EXHIBIT J

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Hospital Reimbursement for Long Acting Reversible Contraceptives (LARCs) & REPEALS: DDS Policy 1088 – Burial Insurance; DDS Policy 2001 – Building and Contents Insurance Claims

DESCRIPTION:

Statement of Necessity

The Long-Acting Reversible Contraceptive (LARC) rule is necessary to comply with Act 581 of 2023 which allows separate reimbursement of long-acting reversible contraceptives for hospitalized Medicaid beneficiaries immediately after birth of a child or during postpartum. Thus, it is necessary to update the appropriate Medicaid provider manuals and state plan to furnish information to providers regarding the rules required to claim reimbursement.

Rule Summary

Physician Manual: Section 292.551 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Nurse Practitioner Manual: Section 214.330 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Certified Nurse Midwife Manual: Section 215.200 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Hospital Manual: Section 216.000 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Medicaid state plan: Amended attachment 4.19-A, Page 11ddd, to establish the reimbursement method for the LARC device and insertion when the beneficiary is a hospital inpatient.

Repeals pursuant to the Governor's Executive Order 23-02:

1. DDS Policy 1088 – Burial Insurance, and
2. DDS Policy 2001 – Building and Contents Insurance Claims.

PUBLIC COMMENT: A public hearing was held on this rule on October 4, 2023. The public comment period expired on October 22, 2023. The agency provided the following summary of the public comment it received and its responses to that comment:

Commenter's Name: Ron Cantrell for Ada Sochanska, MPAS, PA-C, ARAPA President

COMMENT: The Arkansas Academy of Physician Assistants (ARAPA), on behalf of over 150 Physician Assistants (PAs) throughout Arkansas, appreciates the opportunity to provide comments on amendments associated with Arkansas Regulation 10427: Long Acting Reversible Contraceptives (LARCs). By including PAs in the updated sections, we will further encourage PAs to practice to their full extent and ensure that we are not excluding PAs from important rules or amendments pertaining to medical care.
The updates to Long Acting Reversible Contraceptives (LARCs) gives appropriate information to providers surrounding Medicaid provider manuals and State Plan regarding the rules required to claim reimbursement. However, as of this year, PAs have now been designated both rendering and billing providers by Arkansas Medicaid as per Act 303 (2023) and therefore should be incorporated in further updates.

We would like to draw your attention to section II, Nurse Practitioner, Titled "214.330 Family Planning Coverage Information" and respectfully request the Department to have a section that would refer to PAs. Similar to the Nurse Practitioner Section but retitled to "Physician Assistant".

By creating a section specific to PAs this would mimic the section as it is for "Nurse Practitioners" however, it would include specific language update within Section 214.330 C, to change the title from "Nurse Practitioners" to "Physician Assistants" and similarly in section D, update that to state "Physician Assistants". Further in section D, this would include the addition of a bullet title "Nurse Practitioners" and to include them as providers that Physician Assistants would be able to refer patients to.

In light of these changes, ARAPA also requests updating the Nurse Practitioner Section II "214.330 Family Planning Coverage Information" section D to include Physician Assistants as referring providers. In addition, updating the Certified Nurse Midwife Section II "215.220 Family Planning Coverage Information" section D to include Physician Assistants as referring providers.

We thank you for your consideration.
RESPONSE: DMS is preparing a separate promulgation related to Act 303 which will include Medicaid manual revisions for physician assistants. We will review your comments as we draft those proposed rules and look forward to receiving further comments during the promulgation process.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following question and received the following response:

Q. The rules state that providers are allowed to bill for LARC devices and professional services "while the beneficiary remains in an inpatient setting." Where does the inpatient requirement come from? **RESPONSE:** I checked with the subject matter experts. It's not a requirement; currently, the hospital cannot bill for LARC Insertion on an inpatient

stay, because of per diem billing. They could however, bill as an outpatient claim if the patient returned for the insertion. This allows them to insert the LARC and bill us for it before the individual is discharged from the inpatient stay for delivery.

The proposed effective date is January 1, 2024.

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

Per the agency, the total cost to implement this rule is $1,395,537 for the current fiscal year ($139,554 in general revenue and $1,255,984 in federal funds) and $2,791,075 for the next fiscal year ($279,107 in general revenue and $2,511,967 in federal funds). The total estimated cost by fiscal year to state, county, or municipal government as a result of this rule is $139,554 for the current fiscal year and $279,107 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;

Act 581 of 2023 requires Medicaid to allow separate reimbursement of long-acting reversible contraceptives for hospitalized Medicaid beneficiaries immediately after the birth of a child or during postpartum.

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

According to findings of Act 581 of 2023, long-acting reversible contraceptives are cost-prohibitive for providers of healthcare services when provided at the same time as other services rendered at time of birth or during the postpartum eligibility period.

(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;

Allowing separate reimbursement of LARCs removes barriers and provides access to effective family planning services for women of child-bearing age.

(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;

None.

(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;

None.

(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 cost.

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 [Arkansas Medicaid] Program shall reimburse a healthcare provider for providing long-acting reversible contraception immediately and during postpartum." Ark. Code Ann. § 20-77-152(b)(1), *as created by* Act 581 of 2023.

This rule implements Act 581 of 2023. The Act, sponsored by Representative DeAnn Vaught, ensured that healthcare providers are properly reimbursed by the Arkansas Medicaid Program for providing long-acting reversible contraception immediately and during postpartum.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

September 21, 2023

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

Dear Mrs. Rebecca Miller-Rice:

Re: Hospital Reimbursement for Long Acting Reversible Contraceptives (LARCs)

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

Sincerely,

Elizabeth Pitman
Director

EP:

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT Human Services
BOARD/COMMISSION Division of Medical Services
BOARD/COMMISSION DIRECTOR Elizabeth Pitman
CONTACT PERSON Mac Golden
ADDRESS P.O. Box 1437, Slot S295 Little Rock, AR 72203-1437
PHONE NO. (501) 320-6383 **EMAIL** Mac.E.Golden@dhs.arkansas.gov
NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING
Elizabeth Pitman
PRESENTER EMAIL(S) Elizabeth.Pitman@dhs.arkansas.gov

INSTRUCTIONS

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

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

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

Please answer each question completely using layman terms.

****

1. What is the official title of this rule?
Hospital Reimbursement for Long Acting Reversible Contraceptives (LARCs)

2. What is the subject of the proposed rule? See attached.

3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☑

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

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

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

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

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

On what date does the emergency rule expire?_____

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

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

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

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

Act 581 of 2023

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

If yes, please list the rules being repealed.
If no, please explain.

1. DDS Policy 1088 - Burial Insurance
2. DDS Policy 2001 - Building and Contents Insurance Claims

8. Is this a new rule? Yes ☐ No ☑

Does this repeal an existing rule? Yes ☐ No ☑
If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes ☑ No ☐
If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

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

Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

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

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

Act 581 of 2023

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

The Long-Acting Reversible Contraceptive (LARC) rule is necessary to allow separate reimbursement of long acting reversible contraceptives for hospitalized Medicaid beneficiaries immediately after birth of a child or during postpartum. It further updates the Medicaid provider manuals to inform providers regarding required rules and regulations to claim reimbursement.

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

https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

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

If yes, please complete the following:

Date: 10/04/2023

Time: 11:30 am

Place: Zoom meeting: https://us02web.zoom.us/j/84641394854 Webinar ID: 846 4139 4854

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

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. 10/22/2023

15. What is the proposed effective date for this rule? January 01, 2024

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

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

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

Arkansas Hospital Association, for
Physician's groups, for

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

If yes, please explain.

NOTICE OF RULE MAKING

The 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.

The Director of the Division of Medical Services amends Section 292.551 of the Physician Manual, Section 214.330 of the Nurse Practitioner Manual, Section 215.200 of the Certified Nurse Midwife Manual, Section 216.000 of the Hospital Manual, and the Medicaid State Plan to comply with Act 581 of the 94th General Assembly. The proposed effective date is January 1, 2024. Act 581 directs the Arkansas Medicaid Program to reimburse a healthcare provider for providing long-acting reversible contraception immediately after childbirth and during postpartum. The proposed rule estimates a financial impact of $1,395,537 ($1,255,984 of which is federal funds) for state fiscal year (SYF) 2024 and $2,791,075 ($2,511,967 of which is federal funds) for SYF 2025.

Pursuant to the Governor's Executive Order 23-02, DHS repeals the following two rules as part of this promulgation: (1) DDS Policy 1088 – Burial Insurance, and (2) DDS Policy 2001 – Building and Contents Insurance Claims.

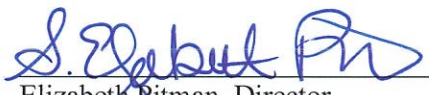
The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state.

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 October 22, 2023. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on October 4th at 11:30 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/84641394854. The webinar ID is 846 4139 4854. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

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. 4502172997



Elizabeth Pitman, Director
Division of Medical Services

From: legalads@arkansasonline.com
To: Lisa Teague
Subject: Re: Full Run AD (r. 239)
Date: Wednesday, September 20, 2023 6:28:47 PM
Attachments: image001.png
image002.png
image012.png
image013.png
image014.png
image015.png

[EXTERNAL SENDER]

Will run Sat 9/23, Sun 9/24, and Mon 9/25.

Thank you.

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

From: "Lisa Teague" <Lisa.Teague@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Anita Castleberry" <Anita.Castleberry@dhs.arkansas.gov>
Sent: Wednesday, September 20, 2023 8:37:19 AM
Subject: Full Run AD (r. 239)

Please run the attached Notice of Public Hearing in the *Arkansas Democrat-Gazette* on the following days:

- Saturday, September 23, 2023
- Sunday, September 24, 2023
- Monday, September 25, 2023

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

Invoice to: **AR Dept of Human Services**
P.O. Box 1437
Slot S535
Little Rock, AR 72203

ATTN: Elaine Stafford
(Elaine.stafford@dhs.arkansas.gov)

Or email invoices to: dms.invoices@arkansas.gov

NOTE: Please reply to this email using "REPLY ALL"

Thank you,

DHS
Lisa Teague
Office of Rules Promulgation
DHS Program Administrator
Phone: 501-396-6428
700 Main St./Slot S295
Little Rock, AR 72203
lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

From:	Lisa Teague
To:	register@sos.arkansas.gov
Cc:	Jack Tiner; Mac Golden; Lakeya Gipson; JAMIE EWING
Subject:	DHS/DMS- Proposed Filing - Hospital Reimbursement for Long Acting Reversible Contraceptives (LARCs) (r.239)
Date:	Thursday, September 21, 2023 9:12:00 AM
Attachments:	SOS Initial (LARC).pdf image001.png image002.png image003.png image004.png image005.png image009.png image006.png image007.png image008.png image010.png

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Attached is the proposed rule for Hospital Reimbursement for Long Acting Reversible Contraceptives (LARCs). The public notice will appear in the Arkansas Democrat Gazette September 23, 24, and 25. The public comment period ends October 22, 2023. Please post.

Thank you,

DHS

Lisa Teague

Office of Rules Promulgation

DHS Program Administrator

Phone: 501-396-6428

700 Main St./Slot S295

Little Rock, AR 72203

lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

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

TITLE OF THIS RULE _____

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

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

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

   If no, please explain:

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

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

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

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

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$139,554	General Revenue	$279,107
Federal Funds	$1,255,984	Federal Funds	$2,511,967
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 1,395,537.00	Total	$ 2,791,075.00

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 139,554.00	$ 279,107.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☑ No ☐

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

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

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

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

FINANCIAL IMPACT STATEMENT ADDENDUM

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

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

Act 581 of 2023 requires Medicaid to allow separate reimbursement of long-acting reversible contraceptives for hospitalized Medicaid beneficiaries immediately after birth of a child or during postpartum.

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

According to findings of ACT 581 of 2023, long-acting reversible contraceptives are cost-prohibitive for providers of healthcare services when provided at the same time as other services rendered at time of birth or during the postpartum eligibility period.

(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;

Allowing separate reimbursement of LARCs removes barriers and provides access to effective family planning services for women of child-bearing age.

(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;

None

(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;

None

(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 cost.

Statement of Necessity and Rule Summary
[Hospital Reimbursement for Long-Acting Reversible Contraceptives]

Why is this change necessary? Please provide the circumstances that necessitate the change.

The Long-Acting Reversible Contraceptive (LARC) rule is necessary to comply with Act 581 of 2023 which allows separate reimbursement of long-acting reversible contraceptives for hospitalized Medicaid beneficiaries immediately after birth of a child or during postpartum. Thus, it is necessary to update the appropriate Medicaid provider manuals and state plan to furnish information to providers regarding the rules required to claim reimbursement.

What is the change? Please provide a summary of the change.

Physician Manual: Section 292.551 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Nurse Practitioner Manual: Section 214.330 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Certified Nurse Midwife Manual: Section 215.200 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Hospital Manual: Section 216.000 is modified to include billing guidelines for Long-Acting Reversible Contraception (LARC) devices and professional services immediately post-partum, while the beneficiary is in an inpatient setting.

Medicaid state plan: Amended attachment 4.19-A, Page 11ddd, to establish the reimbursement method for the LARC device and insertion when the beneficiary is a hospital inpatient.

Repeals pursuant to the Governor's Executive Order 23-02:

1. DDS Policy 1088 – Burial Insurance, and
2. DDS Policy 2001 – Building and Contents Insurance Claims.

TOC not required

292.551 Family Planning Services For Beneficiaries

~~2-1-22~~1-1-24

Family planning services are covered for beneficiaries in full coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in Section 292.552.

A. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.

B. The following procedure table explains family planning procedure codes payable to physicians. These codes require modifier FP except for hospital-based physicians. (See Sections D, E and F below for codes payable to hospital-based physicians.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations.

**This procedure requires special billing instructions. Refer to Section 292.553.

***Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider.

¤This procedure code is not to be billed with an FP modifier but should follow the anesthesia billing protocol as seen in Sections 272.100, 292.440 through 292.442 and 292.444 through 292.447.

C. The following procedure code table explains the family planning visit services payable to physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

D. The following procedure code table explains the codes that are payable to hospital-based physicians.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations; however, these procedure codes are not allowable for Aid Category 69.

**This procedure requires special billing instructions. Refer to Section 292.553.

E. The following procedure code table explains the family planning visit services payable to the hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

F. Effective 1/1/2024,- providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, ~~**see LARC billing combinations for billing codessee**~~ **LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. See ~~**see**~~ **LARC billing combinations for billing codes**.
4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

G. The following procedure code table explains the pathology procedure code payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 292.552**.

TOC not required

292.551 Family Planning Services For Beneficiaries 1-1-24

Family planning services are covered for beneficiaries in full coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in **Section 292.552**.

A. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist**. **View or print form DMS-615 (Spanish) and the checklist**.

B. The following procedure table explains family planning procedure codes payable to physicians. These codes require modifier FP except for hospital-based physicians. (See Sections D, E and F below for codes payable to hospital-based physicians.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations.

**This procedure requires special billing instructions. Refer to Section 292.553.

***Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider.

¤This procedure code is not to be billed with an FP modifier but should follow the anesthesia billing protocol as seen in Sections 272.100, 292.440 through 292.442 and 292.444 through 292.447.

C. The following procedure code table explains the family planning visit services payable to physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

D. The following procedure code table explains the codes that are payable to hospital-based physicians.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations; however, these procedure codes are not allowable for Aid Category 69.

**This procedure requires special billing instructions. Refer to Section 292.553.

E. The following procedure code table explains the family planning visit services payable to the hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

F. Effective 1/1/2024, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. See **LARC billing combinations for billing codes**.
4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

G. The following procedure code table explains the pathology procedure code payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 292.552**.

TOC not required

214.330 Family Planning Coverage Information

~~1-15-16~~1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.

C. Nurse practitioners desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age.

D. Nurse practitioners preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Physicians
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians
8. Certified Nurse-Midwives

E. Effective 1/1/2024, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.

3. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. ~~See s~~**See LARC billing combinations for billing codes**.

4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

TOC not required

214.330 Family Planning Coverage Information 1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.

C. Nurse practitioners desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 241.333 to Medicaid beneficiaries of childbearing age.

D. Nurse practitioners preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Physicians
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians
8. Certified Nurse-Midwives

E. Effective 1/1/2024, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for

the LARC device, if provided by the Physician. **See LARC billing combinations for billing codes**.

4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

TOC not required

215.200 Family Planning Coverage Information

~~10-1-15~~1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, certified nurse-midwives, clinics, and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family Planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 215.200 through 215.260 of this manual for service descriptions and coverage information.

C. Certified nurse-midwives desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 215.210 through 215.260, to Medicaid beneficiaries of childbearing age.

D. Certified nurse-midwives preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners
4. Rural Health Clinics.
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians

E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for

the LARC device, if provided by the Physician. ~~See s~~**See LARC billing combinations for billing codes**.

4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 215.200-215.260.

TOC not required

215.200 Family Planning Coverage Information 1-1-24

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, certified nurse-midwives, clinics, and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family Planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 215.200 through 215.260 of this manual for service descriptions and coverage information.

C. Certified nurse-midwives desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 215.210 through 215.260, to Medicaid beneficiaries of childbearing age.

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1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners
4. Rural Health Clinics.
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physicians

E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediatelyafter childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for

the LARC device, if provided by the Physician. **See LARC billing combinations for billing codes**.

4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

F. Complete billing instructions for family planning services are in Sections 215.200-215.260.

TOC not required

216.000 Family Planning

~~10-1-15~~1-1-24

States participating in the Medicaid Program are required to cover family planning services. Arkansas Medicaid covers family planning services in a variety of settings, including hospitals. See Sections 216.100-216.110, 216.130-216.132, 216.515 and 216.540-216.550 for Family Planning Information.

Effective 1/1/2024~~,~~ providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

A. The Hospital should continue to bill the inpatient stay on an i~~I~~npatient claim (CMS-1450, formerly UB-04).

B. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.

C. Physician charges can be billed for insertion and ~~/~~removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. See **~~see~~ LARC billing combinations for billing codes**.

D. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

TOC not required

216.000 Family Planning 1-1-24

States participating in the Medicaid Program are required to cover family planning services. Arkansas Medicaid covers family planning services in a variety of settings, including hospitals. See Sections 216.100-216.110, 216.130-216.132, 216.515 and 216.540-216.550 for Family Planning Information.

Effective 1/1/2024 providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

A. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).

B. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.

C. Physician charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. See **LARC billing combinations for billing codes**.

D. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

1. Inpatient Hospital Services (continued)

Long-Acting Reversible Contraceptives (LARC)

Effective for claims with dates of service on or after January 1, 2024, all acute care hospitals will be reimbursed in addition to the per diem rates for Food and Drug Administration approved Long-Acting Reversible Contraceptives (LARCs) to include the IUD and contraceptive implants, and insertion and removal. LARC reimbursement will be the same as found in Attachment 4.19-B page 1v.

State of Arkansas
94th General Assembly
Regular Session, 2023

A Bill

HOUSE BILL 1385

By: Representatives Vaught, Scott
By: Senators B. Davis, C. Tucker

For An Act To Be Entitled

AN ACT TO ENSURE THAT HEALTHCARE PROVIDERS ARE PROPERLY REIMBURSED BY THE ARKANSAS MEDICAID PROGRAM FOR PROVIDING LONG-ACTING REVERSIBLE CONTRACEPTION IMMEDIATELY AND DURING POSTPARTUM; AND FOR OTHER PURPOSES.

Subtitle

TO ENSURE THAT HEALTHCARE PROVIDERS ARE PROPERLY REIMBURSED BY THE ARKANSAS MEDICAID PROGRAM FOR PROVIDING LONG-ACTING REVERSIBLE CONTRACEPTION IMMEDIATELY AND DURING POSTPARTUM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is amended to add an additional section to read as follows:

20-77-148. Long-acting reversible contraception coverage — Legislative findings.

(a) The General Assembly finds that:

(1) The Arkansas Medicaid Program currently covers long-acting reversible contraception;

(2) Due to the payment model used by the program for coverage of pregnant women, healthcare providers have found that providing long-acting reversible contraception during postpartum is cost prohibitive; and

(3) Action should be taken to ensure that healthcare providers

can provide long-acting reversible contraception during postpartum.

(b)(1) The Arkansas Medicaid Program shall reimburse a healthcare provider for providing long-acting reversible contraception immediately and during postpartum.

(2) Reimbursement under subdivision (b)(1) of this section shall be in addition to the regular payments for services to pregnant women provided by a healthcare provider.

(c) The Department of Human Services shall apply for any federal waiver, Medicaid state plan amendment, or other authorization necessary to implement this section.

APPROVED: 4/11/23

RULES SUBMITTED FOR REPEAL

Rule #1: DDS Policy 1088 – Burial Insurance

Rule #2: DDS Policy 2001 – Building and Contents Insurance Claims

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Administrative	Burial Insurance	1088

1. **Purpose**: The purpose of this policy is to ensure that burial insurance is offered to any person residing in a Human Development Center (HDC) and to ensure that affected DDS community providers are informed about the existence of burial insurance when an individual moves from an HDC to the community.

2. **Scope**: This policy applies to all employees of DDS.

3. **Definitions**:

A. Burial Insurance – An insurance policy purchased by or for an individual specifically for the purpose of providing funds for burial expenses.

B. Consent – Written permission from the decision-maker approving the purchase of a specific benefit amount of burial insurance.

C. Designated staff member – The employee of an HDC who has been specified by the HDC administrator to perform tasks related to burial insurance.

D. Decision-maker – The individual with the legal authority to consent to or refuse the expenditure of funds. This may be an adult individual receiving services, the parent(s) of a minor child receiving services, or an adult individual's legal guardian.

4. **Procedures**:

A. Prior to or upon admission, the designated staff member will request from the individual, the parent(s), a responsible party, or the legal guardian copies of any burial and/or life insurance policies that are in effect for the individual being admitted.

B. Prior to or upon admission, a designated staff member will discuss with the decision maker burial insurance options that are available.

C. If the decision maker decides to purchase burial insurance, the designated staff member will obtain written consent to purchase burial insurance for the individual and will notify the funeral home chosen by the decision maker. Refusal of burial insurance by the decision maker will also be documented.

D. The cost of the burial insurance will be the responsibility of the decision-maker.

Policy Type	Subject of Policy	Policy No.
Administrative	Burial Insurance	1088

E. Information about burial insurance will be presented to the decision maker at least annually, if burial insurance appears to be warranted and the purchase of burial insurance has previously been refused.

F. The funeral home that sells the burial insurance will normally be named as the beneficiary. If the funeral home that sold the policy will not be the funeral home to conduct the burial, and a transfer of benefits from the former funeral home to the latter is not an option, the designated staff member will ask the decision maker to name another beneficiary.

G. Upon the discharge of an individual from an HDC, the designated staff member will provide information for the continuation of burial insurance to the decision maker, the individual's DDS Service Specialist, and to the DDS community provider who will be providing the individual's services.

5. **Record Keeping**:

Written consent forms for the purchase of burial insurance will be completed and placed in the individual's Master File within 15 days of admission or at the time of signing if the burial insurance is purchased at a later date. Copies of all policies will be maintained in the Master File.

Reviewed: Arkansas Legislative Council Administrative (Rules and Regulations) Subcommittee _____ 2003

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Fiscal	Building and Contents Insurance Claims	2001

1. Purpose. This policy has been prepared to explain the real property insurance claim responsibility of the Department of Human Services Division of Developmental Disabilities Services.

2. Scope. This policy concerns all business managers of Developmental Disabilities Services and other interested parties. The DDS Director/designee(s) has responsibility for ensuring compliance.

3. Agency Responsibility. DDS will carry real property insurance on State buildings and certain of their contents held in trust by the DDS Board.

4. Procedural Additions. Procedures for making insurance claims against real property damage are kept in and disseminated by Department of Human Services – Division of Management Services.

REPEAL-EO 23-02

Replacement Notation: This Policy replaces DDS Deputy Director's Office Policy Number 1001 effective October 17, 1979.

Effective Date: March 15, 1993 Sheet 1 of 1

References: Board Action December 15, 1979

Table of Contents

State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 23-0018

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

November 29, 2023
Janet Mann, Director
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

RE: Arkansas State Plan Amendment (SPA) 23-0018

Dear Director Mann:

We have reviewed the proposed amendment to Attachment 4.19-A and of your Medicaid state plan submitted under transmittal number (TN) 23-0018 effective for services on or after January 1, 2024. The proposed amendment will include hospital reimbursement for long acting reversible contraceptives (LARCs).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act. We hereby inform you that Medicaid State plan amendment 23-0018 is approved effective January 1, 2024. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please contact Diana Dinh at Diana.Dinh@cms.hhs.gov.

Sincerely,

Rory Howe

Rory Howe
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0018
2. STATE: AR
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/2024

5. FEDERAL STATUTE/REGULATION CITATION
1905(a)(4)(C)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 1,883,976
b. FFY 2025 $ 2,511,967

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
4.19 A 11ddd

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None - New Page

9. SUBJECT OF AMENDMENT
Hospital Reimbursement for Long Acting Reversible Contraceptives (LARCs)

10. GOVERNOR'S REVIEW *(Check One)*
- [✓] GOVERNOR'S OFFICE REPORTED NO COMMENT
- [ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- [ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- [ ] OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
E. Pitman

12. TYPED NAME
Elizabeth Pitman

13. TITLE
Director, Division of Medical Services

14. DATE SUBMITTED
9-20-23

15. RETURN TO
Office of Rules Promulgation
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attn: Mac Golden

FOR CMS USE ONLY

16. DATE RECEIVED
September 20, 2023

17. DATE APPROVED
November 29, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

1. Inpatient Hospital Services (continued)

Long-Acting Reversible Contraceptives (LARC)

Effective for claims with dates of service on or after January 1, 2024, all acute care hospitals will be reimbursed in addition to the per diem rates for Food and Drug Administration approved Long-Acting Reversible Contraceptives (LARCs) to include the IUD and contraceptive implants, and insertion and removal. LARC reimbursement will be the same as found in Attachment 4.19-B page 1v.

DHS Responses to Public Comments Regarding Hospital Reimbursement for Long Acting Reversible Contraceptives

Ron Cantrell for

Ada Sochanska, MPAS, PA-C

ARAPA President

Comment: The Arkansas Academy of Physician Assistants (ARAPA), on behalf of over 150 Physician Assistants (PAs) throughout Arkansas, appreciates the opportunity to provide comments on amendments associated with Arkansas Regulation 10427: Long Acting Reversible Contraceptives (LARCs). By including PAs in the updated sections, we will further encourage PAs to practice to their full extent and ensure that we are not excluding PAs from important rules or amendments pertaining to medical care.

The updates to Long Acting Reversible Contraceptives (LARCs) gives appropriate information to providers surrounding Medicaid provider manuals and State Plan regarding the rules required to claim reimbursement. However, as of this year, PAs have now been designated both rendering and billing providers by Arkansas Medicaid as per Act 303 (2023) and therefore should be incorporated in further updates.

We would like to draw your attention to section II, Nurse Practitioner, Titled "214.330 Family Planning Coverage Information" and respectfully request the Department to have a section that would refer to PAs. Similar to the Nurse Practitioner Section but retitled to "Physician Assistant".

By creating a section specific to PAs this would mimic the section as it is for "Nurse Practitioners" however, it would include specific language update within Section 214.330 C, to change the title from "Nurse Practitioners" to "Physician Assistants" and similarly in section D, update that to state "Physician Assistants". Further in section D, this would include the addition of a bullet title "Nurse Practitioners" and to include them as providers that Physician Assistants would be able to refer patients to.

In light of these changes, ARAPA also requests updating the Nurse Practitioner Section II "214.330 Family Planning Coverage Information" section D to include Physician Assistants as referring providers. In addition, updating the Certified Nurse Midwife Section II "215.220 Family Planning Coverage Information" section D to include Physician Assistants as referring providers.

We thank you for your consideration.

Response: DMS is preparing a separate promulgation related to ACT 303 which will include Medicaid manual revisions for physician assistants. We will review your comments as we draft those proposed rules and look forward to receiving further comments during the promulgation process.