additional screens are billable. The Bright Futures/AAP Periodicity Schedule can be found at the following link: periodicity_schedule.pdf (aap.org).

References

*Commonly used developmental screeners in Arkansas include the Ages and Stages Questionnaire (ASQ), the Parents' Evaluation of Developmental Status (PEDS), and Survey of Wellbeing of Young Children (SWYC), but there are others that meet AAP criteria.

**Until April 1, 2024, there is a three-step process for children who have not yet reached school age (up through age six (6) if the kindergarten year has been waived) to initially qualify for EIDT services. A child suspected to need EIDT services must receive a Batelle developmental screen administered by DHS's third-party contracted vendor, Optum, as the first step in the EIDT eligibility determination process. If the results of the Batelle screen indicate the child should be referred for further evaluation, then the child receives a developmental evaluation and other appropriate therapy evaluations from an EIDT provider. If the results of those evaluations demonstrate the child is eligible for EIDT services, then the child's PCP may prescribe the medically necessary amount of EIDT services using a form DMS-640. ■

Provider Revalidation Grace Period

All Arkansas Medicaid providers are required to re-enroll/revalidate every five (5) years regardless of provider type. Arkansas Medicaid no longer allows a grace period for revalidation. Re-enrollment/revalidation must be completed by the date indicated in the revalidation information provided to you by Gainwell Provider Enrollment.

Below are tips to help your re-enrollment process:

- Renew and revalidate your enrollment online using Resume Enrollment.
- You must submit credentials annually. A good rule of thumb is to "Resume Enrollment" on the Health Care Provider Portal when you mail your license/certification renewal fees to your state. Please make certain you attach the current license. Always check the expiration date before attaching.
- When submitting credentials for re-enrollment, always add your provider number. This will help us process your renewal more quickly if there are several providers under the same tax ID number.
- When enrolling for Electronic Fund Transfer (EFT) Authorization for Automatic Deposit, you must attach a voided check or a signed letter from the bank. Deposit slips are not accepted to set up EFTs.
- If you have been inactive with Arkansas Medicaid for 6 months, you must submit a new application.
- W-9 forms and contracts for individual providers must be submitted in their name, with their Social Security number, and their original signature. If the W-9 or contract is for a group or facility, it must include the tax ID number and an original signature. ■

Keeping You Informed

Adult Immunization Coverage

The Centers for Medicare & Medicaid Services has mandated that Medicaid agencies cover all Food and Drug Administration (FDA) approved adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). This will add dengue, varicella, Japanese encephalitis, and HPV vaccines to the list of Medicaid covered adult vaccines. The changes are proposed to be in place on February 1, 2024, with a retroactive effective date of October 1, 2023.

Approved vaccines and their reimbursement rates will be added to the procedure code and fee schedule tables. An October 6, 2023, DHS issued a memorandum explaining the proposed changes for adult immunizations. ■

Completing the DMS-2610 Primary Care Provider (PCP) Referral Form

When a primary care provider (PCP) refers an assigned Medicaid beneficiary to another provider, the PCP has the choice of completing the DMS-2610 PCP referral form or completing a PCP referral template recreated in the provider's EMR which contains all components of the DMS-2610 referral form. The PCP also has a choice to refer verbally. If referring verbally, both the PCP and the referred to provider must document in the Medicaid beneficiary's chart the components of the DMS-2610 referral form. Below is an explanation of how to complete each section of the DMS-2610 referral form:

- Complete all blanks under Member Information

Member Information:

First Name _____ Last Name _____ Middle Initial _____

Medicaid ID# _____ Social Security # _____

Birth Date (mm/dd/yyyy)_____

Mailing Address _____ City_____ State ____ Zip _____

Home Phone _____ Cell Phone _____

Email address_____

- As indicated in Section 171.400 B – Client free choice must be ensured by naming two or more providers of the same type of specialty when completing the PCP referral DMS-2610 referral form. In the "Medicaid Providers Receiving Referral" section, #1 and #2 must contain an individual provider's first and last name. Please do not insert a clinic or group name. If the beneficiary has no physician preference, "first available appointment" can also be written on the DMS-2610 referral form.

Medicaid Providers Receiving Referral:

Per Medicaid policy (Section 171.400, B.) two or more providers of the same type or specialty must be listed in the receiving referral section to ensure member free choice.

1. _____ _____ _____
Physician first and last name | Medicaid Provider ID# | Date of referral

2. _____ _____ _____
Physician first and last name | Medicaid Provider ID# | Date of referral

- The next section of the DMS-2610 referral form is the reason you are referring the Medicaid beneficiary. The DMS-2610 referral form expires 6 months from the PCP signature date, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. If the PCP specifies a number or amount of services for the referral, it would be listed in this section along with the reason for the referral. The PCP must check "yes" if the referral is for a diagnostic or corrective treatment identified during an initial or periodic EPSDT screening service or "no" if the referral is not due to an EPSDT screening service. **Please do not leave this section blank.**

I have performed a clinical assessment of the patient named above whom I am referring for the service listed below:

_____

_____

_____

Please advise me as appropriate, of your medical findings and diagnosis, treatment plan and/or services you provide as a result of this referral. Please note that services beyond the scope of this referral require a new referral. **Referrals for ongoing services require renewal at least every 6 months**.

____Yes ____No Referral is for a diagnostic or corrective treatment identified during an initial or periodic EPSDT screening service.
(Please check one)

- The last section of the DMS-2610 referral form is the referring PCP's information. List the PCP's first and last name, the Medicaid Provider number (not the NPI), and the PCP's phone number. The PCP must sign and date the DMS-2610 referral form.

Primary Care Physician (PCP) Name _____

(Please print, stamp, or type physician's name)

Medicaid Provider Number/Taxonomy Code _____

PCP Signature_____

PCP Phone Number_____

Date (mm/dd/yyyy) _____

If you have any questions, please contact your AFMC Provider Relations Outreach Specialist.

171.400 PCP Referrals 1-1-18

A. Referrals may be only for medically necessary services, supplies or equipment.

B. Enrollee free choice by naming two or more providers of the same type or specialty.

C. PCPs are not required to make retroactive referrals.

D. Since PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.

E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)

F. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and at least every six months (with exceptions as noted in part E, above).

G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.

I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

171.410 PCCM Referrals and Documentation 7-1-05

A. Medicaid provides an optional referral form, form DMS-2610, to facilitate referrals. View or print form DMS-2610.

1. Additionally, PCP referrals may be oral, by note or by letter.
2. Referrals may be faxed.

B. Regardless of the means by which the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.

1. Medicaid also requires documentation in the patient's chart by the provider to whom the referral is made.

2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP. ■

Primary Care Provider (PCP) Assignment Methods

Primary Care Provider (PCP) assignment methods include the ConnectCare online portal, ConnectCare fax line, and the Voice Response System (VRS). Only PCP clinics are allowed to request PCP assignment via the ConnectCare online portal or ConnectCare fax line (501) 375-0705. The PCP clinic must have the beneficiary complete a DMS-2609 PCP selection/change form and submit the form to ConnectCare via fax or submission through the ConnectCare online portal. The PCP must retain a completed copy of the PCP selection/change form in the beneficiary's chart.

When providers submit their PCP selection/change request via the ConnectCare fax line or ConnectCare online portal, the ConnectCare Provider Escalated team can override a PCP's maximum caseload and/or age limit restriction. Because the request is coming from the PCP to be assigned, the PCP is agreeing to accept the beneficiary to their caseload which allows for the age and caseload restriction to be overridden. If your PCP clinic does not have a ConnectCare online portal account and wishes to enroll, please reach out to your Provider Relations Outreach Specialist for assistance. When a beneficiary requests an assignment via web request or through the ConnectCare call center – the provider's caseload and age restrictions cannot be overridden.

The Voice Response System (VRS) can be used by the PCP's clinic that is requesting to be assigned to the beneficiary or by the Emergency Department (ED) to make a PCP assignment. No other providers may use this method to make a PCP assignment. The VRS is an automated PCP assignment process that allows a PCP assignment to be made if the beneficiary isn't currently assigned to a PCP, is in the age range and county the requested PCP accepts, and the requested PCP has available slots on their PCP caseload. The requested PCP's clinic or the ED must have the beneficiary complete a DMS-2609 PCP selection/change form. The PCP must retain a completed copy of the PCP selection/change form in the beneficiary's chart. The assignment effective date will be the date the assignment is made via

the VRS. If the ED makes this assignment on behalf of the beneficiary, the ED is responsible for notifying the PCP by faxing the DMS-2609 PCP selection/change form to the PCP's clinic. This policy process is found in Section 173.400 of all Medicaid provider manuals.

173.400 PCP Selection and Enrollment at Participating Hospitals 7-1-05

Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

A. Enrollment is by means of a Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609) and the voice response system (VRS).
   1. Hospital personnel enter the PCP selection via the VRS.
   2. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.
   3. The OLTP automatically updates the Medicaid Management Information System (MMIS) within 24 hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.

B. The effective date of the PCP enrollment is the date the enrollment is electronically accepted.

C. The enrollee may request and receive a copy of the completed selection form.

D. Hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.

The ConnectCare Beneficiary web portal may only be used by beneficiaries to request a PCP assignment. Beneficiaries must select their 1st and 2nd PCP choices. Beneficiaries will be assigned to their PCP choice selections based on PCP slot availability. The PCP assignment effective date will be the date of the web portal request. Beneficiaries should allow 3 business days for their request to be processed.

Medicaid beneficiaries do not require a PCP assignment if the:

- Beneficiary has Medicare as their primary insurance
- Beneficiary lives in a Nursing facility
- Beneficiary is an Alaskan Native or an American Indian Native
- Beneficiary has Medically Needy Spend Down
- Beneficiary resides in an intermediate care facility for individuals with intellectual disabilities (ICD/IID)
- Beneficiary is in the ARHome Benefit Plan
- Beneficiary is in a PASSE group

If you are a specialty provider, please have the beneficiary contact the ConnectCare Call Center 1-800-275-1131, or the requested PCP's clinic for assistance in assigning the PCP. Specialty providers do not have privileges to make PCP assignments. ■

Patient Centered Medical Home (PCMH)

Updating PCMH Contact Leads

It is important to update PCMH contact leads for PCMH information shared by Medicaid to be sent to the correct contacts. To update PCMH 1st and 2nd clinic contact leads, the participating practice must complete and email Section I of the Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement to ARKPCMH@gainwelltechnologies.com.

PCMH Withdrawal

Once enrolled in the PCMH program, a participating PCMH remains in the PCMH program until the PCMH withdraws; the practice or provider changes ownership, becomes ineligible, is suspended or terminated from the Medicaid program; or the PCMH program, or the Department of Medical Services (DMS) terminates the PCMH program.

To withdraw from the PCMH program, the participating practice must email a completed Arkansas Patient-Centered Medical Home DMS-846 Withdrawal form to ARKPCMH@gainwelltechnologies.com. The DMS-846 withdrawal form is located on the PCMH website.

A practice may return to the PCMH Program beginning on the first day of the following performance year (January 1st) after suspension or termination of practice support. Such application for reinstatement is contingent on documentation of successful implementation of all previously deficient requirements and upon meeting the following requirements:

A. Submitting a complete PCMH Program enrollment application during the designated enrollment period

B. Successful implementation of the activity(s) which the practice failed and which resulted in suspension or termination from the program

Practices who withdraw while on remediation will also have to meet the re-instatement requirements. Successful implementation of the activity(s) will be determined by the Quality Assurance Team.

PCMH withdrawal policy is located in Section 212.000 of the Patient Centered Medical Home manual. Please submit questions to PCMH@afmc.org. ■

All eCQM Informational Metrics are due through the Provider Portal by February 29, 2024.

243.000 Quality Metrics Tracked for Performance Based Incentive Payments

DMS assesses the following Quality Metrics tracked for Performance-Based Incentive Payments (PBIP) according to the targets below. The quality metrics are assessed only if the Shared Performance Entity has at least the minimum number of attributed beneficiaries in the category described for the majority of the performance period. To receive a PBIP, the Shared Performance Entity must meet at least two-thirds of the Quality Metrics on which the entity is assessed.

The Quality Metrics are assessed at the level of the Shared Performance Entity for Voluntary pools and the Petite Pool. Quality Metrics for the default pool are assessed on an individual PCMH-level.

Achievement of targets for Quality Metrics 10, 11, and 12 can be calculated only if the required metric data is submitted through the Provider Portal. Failure to provide the required data by ~~January 31, 2023~~ February 29, 2024, will cause failure to meet targets for Quality Metrics 10, 11, and 12 (eCQM).

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2023 Target
Quality Metrics: Incentive Payment (Claims-Based)				
1	PCP Visits for High Priority Beneficiaries	Percentage of a practice's high priority beneficiaries who were seen by their PCMH at least twice during the measurement year with dates of service at least 14 days apart	≥ 25	≥ 87%
2	Well-Child Visits in the First 15 Months of Life (6+ Visits)	Percentage of beneficiaries who turned 15 months old during the performance period and who had at least six well-child visits during their first 15 months of life (0 – 15 months)	≥ 25	≥ 56%
3	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Percentage of beneficiaries 3-6 who had one or more well-child visits during the measurement period	≥ 25	≥ 75%
4	Well-Child Visits in the Seventh, Eighth, Ninth, Tenth, and Eleventh Years of Life	Percentage of beneficiaries 7-11 years of age who had at least one comprehensive well-care visit during the measurement period.	≥ 25	≥ 60%
5	Adolescent Well-Care Visits (Age 12-20)	Percentage of non-pregnant beneficiaries ages 12-20 who had at least one comprehensive well-care visit during the measurement period	≥ 25	≥ 57%
6	Oral Antibiotic Utilization	Number of oral antibiotic prescriptions per 1,000 attributed beneficiaries during the measurement period.	≥ 25	≤ 1,100
7	Chlamydia Screening in Women	Percentage of women ages 16-24 who were identified as sexually active and who had at least one test for chlamydia during the measurement period.		≥ 49%

Metric #	Metric Name	Description	Minimum Attributed Beneficiaries	2023 Target
Quality Metrics: Incentive Payment (Claims-Based)				
8	Cervical Cancer Screening	Percentage of women ages 21 to 64 who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed within the last 3 years • Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.		≥ 40%
9	Breast Cancer Screening	Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.		≥ 41%
eCQMs Quality Metrics: w/Target				
10	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior to the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period (All payer source).		≥ 64%
11	Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period (All payer source).		≤ 27%
12	Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 12 months AND who received cessation intervention counseling if identified as a tobacco user (All payer source).		≥ 80%

Informational Metrics

DMS assesses the following informational metrics tracked for the PCMH program. The Informational Metrics are reported as "claims-based metrics" with at least the minimum number of attributed beneficiaries in the category described for the majority of the performance period on the PCMH provider report. All eCQM Informational Metrics are due through the Provider Portal by ~~January 31, 2024~~ February 29, 2024.

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
Asthma Medication Ratio (Ages 19-64)	Percentage of beneficiaries 19–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
Asthma Medication Ratio (Ages 5-18)	Percentage of beneficiaries 5–18 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
Body Mass Index	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of height, weight, and body mass index (BMI) percentile documentation during the measurement period.
Diabetes Short-Term Complications Admission Rate	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for beneficiaries age 18 and older.
COPD or Asthma in Older Adults Admission Rate	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for beneficiaries age 40 and older.

Metric	Description
Informational Metrics: w/PCMH State Averages (Claims-Based)	
HIV Viral Load Test	Percentage of beneficiaries with HIV who received an HIV viral load test during the measurement period
Well-Child Visits in the First 15-30 Months of Life	Percentage of children who turned 30 months old who had two or more well-child visits during the last 15 months.
Colorectal Cancer Screening	Percentage of beneficiaries 45-75 years of age who had appropriate screening for colorectal cancer.
Developmental Screening	Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

New EPSDT/Wellness Periodicity Schedule Beginning at Age 3

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) providers can now do a yearly EPSDT/wellness exam beginning at age 3 any time after the beneficiary has their birthday in that year. There no longer needs to be 365 + 1 days between EPSDT/Wellness exams. The Division of Medical Services (DMS) is in the process of updating the EPSDT and ARKids B manuals to reflect this policy change.

The ARKids B wellness exam periodicity schedule mimics the EPSDT periodicity schedule. When a child ages out of ARKids A and ARKids B at age 19, if they apply and qualify for continued Medicaid coverage and are placed in a benefit aid category which offers all Medicaid benefits, they can receive an EPSDT screen at age 19 and 20 because EPSDT services are federally mandated services which state Medicaid plans must cover for those who qualify, through age 20.

Beneficiary Responsibility for Medicaid Charges

Charges that are and aren't beneficiary responsibility and collection of coinsurance/co-payments can be found in Section I of all Medicaid manuals. A Medicaid beneficiary must be advised and agree in writing prior to receiving services to be responsible for non-covered services. If you have any questions, please contact your AFMC Provider Relations Outreach Specialist.

131.000 Charges that Are Not the Responsibility of the Beneficiary 12-1-20

Except for cost sharing responsibilities outlined in Sections 133.000 – 135.000, a beneficiary is not liable for the following charges:

A. A claim or portion of a claim denied for lack of medical necessity.

B. Charges in excess of the Medicaid maximum allowable rate.

C. A claim or portion of a claim denied due to provider error.

D. A claim or portion of a claim denied because of errors made by DMS or the Arkansas Medicaid fiscal agent.

E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.

F. A claim or portion of a claim denied because a provider failed to obtain prior, concurrent, or retroactive authorization for a service.

G. A claim or portion of a claim denied because the claim did not meet Electronic Visit Verification (EVV) requirements (see 145.000).

H. The difference between the beneficiary Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.

I. Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service. Medicaid beneficiaries are not responsible for deductibles, co-payments, or coinsurance amounts to the extent that such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid payment is zero. The beneficiary is responsible for paying applicable Medicaid cost share amounts.

J. The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is billed, the individual must be refunded the full amount of his or her payment for the covered service(s). If it is agreeable with the individual, these funds may be credited against unpaid non-covered services and Medicaid cost-sharing amounts that are the responsibility of the beneficiary.

The beneficiary may not be billed for the completion and submission of a Medicaid claim form.

Exception: Medicaid does not cover the deductible, co-payments, or other cost share amounts levied to Medicare Part D drugs.

132.000 Charges that Are the Responsibility of the Beneficiary 9-1-08

A beneficiary is responsible for:

A. Charges incurred during a time of ineligibility

B. Charges for non-covered services, including services received in excess of Medicaid benefit limitations, if the beneficiary has chosen to receive and agreed to pay for those non-covered services

C. Charges for services which the beneficiary has chosen to receive and agreed to pay for as a private pay patient

D. Spend down liability on the first day of spend down eligibility

E. The beneficiary is also responsible for any applicable cost-sharing amounts such as premiums, deductibles, coinsurance, or co-payments imposed by the Medicaid Program pursuant to 42 C.F.R. §§ 447.50 – 447.60 (2004). These cost-sharing responsibilities are outlined in Sections 124.210 -124.230 and 133.000 - 135.000 of this manual.

The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

Cost Sharing Exclusions and Collection of Coinsurance/Co-payment

134.000 Exclusions from Cost Sharing Policy 1-1-23

The following populations are excluded from the client cost sharing requirement:

A. Individuals under twenty-one (21) years of age, except:

1. ARKids First-B clients (see the ARKids First-B manual for cost share and more information about this program).

B. Pregnant women.

C. Individuals who are American Indian or Native Alaskan

D. Individuals who are inpatients in a long-term care facility (nursing facility (NF) and intermediate care for individuals with intellectual disabilities (ICF/IID) facility) when, as a condition for receiving the institutional services, the individual is required to spend all but a minimal amount (for personal needs) of his or her income for medical care costs.

The fact that a client is a resident of a nursing facility does not on its own exclude the Medicaid services provided to the client from the cost sharing requirement. Unless a Medicaid client has been found eligible for long term care assistance through the Arkansas Medicaid Program, and Medicaid is making a vendor payment to the nursing facility (NF or ICF/IID) for the client, the client is not exempt from the cost sharing requirement.

E. Individuals who are enrolled in a Provider-led Arkansas Shared Savings Entity (PASSE).

F. Individuals receiving hospice care.

G. Individuals who are at or below 20% of the federal poverty level.

The following services are excluded from the client cost sharing requirement:

A. Emergency services - services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

B. Pregnancy-related services

C. Preventive services

D. Services for provider-preventable conditions

E. Family planning services and supplies.

The provider must maintain sufficient documentation in the client's medical record to substantiate any exemption from the client cost sharing requirement.

135.000 Collection of Coinsurance/Co-payment 1-1-23

The method of collecting the coinsurance/co-payment amount from the client is the provider's responsibility. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing (coinsurance or co-payment) from the client remains the provider's responsibility.

The provider may not deny services to a Medicaid client because of the individual's inability to pay the coinsurance or co-payment. However, the individual's inability to pay does not eliminate his or her liability for the coinsurance or co-payment charge.

The client's inability to pay the coinsurance or co-payment does not alter the Medicaid reimbursement for the claim. Unless the client or the service is exempt from cost sharing requirements as listed in Section 134.000, Medicaid reimbursement is made in accordance with the current reimbursement methodology and when applicable cost sharing amounts are deducted from the maximum allowable fee before payment.

Hospitals are required to comply with certain federal rules before assessing non-emergency copays. Hospitals are expected to comply with emergency room screening requirements, help locate alternate providers when screening determines the patient's need to be non-emergent and inform clients of treatment options that have a lesser co-pay before the hospital and the state can charge the non-emergency use of the emergency room co-pay.

Hospitals must develop written policies and tracking mechanisms to identify how they comply with the requirement and produce data on member choice and expenditures. Policies and data must be available upon request of DHS and its designees.

The Medicaid cost-sharing amount for clients who use hospital emergency department services for non-emergency reasons can be found in the ARHOME QHP Cost Share Schedule for clients enrolled in a QHP or the Adult Medicaid Cost Share Schedule. (See Sections 124.230 and 124.250)

This cost-sharing amount will only apply to Medicaid clients who are subject to a copay. There will not be any cost-sharing required from clients who need emergency services or treatment.

The first step in the process will be for hospital emergency departments to conduct an appropriate medical screening to determine whether the client needs emergency services.

If the screening determines that emergency services are needed, hospitals should tell the client what the cost-sharing amount will be for the emergency services provided in the emergency department ($0.00). Hospitals should then provide needed emergency services per their established protocols.

If the screening determines that emergency services are not needed, hospitals may provide non-emergency services in the emergency department. Before providing non-emergency services and imposing client cost sharing for such services, however, the hospital must:

- Tell the client what the cost-sharing amount will be for the non-emergency services provided in the emergency department,
- Give the client the option of paying for and receiving services in the emergency department, or
- Give the client the name and location of an alternate non-emergency services provider that can provide the needed services in a timely manner and at a lower cost than the hospital emergency department, and
- Refer the client to the alternate provider, who will then coordinate scheduling for treatment. ■

What's New for Arkansas Medicaid Providers

Official notices posted from October 1, 2023 – December 31, 2023. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

Title	Posted Date	Category
New Codes Covered Under Vision Contract Effective 12/1/2023	12/22/2023	Procedure Codes
2023 Quarter 4 Healthcare Common Procedure Coding System Level II (HCPCS) Code, Current Procedural Terminology (CPT	11/14/2023	Procedure Codes
COVID-19 Vaccine VFC Admin Rate	10/19/2023	COVID-19
Pneumococcal Vaccine Procedure Code 90677	10/19/2023	Procedure Codes
COVID-19 Vaccine & Vaccine Administration Changes	10/12/2023	COVID-19
Procedure Code A9274	10/09/2023	Procedure Codes

TO: **Health Care Providers – All Providers**
DATE: **October 19, 2023**
SUBJECT: **COVID-19 Vaccine VFC Admin Rate**

I. General Information

Arkansas Department of Human Services has updated coverage for COVID-19 vaccine and vaccine administration codes. Summary of the changes being made:

- VFC Providers will be reimbursed at $40.00 for administration of COVID vaccines, instead of the typical $13.14.

Claims analysis will be performed to identify and reprocess any claims that may have been processed prior to coverage being updated.

Proc Code	Description	Effective Date	Modifier	Age	Rate
91304	SARSCOV2 VAC 5MCG/0.5ML IM	5/12/2023	EP-TJ or SL	12-18	$40.00
91318	SARSCOV2 VAC 3MCG TRS-SUC	9/11/2023	EP-TJ or SL	0-18	$40.00
91319	SARSCV2 VAC 10MCG TRS-SUC IM	9/11/2023	EP-TJ or SL	0-18	$40.00
91320	SARSCV2 VAC 30MCG TRS-SUC IM	9/11/2023	EP-TJ or SL	0-18	$40.00
91321	SARSCOV2 VAC 25 MCG/.25ML IM	9/11/2023	EP-TJ or SL	0-18	$40.00
91322	SARSCOV2 VAC 50 MCG/0.5ML IM	9/11/2023	EP-TJ or SL	0-18	$40.00

TO: **Health Care Providers – All Providers**
DATE: **October 19, 2023**
SUBJECT: **Pneumococcal Vaccine Procedure Code 90677**

I. General Information

Arkansas Department of Human Services has updated coverage for Pneumococcal Vaccine Procedure code:

- Procedure code 90677 is covered under Vaccines for Children (VFC) and ARKids B State Children's Health Insurance Program (SCHIP) for ages 0-18.

Claims analysis will be performed to identify and reprocess any claims that may have been processed prior to coverage being updated.

Proc Code	Description	Current Rate	Effective Date
90480	ADMN SARSCOV2 VACC 1 DOSE	$40.00	9/11/2023

NOTE: Modifiers EP -TJ (billed together) are for Vaccines for Children (VFC).
Modifier SL is for SCHIP.

TO: **Health Care Providers – Visual Care**
DATE: **December 22, 2023**
SUBJECT: **New Codes Covered Under Vision Contract Effective 12/1/2023**

I. General Information

Arkansas Department of Human Services has added coverage for the below mentioned procedure codes under the Vision (VISN), retroactive 12/1/2023.

Claims analysis will be performed to identify and reprocess any claims that may have denied before the coverage was added.

Proc Code	Mod	Description	Contract
11104		PUNCH BX SKIN SINGLE LESION	VISN
11105		PUNCH BX SKIN EA SEP/ADDL	VISN
11106		INCAL BX SKN SINGLE LES	VISN
11107		INCAL BX SKN EA SEP/ADDL	VISN
11443		EXC FACE-MM B9+MARG 2.1-3 CM	VISN
11444		EXC FACE-MM B9+MARG 3.1-4 CM	VISN
11446		EXC FACE-MM B9+MARG >4 CM	VISN
65436		CURETTE/TREAT CORNEA	VISN
65805		DRAINAGE OF EYE	VISN
67825		REVISE EYELASHES	VISN
67850		DSTRJ LESION LID MARGIN <1CM	VISN
67914		REPAIR EYELID DEFECT - SUTURE REPAIR OF TURNING-OUTWARD UPPER OR LOWER EYELID DEFECT	VISN
67915		REPAIR EYELID DEFECT - REPAIR OF TURNING-OUTWARD DEFECT OF UPPER OR LOWER EYELID USING HEAT	VISN

Proc Code	Mod	Description	Contract
67921		REPAIR EYELID DEFECT - SUTURE REPAIR OF TURNING-INWARD EYELID DEFECT	VISN
67922		REPAIR EYELID DEFECT - REPAIR OF TURNING-INWARD EYELID DEFECT USING HEAT	VISN
68200		TREAT EYELID BY INJECTION	VISN
68440		INCISE TEAR DUCT OPENING	VISN
68705		REVISE TEAR DUCT OPENING	VISN
68760		CLOSE TEAR DUCT OPENING	VISN
83861		MICROFLUID ANALY TEARS	VISN
92285		EXTERNAL OCULAR PHOTOGRAPHY	VISN

If you have questions regarding this notice, please contact the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211. If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 320-6428. Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for download from the Division of Medical Services website. ■

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.

Manager

Tabitha Kinggard **501-804-3277**
tkinggard@afmc.org

Supervisor, Provider Relations

Kellie Cornelius **501-804-2501**
kcornelius@afmc.org

Outreach Specialists

Emily Alexander..... **501-804-0184**
ealexander@afmc.org

Shawna Branscum.....**501-804-2373**
sbranscum@afmc.org

Kimberly Breedlove ...**501-553-7642**
kbreedlove@afmc.org

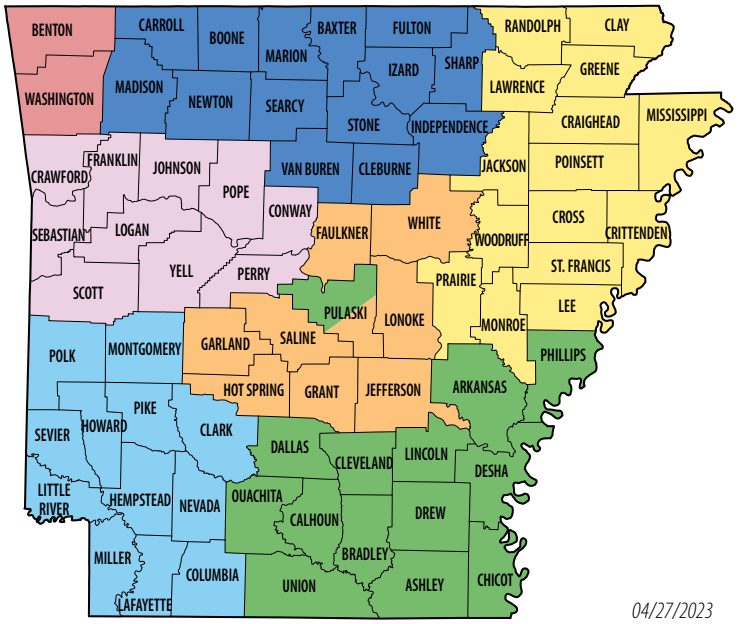
Jackie Clarkson.....**501-553-7665**
jclarkson@afmc.org

Carla Hestir.....**501-804-2901**
chestir@afmc.org

Connie Riley.....**501-545-7873**
criley@afmc.org

Supervisor, Outreach Logistics

Tonyia Long **501-212-8686**
tlong@afmc.org



04/27/2023

GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

Gainwell Provider Assistance Center

In-state toll free **800-457-4454**
Local & out-of-state **501-376-2211**
Gainwell Provider Services Manager
Cynthia Bogard..... **469-830-6768**

Gainwell Technologies Services

Provider Enrollment
P.O. Box 8105
Little Rock, AR 72203
Fax: **501-374-0746**

ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

ARMedicaid

ARKIDS FIRST/MEDICAID MEDICAL ASSISTANCE

https://humanservices.arkansas.gov
- ARKids First Enrollment Information **888-474-8275**

CONNECTCARE

- Toll free **800-275-1131**

MEDICAID FRAUD CONTROL UNIT (PROVIDERS)

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

VOICE RESPONSE SYSTEM

- Toll free **800-805-1512**

AFMC SERVICE CENTER (CLIENTS)

- Toll free **888-987-1200**

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

MAGELLAN MEDICAID ADMINISTRATION

- Pharmacy Help Desk.. **800-424-7895**
  Prescribers, Option 2

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 PHYSICIAN MEDICAID UPDATE

Q3 SFY 2024
(January–March 2024)

- Adult Immunization Coverage
- Independent Assessment/Referral Process
- PCMH - Updating Contact Leads and Withdrawal
- PCP Assignment Methods
- Process Changes - EIDT Services for Children
- Provider Revalidation

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