EXHIBIT W

DEPARTMENT OF HUMAN SERVICES, DIVISION OF COUNTY OPERATIONS

SUBJECT: Expansion of Pregnant Women Medicaid

DESCRIPTION:

Statement of Necessity

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy and various sections of the Medicaid Provider Manual.

Rule Summary

Removes "Pregnant Women Limited" from the Beneficiary Aid Category List. Updates CMS Medicaid Eligibility S28 in the State Plan concerning mandatory coverage for pregnant women.

Medical Services Policy

- A-217 Retroactive Eligibility- Pregnant Woman
  - Remove information regarding Limited Pregnant Woman
  - Delete pin from "NOTE" to be consistent with policy formatting
  - Update formatting to reflect the numeric word preceding the number to be consistent with policy formatting
  - Change format from "i.e.," to "for example"
- C-205 Pregnant Woman (PW) Period of Eligibility
  - Remove information regarding Limited Pregnant Woman
  - Update formatting to reflect the numeric word preceding the number to be consistent with policy formatting
- E-110 Income and Resource Limits for MAGI and Non-MAGI Groups
  - Remove Limited Pregnant Woman information
  - Update the income limit of Full Pregnant Woman
- F-130 Child Support Enforcement Services
  - Remove information regarding Limited Pregnant Woman
  - Correct a grammatical error of making the word medical lower case
  - Update Appendix F of the Medical Services Policy Manual with current federal Poverty Levels
  - Changes to ensure consistent terminology and updated effective dates are made throughout

Medicaid Provider Manuals

- Section I of the Provider Manual
  - Section 124.130
    - Outline the services eligible for Women in Aid Category 61 (PW)

        - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
- Section II of the Nurse Practitioner Provider Manual:
    - Section 214.321
        - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
        - Change "beneficiaries" to "clients", as well as grammar changes in Sections 203.500, 214.321, and 214.600
- Section II of the Physicians Provider Manual:
    - Section 247.100
        - Outline the services Women in Aid Category 61 (PW) are eligible
        - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
        - Change "beneficiaries" to "clients", as well as grammar changes in Sections 203.140, 243.200, and 247.100
- Section II of the ARKids First B Provider Manual:
    - Change "beneficiaries" to "clients", as well as grammar changes in Section 200.110
- Section II of the Hospital/Critical Access Hospital/ESRD Provider Manual:
    - Change "beneficiaries" to "clients", as well as grammar changes in Section 216.100
    - Removes Pregnant Woman Poverty Level and information regarding additional aid categories in Section 216.100
    - Removes limitation of Medicaid-covered family planning services to Pregnant Woman Poverty Level and adds Pregnant Women in Section 216.510
- Section II of the Certified Nurse Midwife Manual:
    - Section 215.260
        - Outline the services Women in Aid Category 61 (PW) are eligible
        - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
        - Removes requirement that the beneficiary is responsible for payment of services not covered under the PW categories
        - Update information for verifying client's eligibility by removing internal system processes and removing some coverage restrictions for temporary Aid Category 62, Pregnant Woman – Presumptive Eligibility (PW-PE)
    - Change "beneficiaries" to "clients", as well as grammar changes in Sections 215.220 and 215.260

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 12, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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

Per the agency, the total estimated cost to implement this rule is $615,853 for the current fiscal year ($174,779 in general revenue and $441,074 in federal funds) and $1,231,707 for the next fiscal year ($349,558 in general revenue and $882,148 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $174,779 for the current fiscal year and $349,558 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy.

(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;

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy.

(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;

N/A

(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;

N/A

(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

N/A

(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.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

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).

Division of County Operations
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501. 320.6266 F: 501. 404.4619 TDD: 501.682.8933

MEMORANDUM

TO: Interested Persons and Providers

FROM: Mary Franklin, Director, Division of County Operations

DATE: October 14, 2022

SUBJ: Expansion of Pregnant Women Medicaid

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov 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 have any comments, please submit those comments in writing, no later than November 12, 2022.

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: Proposed Rules & Public Notices.

NOTICE OF RULE MAKING

The Arkansas Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129.

Effective January 1, 2023:

The Director of the Division of County Operations amends Sections A-217, C-205, E-110, F-130, Appendix F, and the Beneficiary Aid Category List of the Medical Services Policy Manual to raise the income limit of the Pregnant Woman full coverage category and eliminate the limited benefit Pregnant Woman category. To reflect the change, the Director of the Division of Medical Services amends Section I of the Arkansas Medicaid Provider Manual and certain sections of the following provider specific manuals: Nurse Practitioner, Certified Nurse Midwife, Hospital, Critical Access Hospital, End Stage Renal Disease, ARKids First-B, and Physician. Also, updates to the CMS Medicaid Eligibility S28 in the State Plan concerning mandatory coverage for pregnant women and appendices, lists, and terminology were made where appropriate. The projected annual cost of this change for state fiscal year (SFY) 2023 is $615,853 (federal share of $441,074) and for SFY 2024 is $1,231,707 (federal share of $882,148).

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than November 12, 2022. 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 Rules Promulgation at 501-534-4138.

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. 4502100209

Mary Franklin, Director
Division of County Operations

~~A-200 Medicaid Coverage Periods~~

A-200 ~~Health Care Coverage Periods 16 Retroactive Eligibility Foster Children~~

A-217 Retroactive Eligibility-Pregnant Woman

MS Manual ~~08/15/14~~01/01/23

Retroactive eligibility for Pregnant Women (PW) is determined according to the guidelines for current PW eligibility determination. The applicant should have alleged medical expenses for the retroactive period. (Refer to the "No Look Back" policy at MS C-205 and I-610).

The begin date of the retroactive period will be entered in the system at certification (when authorized in conjunction with current PW eligibility).

For Full PW, if application for retroactive PW coverage is made after termination of the pregnancy, the retroactive period may not begin more than three ~~(3)~~ months prior to the date of application, and the retroactive period must end no later than the last day of the month of delivery (~~i.e.~~ for example, the applicant will not be eligible for the postpartum coverage). ~~However, Limited PW may be given postpartum coverage when application is made after termination of the pregnancy (~~Refer~~.~~ to MS C-205).

~~**NOTE:** Retroactive coverage for Unborn Pregnant Woman will follow the rules for the type of pregnancy coverage her eligibility falls in, Full or Limited Pregnant Woman as stated above.~~

Procedures for authorizing retroactive eligibility only~~,~~ (~~i.e.~~ for example, "~~f~~Fixed eligibility~~")~~ are found in (MS A-220).

~~I~~f application for retroactive PW coverage is made after termination of a pregnancy and coverage after the month of delivery is also requested, a separate application must be made

in the appropriate category to provide coverage for the month(s) following the expiration of the PW coverage.

~~C-200 Alternative Application Processes~~

C-20~~0~~5 Alternative Application Processes~~Pregnant Woman (PW) Period of Eligibility~~

C-205 Pregnant Woman (PW) Period of Eligibility

MS Manual ~~07/01/20~~01/01/23

An individual found eligible may receive PW Medicaid coverage only during the period of pregnancy and through the end of the month in which the sixtieth (60th) day postpartum falls. Postpartum coverage will be provided to women who are ~~Medicaid~~ Health Care certified at the time of delivery and to women who have a ~~Medicaid~~ Health Care application pending at the time of birth and are later found eligible for PW coverage.

An individual who applies for Pregnant Woman – Full or Medically Needy Medicaid after termination of a pregnancy may be given benefits to the end of the birth month, if eligible, but may not be given postpartum coverage. A pregnant woman who applies after the birth of the child and is found eligible in the birth month for ~~Limited PW or~~ Unborn Child will be given full postpartum coverage.

If the pregnant woman has medical bills in the three (3) months prior to the date of application, retroactive eligibility will be determined. There must have been medical bills incurred to give retroactive coverage. The medical bills must be for the PW. Medical bills for other family members will not qualify the PW for retroactive PW coverage.

~~C-200 Alternative Application Processes~~

C-2~~1~~00 Alternative Application Processes~~0 Newborn Referral Process~~

If a PW applicant is not income eligible in the month of application or the month in which the forty-fifth (45th) day falls~~,~~ but is income and otherwise eligible in one (1) of the retroactive months, the application will be approved beginning in the earliest month of retroactive eligibility. Eligibility will then continue through the end of the month in which the sixtieth (60th) day postpartum falls, if the applicant is eligible for the postpartum coverage, with disregard of any income changes which occurred after the beginning month of eligibility.

There will be "No Look Back" at later income increases throughout the pregnancy and the postpartum period, even if the applicant is not eligible in the month of application or in the month when the forty-fifth (45th) day of the application falls. Refer to MS I-610.

CO-

~~E-100 Financial Eligibility~~

E-1~~0~~0010 Financial Eligibility ~~Income and Resource Limits for MAGI and Non-MAGI~~

E-100 Financial Eligibility

MS Manual 10/26/15

Each individual applying for or receiving Medicaid benefits must have a financial eligibility determination made at application and, if eligible, on an on-going annual basis or when a change affecting eligibility occurs. Financial eligibility consists of an income test and if the category requires, a resource or asset test.

Most Medicaid eligibility groups have an income limit which an individual's countable income must fall under in order to be eligible for coverage in that group. Income limits and the manner in which countable income is determined vary by eligibility groups. The groups to which an income limit does not apply, and therefore no income determination is made, are the following:

- Newborns (MS B-220);
- Former Foster Care Adults (MS B-280);
- Workers with Disabilities (MS B-330).

NOTE: For the Workers with Disabilities category, before determining eligibility, the applicant must pass a pre-test screening to ensure his/her unearned income does not exceed the SSI individual benefit plus $20. If the applicant meets this criteria, all income is disregarded in the financial eligibility determination. However, both unearned and earned income will be used to determine cost sharing. See MS A-115.

A resource limit applies to most of the eligibility groups that do not use MAGI methodologies for financial eligibility. For these groups, the value of an individual's countable resources must be determined. There is no resource limit, and therefore no resource determination is made, for the following groups:

- Those using MAGI methodologies (MS E-110);
- Newborns (MS B-220);
- Former Foster Care Adults (MS B-260);
- Workers with Disabilities (MS B-330).

E-110 Income and Resource Limits for MAGI and Non-MAGI Groups

MS Manual ~~01/01/19~~01/01/23

Below are the income and resource limits for all ~~Medicaid~~ Health Care groups. When the income limit is based on a percentage of the federal poverty level (FPL), the countable household income will

~~E-100 Financial Eligibility~~

E-0010 Financial Eligibility ~~Income and Resource Limits for MAGI and Non-MAGI~~

be compared to the FPL for the applicable household size. Refer to Appendices F and S for the specific income level amounts.

Category	Income Limit	Resource Limit
ARKids A	142% of FPL *	No Resource Test
ARKids B	211% of FPL *	No Resource Test
Newborns	No Income Test Eligibility is based on mother's ~~Medicaid~~ Health Care eligibility at child's birth	No Resource Test
Pregnant Women: Full ~~Medicaid~~ Pregnant Woman ~~Limited Medicaid Pregnant Woman~~ Unborn Child	 ~~1 person: $124.00~~ ~~2 person: $220.00~~ ~~3 person: $276.00~~ ~~4 person: $334.00~~ ~~5 person: $388.00~~ ~~See Appendix F for household sizes over 5.~~ ~~209~~0914% FPL* ~~209% of FPL *~~ ~~209~~209~~214~~% of FPL *	No Resource Test
Parent and Caretaker Relative	1 person: $124.00 2 person: $220.00 3 person: $276.00 4 person: $334.00 5 person: $388.00 See Appendix F for household sizes over 5.	No Resource Test
Adult Expansion Group	133% of FPL *	No Resource Test
Medically Needy: Exceptional (EC) Spend Down (SD)	 EC – may not exceed the monthly income limit SD – may exceed the quarterly income limit See MS O-710 for the monthly and quarterly income limit	 1 person: $2,000 2 person: $3,000 3 person: $3,100
TEFRA	3 times the SSI Payment Standard Appendix S	$2000

~~E-100 Financial Eligibility~~

E-1 0010 Financial Eligibility ~~Income and Resource Limits for MAGI and Non-MAGI~~

Autism	3 times the SSI Payment Standard Appendix S	$2000
Long-Term Services & Supports: Nursing Facility, DDS, ARChoices,	3 times the SSI Payment Standard	Individual $2000
	Appendix S	Couple $3000

~~E-100 Financial Eligibility~~

E-10010 Financial Eligibility ~~Income and Resource Limits for MAGI and Non-MAGI~~

Assisted Living, and PACE		
Medicare Savings: ARSeniors QMB SMB QI-1 QDWI	Equal to or below 80% FPL 100% FPL Between 100% & 120% FPL 120% but less than 135% FPL 200% FPL Appendix F	ARSeniors, QMB, SMB & QI-1: Individual $7,730 Couple $11,600 QDWI: Individual $4000 Couple $6000
Workers with Disabilities	Unearned income may not exceed SSI individual benefit plus $20	No resource test
PICKLE	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability (COBRA and OBRA '87)	Under the current SSI/SPA level Appendix S	Individual $2000
Widows & Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA '90)	Under the current SSI/SPA level Appendix S	Individual $2000
Disabled Adult Child (DAC)	Under the current SSI/SPA level Appendix S	Individual $2000
***May be eligible for an additional 5% disregard, MS E-268.**		

F-130 Child Support Enforcement Services

MS Manual 0~~1~~3/~~01~~27/202~~2~~3

The Office of Child Support Enforcement (OCSE) is mandated to provide services to all Health Care recipients who have assigned ~~to the state~~ their rights to medical support to the State. Each applicant or recipient who is responsible for the care of a dependent child must cooperate with OCSE in establishing legal paternity and obtaining medical support for each child who has a parent absent from the home. (See exception below.)

OCSE must provide all appropriate services to Health Care applicants and recipients without the OCSE application or fee. The OCSE agency is required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. OCSE will also collect child support payments from the absent parent unless OCSE is notified by the recipient in writing that this service is not needed. Child support payments collected on behalf of Health Care recipients are received and distributed to the custodial parent through the ~~Central Office Child Support~~OCSE Clearinghouse. However, no recovery cost will be collected.

1. Referrals

   ~~An OCSE referral will be made at initial approval for children w~~When a child's parent, guardian, or caretaker relative voluntarily requests a referral to be made, or is receiving Health Care~~, or when the parent, guardian, or caretaker relative voluntarily requests a referral to be made~~ an OCSE referral will be made at initial approval. Refer to Exception and Note below.

   Act 1091 of 1995, amended by Act 1296 of 1997, requires that both parents sign an affidavit acknowledging paternity, or obtain a court order, before the father's name will be added to the birth certificate.

   NOTE: If the father's name is included on the birth certificate of a child born April 10, 1995, or ~~-~~later, paternity has already been established. As paternity establishment is the only service the Office of Child Support Enforcement can offer to a family when both parents ~~-~~are in the home, there is no need to make a referral in these instances.

~~EXCEPTION: Recipients in the Limited Health Care Pregnant Woman eligibility group will not berequired to cooperate with the OCSE on Health Care certified children until after their postpartum period has ended and the recipient enters another group where cooperation with OCSE is required.~~

NOTE: For child-only cases, cooperation with OCSE is voluntary. The only time that a referral to OCSE is necessary is when a parent, guardian, or caretaker relative is eligible in another Health Care eligibility group in which cooperation with OCSE is mandatory. Cooperation with OCSE will be strictly voluntary~~,~~ when a:

- Parent, guardian, or caretaker relative is not receiving Health Care, but the children are receiving Health Care;
- Parent, guardian, or caretaker relative is the only one receiving Health Care and the children are not receiving Health Care; or
- Parent, guardian, or caretaker relative is receiving Health Care in an exempt category ~~(that being, Limited Pregnant Woman)~~.

A parent is considered to be absent for Health Care purposes when the absence is due to divorce, separation, incarceration, institutionalization, participation in a Rehabilitation Service Program away from home, or military service~~,~~. These considerations are regardless of support, maintenance, physical care, guidance, or frequency of contact.

2. Good Cause

An applicant or recipient may have good cause not to cooperate in the state's efforts to collect child or Medical support. The applicant or recipient may be excused from cooperating if they believe that cooperation would not be in the best interest of the child, and if the applicant or recipient can provide evidence to support this claim.

The following are circumstances under which DCO may determine that the applicant or recipient has good cause for refusing to cooperate:

- Cooperation is anticipated to result in serious physical or emotional harm to the child~~;~~.
- Cooperation is anticipated to result in physical or emotional harm to the individual that is so serious it reduces the ability to care for the child adequately~~;~~.
- The child was born as a result of forcible rape or incest~~;~~.
- Court proceedings are in progress for the adoption of the child~~; or~~.
- The individual is working with an agency helping to decide whether or not to place the child for adoption.

3. Refusal to Cooperate-Sanction

~~For Health Care, a~~A child's Health Care benefits cannot be denied or terminated due to the refusal of a parent or another legally responsible person to assign rights or cooperate with OCSE in establishing paternity or obtaining medical support. Health Care for the parent ~~-~~or caretaker relative will end after the appropriate notice has expired.

If a parent or another legally responsible person states that they refuse to cooperate with the OCSE referral process during any case action (~~ie~~~~for example,~~ such as during the initial application or~~,~~ case change~~, or etc.~~), the sanction can be~~-~~ applied~~-~~ by the DHS Eligibility Worker.

TOC not required

122.000 Agencies Responsible for Determining Eligibility

~~6-1-08~~1-1-23

The Department of Human Services (DHS) local county offices or district Social Security offices determine beneficiary eligibility for most Medicaid beneficiaries.

~~The Department of Health determines presumptive eligibility for pregnant women in the SOBRA Pregnant Women, Infants and Children aid category.~~

District Social Security offices determine Supplemental Security Income (SSI) eligibility, which automatically confers Medicaid eligibility for SSI beneficiaries.

124.130 Pregnant Women, Infants & Children

~~9-15-09~~1-1-23

The infants and children in the SOBRA (Sixth Omnibus Budget Reconciliation Act of 1986) aid category receive the full range of Medicaid benefits.~~; however, the SOBRA pregnant women (PW-PL) receive only services related to the pregnancy and services that if not provided to PW-PLs could complicate the pregnancy.~~

~~There are two groups of pregnant women, PW-PL and PW-Unborn CH. Both groups receive the same services during pregnancy. Generally, beneficiaries who are eligible for PW-PL are covered for postpartum follow-up services and family planning services. It is important to note that their~~ Pregnant Women (PW)~~-PL~~ eligibility ends on the last day of the month in which the 60th postpartum day occurs.

~~–~~PW-Unborn Child group (covered through the State Child Health Insurance program, which is authorized by Section 4901 of the Balanced Budget Act of 1997) does not cover sterilization or any other family planning services. Therefore, providers must verify eligibility to determine if the pregnant women is PW-~~PL~~ or PW "Unborn Child" (when providers check eligibility, the system will reflect: "PW Unborn CH-no Ster cov" for the Unborn Child group).

~~A pregnant woman whose unborn child will be a US citizen (PW-Unborn Child) receives the same pregnancy services as those in the PW-PL category; however, after delivery, no family planning services (including sterilization) are covered.~~ Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

A. Prenatal services

B. Delivery

C. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

D. Services for conditions that may complicate the pregnancy

System eligibility verification will specify "PW unborn ch-no ster cov/FP."

TOC required

203.500 The Nurse Practitioner's Role in Family Planning Services 1-15 16 23

Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services provided by nurse practitioners and other providers. Medicaid beneficiariesclients' family planning services benefits are in addition to their other medical benefits. Family planning services do not require PCP referral.

A. Refer to Sections 214.321 through 214.333 of theis manual for family planning coverage information.

B. Refer to Sections 252.430 and 252.431 of theis manual for family planning services special billing instructions and procedure codes.

C. Arkansas Medicaid also covers family planning services for women in Aid Category 61, Pregnant Women Poverty Level (PW-PL). Refer to Sections 214.321 and 214.333 for more information regarding coverage of family planning services for this eligibility category.

214.321 Family Planning Services for Women in Aid Category 61, PW-PL 1-15-2316

Women in Aid Category 61, Pregnant Women – Poverty Level (PW-PL), are eligible for all Medicaid-covered family planning services. *Beneficiaries in Aid Category 61 are eligible for family planning services* through the last day of the month in which the 60th day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.600 Obstetrical Services 1-15-2316

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible beneficiariesclients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW-PL clients are eligible for *limited* full range Medicaid coverage. that includes antepartum services, services for any condition that may complicate the pregnancy, delivery, postpartum services and family planning services. Aid category 61, PW-PL pregnant womaen's eligibility ends on the last day of the month in which the 60th postpartum day falls.

Aid category 62, PW-PE coverage is *limited* to outpatient services only.

TOC required

203.140 Physician's Role in Family Planning Services ~~12-18-15~~1-1-23

A. Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services.

1. Medicaid ~~beneficiarie~~clients' family planning services ~~benefits~~ are in addition to their other medical benefits.

2. Family planning services do not require a PCP referral. PCPs electing not to provide some or all family planning services can use the information in this manual to counsel their Medicaid-eligible patients and help them locate family planning services.

   a. Refer to Sections 221.000 and 221.100 of the~~is~~ manual for family planning services benefit limitations.

   b. Refer to Sections 243.000 through 243.500 of the~~is~~ manual for service descriptions and coverage information.

   c. Refer to Sections 292.550 through 292.553 of the~~is~~ manual for family planning services billing instructions and procedure codes.

B Arkansas Medicaid ~~also~~ covers family planning services for women in ~~some~~ limited aid categories. Refer to Sections 221.100, and 243.000 through 243.500 for more information on coverage of family planning services for these eligibility categories.

~~1. Pregnant Woman-Poverty Level (PW-PL, Aid Category 61).~~

~~2. For information regarding additional aid categories, see Section 124.000.~~

~~221.100 Family Planning Benefits Regarding Aid Categories 69 (FP-W) and 61 (PW-PL)~~ ~~5-1-17~~

~~A. See Sections 292.551 through 292.553 for billable procedure codes.~~

~~B. Family planning services, including sterilization procedures, are also covered for women eligible in the Pregnant Woman-Poverty Level (PW-PL) category, Aid Category 61. Beneficiaries in this aid category are eligible for family planning services through the last day of the month in which the 60th postpartum day falls.~~

243.200 Family Planning Services for Women in Aid Category 61, PW~~-PL~~ ~~2-1-06~~1-1-23

Women in Aid Category 61, Pregnant Wom~~a~~en ~~– Poverty Level~~ (PW~~-PL~~), are eligible for all Medicaid-covered family planning services. ~~The Medicaid Program expects, however, that many of those women who desire family planning services will apply for and obtain eligibility under the Family Planning Services Demonstration Waiver. Beneficiarie~~Clients in aid category 61 Pregnant Women (PW) are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

247.100 Pregnant Women in the PW~~-PL and PW-PE~~ Aid Categor~~y~~~~ies~~ ~~10-13-03~~1-1-23

~~Pregnant women in the PW-PL and PW-PE aid categories (Aid Categories 61 and 62, respectively) are eligible for only obstetrical services and treatment for conditions that may complicate their pregnancy. Coverage for women in beneficiary aid category 62, Pregnant Women-Presumptive Eligibility includes outpatient services only.~~

~~Benefits for women in beneficiary aid category 61, Pregnant Women Poverty Level, include:~~

~~A. Prenatal services.~~

~~B. Delivery.~~

~~C. Postpartum services. (The pregnant woman is eligible for 60 days of postpartum care if she is Medicaid eligible at delivery.)~~

~~D. Family planning services. Family planning services may include tubal ligations.~~

Women in Aid Category 61 (PW) receive the full range of Medicaid benefits. Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

A. Prenatal services

B. Delivery

C. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

D. Services for conditions that may complicate the pregnancy

System eligibility verification will specify “PW unborn ch-no ster cov/FP.”

Aid Category 61 PW Unborn Child does not include family planning benefits.

TOC not required

200.110 ARKids First-A and ARKids First-B

~~7-1-20~~1-1-23

Medicaid-eligible children in the SOBRA eligibility category for pregnant women, infants, and children (category 61 PW~~-PL~~) and newborn children born to Medicaid-eligible mothers (categories 52 and 63), are known as ARKids First-A ~~beneficiarie~~clients. Un~~-~~insured, non~~-~~Medicaid-eligible children that meet additional established eligibility requirements will have health coverage under ARKids First-B, a CHIP separate child health program. All ARKids First ~~beneficiarie~~clients will receive a program identification card without indication of level of coverage (either ARKids First-A or ARKids First-B).

A Medicaid eligibility verification transaction response either through the provider portal via the web or through the Voice Response System (VRS) will indicate that the individual is either an ARKids First-A ~~beneficiary~~client or an ARKids First-B ~~beneficiary~~client. The response will also indicate that cost sharing may be required for ARKids First-B ~~beneficiarie~~clients. Refer to Section I of the Arkansas Medicaid provider manual for automated eligibility verification procedures.

When a child presents as an ARKids First-A eligible ~~beneficiary~~client, the provider must refer to the regular Medicaid provider policy manuals. When an ARKids First-B eligible ~~beneficiary~~ client is identified, the provider must refer to the ARKids First-B Provider Manual for determination of levels of coverage, as well as the associated Medicaid provider policy manuals for the services provided.

TOC required

216.100 Outpatient Hospital's Role in Family Planning Services 10-1-15

A. Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services.

1. Medicaid ~~beneficiarie~~clients' family planning services ~~benefits~~ are in addition to their other medical benefits.

2. Family planning services do not require a PCP referral. PCPs electing not to provide some or all family planning services can use the information in this manual to counsel their Medicaid-eligible patients and help them locate family planning services.

a. Refer to Section 216.110 of this manual for family planning services benefit limitations.

b. Refer to Section 216.130 of this manual for service descriptions and coverage information.

c. Refer to Sections 216.515, and 216.540 through 216.550 of this manual for family planning services, billing instructions, and procedure codes.

B Arkansas Medicaid ~~also~~ covers family planning services for women in some limited aid categories. Refer to Sections 216.500 through 216.510 for more information on coverage of family planning services for these eligibility categories.

~~1. Pregnant Woman Poverty Level (PW-PL, Aid Category 61)~~

~~2. For information regarding additional aid categories, see Section 124.000~~

216.510 Family Planning Services for Women in Aid Category 61 (PW-~~PL~~) 1-15-15

Women in Aid Category 61, Pregnant Wom~~a~~en ~~– Poverty Level~~ (PW-~~PL~~), are eligible for all Medicaid-covered family planning services. ~~The Medicaid Program expects, however, that many of those women who desire family planning services will apply for and obtain eligibility under the Family Planning Services Demonstration Waiver. Family planning services, including sterilization procedures, are also covered for women eligible in the Pregnant Woman Poverty Level (PW-PL) Category, Aid Category 61.~~

~~Beneficiarie~~Clients in Aid Category 61, Pregnant Women (PW) are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

See Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 for family planning services, billing, and coverage restrictions.

TOC required

215.220 Family Planning Services for Women in Aid Category 61, PW~~-PL~~ 10-1-15

Women eligible in Aid Category 61, Pregnant Women~~, Poverty Level~~ (PW~~-PL~~), are eligible for all Medicaid-covered family planning services. ~~Beneficiarie~~Clients in aid category 61 are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.

215.260 Expansion of Medicaid Eligibility for Pregnant Women 7-1-06

A. Arkansas Medicaid provides expanded coverage for pregnant women. Women in Aid Category 61 (PW) ~~may~~ receive ~~only~~ the full range of Medicaid benefits ~~services listed below.~~ Service settings may be both outpatient and inpatient, as appropriate.

Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

1. Prenatal services
2. Delivery
3. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

~~4. Family planning services, including tubal ligations~~

4~~5~~. Services for conditions that may complicate the pregnancy

~~Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are the same as those for Aid Category 61 with the exception of sterilization procedures and family planning services.~~ System eligibility verification will specify "PW unborn ch-no ster cov/FP."

Aid Category 61 PW Unborn Child does not include family planning benefits.

B. When verifying a ~~beneficiary~~client's eligibility, please note the "AID CATEGORY CODE" and "AID CAT DESCRIPTION" fields. The "AID CATEGORY CODE" field contains the 2-digit numeric code identifying the ~~beneficiary~~ client aid category. The "AID CAT DESCRIPTION" field contains an abbreviation of the aid category description, comprising 2 or more characters, usually letters, but sometimes numerals as well as letters.

1. Pregnant Women (PW) eligibility will occasionally overlap with eligibility in another category, such as Aid Category 20, TEA-GR. If a PW-eligible ~~beneficiary~~ client is seeking services that are not for pregnancy or conditions that may complicate pregnancy and are not family planning services, other eligibility segments may be reviewed on the transaction response and other available electronic options. The woman may have benefits for the date of service in question under another aid category. If so, the service may be performed and the claim may be filed with Medicaid as usual.

~~The beneficiary is responsible for payment of services not covered under the PW categories.~~

2. Medicaid also provides coverage in Aid Category 61 (PW~~-PL~~) to children who are eligible for all Medicaid benefits. The aid category code ~~and aid category description are~~ is the same as those of a pregnant woman. ~~The eighth digit of their Beneficiary Identification number (BID) is "2." The claims processing system distinguishes claims for children's services from claims for pregnant women's services by reading the eighth digit of the BID.~~

~~There is also a temporary Aid Category 62, Pregnant Women – Presumptive Eligibility (PW-PE). Coverage is restricted to prenatal services and services for conditions that may complicate the pregnancy. These services are further limited to the outpatient setting only.~~

Aid Categories 62 (PW-PE), 65 (PW-NG), 66 (PW-EC) and 67 (PW-SD) only cover the pregnant woman. Aid Categories 65, 66 and 67 have lower income limits than those listed above for Aid Category 61. Only Aid Category 61 may include eligible pregnant women and/or children.

Beneficiary Aid Category List

Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. The following codes describe each level of coverage.

FR	full range
LB	limited benefits
AC	additional cost sharing
MNLB	medically needy limited benefits
QHP/IABP/MF	Qualified Health Plan/awaiting QHP assignment/medically frail

Category	Category Name	Description	Code
01	ARKIDS B	CHIP Separate Child Health Program	LB, AC
06	ARHOME	New Adult Expansion Group	QHP, AC IABP, AC MF, FR
10	WD	Workers with Disabilities	FR, AC
11	Assisted Individual - Aged	Assisted Living Facility- Individual is >= 65 years old	FR
11	ARChoices - Aged	ARChoices waiver -Individual is >= 65 years old	FR
13	SSI Aged Individual	SSI Medicaid	FR
14	SSI Aged Spouse	SSI Medicaid	FR
15	PACE	Program of All-Inclusive Care for the Elderly (PACE)	FR
16	AA-EC Aged Individual	Medically Needy, Exceptional Category-Individual is >= 65 years old	MNLB
17	AA-SD – Aged	Medically Needy Spend Down- Individual is >= 65 years old	MNLB
18 QMB	AA Aged Individual	Qualified Medicare Beneficiary (QMB)-Individual is >= 65 years old	LB
19	ARSeniors	ARSeniors	FR
20	PCR	Parent Caretaker Relative	FR
25	TM	Transitional Medicaid	FR, AC
26	AFDC Medically Needy-EC	AFDC Medically Needy Exceptional Category	MNLB
27	AFDC Medically Needy-SD	AFDC Medically Needy Spend Down	MNLB
31	Pickle	Disregard COLA Increase	FR
33	SSI Blind Individual	SSI Medicaid	FR
34	SSI Blind Spouse	SSI Medicaid	FR

Category	Category Name	Description	Code
35	SSI Blind Child	SSI Medicaid	FR
36	Blind Medically Needy-EC**	AABD Medically Needy - Individual is Blind as indicated on the Disability screen	MNLB
37	Blind Medically Needy-SD-	Aid to the Blind-Medically Needy Spend Down-Individual has disability type of blind	MNLB
38	Blind – QMB	Aid to the Blind-Qualified Medicare Beneficiary (QMB) - Individual is Blind as indicated on the Disability screen	LB
40	Nursing Facility – Aged	Nursing Facility - Individual age is >= 65 years old	FR
40	Nursing Facility – Blind	Nursing Facility- Individual is Blind as indicated on the Disability screen	FR
40	Nursing Facility – Disabled	Nursing Facility – Individual has a disability	FR
41	Disabled Widow/er Surviving Divorced Spouse	Widows/Widowers and Surviving Divorced Spouses with a Disability (COBRA 90)	FR
41	Assisted Living	Assisted Living Facility-Individual has a disability of any type.	FR
41	ARChoices	ARChoices-Individual has disability type of physical or blind.	FR
41	DAC	Disabled Adult Child	FR
41	Autism	Autism Waiver	FR
41	DDS	DDS Waiver	FR
41	Disregard (1984) Widow/Widow/er	Disabled Widower 50-59 (COBRA)	FR
41	Disregard SSA Disabled Widow/er	Disabled Widower 60-65 (OBRA 87)	FR
41	Disregard SSA Disabled Widow/e	OBRA 90	FR
43	SSI Disabled Individual	SSI Medicaid	FR
44	SSI Disabled Spouse	SSI Medicaid	FR
45	SSI Disabled Child	SSI Medicaid	FR
46	Disabled Medically Needy - EC	AABD Medically Needy - Individual has disability of any type other than blind	MNLB
47	Disabled Medically Needy - SD	AABD Medically Needy Spenddown - Individual has any other disability type other than Blind	MNLB

Category	Category Name	Description	Code
48	Disabled QMB	Qualified Medicare Beneficiary (QMB) - Individual has any other disability type other than Blind	LB
49	TEFRA	TEFRA Waiver for Disabled Child	FR, AC
52	Newborn	Newborn	FR
56 U-18 EC		Under Age 18 Medically Needy Exceptional Category	MNLB
57	U-18 Medically Needy - SD	AFDC U18 Medically Needy Spend Down	MNLB
58	Qualifying Individual (QI-1)	Qualifying Individual-1 (Medicaid pays only the Medicare premium.)	LB
61	ARKids A	ARKids A	FR
~~61~~	~~Pregnant Women-Limited~~	~~Pregnant Women-Limited~~	~~LB~~
61	Unborn	Pregnant Womaen - Unborn Child (No family planning benefits allowed)	LB
65	Pregnant Women – Full	Pregnant Women – Full	FR
66	Pregnant Women Medically Needy - EC	AFDC Pregnant Women Medically Needy	MNLB
67	Pregnant Women Medically Needy - SD	AFDC Pregnant Women Medically Needy Spend Down	MNLB
68	Qualified Disabled and Working individual (QDWI)	Qualified Disabled and Working individual (QDWI) - (Medicaid pays only the Medicare Part A premium.)	LB
76	AFDC UP Medically Needy - EC	Unemployed Parent Medically Needy	MNLB
77	AFDC UP Medically Needy Spenddown	Unemployed Parent Medically Needy Spend Down	MNLB
81	RMA	Refugee Resettlement	FR
87	RMA Spenddown	Refugee Resettlement- Medically Needy Spend Down	MNLB
88	SLMB	Specified Low Income Qualified Medicare Beneficiary (SLMB) (Medicaid pays only the Medicare premium.)	LB
91	Foster Care Non-IV-E	Non IV-E Foster Care - User selection based on Child in Placement screen	FR
92	Foster Care IV-E	IV-E Foster Care - User selection based on Child in Placement screen	FR

Category	Category Name	Description	Code
92	Foster Care ICPC IV-E	ICPC IV-E Foster Care - User selection based on Child in Placement screen	FR
93	Former Foster Care	Former Foster Care Up to Age 26	FR
94	Adoption	Non- IV-E- User selection based on Child in Placement screen	FR
94	Adoption	ICAMA Non- IV-E- User selection based on Child in Placement screen	FR
94	Adoption	IV-E- User selection based on Child in Placement screen	FR
94	Adoption	ICAMA IV-E- User selection based on Child in Placement screen	FR
95	Guardianship (GAP)	Guardianship Non-IV-E - User selection based on Child in Placement screen	FR
95	Guardianship (GAP)	Guardianship IV-E- User selection based on Child in Placement screen	FR
96	Foster Care Exceptional Category	Foster Care Medically Needy Exceptional Category - Individual fails Foster Care Non-IVE Income Test and is eligible for FC EC	MNLB
97 FC-SD	Foster Care Spend Down	Foster Care Medically Needy Spend Down- Individual fails FC EC Income Test/or Income Test of any other higher category and has medical bills to be eligible on spenddown.	MNLB

Medicaid Eligibility

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0027

Eligibility Groups - Mandatory Coverage
Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women -** Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☐ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ○ No

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

The amount of the maximum income standard is: 209 % FPL

■ Income standard chosen

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ Another income standard in-between the minimum and maximum standards allowed.

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

■ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

○ Yes ○ No

PRA Disclosure Statement