EXHIBIT D

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Medication Assisted Treatment (MAT) and OTC (Over the Counter) Updates & REPEALS: PUB 85 – Differential Response: A Family-Centered Approach to Strengthen and Support Families; PUB 357 – Child Maltreatment Investigation Determination Guide

DESCRIPTION:

Statement of Necessity

The Substance Abuse and Mental Health Services Administration (SAMHSA) introduced new regulations pursuant to Section 1262 of the Consolidated Appropriations Act of 2023 (also known as the Omnibus bill). The purpose of the regulations is to remove barriers in Medication Assisted Treatment (MAT) for individuals with Opioid Use Disorders (OUD) and substance use disorders (SUD).

The regulation necessitating change removes the federal requirement that practitioners submit a Notice of Intent (X-Waiver) to prescribe medications for MAT services. All practitioners who have a current Drug Enforcement Administration (DEA) registration may now prescribe and treat OUD and SUD in their practice if permitted by applicable state law.

The 94th General Assembly of the Arkansas State Legislature passed Act 451 and Act 586. Act 451 states a healthcare insurer shall not require prior authorization or impose any other requirement other than a valid prescription and compliance with MAT services for the medication treatment of opioid and alcohol addiction. Act 451 also removed "oral" prescription drugs and included all drugs for MAT, even injectables. The alcohol use disorder diagnosis was mandated by Act 451 and prohibits prior authorization or slot limits to be applied to the prescriptions used for AUD when part of a MAT program. Therefore, the AUD diagnosis was listed in the exceptions for prescriptions, but not the exceptions for other MAT services such as lab/x-ray, office visit limits, etc. The opioid use disorder diagnosis exceptions were mandated at the federal level. Finally, Act 586 amends access to Naloxone and increases availability and access of an opioid antagonist.

Based on the new SAMHSA regulations and state legislation, the Division of Medical Services is updating provider manuals and the Medicaid state plan to show compliance and agreement with new resources available to assist in decreasing and treating OUD, SUD, and AUD (Alcohol Use Disorder) for individuals in need of MAT services.

PUBLIC COMMENT: A public hearing was held on this rule on October 18, 2023. The public comment period expired on October 22, 2023. The agency indicated that it received no public comments.

The proposed effective date is pending legislative review and approval.

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

Per the agency, this rule implements a federal rule or regulation. The total estimated cost to implement the federal rule or regulation is $720,000 for the current fiscal year ($201,600 in general revenue and $518,400 in federal funds) and $960,000 for the next fiscal year ($268,800 in general revenue and $691,200 in federal funds). The total estimated cost to state, county, and local government as a result of this rule is $201,600 for the current fiscal year and $268,800 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 implement rules in compliance with the Substance Abuse and Mental Health Services Administration (SAMHSA) introduced new regulations pursuant to Section 1262 of the Consolidated Appropriations Act of 2023 (also known as the Omnibus bill), and Acts 451 and 586 of the 94th General Assembly.

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

The purpose is to remove barriers in Medication Assisted Treatment (MAT) for individuals with Opioid Use Disorders (OUD) and substance use disorders (SUD). Act 451 states a healthcare insurer shall not require prior authorization or impose any other requirement other than a valid prescription and compliance with MAT services for the medication treatment of opioid and alcohol addiction. Act 451 also removed "oral" prescription drugs and included all drugs for MAT, even injectables. The alcohol use disorder diagnosis was mandated by Act 451 and prohibits prior authorization or slot limits to be applied to the prescriptions used for AUD when part of a MAT program. Therefore, the AUD diagnosis was listed in the exceptions for prescriptions, but not the exceptions for other MAT services such as lab/x-ray, office visit limits, etc. The opioid use disorder diagnosis exceptions were mandated at the federal level. Finally, Act 586 amends access to Naloxone and increases availability and access of an opioid antagonist.

(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;

N/A

(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 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 Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Acts 451 and 586 of 2023. This rule also implements the federal Restoring Hope for Mental Health and Well-Being Act of 2022, which is part of the Consolidated Appropriations Act, 2023.

Act 451, sponsored by Representative Aaron Pilkington, amended the Prior Authorization Transparency Act and modified medication-assisted treatment under the Prior Authorization Transparency Act.

Act 586, sponsored by Representative Bart Schulz, amended the Naloxone Access Act and increased availability and accessibility of an opioid antagonist.

The Restoring Hope for Mental Health and Well-Being Act of 2022, contained within the Consolidated Appropriations Act, 2023, eliminated additional requirements for dispensing narcotic drugs in Schedule III, IV, or V for maintenance or detoxification treatment. *See* 21 U.S.C. § 823(g), *as amended by* Restoring Hope for Mental Health and Well-Being Act of 2022, § 1262(a), 136 Stat. 5681.

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: Medication Assisted Treatment (MAT) and Over the Counter (OTC) Updates

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?
Medication Assisted Treatment (MAT) and OTC (Over the Counter) updates

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.

Section 1262 of the Consolidated Appropriations Act of 2023

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.

Acts 451 and 586 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) PUB 85: Differential Response: A Family-Centered Approach to Strengthen and Support Families; and
(2) PUB 357: Child Maltreatment Investigation Determination Guide.

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).

Acts 451 and 586 of 2023

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

See Attached.

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: 10/18/2023

Time: 10:00 am

Place: https://us02web.zoom.us/j/85614025009 Webinar ID: 856 1402 5009

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? February 1, 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.

Unknown

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

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129. The expected effective date of the state promulgation of the rule is January 1, 2024. DHS requests approval of the state plan amendment by the Centers for Medicare and Medicaid Services to be retroactive to October 1, 2023.

The Director of the Division of Medical Services amends Section I of the Provider Manuals and Section II of the following provider manuals: Federally Qualified Health Center, Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD), Rural Health Clinic, Physician/Independent Lab/CRNA/Radiation Therapy Center, Counseling Services, Nurse Practitioner, and Pharmacy, as well the Medicaid State Plan to comply with Acts 451 and 586 of the 94th General Assembly and Section 1262 of the Consolidated Appropriations Act of 2023. The manual and the state plan amendments show compliance and agreement with new resources available to assist in decreasing and treating Opioid Use Disorders (OUD), substance use disorders (SUD), and AUD (Alcohol Use Disorder) for individuals in need of Medication Assisted Treatment (MAT) services. The rule removes the requirement for practitioners to submit a Notice of Intent (X-Waiver) to prescribe medications for MAT services and removes any prior authorization and any other requirements other than a valid prescription and compliance with MAT services for the medication treatment of opioid and alcohol addiction. Act 451 also removed "oral" prescription drugs and included all drugs for MAT, even injectables. The alcohol use disorder diagnosis was mandated by Act 451 and prohibits prior authorization or slot limits to be applied to the prescriptions used for AUD when part of a MAT program. Therefore, the AUD diagnosis was listed in the exceptions for prescriptions, but not the exceptions for other MAT services such as lab/x-ray, office visit limits, etc. The opioid use disorder diagnosis exceptions were mandated at the federal level. Also, the rule amends access to Naloxone and increases availability and access of an opioid antagonist.

The proposed rule estimates a financial impact of $720,000 ($518,400 of which is federal funds) for state fiscal year (SYF) 2024 and $960,000 ($691,200 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) PUB 85: Differential Response: A Family-Centered Approach to Strengthen and Support Families; and (2) PUB 357: Child Maltreatment Investigation Determination Guide.

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.

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 18th @10:00 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/85614025009. The webinar ID is 856 1402 5009. 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) 320-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502172997

Elizabeth Pitman, Director
Division of Medical Services

From: legalads@arkansasonline.com
To: Renita Jones
Subject: Re: Full Run AD - Medication-Assisted Treatment (MAT) Services (Rule #237)
Date: Wednesday, September 20, 2023 1:22:32 PM
Attachments: image001.png
image002.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: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Renita Jones" <Renita.Jones@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Simone Blagg, DHS" <Simone.A.Blagg@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Tuesday, September 19, 2023 11:29:41 AM
Subject: Full Run AD - Medication-Assisted Treatment (MAT) Services (Rule #237)

Good morning,

Please run the attached public notice on **Saturday, September 23rd**, **Sunday, September 24th**, and **Monday, September 25th**. I am aware that the print version will only be provided to all counties on Sundays. Please let me know if you have any questions or concerns. Please reply to this email using REPLY ALL.

Please 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

Thank you,
DHS

Renita Jones
Office of Legislative & Intergovernmental Affairs
Office of Rules Promulgation
Program Administrator

P: 501.320.3949
F: 501.404.4619
700 Main St.
Little Rock, AR 72203
Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

Renita Jones

To:	register@sos.arkansas.gov
Cc:	Renita Jones; Mac Golden; Jack Tiner; Simone Blagg (DHS); JAMIE EWING; Lakeya Gipson; Cynthia Neuhofel
Subject:	DHS/DMS - Proposed Filing - Medication-Assisted Treatment (MAT) Services (Rule # 237)
Attachments:	Sec of State - Initial Filing - Rule #237 MAT.pdf

Good morning,

Please see attached for initial filing. This rule will run in the newspaper Saturday, September 23rd, Sunday, September 24th and Monday, September 25th. The public comment period ends October 22, 2023. Please let me know if you have any questions.

Thank you,

DHS

Renita Jones
Office of Legislative & Intergovernmental Affairs
Office of Rules Promulgation
Program Administrator

P: 501.320.3949
F: 501.404.4619
700 Main St.
Little Rock, AR 72203
Renita.Jones@dhs.arkansas.gov

humanservices.arkansas.gov

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT 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 Medication Assisted Treatment (MAT) and OTC (Over the Counter)

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

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

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

   If no, please explain:

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

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

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

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

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

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

Current Fiscal Year

General Revenue 201,600
Federal Funds 518,400
Cash Funds
Special Revenue
Other (Identify)

Total $ 720,000.00

Next Fiscal Year

General Revenue 268,800
Federal Funds 691,200
Cash Funds
Special Revenue
Other (Identify)

Total $ 960,000.00

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

Current Fiscal Year

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

Total $ 0.00

Next Fiscal Year

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

Total $ 0.00

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
$ 201,600.00

Next Fiscal Year
$ 268,800.00

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-Medication Assisted Treatment

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: **To implements rules in compliance with the Substance Abuse and Mental Health Services Administration (SAMHSA) introduced new regulations pursuant to Section 1262 of the Consolidated Appropriations Act of 2023 (also known as the Omnibus bill), and Acts 451 and 586 of the 94th General Assembly.**

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute: **See federal and state statutory reference above. The purpose is to remove barriers in Medication Assisted Treatment (MAT) for individuals with Opioid Use Disorders (OUD) and substance use disorders (SUD). Act 451 states a healthcare insurer shall not require prior authorization or impose any other requirement other than a valid prescription and compliance with MAT services for the medication treatment of opioid and alcohol addiction. Act 451 also removed "oral" prescription drugs and included all drugs for MAT, even injectables. The alcohol use disorder diagnosis was mandated by Act 451 and prohibits prior authorization or slot limits to be applied to the prescriptions used for AUD when part of a MAT program. Therefore, the AUD diagnosis was listed in the exceptions for prescriptions, but not the exceptions for other MAT services such as lab/x-ray, office visit limits, etc. The opioid use disorder diagnosis exceptions were mandated at the federal level. Finally, Act 586 amends access to Naloxone and increases availability and access of an opioid antagonist.**

(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; **N/A**

(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 cost.**

Statement of Necessity and Rule Summary
Medication-Assisted Treatment (MAT) Services

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

The Substance Abuse and Mental Health Services Administration (SAMHSA) introduced new regulations pursuant to Section 1262 of the Consolidated Appropriations Act of 2023 (also known as the Omnibus bill). The purpose of the regulations is to remove barriers in Medication Assisted Treatment (MAT) for individuals with Opioid Use Disorders (OUD) and substance use disorders (SUD).

The regulation necessitating change removes the federal requirement that practitioners submit a Notice of Intent (X-Waiver) to prescribe medications for MAT services. All practitioners who have a current Drug Enforcement Administration (DEA) registration may now prescribe and treat OUD and SUD in their practice if permitted by applicable state law.

The 94th General Assembly of the Arkansas State Legislature passed Act 451 and Act 586. Act 451 states a healthcare insurer shall not require prior authorization or impose any other requirement other than a valid prescription and compliance with MAT services for the medication treatment of opioid and alcohol addiction. Act 451 also removed "oral" prescription drugs and included all drugs for MAT, even injectables. The alcohol use disorder diagnosis was mandated by Act 451 and prohibits prior authorization or slot limits to be applied to the prescriptions used for AUD when part of a MAT program. Therefore, the AUD diagnosis was listed in the exceptions for prescriptions, but not the exceptions for other MAT services such as lab/x-ray, office visit limits, etc. The opioid use disorder diagnosis exceptions were mandated at the federal level. Finally, Act 586 amends access to Naloxone and increases availability and access of an opioid antagonist.

Based on the new SAMHSA regulations and state legislation, the Division of Medical Services is updating provider manuals and the Medicaid state plan to show compliance and agreement with new resources available to assist in decreasing and treating OUD, SUD, and AUD (Alcohol Use Disorder) for individuals in need of MAT services.

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

<u>Provider manual changes:</u>

General Section I

- 172.100 – Updated sentence by deleting reference to an X-DEA waivered provider.

Federally Qualified Health Center

- 212.220 and 220.000 – Updated sections to reflect current MAT coverage requirements.

Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)

- 272.501 - Updated section to reflect current MAT coverage requirements.

Rural Health Clinic

- 211.100 and 218.100 - Updated sections to reflect current MAT coverage requirements by removing references to X-DEA waivered providers.

Physician/Independent Lab/CRNA/Radiation Therapy Center

- 201.500, 201.510, 201.520, 203.271, 263.100, and 292.920 - Updated sections to reflect current MAT coverage requirements.

Counseling Services

- 214.200 - Updated section to reflect current MAT coverage requirements.

Nurse Practitioner

- 252.448- -Updated section to reflect current MAT coverage requirements.

Pharmacy

211.105, 212.000, and 213.100, - Updated sections to reflect current MAT coverage requirements.

Medicaid State Plan Amendment (SPA) pages:

Attachment 3.1-A, Page 1d

- Updated sentence by deleting reference to an X-DEA waivered provider.

Attachment 3.1-A, Page 1ee

- Deleted reference to an X-DEA waivered provider throughout page.

Attachment 3.1-A, Page 1f

- Deleted, "…ordered by an X-DEA waivered provider as…"

Attachment 3.1-A, Page 5a

- Updated sentence by deleting "…oral…", adding "…or alcohol…", deleting reference to an X-DEA waivered provider, and correcting spelling of hypercholesterolemia.
- Deleted named drugs throughout the page.
- Deleted sentence that read, "e. non-prescription products for smoking cessation."

Attachment 3.1-B, Page 2a

- Deleted, "…by an X-DEA waivered provider…"

Attachment 3.1-B, Page 2d

- Updated sentence by deleting reference to an X-DEA waivered provider.

Attachment 3.1-B, Page 2ee

- Deleted reference to an X-DEA waivered provider throughout page.

Attachment 3.1-B, Page 2f

- Deleted, "…ordered by an X-DEA waivered provider as…"

Attachment 3.1-B, Page 2xxx

- Updated sentence by deleting "…oral…", adding "…or alcohol…", and deleting reference to an X-DEA waivered provider.

Attachment 3.1-B, Page 4g

- Updated sentence by deleting "…oral…", adding "…or alcohol…", deleting reference to an X-DEA waivered provider, and correcting spelling of hypercholesterolemia.
- Deleted named drugs throughout the page.
- Deleted sentence that read, "e. non-prescription products for smoking cessation."

Attachment 3.1-F, Page 29

- Deleted reference to an X-DEA waivered provider.

Supplement 5 to Attachment 3.1-A

- Added "…and alcohol use disorder (AUD)…"
- Deleted reference to an X-DEA number requirement throughout page.
- Deleted the word "oral".
- Updated to reflect MAT services do not require a prior authorization.

Supplement 1 to Attachment 3.1 B

- Added "…and alcohol use disorder (AUD)…"
- Deleted reference to an X-DEA number requirement throughout page.
- Deleted the word "oral".
- Updated to reflect MAT services do not require a prior authorization.

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

(1) PUB 85: Differential Response: A Family-Centered Approach to Strengthen and Support Families; and
(2) PUB 357: Child Maltreatment Investigation Determination Guide.

Please attach additional documents if necessary

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure**;** opioid use disorder when the visit is ~~rendered by an X-DEA waivered provider as~~ part of a Medication Assisted Treatment Plan**;** and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

CATEOGORICALLY NEEDY

2.b. Rural Health Clinic Services

5. Services of nurse midwives

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is ~~rendered by an X-DEA waivered provider as~~ part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4).

Federally qualified health center services are limited to sixteen (16) encounters per client**,** per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

For federally qualified health center core services beyond the benefit limit, extensions will be available if medically necessary. Beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is ~~rendered by an X-DEA waivered provider as~~ part of a Medication Assisted Treatment plan.

CATEGORICALLY NEEDY

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3. Other Laboratory and X-Ray Services

Other medically necessary diagnostic laboratory or radiology/other services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory **s**ervices benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY**,** July 1 – June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services health benefit limit**s: (**a**)** Malignant neoplasm; **(**b**)** HIV infection; and **(c)** renal failure. The cost of related diagnostic laboratory services, and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limits or the five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD)**,** and the screening is ~~ordered by an X-DEA-waivered provider as~~ part of a Medication Assisted Treatment **(**MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory services health benefit limit.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per SFY outpatient diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY radiology/other services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their place of residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per **S**FY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation, ~~oral~~ prescription drugs for opioid **or alcohol** use disorder ~~prescribed by an X-DEA-waivered provider~~ as part of a Medication Assisted Treatment plan, EPSDT, high blood pressure, ~~hypercholesteriolemia~~**hypercholesterolemia**, blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the Arkansas Medicaid Pharmacy Vendor's Website, are covered:

a. select agents when used for weight gain~~:~~
~~Androgenic Agents;~~

b. select agents when used for the symptomatic relief of cough and colds~~:~~
~~Antitussives; Antitussive Decongestants; and Antitussive Expectorants;~~

c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride~~:~~
~~B-12; Folic Acid; and Vitamin K;~~

d. select nonprescription drugs~~:~~
~~Antiarthritics; Antibacterials and Antiseptics; Antitussives; Antitussives Expectorants; Analgesics; Antipyretics; Antacids; Antihistamines; Antihistamine Decongestants; Antiemetic/Vertigo Agents; Gastrointestinal Agents; Hematinics; Laxatives; Opthalmic Agents; Sympathomimetics; Topical Antibiotics; Topical Antifungals; Topical Antiparasitics; and Vaginal Antifungals; and~~

~~non-prescription products for smoking cessation.~~

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a seventy-two (72) hour supply of drugs in emergency situations.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):

4.d. Tobacco cessation counseling services for pregnant women

☒ Provided: ☐ No limitations ☒ with limitations*

e. Medication-Assisted Treatment for opioid use disorders when provided ~~by an X-DEA waivered provider~~ as part of a Medication Assisted Treatment plan

☒ Provided: ☐ No limitations ☒ with limitations*

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

☒ Provided: ☐ No limitations ☒ with limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

☒ Provided: ☐ No limitations ☒ with limitations*

*Description provided on attachment.

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; opioid use disorder when the visit is ~~rendered by an X-DEA waivered provider as~~ part of a Medication Assisted Treatment plan, and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.b. Rural Health Clinic Services

5. Services of nurse midwives; and

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is ~~rendered by an X-DEA waivered provider as~~ part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) NCFA – Pub. 45-4).

Federally qualified health center services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

Benefit extensions will be available if medically necessary. Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is ~~rendered by an X-DEA waivered provider as~~ part of a Medication Assisted Treatment plan.

3. Other Laboratory and X-Ray Services

Other medically necessary diagnostic laboratory or radiology/other services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services health benefit limits: (a) Malignant neoplasm; (b) HIV infection; and (c) renal failure. The cost of related diagnostic laboratory services and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD), and the screening is ~~ordered by an X-DEA-waivered provider as~~ part of a Medication Assisted Treatment (MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory or radiology/other services health benefit limits.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **S**FY outpatient diagnostic laboratory services benefit limit or five hundred dollars ($500) per SFY radiology/other services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY X-ray services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per SFY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided

4.c. Family Planning Services

(1) Comprehensive family planning services are limited to an original examination and up to three (3) follow-up visits annually. This limit is based on the state fiscal year (July 1 through June 30).

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

*describe if there are any limits on who can provide these counseling services

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations [X] With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

Please describe any limitations:

Face-to-face tobacco cessation counseling services are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per state fiscal year.

4.e. Prescription drugs for treatment of opioid use disorder **or alcohol use disorder**

a. ~~Oral p~~**P**referred prescription drugs (preferred on the PDL) used for treatment of opioid **or alcohol** use disorder require no prior authorization and do not count against the monthly prescription limits when prescribed ~~by an X-DEA-waivered provider~~ as part of a Medication Assisted Treatment plan.

5.a. Physicians' services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere

(1) Physicians' services in a physician's office, patient's home, or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age twenty-one (21) and older.

MEDICALLY NEEDY

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation, ~~oral~~ prescription drugs for opioid **or alcohol** use disorder when ~~prescribed by an X-DEA waivered provider as~~ part of a Medication Assisted Treatment plan, EPSDT , high blood pressure, ~~hypercholesteriolemia~~**hypercholesterolemia**, blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the **Arkansas Medicaid Pharmacy Vendor's Website**, are covered:

a. select agents when used for weight gain:
~~Androgenic Agents;~~
b. select agents when used for the symptomatic relief of cough and colds:
~~Antitussives; Antitussive-Decongestants; and Antitussive-Expectorants;~~
c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
~~B-12; Folic Acid; and Vitamin K;~~
d. select nonprescription drugs:
~~Antiarthritics; Antibacterials and Antiseptics; Antitussives; Antitussives-Expectorants; Analgesics; Antipyretics; Antacids; Antihistamines; Antihistamine-Decongestants; Antiemetic/Vertigo Agents; Gastrointestinal Agents; Hematinics; Laxatives; Opthalmic Agents; Sympathomimetics; Topical Antibiotics; Topical Antifungals; Topical Antiparasities; and Vaginal Antifungals; and~~
~~e. non-prescription products for smoking cessation.~~

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991, will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72-hour supply of drugs in emergency situations.

State: ARKANSAS

Citation	Condition or Requirement

1. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
CFR 438.50
42 CFR 438.10

X The state assures that its state plan program complies with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
Developmental Disabilities Services Community and Employment Support
Family Planning
Anesthesia
Alternative Waiver Programs
Adult Developmental Day Treatment Services Core Services only
Disease Control Services for Communicable Diseases
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Medication-Assisted Treatment Services for opioid use disorder when ~~rendered by X DEA waivered provider as~~ part of a Medication Assisted Treatment plan
Mental health services as follows:
a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. Rehabilitative Services for Youth and Children
Nurse Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, delivery, and postpartum) services
Pharmacy
Physician Services for inpatients acute care
Transportation

State of Arkansas

1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1(b)(1) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(a)(29) __X___MAT as described and limited in Supplement 1 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to the medically needy.

State of Arkansas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid clients who meet the medical necessity criteria for receipt of the service for the period beginning October1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for opioid use disorder (OUD) and alcohol use disorder (AUD) that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

State of Arkansas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT is covered exclusively under section 1905(a)(29) for the period of 10/01/2020 through 9/30/2025.

Services available:

1. Individual Behavioral Health Counseling
2. Group Behavioral Health Counseling
3. Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

b) Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants and Nurse Practitioners ~~who possess a valid and current X-DEA identification number. These practitioners~~ may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT). This group's role is to provide the behavioral and substance use disorder counseling required.

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Arkansas Licensed ~~and possess a current and valid X-DEA number from Substance Abuse and Mental Health Administration (SAMHSA)~~.

Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute ~~and possess a current and valid X-DEA number from SAMHSA~~.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)
_____ Generic first policy
__X__ Preferred drug lists
_____ Clinical criteria
__X__ Quantity limits
_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT drugs and biologicals are limited based on the FDA indication and manufacturers' prescribing guidelines. Some ~~oral~~ medications are also subject to status on the Preferred Drug List (PDL).

~~As of 1/1/2020~~ T~~t~~he preferred (PDL) ~~oral~~ agents for MAT therapy do not ~~no longer~~ require a PA.

The Arkansas Medicaid Pharmacy program removed the prior authorization for preferred Buprenorphine products on 1/1/2020, due to Arkansas State Law from Act 964 which prohibits a prior authorization for Medication Assisted Treatment of Opioid Use Disorder. The removal of prior authorization was for MAT treatment according to SAMHSA guidelines. In addition, on 1/22/2021, per section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), for all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to be covered, Arkansas instructed the pharmacy vendor to bypass the non-rebate-participation, repackaged indicator, inner indicator, and prioritize coverage of all the pharmacy MAT products.

Also, as of 10/1/2023 due to Arkansas State Law from Act 451 of 2023, preferred (PDL) injectable medications for the treatment or detoxification of opioid and alcohol addiction no longer require a prior authorization.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) ___X__MAT as described and limited in Supplement __5__ to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid clients who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone, all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for o~~O~~pioid u~~U~~se d~~D~~isorder (OUD) **and alcohol use disorder (AUD)** that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT is covered exclusively under section 1905(a)(29) for the period of 10/01/2020 through 9/30/2025.

Services available:

1. Individual Behavioral Health Counseling
2. Group Behavioral Health Counseling
3. Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

b) Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants, and Nurse Practitioners ~~who possess a valid and current X-DEA identification number. These practitioners~~ may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT), This group's role is to provide the behavioral and substance use disorder counseling required

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training, and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Arkansas Licensed ~~and possess a current and valid X-DEA number from Substance Abuse and Mental Health Services Administration (SAMHSA)~~.

Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute ~~and possess a current and valid X-DEA number from SAMHSA~~.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

iv. Utilization Controls

__X___ The state has drug utilization controls in place. (Check each of the following that apply)
_____ Generic first policy
___X__ Preferred drug lists
_____ Clinical criteria
___X__ Quantity limits
_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT drugs and biologicals are limited based on the FDA indication and manufacturers' prescribing guidelines. Some ~~oral~~ medications are also subject to status on the Preferred Drug List **(PDL)**.
~~As of 1/1/2020 T~~the preferred **(PDL)** ~~oral~~ agents for MAT therapy **do not** ~~no longer~~ require a Prior Authorization.

The Arkansas Medicaid Pharmacy program removed the prior authorization for preferred Buprenorphine products on 1/1/2020, due to Arkansas State Law from Act 964 which prohibits a prior authorization for Medication Assisted Treatment of Opioid Use Disorder. The removal of prior authorization was for MAT treatment according to SAMHSA guidelines. In addition, on 1/22/2021, per section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), for all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to be covered, Arkansas instructed the pharmacy vendor to bypass the non-rebate-participation, repackaged indicator, inner indicator, and prioritize coverage of all the pharmacy MAT products. **Also, as of 10/1/2023 due to Arkansas State Law from Act 451 of 2023, preferred (PDL) injectable medications for the treatment or detoxification of opioid and alcohol addiction no longer require a prior authorization.**

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TOC- required

214.200 Medication Assisted Treatment and Opioid Use Disorder or Alcohol Use Disorder Treatment Drugs

~~12~~-1-~~23~~4

~~Effective for dates of service on and after September 1, 2020,~~ Medication Assisted Treatment for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid ~~clients~~ beneficiaries.~~when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes.~~ All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

TOC not required

212.220 Services Furnished in Collaboration with a Physician

~~9-1-20~~2-1-24

Nurse practitioner services are performed in collaboration with a physician or physicians.

A. Collaboration is a process in which a nurse practitioner works with one (1) or more physicians to deliver health care services within the scope of the practitioner~~"~~s expertise, with medical direction, and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by State law.

B. The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.

C. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders~~: Effective dates of service on and after **September 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders~~ is available to all qualifying Medicaid beneficiaries~~ when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes~~. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

220.000 Benefit Limits

~~7-1-22~~2-1-24

A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient's home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; and
7. Advanced practice registered nurse services in the office, patient's home, or nursing facility.

B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:

1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.
2. Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.
3. Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.

4. Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis (**View ICD OUD Codes**). ~~and rendered by a MAT specialty prescriber.~~

C. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

TOC required

272.501 Medication Assisted Treatment and Opioid or Alcohol Use Disorder Treatment Drugs

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

~~Effective for dates of service on and after **September 1, 2020**,~~ Medication Assisted Treatment for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. ~~when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes.~~ All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2023~~18~~**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

TOC required

252.448 Medication Assisted Treatment and Opioid or Alcohol Use Disorder Treatment Drugs

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

~~Effective for dates of service on and after **September 1, 2020**,~~ Medication Assisted Treatment for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. ~~when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes.~~ All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2023~~18~~**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Nurse Practitioner services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

TOC required

211.105 Coverage of Medication Assisted Treatment and Opioid Use Disorder or Alcohol Use Disorder Treatment Drugs

~~9-1-20~~2-1-24

~~Effective for claims with dates of service on or after **January 1, 2020**, c~~Coverage of preferred ~~oral~~ prescription drugs (preferred on the PDL) for opioid or alcohol use disorder are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the **DHS contracted Pharmacy vendor's website**.

Coverage and Limitations

A. Reimbursement for preferred ~~oral~~ drugs is available with a valid prescription when prescribed according to FDA approved label.~~and compliance with the guidelines issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) for eligible Medicaid beneficiaries. Additional SAMHSA information is available at **https://www.samhsa.gov/**.~~

B. ~~Oral p~~Prescription drugs will not count against the monthly prescription benefit limit and are not subject to co-pay when used for a primary diagnosis of opioid or alcohol use disorder.

~~C. Injectable opioid use disorder treatment drugs will require a prior authorization. The criteria can be found at the **DHS contracted Pharmacy vendor's website**.~~

~~D~~C. FDA dosing and prescribing limitations apply.

212.000 Exclusions

~~8-1-21~~2-1-24

A. Products manufactured by non-rebating pharmaceutical companies.

B. Effective January 1, 2006, the Medicaid agency will not cover any drug covered by Medicare Part D for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

C. The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid beneficiaries under § 1927 (d) of the Social Security Act, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses; with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR § 423.104 (f) (1) (ii) (A),to full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

The following excluded drugs are set forth on the **DHS Contracted Pharmacy Vendor website.**

1. Select agents when used for weight gain
2. Select agents when used for the symptomatic relief of cough and colds
3. Select prescription vitamins and mineral products, except prenatal vitamins and fluoride
4. Select nonprescription drugs
5. ~~Select agents when used to promote smoking cessation~~

D. Medical accessories are not covered under the Arkansas Medicaid Pharmacy Program. Typical examples of medical accessories are atomizers, nebulizers, hot water bottles, fountain syringes, ice bags and caps, urinals, bedpans, glucose monitoring devices and

supplies, cotton, gauze and bandages, wheelchairs, crutches, braces, supports, diapers, and nutritional products.

213.100 Monthly Prescription Limits

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

A. Each prescription for all Medicaid-eligible clients may be filled for up to a maximum thirty-one-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum thirty-one-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding thirty-one (31) days, the days' supply limit (other than thirty-one (31)), as approved by the agency, will be allowed for claims processing. Contact the Pharmacy Help Desk to inquire about specific days' supply limits on specially packaged dosage units.

View or print the contact information for the DHS contracted Pharmacy vendor.

B. Each Medicaid-eligible client twenty-one (21) years of age and older is limited to six (6) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. Including without limitation, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics, and diaphragms;
2. Prescriptions for Medicaid-eligible long-term care facility residents(must be for Medicaid-covered drugs);
3. Prescriptions for Medicaid-eligible clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. (must be for Medicaid-covered drugs);
4. Prescriptions for opioid or alcohol use disorder treatment ~~when used according to SAMHSA guidelines~~;
5. Prescriptions for tobacco cessation products;
6. Prescriptions for the treatment of high blood pressure;
7. Prescriptions for the treatment of hypercholesterolemia;
8. Blood modifier medications;
9. Prescriptions for the treatment of diabetes; and
10. Inhalers to treat respiratory illness.

C. Living Choices Assisted Living Program clients are eligible for up to nine (9) medically necessary prescriptions per month.

D. After the client has received the maximum monthly benefit or the maximum monthly extended benefit, they will be responsible for paying for their own medications for the remainder of the month.

TOC required

201.500 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder

~~9-1-20~~21-1-24

Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder must be licensed in Arkansas and be enrolled ~~have a current X-DEA identification number on file~~ with Arkansas Medicaid.

201.510 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder in Arkansas and Bordering States

~~9-1-20~~21-1-24

Providers of MAT in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may be included as routine services providers if they meet all participation requirements for enrollment in Arkansas Medicaid and requirements outlined in Section 201.500.

Reimbursement may be available for MAT covered in the Arkansas Medicaid Program when treating Opioid or Alcohol Use Disorders. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.520 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder in States Not Bordering Arkansas

~~9-1-20~~21-1-24

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid Program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

   To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit contact information.**

B. Limited services providers remain enrolled for one (1) year.

   1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.

   2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

203.271 Medication-Assisted Treatment Provider Role for Administering Opioid or Alcohol Use Disorder Services

~~9-1-20~~21-1-24

SAMHSA defines Medication Assisted Treatment (MAT) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery. This definition and other MAT guidelines can be found at the **SAMHSA website**.

Only providers who have met the requirements of Section 201.500 may prescribe medication required for the treatment of ~~o~~Opioid or Alcohol ~~u~~Use ~~d~~Disorder for Arkansas Medicaid beneficiaries in conjunction with coordinating all follow-up and referrals for counseling and other services. This program applies only to prescribers of FDA-approved drugs for treatment of Opioid or Alcohol Use Disorder and will not be reimbursed for the practice of pain management.

263.100 Coverage of ~~Oral~~ Drugs Used for Opioid or Alcohol Use Treatment ~~9-1-202~~-1-24

~~Effective for claims with dates of service on or after **January 1, 2020**,~~ ~~c~~Coverage of preferred ~~oral~~ prescription drugs (preferred on the PDL) for opioid or alcohol use disorder and tobacco cessation are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the **DHS contracted Pharmacy vendor's website.**

Coverage and Limitations

A. Reimbursement for preferred ~~oral~~ drugs is available with a valid prescription when prescribed according to FDA approved label.~~and compliance with the guidelines issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) for eligible Medicaid beneficiaries. Additional SAMHSA information is available at **https://www.samhsa.gov/.**~~

B. Prescription drugs for treatment of opioid or alcohol use disorder will not count against the monthly prescription benefit limit and are not subject to co-pay.

~~C. Injectable products will require a prior authorization. The criteria can be found at the **DHS contracted Pharmacy vendor's website.**~~

~~D~~C. FDA dosing and prescribing limitations apply.

292.920 Medication Assisted Treatment (MAT) for Opioid Use Disorder ~~2-1-222~~-1-24

There are two (2) methods of billing for MAT.

1. Method 1- Inclusive Rate
   a. The inclusive method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 are provided on the same date of service by the same billing group ~~who has at least one (1) performing provider with an X-DEA number on file with Arkansas Medicaid~~.
      i. For new patients, the provider group shall use HCPCS code, modifier X2 and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all services (Office Visit, counseling, case management, medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.
      ii. For established patients requiring continuing follow-up MAT treatment, the provider group shall use HCPCS code, modifiers U8, X2, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.
      iii. For established patients requiring maintenance follow-up MAT treatment, the

provider group shall use HCPCS code, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.

iv. The specific HCPCS code and modifiers found in the following link are required for billing the inclusive rate. **View or print the procedure codes and modifiers for MAT services**.

2. Method 2 – Regular Fee-for-Service Rates

a. The regular Fee-for-Service method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 cannot be provided on the same date of service, or cannot be provided by the same billing group who has the MAT specialized performing provider; therefore, causing some SAMHSA guideline services to be referred elsewhere.

i. For new patients, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

ii. For established patients requiring continuing treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

iii. For established patients requiring maintenance treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X4, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X4 modifier for the screenings required.

Allowable ICD-10 codes for Opioid Use Disorder may be found here: (**View ICD OUD Codes.**)

Allowable lab and screening codes may be found here: (**View Lab and Screening Codes**.)

Providers utilizing telemedicine, regardless of Method, shall adhere to telemedicine rules listed in Sections 105.190 and 305.000 in addition to those above. The provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.

TOC not required

211.100 Rural Health Clinic Core Services

~~9-1-20~~2-1-24

Rural Health Clinic core services are as follows:

A. Professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;

B. Services and supplies furnished "incident to" a physician's professional services;

C. Services provided by non-physician, services of physician assistants, nurse practitioners, nurse midwives, and specialized nurse practitioners when the provider is legally:

1. employed by, or receiving compensation from a rural health clinic;
2. under the medical supervision of a physician;
3. acting in accordance with any medical orders for the care and treatment of a patient prepared by a physician; and
4. acting within their scope of practice by providing services they are legally permitted to perform by the state in which the service is provided if the services would be covered if furnished by a physician;

D. Services and supplies that are furnished as an incident to professional services furnished by a nurse practitioner, physician assistant, nurse midwife, or other specialized nurse practitioner;

E. Visiting nurse services on a part-time or intermittent basis to home-bound patients in areas in which there is a shortage of home health agencies.

Note: For purposes of visiting nurse care, a home-bound patient is one who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. Institutions, such as a hospital or nursing care facility, are not considered a patient's residence.

Note: A patient's place of residence is where he or she lives, unless he or she is in an institution such as a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities (ICF/IID); and

F. ~~Effective for dates of service on and after **September 1, 2020**,~~ Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries~~when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes.~~ All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

218.100 RHC Encounter Benefit Limits

~~7-1-22~~2-1-24

A. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic RHC encounter benefit limit.

B. A benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30, has been established for clients twenty-one (21) years or older. The following services are counted toward the per SFY encounter benefit limit:

1. Provider visits in the office, client's home, or nursing facility;
2. Certified nurse-midwife visits;
3. RHC encounters;
4. Medical services provided by a dentist;
5. Medical services provided by an optometrist;
6. Advanced practice registered nurse (APRN) services in the office, client's home, or nursing facility; and
7. Federally qualified health center (FQHC) encounters.

Global obstetric fees are not counted against the service encounter limit. Itemized obstetric office visits are not counted in the limit.

The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis ~~and rendered by a qualified X-DEA waivered provider.~~ (**View ICD OUD Codes**).

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

TOC required

172.100 Services not Requiring a PCP Referral

~~9-1-20~~2-1-24

The services listed in this section do not require a PCP referral:

A. Adult Developmental Day Treatment (ADDT) core services;

B. ARChoices waiver services;

C. Anesthesia services, excluding outpatient pain management;

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP);

E. Chiropractic services;

F. Dental services;

G. Developmental Disabilities Services Community and Employment Support;

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS;

I. Emergency services in an acute care hospital emergency department, including emergency physician services;

J. Family Planning services;

K. Gynecological care;

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner
2. Medication Assisted Treatment for Opioid Use Disorder ~~when rendered by an X-DEA waivered practitioner~~
3. Rehabilitative Services for Youth and Children (RSYC) Program

N. Obstetric (antepartum, delivery, and postpartum) services

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services;

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye;

Q. Optometry services;

R. Pharmacy services;

S. Physician services for inpatients in an acute care hospital, including direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and indirect care (pathology, interpretation of X-rays, etc.);

T. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

U. Physician visits (except consultations, which do require PCP referral) in the outpatient departments of acute care hospitals but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

V. Professional components of diagnostic laboratory, radiology, and machine tests in the outpatient departments of acute care hospitals, but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services;

X. Transportation (emergency and non-emergency) to Medicaid-covered services; and

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity or would create unnecessary hardship.

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure**;** opioid use disorder when the visit is part of a Medication Assisted Treatment Plan**;** and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.b. Rural Health Clinic Services

5. Services of nurse midwives

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4). Federally qualified health center services are limited to sixteen (16) encounters per client**,** per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

For federally qualified health center core services beyond the benefit limit, extensions will be available if medically necessary. Beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

3. Other Laboratory and X-Ray Services

Other medically necessary diagnostic laboratory or radiology/other services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory **s**ervices benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY**,** July 1 – June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services health benefit limit**s: (**a**)** Malignant neoplasm; **(**b**)** HIV infection; and **(c)** renal failure. The cost of related diagnostic laboratory services, and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limits or the five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD)**,** and the screening is part of a Medication Assisted Treatment **(**MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory services health benefit limit.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per SFY outpatient diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY radiology/other services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their place of residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per **S**FY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation**,** prescription drugs for opioid **or alcohol** use disorder as part of a Medication Assisted Treatment plan, EPSDT, high blood pressure**, hypercholesterolemia,** blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the Arkansas Medicaid Pharmacy Vendor's Website, are covered:

a. select agents when used for weight gain

b. select agents when used for the symptomatic relief of cough and colds

c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride

d. select nonprescription drugs

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a seventy-two (72) hour supply of drugs in emergency situations.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):

4.d. Tobacco cessation counseling services for pregnant women

☒ Provided: ☐ No limitations ☒ with limitations*

e. Medication-Assisted Treatment for opioid use disorders when provided as part of a Medication Assisted Treatment plan

☒ Provided: ☐ No limitations ☒ with limitations*

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

☒ Provided: ☐ No limitations ☒ with limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

☒ Provided: ☐ No limitations ☒ with limitations*

*Description provided on attachment.

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; opioid use disorder when the visit is part of a Medication Assisted Treatment plan, and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.b. Rural Health Clinic Services

5. Services of nurse midwives; and

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) NCFA – Pub. 45-4).

Federally qualified health center services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

Benefit extensions will be available if medically necessary. Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

3. Other Laboratory and X-Ray Services

Other medically necessary diagnostic laboratory or radiology/other services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services health benefit limits: (a) Malignant neoplasm; (b) HIV infection; and (c) renal failure. The cost of related diagnostic laboratory services and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD), and the screening is part of a Medication Assisted Treatment (MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory or radiology/other services health benefit limits.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **S**FY outpatient diagnostic laboratory services benefit limit or five hundred dollars ($500) per SFY radiology/other services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY X-ray services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per SFY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided

4.c. Family Planning Services

(1) Comprehensive family planning services are limited to an original examination and up to three (3) follow-up visits annually. This limit is based on the state fiscal year (July 1 through June 30).

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

*describe if there are any limits on who can provide these counseling services

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations [X] With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

Please describe any limitations:

Face-to-face tobacco cessation counseling services are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per state fiscal year.

4.e. Prescription drugs for treatment of opioid use disorder **or alcohol use disorder**

a. Preferred prescription drugs (preferred on the PDL) used for treatment of opioid **or alcohol** use disorder require no prior authorization and do not count against the monthly prescription limits when prescribed as part of a Medication Assisted Treatment plan.

5.a. Physicians' services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere

(1) Physicians' services in a physician's office, patient's home, or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age twenty-one (21) and older.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation**,** prescription drugs for opioid **or alcohol** use disorder when part of a Medication Assisted Treatment plan, EPSDT, high blood pressure, h**ypercholesterolemia,** blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the **Arkansas Medicaid Pharmacy Vendor's Website**, are covered:

a. select agents when used for weight gain:

b. select agents when used for the symptomatic relief of cough and colds:

c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:

d. select nonprescription drugs:

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991, will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72-hour supply of drugs in emergency situations.

Citation	Condition or Requirement

1. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
CFR 438.50
42 CFR 438.10

X The state assures that its state plan program complies with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
Developmental Disabilities Services Community and Employment Support
Family Planning
Anesthesia
Alternative Waiver Programs
Adult Developmental Day Treatment Services Core Services only
Disease Control Services for Communicable Diseases
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Medication-Assisted Treatment Services for opioid use disorder when part of a Medication Assisted Treatment plan
Mental health services as follows:
a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. Rehabilitative Services for Youth and Children
Nurse Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, delivery, and postpartum) services
Pharmacy
Physician Services for inpatients acute care
Transportation

State of Arkansas

1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1(b)(1) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(a)(29) __X___MAT as described and limited in Supplement 1 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to the medically needy.

State of Arkansas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid clients who meet the medical necessity criteria for receipt of the service for the period beginning October1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for opioid use disorder (OUD) **and alcohol use disorder (AUD)** that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

State of Arkansas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT is covered exclusively under section 1905(a)(29) for the period of 10/01/2020 through 9/30/2025.

Services available:

1. Individual Behavioral Health Counseling
2. Group Behavioral Health Counseling
3. Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

b) Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants and Nurse Practitioners may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT). This group's role is to provide the behavioral and substance use disorder counseling required.

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Arkansas Licensed.

Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute.

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

_____ Generic first policy
___X__ Preferred drug lists
_____ Clinical criteria
___X__ Quantity limits
_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT drugs and biologicals are limited based on the FDA indication and manufacturers' prescribing guidelines. Some medications are also subject to status on the Preferred Drug List **(PDL).**

The preferred **(PDL)** agents for MAT therapy **do not** require a PA.

The Arkansas Medicaid Pharmacy program removed the prior authorization for preferred Buprenorphine products on 1/1/2020, due to Arkansas State Law from Act 964 which prohibits a prior authorization for Medication Assisted Treatment of Opioid Use Disorder. The removal of prior authorization was for MAT treatment according to SAMHSA guidelines. In addition, on 1/22/2021, per section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), for all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to be covered, Arkansas instructed the pharmacy vendor to bypass the non-rebate-participation, repackaged indicator, inner indicator, and prioritize coverage of all the pharmacy MAT products. **Also, as of 10/1/2023 due to Arkansas State Law from Act 451 of 2023, preferred (PDL) injectable medications for the treatment or detoxification of opioid and alcohol addiction no longer require a prior authorization.**

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) ___X__MAT as described and limited in Supplement __5__ to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid clients who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone, all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for **o**pioid **u**se **d**isorder (OUD) **and alcohol use disorder (AUD)** that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT is covered exclusively under section 1905(a)(29) for the period of 10/01/2020 through 9/30/2025.

Services available:

1. Individual Behavioral Health Counseling
2. Group Behavioral Health Counseling
3. Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

b) Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants, and Nurse Practitioners may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT), This group's role is to provide the behavioral and substance use disorder counseling required

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training, and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Arkansas Licensed.

Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

iv. Utilization Controls

__X___ The state has drug utilization controls in place. (Check each of the following that apply)
_____ Generic first policy
___X__ Preferred drug lists
_____ Clinical criteria
___X__ Quantity limits
_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT drugs and biologicals are limited based on the FDA indication and manufacturers' prescribing guidelines. Some medications are also subject to status on the Preferred Drug List **(PDL).**
The preferred **(PDL)** agents for MAT therapy **do not** require a Prior Authorization.

The Arkansas Medicaid Pharmacy program removed the prior authorization for preferred Buprenorphine products on 1/1/2020, due to Arkansas State Law from Act 964 which prohibits a prior authorization for Medication Assisted Treatment of Opioid Use Disorder. The removal of prior authorization was for MAT treatment according to SAMHSA guidelines. In addition, on 1/22/2021, per section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), for all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to be covered, Arkansas instructed the pharmacy vendor to bypass the non-rebate-participation, repackaged indicator, inner indicator, and prioritize coverage of all the pharmacy MAT products. **Also, as of 10/1/2023 due to Arkansas State Law from Act 451 of 2023, preferred (PDL) injectable medications for the treatment or detoxification of opioid and alcohol addiction no longer require a prior authorization.**

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TOC required

214.200 Medication Assisted Treatment and Opioid Use Disorder or Alcohol Use Disorder Treatment Drugs 2-1-24

Medication Assisted Treatment for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

TOC not required

212.220 Services Furnished in Collaboration with a Physician 2-1-24

Nurse practitioner services are performed in collaboration with a physician or physicians.

A. Collaboration is a process in which a nurse practitioner works with one (1) or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction, and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by State law.

B. The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.

C. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

220.000 Benefit Limits 2-1-24

A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient's home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; and
7. Advanced practice registered nurse services in the office, patient's home, or nursing facility.

B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:

1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.
2. Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.
3. Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.
4. Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis (**View ICD OUD Codes**).

C. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

TOC required

272.501 Medication Assisted Treatment and Opioid or Alcohol Use Disorder Treatment Drugs 2-1-24

Medication Assisted Treatment for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2023**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

TOC required

252.448 Medication Assisted Treatment and Opioid or Alcohol Use Disorder Treatment Drugs 2-1-24

Medication Assisted Treatment for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2023**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Nurse Practitioner services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

TOC required

211.105 Coverage of Medication Assisted Treatment and Opioid Use Disorder or Alcohol Use Disorder Treatment Drugs 2-1-24

Coverage of preferred prescription drugs (preferred on the PDL) for opioid or alcohol use disorder are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the **DHS contracted Pharmacy vendor's website**.

Coverage and Limitations

A. Reimbursement for preferred drugs is available with a valid prescription when prescribed according to FDA approved label.

B. Prescription drugs will not count against the monthly prescription benefit limit and are not subject to co-pay when used for a primary diagnosis of opioid or alcohol use disorder.

C. FDA dosing and prescribing limitations apply.

212.000 Exclusions 2-1-24

A. Products manufactured by non-rebating pharmaceutical companies.

B. Effective January 1, 2006, the Medicaid agency will not cover any drug covered by Medicare Part D for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

C. The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid beneficiaries under § 1927 (d) of the Social Security Act, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses; with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 CFR § 423.104 (f) (1) (ii) (A),to full-benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

The following excluded drugs are set forth on the **DHS Contracted Pharmacy Vendor website.**

1. Select agents when used for weight gain
2. Select agents when used for the symptomatic relief of cough and colds
3. Select prescription vitamins and mineral products, except prenatal vitamins and fluoride
4. Select nonprescription drugs

D. Medical accessories are not covered under the Arkansas Medicaid Pharmacy Program. Typical examples of medical accessories are atomizers, nebulizers, hot water bottles, fountain syringes, ice bags and caps, urinals, bedpans, glucose monitoring devices and supplies, cotton, gauze and bandages, wheelchairs, crutches, braces, supports, diapers, and nutritional products.

213.100 Monthly Prescription Limits 2-1-24

A. Each prescription for all Medicaid-eligible clients may be filled for up to a maximum thirty-one-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum thirty-one-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially

packaged for therapy exceeding thirty-one (31) days, the days' supply limit (other than thirty-one (31)), as approved by the agency, will be allowed for claims processing. Contact the Pharmacy Help Desk to inquire about specific days' supply limits on specially packaged dosage units.

View or print the contact information for the DHS contracted Pharmacy vendor.

B. Each Medicaid-eligible client twenty-one (21) years of age and older is limited to six (6) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. Including without limitation, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics, and diaphragms;
2. Prescriptions for Medicaid-eligible long-term care facility residents(must be for Medicaid-covered drugs);
3. Prescriptions for Medicaid-eligible clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. (must be for Medicaid-covered drugs);
4. Prescriptions for opioid or alcohol use disorder treatment;
5. Prescriptions for tobacco cessation products;
6. Prescriptions for the treatment of high blood pressure;
7. Prescriptions for the treatment of hypercholesterolemia;
8. Blood modifier medications;
9. Prescriptions for the treatment of diabetes; and
10. Inhalers to treat respiratory illness.

C. Living Choices Assisted Living Program clients are eligible for up to nine (9) medically necessary prescriptions per month.

D. After the client has received the maximum monthly benefit or the maximum monthly extended benefit, they will be responsible for paying for their own medications for the remainder of the month.

TOC required

201.500 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder 2-1-24

Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder must be licensed in Arkansas and be enrolled with Arkansas Medicaid.

201.510 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder in Arkansas and Bordering States 2-1-24

Providers of MAT in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may be included as routine services providers if they meet all participation requirements for enrollment in Arkansas Medicaid and requirements outlined in Section 201.500.

Reimbursement may be available for MAT covered in the Arkansas Medicaid Program when treating Opioid or Alcohol Use Disorders. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.520 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder in States Not Bordering Arkansas 2-1-24

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid Program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

   To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit contact information.**

B. Limited services providers remain enrolled for one (1) year.

   1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.

   2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

203.271 Medication-Assisted Treatment Provider Role for Administering Opioid or Alcohol Use Disorder Services 2-1-24

SAMHSA defines Medication Assisted Treatment (MAT) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery. This definition and other MAT guidelines can be found at the **SAMHSA website**.

Only providers who have met the requirements of Section 201.500 may prescribe medication required for the treatment of Opioid or Alcohol Use Disorder for Arkansas Medicaid beneficiaries in conjunction with coordinating all follow-up and referrals for counseling and other services. This program applies only to prescribers of FDA-approved drugs for treatment of Opioid or Alcohol Use Disorder and will not be reimbursed for the practice of pain management.

263.100 Coverage of Drugs Used for Opioid or Alcohol Use Treatment 2-1-24

Coverage of preferred prescription drugs (preferred on the PDL) for opioid or alcohol use disorder and tobacco cessation are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the **DHS contracted Pharmacy vendor's website.**

Coverage and Limitations

A. Reimbursement for preferred drugs is available with a valid prescription when prescribed according to FDA approved label.

B. Prescription drugs for treatment of opioid or alcohol use disorder will not count against the monthly prescription benefit limit and are not subject to co-pay.

C. FDA dosing and prescribing limitations apply.

292.920 Medication Assisted Treatment (MAT) for Opioid Use Disorder 2-1-24

There are two (2) methods of billing for MAT.

1. Method 1- Inclusive Rate

    a. The inclusive method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 are provided on the same date of service by the same billing group.

        i. For new patients, the provider group shall use HCPCS code, modifier X2 and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all services (Office Visit, counseling, case management, medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

        ii. For established patients requiring continuing follow-up MAT treatment, the provider group shall use HCPCS code, modifiers U8, X2, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

        iii. For established patients requiring maintenance follow-up MAT treatment, the provider group shall use HCPCS code, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.

        iv. The specific HCPCS code and modifiers found in the following link are required

for billing the inclusive rate. **View or print the procedure codes and modifiers for MAT services**.

2. Method 2 – Regular Fee-for-Service Rates

   a. The regular Fee-for-Service method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 cannot be provided on the same date of service, or cannot be provided by the same billing group who has the MAT specialized performing provider; therefore, causing some SAMHSA guideline services to be referred elsewhere.

      i. For new patients, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

      ii. For established patients requiring continuing treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

      iii. For established patients requiring maintenance treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X4, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X4 modifier for the screenings required.

Allowable ICD-10 codes for Opioid Use Disorder may be found here: (**View ICD OUD Codes.**)

Allowable lab and screening codes may be found here: (**View Lab and Screening Codes**.)

Providers utilizing telemedicine, regardless of Method, shall adhere to telemedicine rules listed in Sections 105.190 and 305.000 in addition to those above. The provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.

TOC not required

211.100 Rural Health Clinic Core Services 2-1-24

Rural Health Clinic core services are as follows:

A. Professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;

B. Services and supplies furnished "incident to" a physician's professional services;

C. Services provided by non-physician, services of physician assistants, nurse practitioners, nurse midwives, and specialized nurse practitioners when the provider is legally:

1. employed by, or receiving compensation from a rural health clinic;
2. under the medical supervision of a physician;
3. acting in accordance with any medical orders for the care and treatment of a patient prepared by a physician; and
4. acting within their scope of practice by providing services they are legally permitted to perform by the state in which the service is provided if the services would be covered if furnished by a physician;

D. Services and supplies that are furnished as an incident to professional services furnished by a nurse practitioner, physician assistant, nurse midwife, or other specialized nurse practitioner;

E. Visiting nurse services on a part-time or intermittent basis to home-bound patients in areas in which there is a shortage of home health agencies.

Note: For purposes of visiting nurse care, a home-bound patient is one who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. Institutions, such as a hospital or nursing care facility, are not considered a patient's residence.

Note: A patient's place of residence is where he or she lives, unless he or she is in an institution such as a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities (ICF/IID); and

F. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

218.100 RHC Encounter Benefit Limits 2-1-24

A. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic RHC encounter benefit limit.

B. A benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30, has been established for clients twenty-one (21) years or older. The following services are counted toward the per SFY encounter benefit limit:

1. Provider visits in the office, client's home, or nursing facility;
2. Certified nurse-midwife visits;
3. RHC encounters;

4. Medical services provided by a dentist;
5. Medical services provided by an optometrist;
6. Advanced practice registered nurse (APRN) services in the office, client's home, or nursing facility; and
7. Federally qualified health center (FQHC) encounters.

Global obstetric fees are not counted against the service encounter limit. Itemized obstetric office visits are not counted in the limit.

The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis (**View ICD OUD Codes**).

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

TOC required

172.100 Services not Requiring a PCP Referral 2-1-24

The services listed in this section do not require a PCP referral:

A. Adult Developmental Day Treatment (ADDT) core services;

B. ARChoices waiver services;

C. Anesthesia services, excluding outpatient pain management;

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP);

E. Chiropractic services;

F. Dental services;

G. Developmental Disabilities Services Community and Employment Support;

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS;

I. Emergency services in an acute care hospital emergency department, including emergency physician services;

J. Family Planning services;

K. Gynecological care;

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner
2. Medication Assisted Treatment for Opioid Use Disorder
3. Rehabilitative Services for Youth and Children (RSYC) Program

N. Obstetric (antepartum, delivery, and postpartum) services

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services;

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye;

Q. Optometry services;

R. Pharmacy services;

S. Physician services for inpatients in an acute care hospital, including direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and indirect care (pathology, interpretation of X-rays, etc.);

T. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

U. Physician visits (except consultations, which do require PCP referral) in the outpatient departments of acute care hospitals but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

V. Professional components of diagnostic laboratory, radiology, and machine tests in the outpatient departments of acute care hospitals, but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services;

X. Transportation (emergency and non-emergency) to Medicaid-covered services; and

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity or would create unnecessary hardship.

State of Arkansas
94th General Assembly
Regular Session, 2023

A Bill

HOUSE BILL 1558

By: Representative Pilkington

For An Act To Be Entitled

AN ACT TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO MODIFY MEDICATION-ASSISTED TREATMENT UNDER THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND TO MODIFY THE MEDICATION-ASSISTED TREATMENT UNDER THE PRIOR AUTHORIZATION TRANSPARENCY ACT.

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

SECTION 1. Arkansas Code § 23-99-1119 is amended to read as follows:

23-99-1119. Medication-assisted treatment for opioid addiction.

(a) ~~Except in the case of injectables, a~~ A healthcare insurer, including Medicaid, shall not:

(1) Require prior authorization in order for a patient to obtain coverage of buprenorphine, naloxone, naltrexone, methadone, and their various formulations and combinations approved by the United States Food and Drug Administration for the treatment or detoxification of opioid and alcohol addiction; or

(2) Impose any other requirement other than a valid prescription and compliance with the medication-assisted treatment guidelines issued by the United States Substance Abuse and Mental Health Services Administration under the United States Department of Health and Human Services in order for a patient to obtain coverage for buprenorphine, naloxone, naltrexone,

methadone, and their various formulations and combinations approved by the United States Food and Drug Administration for the treatment or detoxification of opioid and alcohol addiction.

(b) Subdivision (a)(1) of this section shall only apply to the Arkansas Medicaid Program as it pertains to prescription drugs for treatment or detoxification of opioid and alcohol addiction designated as preferred on the evidence-based preferred drug list, provided there is at least one (1) of each of the drugs listed in subdivision (a)(1) of this section with the preferred designation on the preferred drug list or available without prior authorization.

(c) If a new formulation or medication approved by the United States Food and Drug Administration for use as a prescription for medication-assisted treatment becomes available after April 12, 2019, and is either more expensive or has not been shown to be more effective than the formulations and medications in subsection (a) of this section, then the healthcare insurer may require prior authorization of the new formulation or medication.

(d) A healthcare insurer utilizing a tiered drug formulary shall place on the lowest-cost benefit tier at least one (1) product for each of the following medications that is approved by the United States Food and Drug Administration:

(1) Buprenorphine;

(2) Naloxone;

(3) Naltrexone;

(4) Methadone; and

(5) A product containing both buprenorphine and naloxone.

(e) For purposes of any limit a healthcare insurer imposes on the number of prescriptions for a patient, a prescription for medication-assisted treatment shall not be counted.

(f) This section does not affect the responsibility of a healthcare provider to comply with the standard of care for medication-assisted treatment, including without limitation the use of therapy in combination with medication.

~~(g) The Arkansas Medicaid Program shall have until January 1, 2020, to comply with this section.~~

APPROVED: 4/4/23

State of Arkansas
94th General Assembly
Regular Session, 2023

A Bill

HOUSE BILL 1562

By: Representatives Schulz, L. Johnson, J. Mayberry
By: Senator Gilmore

For An Act To Be Entitled

AN ACT TO AMEND THE NALOXONE ACCESS ACT; TO INCREASE AVAILABILITY AND ACCESSIBILITY OF AN OPIOID ANTAGONIST; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE NALOXONE ACCESS ACT; TO INCREASE AVAILABILITY AND ACCESSIBILITY OF AN OPIOID ANTAGONIST; AND TO DECLARE AN EMERGENCY.

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

SECTION 1. DO NOT CODIFY. Legislative findings and intent.

(a) The General Assembly finds that:

(1) As a result of the continued consequences of the opioid crisis affecting our nation, an opioid public health emergency has been in effect since October 26, 2017;

(2) Despite efforts since that time, annual overdose deaths reached record levels during the coronavirus 2019 (COVID-19) pandemic;

(3) Opioid antagonists can be safely administered to prevent overdose-related injuries not only by health care professionals but also by lay people who witness an overdose; and

(4) While this state has enacted laws expanding access to opioid antagonists, more can be done to increase availability and accessibility.

(b) It is the intent of the General Assembly to ensure that opioid

antagonists are more widely available and accessible to people at risk of experiencing or witnessing an overdose.

SECTION 2. Arkansas Code § 20-13-1804 is amended to read as follows:

20-13-1804. Opioid antagonist — Immunity.

(a) A healthcare professional acting in good faith may directly or by standing order prescribe, ~~and~~ dispense, and supply an opioid antagonist to:

(1) A person at risk of experiencing an opioid-related drug overdose;

(2) A ~~pain management clinic~~ A family member, friend, or other individual in a position to assist an individual at risk of experiencing an opioid-related overdose;

(3) ~~A harm reduction organization~~ An individual who is employed or contracted by a public or private organization, including without limitation:

(A) A state, municipal, or county entity;

(B) A hospital or clinic;

(C) A law enforcement agency;

(D) A harm reduction organization;

(E) A shelter or homeless services organization;

(F) An educational institution;

(G) A building manager; or

(H) A pain management center;

(4) An emergency medical services technician;

(5) A first responder;

(6) A law enforcement officer ~~or agency~~; or

(7) An employee of the State Crime Laboratory~~; or~~

~~(8) A family member or friend of a person at risk of experiencing an opioid-related drug overdose~~.

(b) Notwithstanding any other law, an individual that has been prescribed, dispensed, or supplied with an opioid antagonist under subsection (a) of this section:

(1) Shall follow manufacturer instructions for storage, replacement, and disposal of the opioid antagonist; and

(2) May provide the opioid antagonist, directly or indirectly, and at no cost, to a person described in subdivision (a)(1) or (2) of this

section.

(c) If an individual listed in subsection (a) of this section does not have access to a healthcare practitioner to issue a standing order for a prescription for an opioid antagonist, then the Secretary of the Department of Health, or his or her designee who is otherwise authorized to prescribe an opioid antagonist, may issue a standing order for an individual to act under subsection (b) of this section.

~~(b)~~(d) A person acting in good faith who reasonably believes that another person is experiencing an opioid-related drug overdose may administer an opioid antagonist that was prescribed, ~~and~~ dispensed, or supplied under section (a) of this section.

~~(c)~~(e) The following individuals are immune from civil liability, criminal liability, or professional sanctions for administering, prescribing, ~~or~~ dispensing, or supplying an opioid antagonist under this section:

(1) A healthcare professional who prescribes an opioid antagonist under subsection (a) of this section;

(2) A healthcare professional or pharmacist who acts in good faith and in compliance with the standard of care that dispenses or supplies an opioid antagonist under subsection (a) of this section; and

(3) A person other than a healthcare professional who administers an opioid antagonist under subsection ~~(b)~~ (d) of this section or who is supplied with an opioid antagonist under subsection (a) of this section.

SECTION 3. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the ability to supply naloxone to an individual at risk of an overdose, or the friends or family of an individual at risk of an overdose, is restricted under current state law; that nearly every witnessed opioid overdose is reversible with the timely administration of an opioid antagonist; that this act would make opioid antagonists more widely distributed and available save countless lives by reversing potential overdoses; and that this act is immediately necessary to save the lives of individuals at risk of an overdose that could be reversed by an opioid antagonist. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

APPROVED: 4/11/23

RULES SUBMITTED FOR REPEAL

Rule #1: PUB 85: Differential Response: A Family-Centered Approach to Strengthen and Support Families

Rule #2: PUB 357: Child Maltreatment Investigation Determination Guide

support

What is Differential Response?

Differential Response (DR) is another way of responding to allegations of child maltreatment. DR is different from DCFS's traditional investigation process. It allows some allegations that meet the criteria of maltreatment to be diverted from the investigative pathway and serviced through the Differential Response track. DR is designed to engage low to moderate risk families in the services needed to address the allegation and prevent the occurrence of future maltreatment.

How to Obtain a Copy of Your DR Case

If you are the parent (custodial or non-custodial), guardian, or legal custodian of the child you can request a copy of the DR Case (after it is closed) by sending a written notarized request with your name and child's name, Social Security Numbers, and a $10 check or money order (no cash or temporary checks) made payable to the Department of Human Services. The request should be mailed to :

Central Registry
P.O. Box 1437, (Slot S 566)
Little Rock, AR 72203-1437

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Family Service Worker Telephone

Family Service Worker Supervisor Telephone

Cherisse Cashaw 501-682-6807

DR Coordinator Telephone

ARKANSAS DEPARTMENT OF HUMAN SERVICES

The Division of Children and Family Services

family

Differential Response:

a family-centered approach to strengthen and support families

PUB-85 (03/2020)

the Big Picture:

Partnering with community providers to support families

How Does DR Work?

1. A report of alleged maltreatment is made to the Child Abuse Hotline.
2. An initial screening of the report is conducted by the hotline worker to determine if the allegations meet the legal criteria for maltreatment.
3. Reports are either "screened-in" or "screened-out" based upon state maltreatment criteria (the child's age and any disabilities will further determine whether these allegations will go to the DR or investigative track.
4. If a report is "screened–in", it then becomes eligible to be assigned to either the investigative track or the Differential Response track (if it meets the criteria for DR).
5. DR will be assigned to the local DCFS Office to begin engagement and assessment of needs with the family.

focused solutions can help keep families together

Care * Commit * Connect




What are the Criteria to Qualify for DR?

1. Identifying information for the family members and their current address or a means to locate them is known at the time of the report.
2. The caregivers are parents, birth or adoptive, legal guardians, custodians, or any person standing in place of a parent.
3. The family has no pending investigation or open protective services or supportive services case.
4. The children, siblings, or other house-hold members are not currently in the care and custody of DCFS or wards of the court.
5. Protective Custody of the children has not been taken or required in the current investigation.
6. The reported allegations shall only include those allegations listed on the next page under "What Allegations are Accepted to DR?".

What Allegations are Accepted to DR?

- Inadequate Food
- Inadequate Clothing
- Inadequate Shelter
- Inadequate Supervision
- Educational Neglect
- Environmental Neglect
- Medical Neglect
- Lock Out

The allegations below will also be sent to the DR track if they allegedly occurred more than one year ago and/or if the hotline caller cannot verify an injury through physical signs (e.g., scarring), medical information, dated photographs, etc.:*

- Striking a child age 7 or older on the face
- Striking a child with a closed fist
- Human Bites
- Sprains/Dislocations
- Throwing a child

**If any of these five allegations allegedly occurred less than one year and/or if the caller can verify an injury through physical signs, medical information, dated photographs, etc. then the allegations will be sent to the investigative track.*

Arkansas Department of Human Services

Division of Children and Family Services

Child Maltreatment Investigation Determination Guide

REPEAL-EO 23-02

PUB-357 R. July 2020

Table of Contents

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Introduction

This publication outlines the legal elements required to make a true finding for child maltreatment at the conclusion of a child maltreatment investigation as per the Child Maltreatment Act. This publication is promulgated under the authority of § 12-18-105 of the Arkansas Code to carry out the Child Maltreatment Act. The information within this publication, therefore, has the force and effect of law.

This publication is designed to help investigators identify the elements that must be established before an allegation of child maltreatment can be determined true under the Child Maltreatment Act, which defines child maltreatment as conduct that falls under one (1) or more of five (5) categories: (1) Abandonment, (2) Abuse, (3) Neglect, (4) Sexual Abuse, and (5) Sexual Exploitation.

To do this, Section 1 sets out the statutory definition and exceptions for each category of child maltreatment. Section 1 then explains the elements required to make a true finding for each category of child maltreatment and each type of child maltreatment that may occur under each category of child maltreatment. Section 2 provides an index of all thirty-eight (38) types of child maltreatment.

An investigator can only make a true finding as to one (1) or more of the five (5) categories of child maltreatment and only then if the investigator finds that each of the elements for the applicable child maltreatment category type are established by a preponderance of the evidence. “Preponderance of the evidence” is a legal standard of proof that means that it is “more likely than not” that child maltreatment occurred based on all the evidence that the investigator is able to collect during the given investigation.

A true finding cannot be made based solely on the examples given in this publication; a true finding must be based on the investigator’s determination that each element of the given category type of child maltreatment is supported by a preponderance of the evidence. The examples do not change the elements required to constitute child maltreatment, but rather merely provide possible ways in which a given category type of child maltreatment could occur.

Glossary

A/O. Alleged Offender: The person alleged to have committed child maltreatment.

A/V. Alleged Victim: The person who is the alleged victim of child maltreatment.

Investigator: An employee of the Department of Human Services (DHS) or the Arkansas State Police who investigates allegations of child maltreatment.

Section 1: Categories and Types and Maltreatment

1.1 Abandonment.

1.2 Abuse.

1.3 Neglect.

1.4 Sexual Abuse.

1.5 Sexual Exploitation.

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1.1 Abandonment

Definition

Abandonment means the failure of a parent to provide reasonable support and to maintain regular contact with a child through statement or contact when the failure is accompanied by an intention on the part of the parent to permit the condition to continue for an indefinite period in the future or the failure of a parent to support or maintain regular contact with a child without just cause. Abandonment also means an articulated intent to forego parental responsibility.

Exceptions

Married Minor Exception. Abandonment does not include acts or omissions of a parent towards a married minor.

Disrupted Adoption Exception. Abandonment does not include situations in which a child has disrupted his or her adoption and the adoptive parent has exhausted the available resources.

Making a True Determination

Based on the definition above and unless an exception applies, an investigator may determine that an allegation of abandonment is true if a preponderance of the evidence establishes each of the elements for at least one (1) type of abandonment:

Abandonment for an indefinite period:

1) A/O is a parent of the A/V;
2) A/V was under eighteen (18) years old when the alleged abandonment occurred;
3) A/O did not provide reasonable support for the A/V and maintain regular contact with the A/V through statement or contact; and
4) A/O intends to continue the lack of reasonable support and regular contact for an indefinite period in the future.

Abandonment without just cause:

1) A/O is a parent of the A/V;
2) A/V was under eighteen (18) years old when the alleged abandonment occurred;
3) A/O did not provide reasonable support for the A/V or maintain regular contact with the A/V through statement or contact; and

4) A/O did not have just cause in failing to support or maintain regular contact with the A/V.

Abandonment by articulated intent:

1) A/O is a parent of the A/V;
2) A/V was under eighteen (18) years old when the alleged abandonment occurred; and
3) A/O articulated an intent to forego parental responsibility of the A/V.

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1.2 Abuse

Definition

Abuse means any of the following acts or omissions by a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older living in the home with a child whether related or unrelated to the child, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the child's parent, or any person legally responsible for the child's welfare, but excluding the spouse of a minor:

- Extreme or repeated cruelty to a child;
- Engaging in conduct creating a realistic and serious threat of death, permanent or temporary disfigurement, or impairment of any bodily organ;
- Injury to a child's intellectual, emotional, or psychological development as evidenced by observable and substantial impairment of the child's ability to function within the child's normal range of performance and behavior;

- Any injury that is at variance with the history given;
- Any nonaccidental physical injury;
- Any of the following intentional or knowing acts, with physical injury and without justifiable cause: throwing, kicking, burning, biting, or cutting a child; striking a child with a closed fist; shaking a child; or striking a child on the face or head;
- Any of the following intentional or knowing acts, with or without physical injury: striking a child six (6) years of age or younger on the face or head; shaking a child three (3) years of age or younger; interfering with a child's breathing; pinching, biting, or striking a child in the genital area; tying a child to a fixed or heavy object or binding or tying a child's limbs together;
- Any of the following intentional or knowing acts, with or without physical injury: giving a child or permitting a child to consume or inhale a poisonous or noxious substance not prescribed by a physician that has the capacity to interfere with normal physiological functions;

- Any of the following intentional or knowing acts, with or without physical injury: giving a child or permitting a child to consume or inhale a substance not prescribed by a physician that has the capacity to alter the mood of the child, including, but not limited to marijuana, alcohol (excluding alcohol given to a child during a recognized and established religious ceremony or service), a narcotic, or an over-the-counter drug if a person purposely administers an overdose to a child or purposely gives an inappropriate over-the-counter drug to a child and the child is detrimentally impacted by the overdose or the over-the-counter drug;

- Any of the following intentional or knowing acts, with or without physical injury: exposing a child to a chemical that has the capacity to interfere with normal physiological functions, including, but not limited to, a chemical used or generated during the manufacture of methamphetamine;

- Any of the following intentional or knowing acts, with or without physical injury: subjecting a child to Munchausen syndrome by proxy or a factitious illness by proxy if the incident is confirmed by medical personnel;

- Recruiting, harboring, transporting, or obtaining a child for labor or services, through force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery; or

- Female genital mutilation.

This list is illustrative of unreasonable action and is not intended to be exclusive. No unreasonable action shall be construed to permit a finding of abuse without having established the elements of abuse. This means that other acts or omission can constitute abuse if the action is unreasonable and the A/O is a parent, guardian, custodian, person eighteen (18) years of age or older who lives in the home with the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare. However, if the act or omission could fall within the definition of one (1) of the types of abuse, then the act or omission must meet the elements of that type of abuse to constitute child maltreatment.

Exceptions

Physical Discipline Exception. Abuse does not include physical discipline of a child when it is reasonable and moderate and is inflicted by a parent or guardian for purposes of restraining or

correcting the child. Reasonable and moderate physical discipline inflicted by a parent or guardian does not include any act that is likely to cause, and which does cause, injury more serious than transient pain or minor temporary marks. The age, size, and condition of the child and the location of the injury and the frequency or recurrence of injuries shall be considered when determining whether the physical discipline is reasonable or moderate.

Appropriate Restraint Exception. Abuse does not include when a child suffers transient pain or minor temporary marks as a result of an appropriate restraint if: the person exercising the restraint is an employee of a child welfare agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act; the person exercising the restraint is acting in his or her official capacity while on duty at a child welfare agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act; the child welfare agency has policy and procedures regarding restraints; no other alternative exists to control the child except for a restraint; the child is in danger or hurting himself or herself or others; the person exercising the restraint has been trained in properly restraining children, de-escalation, and conflict resolution techniques; the restraint is for a reasonable period of time; and the restraint is in conformity with training and child welfare agency's policies and procedures.

<u>Making a True Determination</u>

Based on the definition above and unless an exception applies, an investigator may determine that an allegation of abuse is true if a preponderance of the evidence establishes each of the elements for at least one (1) type of abuse.

Extreme or repeated cruelty:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred; and
3) At least one (1) act or omission of the A/O towards the child was extremely cruel or more than (1) one act or omission of the A/O towards the child was cruel.

Threat of harm:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related

or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;

2) A/V was under eighteen (18) years old when the alleged abuse occurred; and

3) A/O's acts or omissions created a realistic and serious threat to the A/V of death, permanent or temporary disfigurement, or impairment of a bodily organ.

NOTE: True findings for abuse involving the threat of harm can be made even if the A/V was not injured; this type only requires that the A/O created a realistic and serious threat to the A/V of death, disfigurement, or impairment of a bodily organ.

Mental injury:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;

2) A/V was under eighteen (18) years old when the alleged abuse occurred; and

3) A/O's acts or omissions caused injury to A/V's intellectual, emotional, or psychological development as evidenced by observable and substantial impairment of the A/V's ability to function within the A/V's normal range of performance and behavior related to intellectual, emotional, or psychological development.

Injury at variance with explanation given:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's

parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;

2) A/V was under eighteen (18) years old when the alleged abuse occurred; and
3) A/V's injury is not consistent with the history given by the A/O or given by anyone else related to the A/O's care of the A/V.

Nonaccidental physical injury:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred; and
3) A/O's act or omission caused any nonaccidental physical injury to the A/V.

NOTE: True findings for nonaccidental physical injuries can be made regardless of whether the A/O intended to cause the physical injury that the A/V suffered; the relevant and culpable act or omission is the act or omission that caused the nonaccidental physical injury.

Abuse with physical injury and without justifiable cause:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred;
3) A/O threw the A/V, kicked the A/V, burned the A/V, bit the A/V, cut the A/V, struck the A/V with a closed fist, shook the A/V, or struck the A/V's face or head;
4) A/O intentionally or knowingly committed the act in 3);
5) A/O did not have a justifiable cause in committing the act or omission; and

6) A/O's act or omission caused any physical injury to the A/V.

Abuse with or without physical injury:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred;
3) A/O struck the A/V who was six (6) years of age or younger on the face or head, shook the A/V who was three (3) years of age or younger, interfered with the A/V's breathing, pinched the A/V in the genital area, bit the A/V in the genital area, struck the A/V in the genital area, tied the A/V to a fixed or heavy object, or bound or tied the A/V's limbs together; and
4) A/O intentionally or knowingly committed the act in 3).

NOTE: True findings for abuse with or without physical injuries can be made regardless of whether the act caused A/V any physical injuries.

Abuse involving noxious or poisonous substances that may interfere with normal physiological functions:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V , or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred;
3) A/O gave or permitted the A/V to consume or inhale a poisonous or noxious substance not prescribed by a physician that has the capacity to interfere with normal physiological functions; and
4) A/O intentionally or knowingly committed the act in 3).

NOTE: True findings for abuse involving substances that may interfere with normal physiological functions can be made regardless of whether the act caused A/V any physical injuries or whether the substance

interfered with the A/V's normal physiological functions.

NOTE: Normal physiological functions are the functions of the body and include without limitation metabolism, responsiveness, cognition, movement, reproduction, growth, respiration, digestion, and excretion. Staff are encouraged to consult with a physician as needed for any questions related to what may constitute normal physiological function.

Abuse involving substances that may alter the mood of a child:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V , or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred;
3) A/O gave, or permitted the A/V to consume or inhale, a substance not prescribed by a physician that has the capacity to alter the mood of the child, including without limitation:
   A. Marijuana;
   B. Alcohol unless it is given to the A/V during a recognized and established religious ceremony or service;
   C. A narcotic; or
   D. An over-the-counter drug, but only if:
      1. A/O purposely administers an overdose to the A/V or purposely gives an inappropriate over-the-counter drug to the A/V: and
      2. A/V is detrimentally impacted by the overdose or the inappropriate over-the-counter drug; and
4) A/O intentionally or knowingly committed the act in 3).

NOTE: True findings for abuse with or without physical injuries can be made regardless of whether the act caused A/V any physical injuries.

Abuse involving exposure to a chemical that may interfere with normal physiological functions:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V , or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited

to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;

2) A/V was under eighteen (18) years old when the alleged abuse occurred;
3) A/O exposed A/V to a chemical that has the capacity to interfere with normal physiological functions, including without limitation, a chemical used or generated during the manufacture of methamphetamine; and
4) A/O intentionally or knowingly committed the act in 3).

NOTE: True findings for abuse involving exposure to a chemical that may interfere with normal physiological functions can be made regardless of whether the act caused A/V any physical injuries or whether the substance actually interfered with the A/V's physiological functions.

NOTE: Normal physiological functions are the functions of the body and include without limitation metabolism, responsiveness, cognition, movement, reproduction, growth, respiration, digestion, and excretion.

Abuse involving subjection of a child to Munchausen syndrome by proxy or factitious illness:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred;
3) A/O subjected the A/V to Munchausen syndrome by proxy or a factitious illness by proxy;
4) Medical personnel confirmed that A/O subjected the A/V to Munchausen syndrome by proxy or a factitious illness by proxy; and
5) A/O intentionally or knowingly committed Munchausen syndrome by proxy or a factitious illness by proxy.

NOTE: True findings for abuse involving subjection of a child to Munchausen syndrome by proxy or factitious illness can be made regardless of whether the act caused A/V any physical injuries.

NOTE: Munchausen syndrome by proxy and factitious illness by proxy are

often diagnosed with newer terms such as factitious disorder imposed on another, pediatric condition falsification, or medical child abuse. If the A/O sought treatment for a fabricated medical condition, then these other diagnoses are each sufficient to establish Munchausen syndrome by proxy or factitious illness by proxy.

Human trafficking:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was under eighteen (18) years old when the alleged abuse occurred;
3) A/O recruited, harbored, transported, or obtained the A/V for labor or services;
4) A/O committed the act in 3) through force, fraud, or coercion;
5) A/O committed the act in 3) for the purpose of subjecting the A/V to involuntary servitude, peonage, debt bondage, or slavery.

Female genital mutilation:

1) A/O is a parent, guardian, custodian, foster parent, person eighteen (18) years of age or older who lives in the home with the A/V whether related or unrelated to the A/V, or any person entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, a significant other of the A/V's parent, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor;
2) A/V was a female under eighteen (18) years old when the alleged abuse occurred; and
3) A/O removed all or part of the A/V's external female genitalia or otherwise harmed the A/V's female genitalia unless
    A. The conduct is performed by a licensed medical professional;
    B. The conduct occurs in the furtherance of a surgical or other lawful medical procedure; and
    C. The procedure is:
        1. Necessary to preserve or protect the physical health of the A/V; or

2. Part of a sex reassignment procedure requested by the A/V.

NOTE: Female genital mutilation includes without limitation procedures such as a clitoridectomy; the partial or total removal of the clitoris or the prepuce; the excision or the partial or total removal of the clitoris and the labia minora (with or without the excision of the labia majora); the infibulation or the narrowing of the vaginal orifice with the creation of a covering seal by cutting or appositioning the labia minora or the labia majora (with or without the excision of the clitoris); pricking, piercing, incising, scraping, or cauterizing the genital area; or any other action to purposely alter the structure or function of the female genitalia for a nonmedical reason.

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1.3 Neglect

Definition

Neglect means acts or omissions by a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible under state law for the child's welfare, but excluding the spouse of a minor and the parents of a married minor, that constitute one (1) of the following:

- Failure or refusal to prevent the abuse of the child when the person knows or has reasonable cause to know the child is or has been abused;
- Failure or refusal to provide necessary food, clothing, shelter, or medical treatment necessary for the child's well-being, except when the failure or refusal is caused primarily by the financial inability of the person legally responsible and no services for relief have been offered;
- Failure to take reasonable action to protect the child from abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness when the existence of the condition was known or should have been known;
- Failure or irremediable inability to provide for the essential and necessary physical, mental, or emotional needs of the child, including the failure to provide a shelter that does not pose a risk to the health or safety of the child;
- Failure to provide for the child's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care;
- Failure, although able, to assume responsibility for the care and custody of the child or to participate in a plan to assume such responsibility;
- Failure to appropriately supervise the child that results in the child's being left alone at an inappropriate age creating a dangerous situation or a situation that puts the child at risk of harm, or, in inappropriate circumstances creating a dangerous situation or a situation that puts the child at risk of harm;

- Failure to appropriately supervise the child that results in the child's being placed in inappropriate circumstances creating a dangerous situation, or a situation that puts the child at risk of harm;

- Failure to ensure a child between six (6) years of age and seventeen (17) years of age is enrolled in school or is being legally home schooled;

- An act or omission by the child's parent, custodian, or guardian resulting in the child being habitually and without justification absent from school;

- Causing a child to be born with an illegal substance present in the child's bodily fluids or bodily substances as a result of the pregnant mother knowingly using an illegal substance before the birth of the child; or

- At the time of the birth of a child, the presence of an illegal substance in the mother's bodily fluids or bodily substances as a result of the pregnant mother knowingly using an illegal substance before the birth of the child.

Exceptions

None.

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Making a True Determination

Based on the definition above, an investigator may determine that an allegation of neglect is true if a preponderance of the evidence establishes each of the elements for at least one (1) type of neglect:

Failure to prevent abuse:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was under eighteen (18) years old when the alleged neglect occurred;
3) A/O failed or refused to prevent the abuse of the A/V; and
4) A/O knew or had reasonable cause to know the A/V was being abused or had been abused.

NOTE: True findings for neglect involving the failure to prevent abuse can be made only if the A/V was abused. If the A/V did not suffer abuse, the separate type of neglect involving the failure to protect from maltreatment or parental unfitness may be applicable because that type does not require that the A/V be maltreated.

Failure to provide necessary food, clothing, shelter, or medical treatment:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was under eighteen (18) years old when the alleged neglect occurred; and
3) A/O failed or refused to provide necessary food, clothing, shelter, or medical treatment necessary for the A/V's well-being unless
   A. The failure or refusal is caused primarily by the financial inability of the person legally responsible for the A/V, and
   B. No services for relief have been offered.

Failure to protect from maltreatment or parental unfitness:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the A/V's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, A/V care facility, public or private school, or any person legally responsible for the A/V's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was under eighteen (18) years old when the alleged neglect occurred;
3) A/O failed to take reasonable action to protect the child from abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness; and
4) A/O knew or should have known about the condition that posed a risk of abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness to the A/V.

NOTE: True findings for neglect involving the failure to protect from child maltreatment or parental unfitness can be made even if the A/V was not maltreated or subjected to parental unfitness; this type only requires that the A/O failed to take reasonable action to protect the A/V from the risk of child maltreatment or parental unfitness.

Failure to provide for essential and necessary needs:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was under eighteen (18) years old when the alleged neglect occurred; and
3) A/O failed to provide, or is irremediably unable to provide, for the essential physical, mental, or emotional needs of the A/V, including without limitation the failure to provide a shelter that does not pose a risk to the health or safety of the A/V.

Failure to provide for care, maintenance, or support:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;

2) A/V was under eighteen (18) years old when the alleged neglect occurred; and
3) A/O failed to provide for the A/V's
   A. Care and maintenance,
   B. Proper and necessary support, or
   C. Medical, surgical, or other necessary care.

Failure to assume responsibility for a child:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was under eighteen (18) years old when the alleged neglect occurred; and
3) A/O failed to assume responsibility for the care and custody of the A/V even though the A/O was able to do so, or to participate in a plan to assume responsibility for the care and custody of the A/V even though the A/O was able to do so.

Inadequate supervision by leaving a child alone:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was under eighteen (18) years old when the alleged neglect occurred;
3) A/O failed to appropriately supervise the A/V and left the A/V alone at an inappropriate age or in inappropriate circumstances; and
4) The A/O's act or omission created a dangerous situation or a situation that put the A/V at risk of harm.

NOTE: The foreseeability of harm and the A/O's awareness of dangerous circumstances are two (2) factors relevant to whether neglect by inadequate supervision has occurred. Specifically, the foreseeability of harm and the awareness of dangerous circumstances are relevant to the appropriateness of the circumstances in which the A/O placed the A/V and the foreseeability of harm if the A/V was left alone in those circumstances.

Inadequate supervision by placing child in a dangerous situation:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was under eighteen (18) years old when the alleged neglect occurred; and
3) A/O failed to appropriately supervise the A/V and placed the A/V in:
   A. Inappropriate circumstances that created a dangerous situation, or
   B. A situation that put the A/V at risk of harm.

NOTE: The foreseeability of harm and the A/O's awareness of dangerous circumstances are two factors relevant to whether neglect by inadequate supervision has occurred. Specifically, the foreseeability of harm and the awareness of dangerous circumstances are relevant to the appropriateness of the circumstances in which the A/O placed the A/V.

Educational neglect by failing to enroll a child in school:

1) A/O is a parent, guardian, custodian, foster parent, or any person who is entrusted with the child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the child's welfare, but excluding the spouse of a minor and the parents of a married minor;
2) A/V was between six (6) years of age and seventeen (17) years of age when the alleged neglect occurred; and
3) A/O failed to ensure that A/V was enrolled in school or was being legally homeschooled.

NOTE: A home school is a school provided by a parent or legal guardian for his or her own child.

NOTE: Staff must determine if a child is legally home-schooled as per A.C.A. 6-15-503. Please consult with local Office of Chief Counsel (OCC) attorney to determine if a child is legally home-schooled.

Educational neglect due to absence from school:

1) A/O is a parent, custodian, or guardian;
2) A/V was under eighteen (18) years old when the alleged neglect occurred;
3) A/O's act or omission caused the A/V to be habitually absent from school; and
4) A/V's absences were not justified.

Presence of illegal substance in a child when a child is born:

1) A/O is the A/V's mother;
2) A/V was under eighteen (18) years old when the alleged neglect occurred;
3) A/O knowingly used an illegal substance before the birth of the A/V and during the pendency of the A/O pregnancy with A/V; and
4) A/V had the illegal substance in the A/V's bodily fluids or bodily substances at the time of the A/V's birth.

NOTE: An illegal substance means a drug that is prohibited to be used or possessed without a prescription under the Arkansas Criminal Code.

NOTE: A test of the A/V's bodily fluids or substances may be used as evidence to establish neglect by presence of an illegal substance in the

A/V at birth.

Presence of illegal substance in a mother when a child is born:

1) A/O is the A/V's mother;
2) A/V was under eighteen (18) years old when the alleged neglect occurred;
3) A/O knowingly used an illegal substance before the birth of the A/V and during the pendency of the A/O pregnancy with A/V; and
4) A/O had the illegal substance in the A/O's bodily fluids or bodily substances at the time of the A/V's birth.

NOTE: An illegal substance means a drug that is prohibited to be used or possessed without a prescription under the Arkansas Criminal Code.

NOTE: A test of the A/O's bodily fluids or substances may be used as evidence to establish neglect by presence of an illegal substance in the A/O when the A/V is born.

REPEAL-EO 23-02

1.4 Sexual Abuse

Definition

Sexual abuse means:

- By a person fourteen (14) years of age or older to a person younger than eighteen (18) years of age: Actual or attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; indecent exposure; or forcing the watching of pornography or live sexual activity;

- By a person eighteen (18) years of age or older to a person not his or her spouse who is younger than fifteen (15) years of age: Actual or attempt sexual intercourse, deviate sexual activity, or sexual contact; or the solicitation of sexual intercourse, deviate sexual activity, or sexual contact;

- By a person twenty (20) years of age or older to a person not his or her spouse who is younger than sixteen (16) years of age: Actual or attempt sexual intercourse, deviate sexual activity, or sexual contact; or the solicitation of sexual intercourse, deviate sexual activity, or sexual contact;

- By a caretaker to a person younger than eighteen (18) years of age: Actual or attempted sexual intercourse, deviate sexual activity, or sexual contact; forcing or encouraging the watching of pornography; forcing, permitting, or encouraging the watching of live sexual activity; forcing the listening to a phone sex line; an act of voyeurism; or the solicitation of sexual intercourse, deviate sexual activity, or sexual contact;

- By a person younger than fourteen (14) years of age to a person younger than eighteen (18) years of age: Actual or attempted sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion; or

- By a person eighteen (18) years of age or older to a person who is younger than (18) years of age, the recruiting, harboring, transporting, obtaining, patronizing, or soliciting of a child for the purpose of a commercial sex act.

Exceptions

Defense and Affirmative Defense Exceptions.
Pursuant to 12-18-804, for any act or omission of child maltreatment that would be a criminal

offense or an act of delinquency, any defense or affirmative defense, including the burden of proof regarding the affirmative defense, that would apply to the criminal offense or delinquent act is also cognizable in a child maltreatment proceeding with the exception of: a statute of limitation; lack of capacity as a result of mental disease or defect under § 5-2-312; and affirmative defenses under §§ 5-1-112 — 5-1-114.

For example, if a teacher and a student have a sexual relationship, an affirmative defense may apply. If the teacher engages in sexual intercourse or deviate sexual activity with a student less than 21 years of age and the teacher uses his or her position of trust or authority over the victim, then the conduct would fall under the definition of sexual abuse. However, if the teacher was no more than 3 years older than the student, then the affirmative defense would apply.

Staff must consult with local OCC attorney regarding possible defense and affirmative defense exceptions.

Making a True Determination

Based on the definition above and unless an exception applies, an investigator may determine that an allegation of sexual abuse is true if a preponderance of the evidence establishes each of the elements for at least one (1) type of sexual abuse:

Sexual intercourse:

1) If the A/O was twenty (20) years old or older and the A/V was less than sixteen (16) years old, a true finding for sexual abuse can be made if:
    1. A/O was twenty (20) years old or older when the alleged sexual abuse occurred;
    2. A/V was less than sixteen (16) years old when the alleged sexual abuse occurred; and
    3. A/O engaged in sexual intercourse with the A/V, attempted to engage in sexual intercourse with the A/V, or solicited the A/V to engage in sexual intercourse; or

    NOTE: This type of sexual abuse provides that if the A/O is twenty (20) years old or older and the A/V is sixteen (16) years old or older, a true finding for sexual abuse cannot be made unless the circumstances satisfy a type of sexual abuse by sexual intercourse described below that require that the A/O either was the A/V's caretaker or used forcible compulsion.

2) If the A/O was eighteen (18) years old or older and the A/V was less than fifteen (15) years old, a true finding for sexual abuse can be made if:

A. A/O was eighteen (18) years old or older when the alleged sexual abuse occurred;
B. A/V was less than fifteen (15) years old when the alleged sexual abuse occurred; and
C. A/O engaged in sexual intercourse with the A/V, attempted to engage in sexual intercourse with the A/V, or solicited the A/V to engage in sexual intercourse; or

NOTE: This type of sexual abuse provides that if the A/O is eighteen (18) to nineteen (19) years old and the A/V is fifteen (15) or sixteen (16) years old, a true finding for sexual abuse cannot be made unless the circumstances satisfy a type of sexual abuse by sexual intercourse described below that require that the A/O either was the A/V's caretaker or used forcible compulsion.

3) If the A/O was fourteen (14) years old or older and A/V was less than eighteen (18) years old, a true finding for sexual abuse can be made if:
A. The A/O was the A/V's caretaker where the following facts are established:
1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
2. The A/O was the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;
3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred; and
4. A/O engaged in sexual intercourse with the A/V, attempted to engage in sexual intercourse with the A/V, or solicited the A/V to engage in sexual intercourse; or

NOTE: No forcible compulsion is required to establish sexual abuse by a caretaker.

B. The A/O was not the A/V's caretaker where the following facts are established:
1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;

2. A/O was not the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school, or any other person responsible for A/V's welfare, or the spouse of the A/V;
3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
A/O engaged in sexual intercourse, or attempted to engage in sexual intercourse, with the A/V;

NOTE: This type of sexual abuse provides that if the A/O is fourteen (14) years old to seventeen (17) years old, a true finding for this type of sexual abuse cannot be made unless the A/O used forcible compulsion.

NOTE: The age, developmental stage, and stature of the A/V and the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

4) A/O was less than fourteen (14) years old and the A/V was eighteen (18) years old or younger.
   A. A/O was less than fourteen (14) years old when the alleged sexual abuse occurred;
   B. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
   C. A/O engaged in sexual intercourse, or attempted to engage in sexual intercourse, with the A/V; and
   D. A/O used forcible compulsion to engage in the sexual intercourse or attempted sexual intercourse, which is where either A/V did not want to engage in the sexual intercourse or attempted sexual intercourse, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to engage in the sexual intercourse or attempted sexual intercourse.

   NOTE: The age, developmental stage, and stature of the A/V and

the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

NOTE: The exception to sexual abuse may apply to this type of sexual abuse.

Deviate sexual activity:

1) If the A/O was twenty (20) years old or older and the A/V was less than sixteen (16) years old, a true finding for sexual abuse can be made if:
   A. A/O was twenty (20) years old or older when the alleged sexual abuse occurred;
   B. A/V was less sixteen (16) years old when the alleged sexual abuse occurred;
   C. A/O engaged in deviate sexual activity with the A/V, attempted to engage in deviate sexual activity with the A/V, or solicited the A/V to engage in deviate sexual activity; and
   D. Where deviate sexual activity is:
      1. An act of sexual gratification; and
      2. Involves either
         a. The penetration, however slight, of the anus or mouth of one (1) person by the penis of another person, or
         b. The penetration, however slight, of the labia majora or anus of one (1) person by any body member or foreign instrument manipulated by another person; or

NOTE: This type of sexual abuse provides that if the A/O is twenty (20) years old or older and the A/V is sixteen (16) years old or older, a true finding for sexual abuse cannot be made unless the circumstances satisfy a type of sexual abuse by deviate sexual activity described below that require that the A/O either was the A/V's caretaker or used forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

2) If the A/O was eighteen (18) years old or older and the A/V was less than fifteen (15) years old, a true finding for sexual abuse can be made if:

A. A/O was eighteen (18) years old or older when the alleged sexual abuse occurred;
B. A/V was less than fifteen (15) years old when the alleged sexual abuse occurred;
C. A/O engaged in deviate sexual activity with the A/V, attempted to engage in deviate sexual activity with the A/V, or solicited the A/V to engage in deviate sexual activity; and
D. Where deviate sexual activity is:
    1. An act of sexual gratification; and
    2. Involves either
        a. The penetration, however slight, of the anus or mouth of one (1) person by the penis of another person; or
        b. The penetration, however slight, of the labia majora or anus of one (1) person by any body member or foreign instrument manipulated by another person; or

NOTE: This type of sexual abuse provides that if the A/O is eighteen (18) to nineteen (19) years old and the A/V is fifteen (15) or sixteen (16) years old, a true finding for sexual abuse cannot be made unless the circumstances satisfy a type of sexual abuse by deviate sexual activity described below that require that the A/O either was the A/V's caretaker or used forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

3) If the A/O was fourteen (14) years old or older and A/V was less than eighteen (18) years old, a true finding for sexual abuse can be made if:
A. The A/O was the A/V's caretaker where the following facts are established:
    1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
    2. The A/O was the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private

school or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;

3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
4. A/O engaged in deviate sexual activity with the A/V, attempted to engage in deviate sexual activity with the A/V, or solicited the A/V to engage in deviate sexual activity; and
5. Where deviate sexual activity is:
    a. An act of sexual gratification; and
    b. Involves either
        (1) The penetration, however slight, of the anus or mouth of one (1) person by the penis of another person; or
        (2) The penetration, however, slight of the labia majora or anus of one (1) person by any body member or foreign instrument manipulated by another person; or

NOTE: No forcible compulsion is required to establish sexual abuse by a caretaker.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

B. The A/O was not the A/V's caretaker where the following facts are established:
    1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
    2. A/O was not the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school, or any other person responsible for A/V's welfare, or the spouse of the A/V;
    3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
    4. A/O engaged in deviate sexual activity, or attempted to engage in deviate sexual activity, with the A/V;

5. A/O used forcible compulsion to engage in the deviate sexual activity or attempted deviate sexual activity, which is where either A/V did not want to engage in the deviate sexual activity or attempted deviate sexual activity, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to engage in the deviate sexual activity or attempted deviate sexual activity; and
6. Where deviate sexual activity is:
    a. An act of sexual gratification; and
    b. Involves either
        (1) The penetration, however slight, of the anus or mouth of one (1) person by the penis of another person; or
        (2) The penetration, however slight, of the labia majora or anus of one (1) person by any body member or foreign instrument manipulated by another person; or

NOTE: This type of sexual abuse provides that if the A/O is fourteen (14) years old to seventeen (17) years old, a true finding for this type of sexual abuse cannot be made unless the A/O used forcible compulsion.

NOTE: The age, developmental stage, and stature of the A/V and the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

4) A/O was less than fourteen (14) years old and the A/V was eighteen (18) years old or younger.
    A. A/O was less than fourteen (14) years old when the alleged sexual abuse occurred;
    B. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;

C. A/O engaged in deviate sexual activity, or attempted to engage in deviate sexual activity, with the A/V; and

D. A/O used forcible compulsion to engage in the deviate sexual activity or deviate sexual activity, which is where either A/V did not want to engage in the deviate sexual activity or attempted deviate sexual activity, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to engage in the deviate sexual activity or attempted deviate sexual activity.

E. Where deviate sexual activity is:

1. An act of sexual gratification; and
2. Involves either
   a. The penetration, however slight, of the anus or mouth of one (1) person by the penis of another person; or
   b. The penetration, however slight, of the labia majora or anus of one (1) person by any body member or foreign instrument manipulated by another person.

NOTE: The age, developmental stage, and stature of the A/V and the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

NOTE: The exception to sexual abuse may apply to this form of sexual abuse.

Sexual contact:

1) If the A/O was twenty (20) years old or older and the A/V was less than sixteen (16) years old, a true finding for sexual abuse can be made if:

A. A/O was twenty (20) years old or older when the alleged sexual abuse occurred;

B. A/V was less than sixteen (16) years old when the alleged sexual abuse occurred;

C. A/O engaged in sexual contact with the A/V, attempted to engage in sexual contact with the A/V, or solicited the A/V to engage in sexual contact; and

D. Where sexual contact is:
   1. An act of sexual gratification; and
   2. Involves
      a. The touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;
      b. The encouraging of the A/V to touch the offender in a sexual manner; or
      c. The offender requesting to touch the A/V in a sexual manner; or

NOTE: This type of sexual abuse provides that if the A/O is twenty (20) years old or older and the A/V is sixteen (16) years old or older, a true finding for sexual abuse cannot be made unless the circumstances satisfy a type of sexual abuse by sexual contact described below that require that the A/O either was the A/V's caretaker or used forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

NOTE: Sexual contact does not include contact incidental to normal affectionate hugging.

2) If the A/O was eighteen (18) years old or older and the A/V was less than fifteen (15) years old, a true finding for sexual abuse can be made if:
   A. A/O was eighteen (18) years old or older when the alleged sexual abuse occurred;
   B. A/V was less than fifteen (15) years old when the alleged sexual abuse occurred;
   C. A/O engaged in sexual contact with the A/V, attempted to engage in sexual contact with the A/V, or solicited the A/V to engage in sexual contact; and
   D. Where sexual contact is:
      1. An act of sexual gratification; and
      2. Involves
         a. The touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;
         b. The encouraging of the A/V to touch the offender in a sexual manner; or

c. The offender requesting to touch the A/V in a sexual manner; or

NOTE: This type of sexual abuse provides that if the A/O is eighteen (18) to nineteen (19) years old and the A/V is fifteen (15) or sixteen (16) years old, a true finding for sexual abuse cannot be made unless the circumstances satisfy a type of sexual abuse by deviate sexual activity described below that require that the A/O either was the A/V's caretaker or used forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

NOTE: Sexual contact does not include contact incidental to normal affectionate hugging.

3) If the A/O was fourteen (14) years old or older and A/V was less than eighteen (18) years old, a true finding for sexual abuse can be made if:
   A. The A/O was the A/V's caretaker where the following facts are established:
      1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
      2. The A/O was the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school, or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;
      3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
      4. A/O engaged in sexual contact with the A/V, attempted to engage in sexual contact with the A/V, or solicited the A/V to engage in sexual contact; and
      5. Where sexual contact is:
         a. An act of sexual gratification; and
         b. Involves
            (1) The touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;

(2) The encouraging of the A/V to touch the offender in a sexual manner; or

(3) The offender requesting to touch the A/V in a sexual manner; or

NOTE: No forcible compulsion is required to establish sexual abuse by a caretaker.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

NOTE: Sexual contact does not include contact incidental to normal affectionate hugging.

B. The A/O was not the A/V's caretaker where the following facts are established:

1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
2. A/O was not the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school, or any other person responsible for A/V's welfare, or the spouse of the A/V;
3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
4. A/O engaged in sexual contact, or attempted to engage in sexual contact, with the A/V;
5. A/O used forcible compulsion to engage in the sexual contact or attempted sexual contact, which is where either A/V did not want to engage in the sexual contact or attempted sexual contact, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to engage in the sexual contact or attempted sexual contact; and
6. Where sexual contact is:
   a. An act of sexual gratification; and
   b. Involves

(1) The touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;
(2) The encouraging of the A/V to touch the offender in a sexual manner; or
(3) The offender requesting to touch the A/V in a sexual manner; or

NOTE: This type of sexual abuse provides that if the A/O is fourteen (14) years old to seventeen (17) years old, a true finding for this type of sexual abuse cannot be made unless the A/O used forcible compulsion.

NOTE: The age, developmental stage, and stature of the A/V and the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

NOTE: Sexual contact does not include contact incidental to normal affectionate hugging.

4) A/O was less than fourteen (14) years old and the A/V was eighteen (18) years old or younger.
   A. A/O was less than fourteen (14) years old when the alleged sexual abuse occurred;
   B. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
   C. A/O engaged in sexual contact, or attempted to engage in sexual contact, with the A/V; and
   D. A/O used forcible compulsion to engage in the sexual contact or sexual contact, which is where either A/V did not want to engage in the sexual contact or attempted sexual contact, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to engage in the sexual contact or attempted sexual contact.

E. Where sexual contact is:

1. An act of sexual gratification; and
2. Involves
   a. The touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female;
   b. The encouraging of the A/V to touch the offender in a sexual manner; or
   c. The offender requesting to touch the A/V in a sexual manner.

NOTE: The age, developmental stage, and stature of the A/V and the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

NOTE: Sexual contact does not include contact incidental to normal affectionate hugging.

Indecent exposure:

1) A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
2) A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
3) A/O exposed his or her sexual organs to the A/V;
4) A/O intended to arouse or gratify the sexual desire of the A/O or some other person; and
5) A/O knew that exposing his or her sexual organs was likely to cause affront or alarm.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

Pornography:

1) If the A/O was fourteen (14) years old or older and A/V was less than eighteen (18) years old, a true finding for sexual abuse can be made if:

A. The A/O was the A/V's caretaker where the following facts are established:

1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
2. The A/O was the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;
3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred; and
4. A/O forced or encouraged A/V to watch pornography, which is:
    a. Any picture, movie, or video that lacks serious literary, artistic, political, or scientific value and that, when taken as a whole and applying contemporary community standards, would appear to the average person to appeal to the prurient interest;
    b. Material that depicts sexual conduct in a patently offensive manner lacking serious literary, artistic, political, or scientific value; or
    c. Obscene or licentious material; or

    NOTE: No force is required to establish sexual abuse by a caretaker; it is sufficient that the A/O encouraged or directed the A/V to watch pornography.

B. The A/O was not the A/V's caretaker where the following facts are established:

1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
2. A/O was not the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private

school, or any other person responsible for A/V's welfare, or the spouse of the A/V;

3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
4. A/O forced A/V to watch pornography, which is
   a. Any picture, movie, or video that lacks serious literary, artistic, political, or scientific value and that, when taken as a whole and applying contemporary community standards, would appear to the average person to appeal to the prurient interest;
   b. Material that depicts sexual conduct in a patently offensive manner lacking serious literary, artistic, political, or scientific value; or
   c. Obscene or licentious material; and
5. A/O forced A/V where either A/V did not want to watch the pornography, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to force the A/V to watch pornography.

NOTE: The age, developmental stage, and stature of the A/V and the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

Live Sexual Activity:

1) If the A/O was fourteen (14) years old or older and the A/V was less than eighteen (18) years old, a true finding for sexual abuse can be made if:
   A. The A/O was the A/V's caretaker where the following facts are established:
      1. The A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
      2. The A/O was the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private

school or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;

3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred; and
4. A/O forced, encouraged, or permitted the A/V to watch live sexual activity; or

NOTE: No force is required to establish sexual abuse by a caretaker; it is sufficient that the A/O encouraged or even permitted the A/V to watch live sexual activity.

B. The A/O was not the A/V's caretaker where the following facts are established:

1. A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
2. A/O was not the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school, or any other person responsible for A/V's welfare, or the spouse of the A/V;

3. A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
4. A/O forced A/V to watch live sexual activity; and
5. A/O forced A/V where either A/V did not want to watch the live sexual activity, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to force the A/V to watch live sexual activity.

NOTE: The age, developmental stage, and stature of the A/V and the relationship of the A/V to the A/O, as well as the threat of deprivation of affection, rights, and privileges from the A/V by the A/O, shall be considered in weighing the sufficiency of the evidence to prove forcible compulsion.

Phone Sex Line:

1) A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;

2) The A/O was the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;
3) A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
4) A/O forced A/V to listen to a phone sex line; and
5) A/O forced A/V where either A/V did not want to listen to the phone sex line, or the A/O used physical force, intimidation, or a threat, express or implied, of physical injury, death, rape, sexual abuse, or kidnapping of any person to force the A/V to listen to the phone sex line.

Voyeurism:

1) A/O was fourteen (14) years old or older when the alleged sexual abuse occurred;
2) The A/O was the A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school, or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;
3) A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
4) A/O looked at the A/V in a private location or place in which a child may reasonably be expected to be nude or partially nude; and
5) A/O's purpose in looking was for sexual arousal or gratification.

NOTE: Evidence of sexual gratification may be inferred from the attendant circumstances surrounding the specific complaint of child maltreatment.

Sex Trafficking:

1) A/O was eighteen (18) years old or older when the alleged sexual abuse occurred;
2) A/V was less than eighteen (18) years old when the alleged sexual abuse occurred;
3) A/O recruited, harbored, transported, obtained, patronized, or solicited A/V; and
4) A/O's purpose was to facilitate a commercial sex act.

1.5 Sexual Exploitation

Definition

Sexual exploitation means:

- By a person eighteen (18) years of age or older to a child who is not his or her spouse: Allowing, permitting, or encouraging participation or depiction of the child in prostitution, obscene photography, or obscene filming; or obscenely depicting, obscenely posing, or obscenely posturing the child for any use or purpose.

- By a caretaker to a child: Allowing, permitting, or encouraging participation or depiction of the child in prostitution, obscene photography, or obscene filming; or obscenely depicting, obscenely posing, or obscenely posturing the child for any use or purpose.

Exceptions

None.

Making a True Determination

Based on the definition above, an investigator may determine that an allegation of sexual abuse is true if a preponderance of the evidence establishes each of the elements for at least one (1) type of sexual exploitation:

Sexual exploitation:

1) A/O was, when the alleged sexual abuse occurred:
   A. Eighteen (18) years old or older and not A/V's spouse; or
   B. A/V's parent, guardian, custodian, foster parent, or any person fourteen (14) years old or older who was entrusted with the A/V's care by the A/V's parent, guardian, custodian, or foster parent, including without limitation an agent or employee of a public or private residential home, child care facility, public or private school or any other person responsible for the A/V's welfare, but excluding a spouse of the A/V;
2) A/V was less than eighteen (18) years old when the alleged sexual abuse occurred; and
3) A/O:

A. Allowed, permitted, or encouraged A/V to participate or be depicted in prostitution, obscene photography, or obscene filming; or
B. Obscenely depicted, obscenely posed, or obscenely postured the A/V for any use or purpose.

Section 2: Index of All Child Maltreatment Types Within Each Maltreatment Category (types listed alphabetically within each category)

Abandonment:

Abandonment for an indefinite period

Abandonment without just cause

Abandonment by articulated intent

Abuse:

Abuse involving exposure to a chemical that may interfere with normal physiological functions

Abuse involving subjection of a child to Munchausen syndrome by proxy or factitious illness

Abuse involving substances that may alter the mood of a child

Abuse involving noxious or poisonous substances that may interfere with normal physiological functions

Abuse with physical injury and without justifiable cause

Abuse with or without physical injury

Extreme or repeated cruelty

Female genital mutilation

Human trafficking

Injury at variance with explanation given

Mental injury

Nonaccidental physical injury

Threat of Harm

Neglect:

Educational neglect by failing to enroll a child in school

Educational neglect due to absence from school

Failure to assume responsibility for a child

Failure to prevent abuse

Failure to protect from maltreatment or parental unfitness

Failure to provide necessary food, clothing, shelter, or medical treatment

Failure to provide for care, maintenance, or support

Failure to provide for essential and necessary needs

Inadequate supervision by leaving a child alone

Inadequate supervision by placing child in a dangerous situation

Presence of illegal substance in a child when a child is born

Presence of illegal substance in a mother when a child is born

Sexual Abuse:

Deviate sexual activity

Indecent exposure

Live sexual activity

Phone sex line

Pornography

Sex trafficking

Sexual contact

Sexual intercourse

Voyeurism

Sexual Exploitation:

Sexual exploitation

REPEAL-EO 23-02

Table of Contents

State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 23-0017

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

December 11, 2023

Janet Mann
Director of Health and Medicaid Director
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

Re: Arkansas State Plan Amendment (SPA) AR-23-0017

Dear Director Mann:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) AR-23-0017. This amendment proposes to add medication-assisted treatment (MAT) as a mandatory benefit in the Medicaid state plan. This letter is to inform you that Arkansas' Medicaid SPA Transmittal Number AR-23-0017 is approved effective October 1, 2023 until September 30, 2025, pursuant to 1905(a)(29) of the Social Security Act and Section 1006(b) of the SUPPORT Act.

Section 1006(b) of the SUPPORT for Patients and Communities Act (SUPPORT Act), signed into law on October 24, 2018, amended section 1902(a)(10)(A) of the Act to require state Medicaid plans to include coverage of MAT for all eligible to enroll in the state plan or waiver of state plan. Section 1006(b) also added a new paragraph 1905(a)(29) to the Act to include the new required benefit in the definition of "medical assistance" and to specify that the new required benefit will be in effect for the period beginning October 1, 2020, and ending September 30, 2025.

Section 1006(b) of the SUPPORT Act also added section 1905(ee)(1) to the Act to define MAT, for purposes of the new required coverage, as:

> . . . all drugs approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), including methadone, and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders; and[,] . . . with respect to the provision of such drugs and biological products, counseling services and behavioral therapy.

Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, due to the COVID-19 public health emergency (PHE), CMS issued an approval letter on September 20, 2023 allowing Arkansas to modify the SPA submission requirements at 42 C.F.R. 430.20, to allow the state to submit a SPA implementing section 1905(a)(29) of the Act by March 31, 2021 that would take effect on October 1, 2020.

Pursuant to section 1135(b)(5) and/or 1135(b)(1)(C) of the Act, due to the COVID-19 PHE, CMS issued an approval letter on September 20, 2023 allowing Arkansas to modify the public notice time frames set forth at 42 C.F.R. 447.205, in order to obtain an effective date of October 1, 2020 for its SPA implementing statewide methods and standards for setting payment rates for the benefit described at section 1905(a)(29) of the Act. The state issued public notice on October 18, 2023.

CMS conducted our review of your submittal according to statutory requirements in Title XIX of the Act and implementing regulations.

If you have any questions regarding this approval, please contact Lee Herko at 570-230-4048 or via email at lee.herko@cms.hhs.gov .

Sincerely,

Ruth Hughes -S

Digitally signed by Ruth Hughes -S
Date: 2023.12.11 12:00:23 -06'00'

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures

cc: Elizabeth Pittman
Anita Castleberry
Lisa Teague
Jack Tiner

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: 23-0017

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
10/1/2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 8

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 691,200
b. FFY 2025 $ 691,200

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See Attached.

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See Attached.

9. SUBJECT OF AMENDMENT

Medication-Assisted Treatment (MAT) Services. The Division of Medical Services has updated the state plan to comply with both federal and state regulations regarding MAT. Federal regulations removed the need for practitioners to submit a notice of intent (X-Waiver) before prescribing MAT services. Act 451 removes the requirement for prior authorization when subscribing MAT services. Act 586 amends access to Naloxone and increases availability and access of an opioid antagonist. The federal and state measures are aimed at reducing drug overdoses and increasing access to services for beneficiaries in need of MAT services.

10. GOVERNOR'S REVIEW *(Check One)*

- [x] 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. Elizabeth Pitman

12. TYPED NAME
Elizabeth Pitman

13. TITLE
Director, Division of Medical Services

14. DATE SUBMITTED
September 21, 2023

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 21, 2023

17. DATE APPROVED
December 7, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Ruth Hughes -S
Digitally signed by Ruth Hughes -S
Date: 2023.12.11 12:01:03 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL
Ruth A. Hughes

21. TITLE OF APPROVING OFFICIAL
Acting Director, Division of Program Operations

22. REMARKS

11/28/2023 State requests Attachment 3.1B Page 2xxxx
be withdrawn from the SPA package.

State Plan Amendment #23-0017 – Medication Assisted Treatment Services (MAT)

PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
3.1A, Page 1d	3.1A, Page 1d, Approved 8-1-20, Supersedes TN 20-0013
3.1A, Page 1ee	3.1A, Page 1ee, Approved 7-1-22, Supersedes TN 22-0010
3.1A, Page 1f	3.1A, Page 1f, Approved 7-1-22, Supersedes TN 22-0003
3.1A, Page 5a	3.1A, Page 5a, Approved 1-1-22, Supersedes TN 21-0009
3.1B, Page 2a	3.1B, Page 2a, Approved 8-1-20, Supersedes TN 20-0013
3.1B, Page 2d	3.1B, Page 2d, Approved 8-1-20, Supersedes TN 20-0013
3.1B, Page 2ee	3.1B, Page 2ee, Approved 7-1-22, Supersedes TN 22-0010
3.1B, Page 2f	3.1B, Page 2f, Approved 7-1-22, Supersedes TN 22-0003
3.1B, Page 2xxx	3.1B, Page 2xxx, Approved 8-1-20, Supersedes TN 20-0013
3.1B, Page 4g	3.1B, Page 4g, Approved 1-1-22, Supersedes TN 21-0009
3.1F, Page 29	3.1F, Page 29, Approved 8-1-20, Supersedes TN 20-0013
Supplement 1 to Attach.3.1B, Pages 1-6	Supplement 1 to Attach. 3.1B, Pages 1-6, Approved 10-1-20, Supersedes TN 21-0003
Supplement 5 to Attach. 3.1A, Pages 1-6	Supplement 5 to Attach. 3.1A, Pages 1-6, Approved 10-1-20, Supersedes TN 21-0003

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure**;** opioid use disorder when the visit is part of a Medication Assisted Treatment Plan**;** and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.b. Rural Health Clinic Services

5. Services of nurse midwives

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4). Federally qualified health center services are limited to sixteen (16) encounters per client**,** per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

For federally qualified health center core services beyond the benefit limit, extensions will be available if medically necessary. Beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.

3. Other Laboratory and X-Ray Services

Other **professional and technical laboratory and radiological services** are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined **under 42 CFR 440.30 in an office or similar facility other than a hospital outpatient department or clinic.**

Diagnostic laboratory **s**ervices benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY**,** July 1 – June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services health benefit limit**s: (**a**)** Malignant neoplasm; **(**b**)** HIV infection; and **(c)** renal failure. The cost of related diagnostic laboratory services, and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limits or the five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD)**,** and the screening is part of a Medication Assisted Treatment **(**MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory services health benefit limit.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per SFY outpatient diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limits.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY radiology/other services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their place of residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per **S**FY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation**,** prescription drugs for opioid **or alcohol** use disorder as part of a Medication Assisted Treatment plan, EPSDT, high blood pressure**, hypercholesterolemia,** blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the Arkansas Medicaid Pharmacy Vendor's Website, are covered:

a. select agents when used for weight gain

b. select agents when used for the symptomatic relief of cough and colds

c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride

d. select nonprescription drugs

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a seventy-two (72) hour supply of drugs in emergency situations.

State/Territory: ARKANSAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):

4.d. Tobacco cessation counseling services for pregnant women

☒ Provided: ☐ No limitations ☒ with limitations*

e. Medication-Assisted Treatment for opioid use disorders when provided as part of a Medication Assisted Treatment plan

☒ Provided: ☐ No limitations ☒ with limitations*

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

☒ Provided: ☐ No limitations ☒ with limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

☒ Provided: ☐ No limitations ☒ with limitations*

*Description provided on attachment.

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; opioid use disorder when the visit is part of a Medication Assisted Treatment plan, and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

2.b. Rural Health Clinic Services

5. Services of nurse midwives; and

6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the rural health clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the rural health clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) NCFA – Pub. 45-4).

Federally qualified health center services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.

Benefit extensions will be available if medically necessary. Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.

3. Other Laboratory and X-Ray Services

Other professional and technical laboratory and radiological services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined under 42 CFR 440.30 in an office or similar facility other than a hospital outpatient department or clinic.

Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to recipients under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services health benefit limits: (a) Malignant neoplasm; (b) HIV infection; and (c) renal failure. The cost of related diagnostic laboratory services and radiology/other services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD), and the screening is part of a Medication Assisted Treatment (MAT**)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory or radiology/other services health benefit limits.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **S**FY outpatient diagnostic laboratory services benefit limit or five hundred dollars ($500) per SFY radiology/other services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit or the recipient's five hundred dollars ($500) per SFY radiology/other services health benefit limit.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY X-ray services benefit limit. Extensions of the benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in their residence upon the written order of the recipient's physician. Portable X-ray **s**ervices are limited to the following:

a. Skeletal films that involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films that do not involve the use of contrast media; and
c. Abdominal films that do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per SFY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for recipients twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided

4.c. Family Planning Services

(1) Comprehensive family planning services are limited to an original examination and up to three (3) follow-up visits annually. This limit is based on the state fiscal year (July 1 through June 30).

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

[X] (i) By or under supervision of a physician;

[X] (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

***D**escribe if there are any limits on who can provide these counseling services

Arkansas Medicaid does not limit who can provide these counseling services at this time so long as they meet (ii) and (iii).

****Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.**

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: **[**x] No limitations [] With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

4.e. Prescription drugs for treatment of opioid use disorder

a. **P**referred prescription drugs (preferred on the PDL) used for treatment of opioid **or alcohol** use disorder require no prior authorization and do not count against the monthly prescription limits when prescribed as part of a Medication Assisted Treatment plan.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

(1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. Family Planning, tobacco cessation**,** prescription drugs for opioid **or alcohol** use disorder when part of a Medication Assisted Treatment plan, EPSDT, high blood pressure, h**ypercholesterolemia,** blood modifiers, diabetes and respiratory illness inhaler prescriptions do not count against the prescription limit.

(2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

(3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the **Arkansas Medicaid Pharmacy Vendor's Website**, are covered:

a. select agents when used for weight gain:

b. select agents when used for the symptomatic relief of cough and colds:

c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:

d. select nonprescription drugs:

(4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991, will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72-hour supply of drugs in emergency situations.

Citation	Condition or Requirement

1. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
CFR 438.50
42 CFR 438.10

X The state assures that its state plan program complies with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
Developmental Disabilities Services Community and Employment Support
Family Planning
Anesthesia
Alternative Waiver Programs
Adult Developmental Day Treatment Services Core Services only
Disease Control Services for Communicable Diseases
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Medication-Assisted Treatment Services for opioid use disorder when part of a Medication Assisted Treatment plan
Mental health services as follows:
- a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
- b. Rehabilitative Services for Youth and Children

Nurse Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, delivery, and postpartum) services
Pharmacy
Physician Services for inpatients acute care
Transportation

State of Arkansas

1905(a)(29) Medication Assisted Treatment (MAT)

Citation: 3.1(b)(1) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(a)(29) __X___MAT as described and limited in Supplement 1 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to the medically needy.

State of Arkansas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid clients who meet the medical necessity criteria for receipt of the service for the period beginning October1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for opioid use disorder (OUD) that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

State of Arkansas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT is covered exclusively under section 1905(a)(29) for the period of 10/01/2020 through 9/30/2025.

Services available:

1. Individual Behavioral Health Counseling
2. Group Behavioral Health Counseling
3. Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

b) Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants and Nurse Practitioners may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT). This group's role is to provide the behavioral and substance use disorder counseling required.

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Arkansas Licensed.

Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute.

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)
_____ Generic first policy
___X__ Preferred drug lists
_____ Clinical criteria
___X__ Quantity limits
_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT drugs and biologicals are limited based on the FDA indication and manufacturers' prescribing guidelines. Some medications are also subject to status on the Preferred Drug List **(PDL).**

The preferred **(PDL)** agents for MAT therapy **do not** require a PA.

The Arkansas Medicaid Pharmacy program removed the prior authorization for preferred Buprenorphine products on 1/1/2020, due to Arkansas State Law from Act 964 which prohibits a prior authorization for Medication Assisted Treatment of Opioid Use Disorder. The removal of prior authorization was for MAT treatment according to SAMHSA guidelines. In addition, on 1/22/2021, per section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), for all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to be covered, Arkansas instructed the pharmacy vendor to bypass the non-rebate-participation, repackaged indicator, inner indicator, and prioritize coverage of all the pharmacy MAT products.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(29) ___X__MAT as described and limited in Supplement __5__ to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid clients who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone, all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for **o**pioid **u**se **d**isorder (OUD)that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT is covered exclusively under section 1905(a)(29) for the period of 10/01/2020 through 9/30/2025.

Services available:

1. Individual Behavioral Health Counseling
2. Group Behavioral Health Counseling
3. Marital/Family Behavioral Health Counseling that involves the participation of a non-Medicaid eligible is for the direct benefit of the client. The service must actively involve the client in the sense of being tailored to the client's individual needs. There may be times when, based on clinical judgment, the client is not present during the delivery of the service, but remains the focus of the service.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

b) Please include each practitioner and provider entity that furnishes each service and component service.

1. Physicians, Physician Assistants, and Nurse Practitioners may provide counseling and behavioral health therapies.

2. Licensed Behavioral Health Practitioners: Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), Licensed Marital and Family Therapists (LMFT), This group's role is to provide the behavioral and substance use disorder counseling required

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training, and supervisory arrangements that the state requires.

Physicians and Nurse Practitioners must be Arkansas Licensed.

Physician Assistants must have a legal agreement to practice under an Arkansas Licensed Physician per Arkansas statute.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Licensed Psychologists (LP), Licensed Psychological Examiners – Independent (LPEI), Licensed Professional Counselors (LPC), Licensed Certified Social Workers (LCSW), and Licensed Marital and Family Therapists (LMFT) must possess a current and valid Arkansas license.

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)
_____ Generic first policy
__X__ Preferred drug lists
_____ Clinical criteria
__X__ Quantity limits
_____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state's limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

MAT drugs and biologicals are limited based on the FDA indication and manufacturers' prescribing guidelines. Some medications are also subject to status on the Preferred Drug List **(PDL).**
The preferred **(PDL)** agents for MAT therapy **do not** require a Prior Authorization.

The Arkansas Medicaid Pharmacy program removed the prior authorization for preferred Buprenorphine products on 1/1/2020, due to Arkansas State Law from Act 964 which prohibits a prior authorization for Medication Assisted Treatment of Opioid Use Disorder. The removal of prior authorization was for MAT treatment according to SAMHSA guidelines. In addition, on 1/22/2021, per section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), for all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to be covered, Arkansas instructed the pharmacy vendor to bypass the non-rebate-participation, repackaged indicator, inner indicator, and prioritize coverage of all the pharmacy MAT products.

State of ARKANSAS

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.