EXHIBIT F

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Provider Refunds and Primary Care Provider Qualification Updates

DESCRIPTION:

Statement of Necessity

As a result of previous audit findings and to ensure compliance with federal requirements, the Division of Medical Services (DMS) updates the Arkansas Medicaid Provider Manual. DMS clarifies methods for providers to refund balances related to adverse actions pertaining to Medicaid claims findings and updates the qualifications for participating as a primary care provider.

Rule Summary

Section I of the Arkansas Medicaid Provider Manuals is revised as follows:

- **Section 142.600:** Added paragraph stating, "Any outstanding balances over thirty (30) days will be recouped against future payments. Providers unable to refund their outstanding balance within thirty (30) days must contact Gainwell Technologies Provider Assistance Center (PAC) to discuss repayment options. Note: All outstanding balances must be paid back within one (1) year. View or print the Provider Assistance Center contact information."
- **Section 171.100**
    - Remove language requiring clinics to enroll as PCPs and remove the exception for physicians employed exclusively by an Area Health Education Center, a Federally Qualified Health Center, a Medical College Physician's Group, or a hospital for enrolling in the PCP program.
    - Remove language defining qualified clinics and health centers as single-entity PCP's and listing them.
- **Section 171.110:** Remove the exception of family practice and internal medicine clinics at UAMS as physician group practices under the exclusions rule.
- **Section 171.130:** Remove PCP qualified single entity providers from list of providers required to execute Child Health Services (EPSDT) agreements.
- **Section 171.140:** Remove PCP qualified single entity providers from list of providers required to execute Child Health Services (EPSDT) agreements under the Primary Care Case Manager Agreement.
- **Section 171.150:** Delete Section specifying what practice groups were allowed to enroll as single-entity PCPs.

PUBLIC COMMENT: A public hearing was held on this rule on January 24, 2024. The public comment period expired on February 12, 2024. The agency provided the following public comment summary:

Commenter's Name: Jen Mace, Compliance Director, Summit Community Care

COMMENT: Below please see Summit's comments/questions concerning the DHS Proposed Rule Change to Provider Refunds and Primary Care Provider Qualification Updates:

Currently, Summit allows Member assignment at either the FQHC or FQHC Practitioner level. If we can only assign members at an individual FQHC practitioner level, for Member visibility, does this change mean we are obligated to list each individual FQHC practitioner in the provider directory instead of the FQHC location? If so, this is a significant change in our process and may materially impact our FQHC provider partners.

RESPONSE: Listing every enrolled individual provider in the provider directory is necessary to meet Medicaid managed care rules. Publishing individual providers within the FQHC of practice is essential for beneficiaries to make an informed choice pertaining to their overall healthcare.

These changes were brought about as the result of a Payment Error Rate Measurement (PERM) audit to bring AR Medicaid into compliance with the Affordable Care Act (ACA). The ACA requires the National Provider Identifier (NPI) of the Ordering, Referring, Prescribing (ORP) provider be on the claim of service. Therefore, each ORP provider must be enrolled as an individual (Entity Type 1) in the Medicaid program for the claim date of service. Managed Care Organizations must also comply with the ACA regulations.

This means a Medicaid beneficiary needs to be assigned to an individual provider, not a provider group as previously allowed. This does not mean the individual provider is the only one the beneficiary is allowed to see for services within the practice. Medicaid does allow for PCP Substitutes. Under Section 171.601, 171.610, and 171.620 of Section I – General Policy, beneficiaries may see other providers within the practice if the assigned PCP's schedule is full and for several other acceptable reasons.

The proposed effective date is April 1, 2024.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

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 federal regulations. A state Medicaid agency "must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services." 42 C.F.R. § 455.440.

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

January 12, 2024

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: Provider Refunds and Primary Care Provider Qualification 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 Department of 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?
Provider Refunds and Primary Care Provider Qualification Updates

2. What is the subject of the proposed rule? Revise Medicaid Provider Manuals as a result of previous audit

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.

42 CFR § 455.440
42 CFR § 440.110
42 CFR § 440.30
42 CFR § 440.70

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.

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.

Governor's Exception

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).

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

The rule is necessary to correct previous information related to the qualifications for participating as a primary care provider. The rule also clarifies methods for providers to refund balances related to adverse actions pertaining to Medicaid claims findings. This rule is being amended to as a result of previous audit findings and to ensure compliance with CMS regulations.

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).

ar.gov/dhs-proposed-rules

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

If yes, please complete the following:

Date: 01/24/2024

Time: 2:30 pm

Place: ZOOM: https://us02web.zoom.us/j/82351019847 ; webinar ID: 823 5101 9847

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. 02/12/2024

15. What is the proposed effective date for this rule? 4/1/2024

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.

Federally Qualified Health Centers (FQHCs), Arkansas Health Education Centers (AHEC), and UAMS PCP Groups: These groups are aware of the federal requirement, have been in consultation with DHS, and are working to update their practices to implement the requirements.

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

If yes, please explain.

See #18 above.

NOTICE OF RULE MAKING

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

The Division of Medical Services (DMS) updates Section I of the Arkansas Medicaid Provider Manuals as a result of previous audit findings and to ensure compliance with federal requirements. The proposed effective date of the rule is April 1, 2024. There is no fiscal impact.

DMS clarifies methods for providers to refund balances related to adverse actions pertaining to Medicaid claims findings. Any outstanding balances over 30 days will be recouped against future payments and providers unable to refund their outstanding balance within 30 days must contact Gainwell Technologies Provider Assistance Center to discuss repayment options. All outstanding balances must be paid back within one year.

DMS also updates the qualifications for participating as a primary care provider (PCP). DMS removes language requiring clinics to enroll as PCPs and remove the exception for physicians employed exclusively by an Area Health Education Center, a Federally Qualified Health Center, a Medical College Physician's Group, or a hospital for enrolling in the PCP program and language defining qualified clinics and health centers as single-entity PCP's and listing them. DMS removes the exception of family practice and internal medicine clinics at UAMS as physician group practices under the exclusions rule, removes PCP qualified single entity providers from the list of providers required to execute Child Health Services agreements under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Agreement Requirement or Primary Care Case Manager Agreement. Finally, DMS deleted specific practice groups allowed to enroll as single-entity PCPs.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than February 12, 2024. 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 January 24, 2024 at 2:30 p.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/82351019847. The webinar ID is 823 5101 9847. 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. 4502172997

Elizabeth Pitman, Director
Division of Medical Services

From:	Legal Ads
To:	Chloe Crater
Subject:	Re: FULL RUN AD - Provider Refunds and Primary Care Provider Qualification Updates Signature
Date:	Friday, January 12, 2024 11:04:53 AM
Attachments:	image001.png image002.png

[EXTERNAL SENDER]

Will run Sun 1/14, Mon 1/15 and Tues 1/16.

You will receive two invoices: One for Sun, the other for the other days.

Thank you.

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

From: "Chloe Crater" <Chloe.Crater@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Friday, January 12, 2024 10:43:14 AM
Subject: FULL RUN AD - Provider Refunds and Primary Care Provider Qualification Updates Signature

Hi Gregg,

Please run the attached ad in the Arkansas Democrat-Gazette on the following days:

- Sunday January 14, 2024
- Monday January 15, 2024
- Tuesday January 16, 2024

A public hearing by remote access only will be held through a Zoom webinar. The public comment period will end on February 12, 2024.

-Thanks,
Chloe

DHS
CHLOE CRATER-BETTON

OFFICE OF LEGISLATIVE AND INTERGOVERNMENTAL AFFAIRS – RULES PROMULGATION
PROGRAM ADMINISTRATOR

P: 501-320-6217
700 MAIN STREET
Little Rock, AR 72201
Chloe.Crater@dhs.arkansas.gov

humanservices.arkansas.gov

From:	Legal Ads
To:	Chloe Crater
Subject:	Re: CORRECTED NOTICE OF RULEMAKING (FULL RUN AD - Provider Refunds and Primary Care Provider Qualification Updates Signature)
Date:	Wednesday, January 17, 2024 9:02:21 AM
Attachments:	image001.png image002.png

[EXTERNAL SENDER]

Will run Fri 1/19, Sat 1/20, and Sun 1/21. You will receive 2 invoices (one for Fri/Sat, the other for Sun).

Thank you.

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

From: "Chloe Crater" <Chloe.Crater@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Tuesday, January 16, 2024 8:47:50 AM
Subject: CORRECTED NOTICE OF RULEMAKING (FULL RUN AD - Provider Refunds and Primary Care Provider Qualification Updates Signature)

Hi Gregg,
I need to correct a notice and run it again on the dates listed below. I listed the public hearing date in it as 2/24 rather than 1/24.

Please run the attached ad in the Arkansas Democrat-Gazette on the following days:

- Friday January 19, 2024
- Saturday January 20, 2024
- Sunday January 21, 2024

A public hearing by remote access only will be held through a Zoom webinar. The public comment period will end on February 12, 2024.

-Thanks,
Chloe

CHLOE CRATER-BETTON
OFFICE OF LEGISLATIVE AND INTERGOVERNMENTAL AFFAIRS – RULES PROMULGATION
PROGRAM ADMINISTRATOR

P: 501-320-6217
700 MAIN STREET
Little Rock, AR 72201
Chloe.Crater@dhs.arkansas.gov

humanservices.arkansas.gov

From:	Chloe Crater
To:	register@sos.arkansas.gov
Cc:	Mac Golden; Jack Tiner; Lakeya Gipson; JAMIE EWING
Subject:	DHS/DMS - PROPOSED FILING - Provider Refunds and Primary Care Provider Qualification Updates Signature
Date:	Friday, January 12, 2024 11:08:00 AM
Attachments:	image001.png image002.png RULE 258 - SOS INITIAL FILING PACKET.pdf

---

The Rule will run the following three consecutive Days in the Arkansas Democrat Gazette.

- Sunday January 14, 2024
- Monday January 15, 2024
- Tuesday January 16, 2024

A public hearing by remote access only will be held through a Zoom webinar. The public comment period will end on February 12, 2024.

Thanks,
Chloe

DHS
CHLOE CRATER-BETTON
OFFICE OF LEGISLATIVE AND INTERGOVERNMENTAL AFFAIRS – RULES PROMULGATION
PROGRAM ADMINISTRATOR

P: 501-320-6217
700 MAIN STREET
Little Rock, AR 72201
Chloe.Crater@dhs.arkansas.gov

humanservices.arkansas.gov

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

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

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

TITLE OF THIS RULE Provider Refunds and Primary Care Provider Qualification Updates

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ☐ No ☑

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

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

   If no, please explain:

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

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

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

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

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

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	Total	$ 0.00

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$ 0.00	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	**Next Fiscal Year**
$ 0.00	$ 0.00

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.

Statement of Necessity and Rule Summary
[Provider Refunds and Primary Care Provider Qualification Updates]

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

As a result of previous audit findings and to ensure compliance with federal requirements, the Division of Medical Services (DMS) updates the Arkansas Medicaid Provider Manual. DMS clarifies methods for providers to refund balances related to adverse actions pertaining to Medicaid claims findings and updates the qualifications for participating as a primary care provider.

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

Section I of the Arkansas Medicaid Provider Manuals is revised as follows:

Section 142.600	Added paragraph stating, "Any outstanding balances over thirty (30) days will be recouped against future payments. Providers unable to refund their outstanding balance within thirty (30) days must contact Gainwell Technologies Provider Assistance Center (PAC) to discuss repayment options. **Note:** All outstanding balances must be paid back within one (1) year. **View or print the Provider Assistance Center contact information.**"
Section 171.100	Remove language requiring clinics to enroll as PCPs and remove the exception for physicians employed exclusively by an Area Health Education Center, a Federally Qualified Health Center, a Medical College Physician's Group, or a hospital for enrolling in the PCP program. Remove language defining qualified clinics and health centers as single-entity PCP's and listing them.
Section 171.110	Remove the exception of family practice and internal medicine clinics at UAMS as physician group practices under the exclusions rule.
Section 171.130	Remove PCP qualified single entity providers from list of providers required to execute Child Health Services (EPSDT) agreements.
Section 171.140	Remove PCP qualified single entity providers from list of providers required to execute Child Health Services (EPSDT) agreements under the Primary Care Case Manager Agreement.
Section 171.150	Delete Section specifying what practice groups were allowed to enroll as single-entity PCPs.

TOC required

142.600 Conditions Related to Provider Refunds to DMS

~~12-1-03~~4-1-24

Within thirty (30) days, a provider must refund any money the state is obligated to repay the federal government as a result of disallowance, recoupment or other adverse action in connection with Medicaid payments to the provider.

Any outstanding balances over thirty (30) days will be recouped against future payments. Providers unable to refund their outstanding balance within thirty (30) days must contact Gainwell Technologies Provider Assistance Center (PAC) to discuss repayment options. **Note:** All outstanding balances must be paid back within one (1) year. **View or print the Provider Assistance Center contact information.**

171.100 PCP-Qualified Physicians~~,~~ and Advanced Practice Nurse Practitioners~~, and Single-Entity Providers~~

~~7-1-22~~4-1-24

A. Primary Care Provider (PCP)-qualified physicians are those whose sole or primary specialty is

1. Family practice
2. General practice
3. Internal medicine
4. Pediatrics and adolescent medicine
5. Obstetrics and gynecology

B. Obstetricians and gynecologists may choose whether to be PCPs.

C. Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed in part A above.

D. All other PCP-qualified physicians ~~and clinics~~ must enroll as PCPs~~, except for those who certify in writing that they are employed exclusively by a University of Arkansas Medical School (UAMS) Regional Program, a federally qualified health center (FQHC), a Medical College Physicians Group, or a hospital (i.e., they are "hospitalists", and they practice exclusively in a hospital)~~.

E. Advanced practice registered nurses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.

~~F. PCP-qualified clinics and health centers (single-entity PCPs) are~~

~~1. UAMS Regional Programs~~

~~2. FQHCs~~

~~3. The family practice and internal medicine clinics at the University of Arkansas for Medical Sciences~~

171.110 Exclusions

~~9-15-09~~4-1-24

A. Physicians whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs.

B. Physician group practices ~~(except the family practice and internal medicine clinics at UAMS)~~ may not be PCPs.

C. Rural Health Clinics (RHCs) may not be PCPs, but PCP-qualified physicians affiliated with RHCs must be PCPs.

D. Physicians who certify in writing that they are employed.

171.130 EPSDT Agreement Requirement

~~9-15-09~~4-1-24

A. A PCP applicant must sign an agreement to participate as a screening provider in the Child Health Services (EPSDT) program.

B. Internists, obstetricians, gynecologists, and physicians who customarily carry a caseload of patients who are 21 years of age or older are not required to furnish EPSDT screens.

1. Their participation in the Child Health Services (EPSDT) program is optional.
2. They must, however, sign Child Health Services (EPSDT) agreements if they elect to be screening providers.

~~C. PCP-qualified single-entity providers must execute Child Health Services (EPSDT) agreements.~~

171.140 Primary Care Case Manager Agreement

~~7-1-05~~4-1-24

A. Every PCP applicant must sign a Primary Care Case Manager (PCCM) contract.

~~B. PCP-qualified single-entity providers must execute Child Health Services (EPSDT) agreements.~~

~~171.150 Physician Group Single-Entity PCCMs~~

~~7-1-05~~

~~The family practice and internal medicine groups at the University of Arkansas for Medical Sciences are the only physician group providers that may enroll as single-entity PCPs.~~

TOC required

142.600 Conditions Related to Provider Refunds to DMS 4-1-24

Within thirty (30) days, a provider must refund any money the state is obligated to repay the federal government as a result of disallowance, recoupment or other adverse action in connection with Medicaid payments to the provider.

Any outstanding balances over thirty (30) days will be recouped against future payments. Providers unable to refund their outstanding balance within thirty (30) days must contact Gainwell Technologies Provider Assistance Center (PAC) to discuss repayment options. **Note:** All outstanding balances must be paid back within one (1) year. **View or print the Provider Assistance Center contact information.**

171.100 PCP-Qualified Physicians and Advanced Practice Nurse Practitioners 4-1-24

A. Primary Care Provider (PCP)-qualified physicians are those whose sole or primary specialty is

1. Family practice
2. General practice
3. Internal medicine
4. Pediatrics and adolescent medicine
5. Obstetrics and gynecology

B. Obstetricians and gynecologists may choose whether to be PCPs.

C. Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed in part A above.

D. All other PCP-qualified physicians must enroll as PCPs.

E. Advanced practice registered nurses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.

171.110 Exclusions 4-1-24

A. Physicians whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs.

B. Physician group practices may not be PCPs.

C. Rural Health Clinics (RHCs) may not be PCPs, but PCP-qualified physicians affiliated with RHCs must be PCPs.

D. Physicians who certify in writing that they are employed.

171.130 EPSDT Agreement Requirement 4-1-24

A. A PCP applicant must sign an agreement to participate as a screening provider in the Child Health Services (EPSDT) program.

B. Internists, obstetricians, gynecologists, and physicians who customarily carry a caseload of patients who are 21 years of age or older are not required to furnish EPSDT screens.

1. Their participation in the Child Health Services (EPSDT) program is optional.

2. They must, however, sign Child Health Services (EPSDT) agreements if they elect to be screening providers.

171.140 Primary Care Case Manager Agreement 4-1-24

A. Every PCP applicant must sign a Primary Care Case Manager (PCCM) contract.

42 CFR 440.30

This document is current through the Oct. 25, 2023 issue of the Federal Register, with the exception of the amendments appearing at 88 FR 73234, 88 FR 73424, and 88 FR 73458.

LEXISNEXIS' CODE OF FEDERAL REGULATIONS > Title 42 Public Health > Chapter IV — Centers for Medicare & Medicaid Services, Department of Health and Human Services > Subchapter C — Medical Assistance Programs > Part 440 — Services: General Provisions > Subpart A — Definitions

§ 440.30 Other laboratory and X-ray services.

Other laboratory and X-ray services means professional and technical laboratory and radiological services—

(a) Ordered and provided by or under the direction of a physician or other licensed practioner of the healing arts within the scope of his practice as defined by State law or ordered by a physician but provided by referral laboratory;

(b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and

(d) During the Public Health Emergency defined in *42 CFR 400.200* or any future Public Health Emergency resulting from an outbreak of communicable disease, and during any subsequent period of active surveillance (as defined in this paragraph), Medicaid coverage is available for laboratory tests and X-ray services that do not meet conditions specified in paragraph (a) or (b) of this section, if the purpose of such laboratory and X-ray services is to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, COVID-19, or the communicable disease named in the Public Health Emergency or its causes, and if the deviation from the conditions specified in paragraph (a) or (b) of this section is intended to avoid transmission of the communicable disease. For purposes of this paragraph, a period of active surveillance is defined as an outbreak of communicable disease during which no approved treatment or vaccine is widely available, and it ends on the date the Secretary terminates it, or the date that is two incubation periods after the last known case of the communicable disease, whichever is sooner. Additionally, during the Public Health Emergency defined in *42 CFR 400.200* or any future Public Health Emergency resulting from an outbreak of communicable disease, and during any subsequent period of active surveillance (as defined in this paragraph), Medicaid coverage is available for laboratory processing of self-collected laboratory test systems that are authorized by the FDA for home use, if available to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, COVID-19, or the communicable disease named in the Public Health Emergency or its causes, even if those self-collected tests would not otherwise meet the requirements of paragraph (a) or (b) of this section, provided that the self-collection of the test is intended to avoid transmission of the communicable disease. If, pursuant to this paragraph, a laboratory processes a self-collected test system that is authorized by the FDA for home use, and the test system does not meet the conditions in paragraph (a) of this section, the laboratory must notify the patient and the

patient's physician or other licensed non-physician practitioner (if known by the laboratory), of the results.

(c) Furnished by a laboratory that meets the requirements of part 493 of this chapter.

Statutory Authority

Sec. 1102 of the Social Security Act (*42 U.S.C. 1302*).

Authority Note Applicable to 42 CFR Ch. IV, Subch. C, Pt. 440

History

[46 FR 42672, Aug. 24, 1981, as amended at 57 FR 7135, Feb. 28, 1992; *85 FR 27550*, 27626, May 8, 2020]

Annotations

Notes

[EFFECTIVE DATE NOTE:

85 FR 27550, 27626, May 8, 2020, added paragraph (d), effective May 8, 2020.]

Notes to Decisions

Healthcare Law: Business Administration & Organization: Licenses: General Overview

Public Health & Welfare Law: Social Security: Medicaid: General Overview

Public Health & Welfare Law: Social Security: Medicaid: Coverage: General Overview

Public Health & Welfare Law: Social Security: Medicaid: Providers: Types: Physicians

Public Health & Welfare Law: Social Security: Medicaid: State Plans: Mandatory Services

Public Health & Welfare Law: Social Security: Medicare: Providers: Types: Hospitals

Public Health & Welfare Law: Social Security: Medicare: Providers: Types: Physicians

Healthcare Law: Business Administration & Organization: Licenses: General Overview

Katz v. New Mexico Dep't of Human Servs., Income Support Div., 95 N.M. 530, 624 P.2d 39, 1981 N.M. LEXIS 2250 (N.M. 1981).

Katz v. New Mexico Dep't of Human Servs., Income Support Div., 95 N.M. 530, 624 P.2d 39, 1981 N.M. LEXIS 2250 (N.M. 1981).

Overview: *New Mexico's Medicaid program did not cover treatment a claimant received from a chiropractor and a physical therapist because their services were optional under federal law, and the denial of benefits did not violate equal protection principles.*

- Laboratory and X-ray services fall within the five mandatory categories of medical services. *42 U.S.C.S. § 1396d(a)(3)*. *42 C.F.R. § 440.30* interprets laboratory and X-ray services as professional and technical laboratory and radiological services — (a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law. A licensed chiropractor must be considered a "practitioner of the healing arts" under N.M. Stat. Ann. § 61-4-2 (1978). To the extent that the state manual disallows coverage of laboratory and X-ray services on the basis that those services are ordered or performed by a licensed chiropractor, it conflicts with federal law. State law requires the New Mexico Department of Human Services to administer the program consistent with the federal act. N.M. Stat. Ann. § 27-2-12. *Go To Headnote*

Public Health & Welfare Law: Social Security: Medicaid: General Overview

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

Overview: *Plaintiffs' request for reimbursement from the state as to x-ray services they rendered to qualified Medicare beneficiaries prior to the date of the parties' stipulation constituted retroactive relief that was barred under the Eleventh Amendment.*

- The full text of *42 C.F.R. § 440.30* states that other laboratory and X-ray services means professional and technical laboratory and radiological services —(a) ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law or ordered by a physician but provided by a referral laboratory; (b) provided in an office or similar facility other than a hospital outpatient department or clinic; and (c) furnished by a laboratory that meets the requirements of part 493 of the chapter. *Go To Headnote*

Ellis v. Patterson, 713 F. Supp. 292, 1988 U.S. Dist. LEXIS 16201 (E.D. Ark.), vacated, remanded, *859 F.2d 52, 1988 U.S. App. LEXIS 13051 (8th Cir. 1988)*.

Overview: *Transplant candidate did not have a constitutional right to a liver transplant, as the Medicare statutes and regulations granted to the state the discretion to choose to fund certain transplant procedures and not others.*

- *42 C.F.R. § 440.210*provides that a state plan must, at minimum, specify that the categorically needy are provided certain services, which are specified at *42 C.F.R. §§ 440.10* through *440.50* and *440.70*. These services include: inpatient hospital services (*42 C.F.R. § 440.10*), other laboratory and x-ray services (*42 C.F.R. § 440.30*), and physicians' services (*42 C.F.R. § 440.50*). *Go To Headnote*

Public Health & Welfare Law: Social Security: Medicaid: Coverage: General Overview

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

Overview: *Plaintiffs' request for reimbursement from the state as to x-ray services they rendered to qualified Medicare beneficiaries prior to the date of the parties' stipulation constituted retroactive relief that was barred under the Eleventh Amendment.*

- A state's Medicaid plan must include at least the care and services listed in paragraphs (1) through (5) of *42 U.S.C.S. § 1396d(a). 42 U.S.C.S. § 1396a(a)(10)(A). 42 U.S.C.S. § 1396d(a)(3)* specifically mentions other laboratory and x-ray services. Other laboratory and x-ray services are defined as professional and technical laboratory and radiological services ordered and provided by or under the direction of a physician or other licensed practitioner or ordered by a physician but provided by a referral laboratory. *42 C.F.R. § 440.30(a)*. *Go To Headnote*

- Under the plain language of the Medicaid Act, *42 U.S.C.S. §§ 1396-1396v*, a state that chooses to participate in the Medicaid program must implement a medical assistance plan which at least provides for "other" x-ray services. The Medicaid Act itself does not mandate that these "other" x-ray services be rendered by a physician. While New York State has the discretion to set reasonable qualification standards for x-ray providers, the state is obligated to provide beneficiaries with certain minimum services, which include "other" x-ray services rendered by either a physician, licensed practitioner, or referral laboratory when ordered by a physician. *42 U.S.C.S. § 1396a(a)(10)(A)*; *42 U.S.C.S. § 1396d(a)(3)*; *42 C.F.R. § 440.30*. *Go To Headnote*

Katz v. New Mexico Dep't of Human Servs., Income Support Div., 95 N.M. 530, 624 P.2d 39, 1981 N.M. LEXIS 2250 (N.M. 1981).

Overview: *New Mexico's Medicaid program did not cover treatment a claimant received from a chiropractor and a physical therapist because their services were optional under federal law, and the denial of benefits did not violate equal protection principles.*

- Laboratory and X-ray services fall within the five mandatory categories of medical services. *42 U.S.C.S. § 1396d(a)(3)*. *42 C.F.R. § 440.30* interprets laboratory and X-ray services as professional and technical laboratory and radiological services — (a) Ordered and provided by or

under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law. A licensed chiropractor must be considered a "practitioner of the healing arts" under N.M. Stat. Ann. § 61-4-2 (1978). To the extent that the state manual disallows coverage of laboratory and X-ray services on the basis that those services are ordered or performed by a licensed chiropractor, it conflicts with federal law. State law requires the New Mexico Department of Human Services to administer the program consistent with the federal act. N.M. Stat. Ann. § 27-2-12. *Go To Headnote*

Public Health & Welfare Law: Social Security: Medicaid: Providers: Types: Physicians

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

Overview: *Plaintiffs' request for reimbursement from the state as to x-ray services they rendered to qualified Medicare beneficiaries prior to the date of the parties' stipulation constituted retroactive relief that was barred under the Eleventh Amendment.*

- A state's Medicaid plan must include at least the care and services listed in paragraphs (1) through (5) of *42 U.S.C.S. § 1396d(a). 42 U.S.C.S. § 1396a(a)(10)(A). 42 U.S.C.S. § 1396d(a)(3)* specifically mentions other laboratory and x-ray services. Other laboratory and x-ray services are defined as professional and technical laboratory and radiological services ordered and provided by or under the direction of a physician or other licensed practitioner or ordered by a physician but provided by a referral laboratory. *42 C.F.R. § 440.30(a)*. *Go To Headnote*

- Under the plain language of the Medicaid Act, *42 U.S.C.S. §§ 1396-1396v*, a state that chooses to participate in the Medicaid program must implement a medical assistance plan which at least provides for "other" x-ray services. The Medicaid Act itself does not mandate that these "other" x-ray services be rendered by a physician. While New York State has the discretion to set reasonable qualification standards for x-ray providers, the state is obligated to provide beneficiaries with certain minimum services, which include "other" x-ray services rendered by either a physician, licensed practitioner, or referral laboratory when ordered by a physician. *42 U.S.C.S. § 1396a(a)(10)(A)*; *42 U.S.C.S. § 1396d(a)(3)*; *42 C.F.R. § 440.30*. *Go To Headnote*

Public Health & Welfare Law: Social Security: Medicaid: State Plans: Mandatory Services

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

K & A Radiologic Tech. Servs. v. Wing, 13 F. Supp. 2d 264, 58 Soc. Sec. Rep. Service 209, 1998 U.S. Dist. LEXIS 4514 (N.D.N.Y. 1998), aff'd in part, rev'd, vacated, remanded, *189 F.3d 273, 63 Soc. Sec. Rep. Service 411, 1999 U.S. App. LEXIS 19652 (2d Cir. 1999)*.

Overview: *Plaintiffs' request for reimbursement from the state as to x-ray services they rendered to qualified Medicare beneficiaries prior to the date of the parties' stipulation constituted retroactive relief that was barred under the Eleventh Amendment.*

- Under the plain language of the Medicaid Act, *42 U.S.C.S. §§ 1396-1396v*, a state that chooses to participate in the Medicaid program must implement a medical assistance plan which at least provides for "other" x-ray services. The Medicaid Act itself does not mandate that these "other" x-ray services be rendered by a physician. While New York State has the discretion to set reasonable qualification standards for x-ray providers, the state is obligated to provide beneficiaries with certain minimum services, which include "other" x-ray services rendered by either a physician, licensed practitioner, or referral laboratory when ordered by a physician. *42 U.S.C.S. § 1396a(a)(10)(A)*; *42 U.S.C.S. § 1396d(a)(3)*; *42 C.F.R. § 440.30*. Go To Headnote

Buhs v. State, Dep't of Public Welfare, 306 N.W.2d 127, 1981 Minn. LEXIS 1314 (Minn. 1981).

Overview: *In an action to collect Medicaid benefits, the court held that the federal statutes and regulations did not prohibit payment for chiropractic X-rays.*

- X-ray services are defined by regulation. Laboratory and X-ray services means professional and technical laboratory and radiological services—(a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law; (b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and (c) Provided by a laboratory that meets the requirements for participation in Medicare. *42 C.F.R. § 440.30 (1980)*. Because a chiropractor is a "licensed practitioner of the healing arts," chiropractic X-rays are specifically included as a service that states must provide under Medicaid. Go To Headnote

Katz v. New Mexico Dep't of Human Servs., Income Support Div., 95 N.M. 530, 624 P.2d 39, 1981 N.M. LEXIS 2250 (N.M. 1981).

Overview: *New Mexico's Medicaid program did not cover treatment a claimant received from a chiropractor and a physical therapist because their services were optional under federal law, and the denial of benefits did not violate equal protection principles.*

- Laboratory and X-ray services fall within the five mandatory categories of medical services. *42 U.S.C.S. § 1396d(a)(3)*. *42 C.F.R. § 440.30* interprets laboratory and X-ray services as professional and technical laboratory and radiological services — (a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law. A licensed chiropractor must be considered a "practitioner of the healing arts" under N.M. Stat. Ann. § 61-4-2 (1978). To the extent that the state manual disallows coverage of laboratory and X-ray services on the basis that those services are ordered or performed by a licensed chiropractor, it conflicts with federal law. State law requires the New

Mexico Department of Human Services to administer the program consistent with the federal act. N.M. Stat. Ann. § 27-2-12. Go To Headnote

Public Health & Welfare Law: Social Security: Medicare: Providers: Types: Hospitals

Buhs v. State, Dep't of Public Welfare, 306 N.W.2d 127, 1981 Minn. LEXIS 1314 (Minn. 1981).

Buhs v. State, Dep't of Public Welfare, 306 N.W.2d 127, 1981 Minn. LEXIS 1314 (Minn. 1981).

Overview: *In an action to collect Medicaid benefits, the court held that the federal statutes and regulations did not prohibit payment for chiropractic X-rays.*

- X-ray services are defined by regulation. Laboratory and X-ray services means professional and technical laboratory and radiological services—(a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law; (b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and (c) Provided by a laboratory that meets the requirements for participation in Medicare. *42 C.F.R. § 440.30 (1980)*. Because a chiropractor is a "licensed practitioner of the healing arts," chiropractic X-rays are specifically included as a service that states must provide under Medicaid. Go To Headnote

Public Health & Welfare Law: Social Security: Medicare: Providers: Types: Physicians

Buhs v. State, Dep't of Public Welfare, 306 N.W.2d 127, 1981 Minn. LEXIS 1314 (Minn. 1981).

Buhs v. State, Dep't of Public Welfare, 306 N.W.2d 127, 1981 Minn. LEXIS 1314 (Minn. 1981).

Overview: *In an action to collect Medicaid benefits, the court held that the federal statutes and regulations did not prohibit payment for chiropractic X-rays.*

- X-ray services are defined by regulation. Laboratory and X-ray services means professional and technical laboratory and radiological services—(a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law; (b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and (c) Provided by a laboratory that meets the requirements for participation in Medicare. *42 C.F.R. § 440.30 (1980)*. Because a chiropractor is a "licensed practitioner of the healing arts," chiropractic X-rays are specifically included as a service that states must provide under Medicaid. Go To Headnote

Research References & Practice Aids

Hierarchy Notes:

42 CFR Ch. IV

42 CFR Ch. IV, Subch. C, Pt. 440

End of Document

42 CFR 440.70

This document is current through the Oct. 25, 2023 issue of the Federal Register, with the exception of the amendments appearing at 88 FR 73234, 88 FR 73424, and 88 FR 73458.

§ 440.70 Home health services.

(a) "Home health services" means the services in paragraph (b) of this section that are provided to a beneficiary —

(1) At his place of residence, as specified in paragraph (c) of this section; and

(2) On orders written by a physician, nurse practitioner, clinical nurse specialist or physician assistant, working in accordance with State law, as part of a written plan of care that the ordering practitioner reviews every 60 days for services described in (b)(1), (2), and (4) of this section; and

(3) On his or her physician's orders or orders written by a licensed practitioner of the healing arts acting within the scope of practice authorized under State law, as part of a written plan of care for services described in paragraph (b)(3) of this section. The plan of care must be reviewed by the ordering practitioner as specified in paragraph (b)(3)(iii) of this section.

(b) Home health services include the following services and items. Paragraphs (b)(1), (2) and (3) of this section are required services and items that must be covered according to the home health coverage parameters. Services in paragraph (b)(4) of this section are optional. Coverage of home health services cannot be contingent upon the beneficiary needing nursing or therapy services.

(1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who —

(i) Is currently licensed to practice in the State;

(ii) Receives written orders from the patient's practitioner as defined in (a)(2) of this section;

(iii) Documents the care and services provided; and

(iv) Has had orientation to acceptable clinical and administrative recordkeeping from a health department nurse.

(2) Home health aide service provided by a home health agency,

(3) Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, as defined at § 440.70(c)(1).

(i) Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

(ii) Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.

(iii) A beneficiary's need for medical supplies, equipment, and appliances must be reviewed by a physician or, as defined in § 400.200 of this chapter, an other licensed practitioner of the healing arts acting within the scope of practice authorized under State law, annually.

(iv) Frequency of further physician or, as defined in § 400.200 of this chapter, an other licensed practitioner review of a beneficiary's continuing need for the items is determined on a case-by-case basis based on the nature of the item prescribed.

(v) States can have a list of preapproved medical equipment supplies and appliances for administrative ease but States are prohibited from having absolute exclusions of coverage on medical equipment, supplies, or appliances. States must have processes and criteria for requesting medical equipment that is made available to individuals to request items not on the State's list. The procedure must use reasonable and specific criteria to assess items for coverage. When denying a request, a State must inform the beneficiary of the right to a fair hearing.

(4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (See § 441.15 of this subchapter.)

(c) A beneficiary's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities, except for home health services in an intermediate care facility for individuals with intellectual disabilities that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a beneficiary in an intermediate care facility for individuals with intellectual disabilities during an acute illness to avoid the beneficiary's transfer to a nursing facility.

(1) Nothing in this section should be read to prohibit a beneficiary from receiving home health services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound.

(2) Additional services or service hours may, at the State's option, be authorized to account for medical needs that arise in the settings home health services are provided.

(d) "Home health agency" means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare, including the capitalization requirements under § 489.28 of this chapter.

(e) A "facility licensed by the State to provide medical rehabilitation services" means a facility that —

(1) Provides therapy services for the primary purpose of assisting in the rehabilitation of disabled individuals through an integrated program of —

(i) Medical evaluation and services; and

(ii) Psychological, social, or vocational evaluation and services; and

(2) Is operated under competent medical supervision either —

(i) In connection with a hospital; or

(ii) As a facility in which all medical and related health services are prescribed by or under the direction of individuals licensed to practice medicine or surgery in the State.

(f) No payment may be made for services referenced in paragraphs (b)(1) through (4) of this section, unless a practitioner referenced in paragraph (a)(2) of this section or for medical equipment, a practitioner described in paragraph (a)(3) of this section documents that there was a face-to-face encounter with the beneficiary that meets the following requirements.

(1) For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or within the 30 days after the start of the services.

(2) For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.

(3) The face-to-face encounter may be conducted by one of the following practitioners:

(i) A physician;

(ii) A nurse practitioner or clinical nurse specialist, as those terms are defined in section 1861(aa)(5) of the Act, in accordance with State law, in accordance with State law;

(iii) A certified nurse midwife, as defined in section 1861(gg) of the Act, as authorized by State law;

(iv) A physician assistant, as defined in section 1861(aa)(5) of the Act, in accordance with State law; or

(v) For beneficiaries admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

(vi) For medical equipment, supplies, or appliances, a licensed practitioner of the healing arts acting within the scope of practice authorized under state law.

(4) If State law does not allow the non-physician practitioner, as described in paragraphs (f)(3)(ii) through (vi) of this section, to perform the face-to-face encounter independently, the non-physician practitioner must communicate the clinical findings of that face-to-face

encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.

(5) To assure clinical correlation between the face-to-face encounter and the associated home health services, the practitioner responsible for ordering the services must:

(i) Document the face-to-face encounter which is related to the primary reason the patient requires home health services, occurred within the required timeframes prior to the start of home health services.

(ii) Must indicate the practitioner who conducted the encounter, and the date of the encounter.

(6) The face-to-face encounter may occur through telehealth, as implemented by the State.

(g)

(1) No payment may be made for medical equipment, supplies, or appliances referenced in paragraph (b)(3) of this section to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program, unless a practitioner referenced in paragraph (a)(3) of this section documents a face-to-face encounter with the beneficiary consistent with the requirements of paragraph (f) of this section except as indicated in paragraph (g)(2) of this section.

(2) The face-to-face encounter may be performed by any of the practitioners described in paragraph (f)(3) of this section, with the exception of certified nurse-midwives, as described in paragraph (f)(3)(iii) of this section.

Statutory Authority

Sec. 1102 of the Social Security Act (*42 U.S.C. 1302*).

Authority Note Applicable to 42 CFR Ch. IV, Subch. C, Pt. 440

History

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, April 11, 1980; *62 FR 47896*, 47902, Sept. 11, 1997, as corrected at Sept. 23, 1997; *63 FR 292*, 310, Jan. 5, 1998.; *81 FR 5530*, 5566, Feb. 2, 2016; *85 FR 19230*, 19291, Apr. 6, 2020; *85 FR 27550*, 27626, May 8, 2020]

Annotations

Notes

[EFFECTIVE DATE NOTE:

62 FR 47896 , 47902, Sept. 11, 1997, amended this section, effective Nov. 10, 1997; *63 FR 292, 310, Jan. 5, 1998*, revised paragraph (d), effective Jan. 1, 1998; *81 FR 5530* , 5566, Feb. 2, 2016, amended this section, effective July 1, 2016; *85 FR 19230* , 19291, Apr. 6, 2020, amended this section, effective Mar. 31, 2020; *85 FR 27550* , 27626, May 8, 2020, amended this section, effective May 8, 2020.]

Research References & Practice Aids

Hierarchy Notes:

42 CFR Ch. IV

42 CFR Ch. IV, Subch. C, Pt. 440

End of Document

42 CFR 440.110

This document is current through the Oct. 25, 2023 issue of the Federal Register, with the exception of the amendments appearing at 88 FR 73234, 88 FR 73424, and 88 FR 73458.

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) Physical therapy.

(1) Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A "qualified physical therapist" is an individual who meets personnel qualifications for a physical therapist at § 484.115.

(b) Occupational therapy.

(1) Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a beneficiary by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A "qualified occupational therapist" is an individual who meets personnel qualifications for an occupational therapist at § 484.115.

(c) Services for individuals with speech, hearing, and language disorders.

(1) Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

(2) A "speech pathologist" is an individual who meets one of the following conditions:

(i) Has a certificate of clinical competence from the American Speech and Hearing Association.

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate.

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(3) A "qualified audiologist" means an individual with a master's or doctoral degree in audiology that maintains documentation to demonstrate that he or she meets one of the following conditions:

(i) The State in which the individual furnishes audiology services meets or exceeds State licensure requirements in paragraph (c)(3)(ii)(A) or (c)(3)(ii)(B) of this section, and the individual is licensed by the State as an audiologist to furnish audiology services.

(ii) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one of the following conditions:

(A) Have a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association.

(B) Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

Statutory Authority

Sec. 1102 of the Social Security Act (*42 U.S.C. 1302*).

Authority Note Applicable to 42 CFR Ch. IV, Subch. C, Pt. 440

History

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980; 56 FR 8854, Mar. 1, 1991; 60 FR 19861, Apr. 21, 1995; *69 FR 30580*, 30587, May 28, 2004; *77 FR 29002*, 29031, May 16, 2012; *82 FR 4504*, 4578, Jan. 13, 2017; *82 FR 31729*, July 10, 2017]

Annotations

Notes

[EFFECTIVE DATE NOTE:

82 FR 4504 , 4578, Jan. 13, 2017, amended paragraphs (a)(2) and (b)(2), effective July 13, 2017; *82 FR 31729*, July 10, 2017, delayed the effective date of the amendment appearing at *82 FR 4504*, until Jan. 13, 2018.]

Notes to Decisions

Public Health & Welfare Law: Social Security: Medicaid: State Plans: Amount, Duration & Scope of Benefits

Public Health & Welfare Law: Social Security: Medicaid: State Plans: Categorically & Medically Needy Claimants

Public Health & Welfare Law: Social Security: Medicaid: State Plans: Amount, Duration & Scope of Benefits

William T. v. Taylor, 465 F. Supp. 2d 1267, 2000 U.S. Dist. LEXIS 22826 (N.D. Ga. 2000).

William T. v. Taylor, 465 F. Supp. 2d 1267, 2000 U.S. Dist. LEXIS 22826 (N.D. Ga. 2000).

Overview: *"Augmentative and alternative communication devices" (ACD) were durable medical equipment and speech-language pathology services under 42 U.S.C.S. § 1396d(a)(7), (11), and no court had permitted a Medicaid program to exclude ACDs, thus, the Georgia Department of Medical Assistance Commissioner had to adopt reasonable criteria for coverage of ACDs.*

- Speech-language pathology services are included in the statutory "physical therapy and related services" benefits category. *42 U.S.C.S. § 1396d(a)(11)*. The federal regulations define services for individual with speech, hearing, and language disorders as diagnostic, screening, preventative, or corrective services provided by or under the direction of a speech pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts. It includes any necessary supplies and equipment. *42 C.F.R. § 440.110(c) (1998)*. *Go To Headnote*

Public Health & Welfare Law: Social Security: Medicaid: State Plans: Categorically & Medically Needy Claimants

William T. v. Taylor, 465 F. Supp. 2d 1267, 2000 U.S. Dist. LEXIS 22826 (N.D. Ga. 2000).

William T. v. Taylor, 465 F. Supp. 2d 1267, 2000 U.S. Dist. LEXIS 22826 (N.D. Ga. 2000).

Overview: *"Augmentative and alternative communication devices" (ACD) were durable medical equipment and speech-language pathology services under 42 U.S.C.S. § 1396d(a)(7), (11), and no court had permitted a Medicaid program to exclude ACDs, thus, the Georgia Department of Medical Assistance Commissioner had to adopt reasonable criteria for coverage of ACDs.*

- Speech-language pathology services are included in the statutory "physical therapy and related services" benefits category. *42 U.S.C.S. § 1396d(a)(11)*. The federal regulations define services for individual with speech, hearing, and language disorders as diagnostic, screening, preventative, or corrective services provided by or under the direction of a speech pathologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts. It includes any necessary supplies and equipment. *42 C.F.R. § 440.110(c) (1998)*. *Go To Headnote*

Research References & Practice Aids

Hierarchy Notes:

42 CFR Ch. IV

42 CFR Ch. IV, Subch. C, Pt. 440

End of Document

42 CFR 455.440

This document is current through the Oct. 25, 2023 issue of the Federal Register, with the exception of the amendments appearing at 88 FR 73234, 88 FR 73424, and 88 FR 73458.

LEXISNEXIS' CODE OF FEDERAL REGULATIONS > Title 42 Public Health > Chapter IV — Centers for Medicare & Medicaid Services, Department of Health and Human Services > Subchapter C — Medical Assistance Programs > Part 455 — Program Integrity: Medicaid > Subpart E — Provider Screening and Enrollment

§ 455.440 National Provider Identifier.

The State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

Statutory Authority

Sec. 1102 of the Social Security Act (*42 U.S.C. 1302*).

Authority Note Applicable to 42 CFR Ch. IV, Subch. C, Pt. 455

History

[*76 FR 5862*, 5968, Feb. 2, 2011]

Annotations

Notes

[EFFECTIVE DATE NOTE:

76 FR 5862, 5968, Feb. 2, 2011, added Subpart E, effective Mar. 25, 2011.]

Research References & Practice Aids

Hierarchy Notes:

42 CFR Ch. IV

42 CFR Ch. IV, Subch. C, Pt. 455

End of Document

DHS Responses to Public Comments Regarding Rule 258 Provider Refunds and Primary Care Provider Qualification Updates

Jen Mace

Compliance Director

Summit Community Care

Comment:

Below please see Summit's comments/questions concerning the DHS Proposed Rule Change to Provider Refunds and Primary Care Provider Qualification Updates:

Currently, Summit allows Member assignment at either the FQHC or FQHC Practitioner level. If we can only assign members at an individual FQHC practitioner level, for Member visibility, does this change mean we are obligated to list each individual FQHC practitioner in the provider directory instead of the FQHC location? If so, this is a significant change in our process and may materially impact our FQHC provider partners.

Response:

Listing every enrolled individual provider in the provider directory is necessary to meet Medicaid managed care rules. Publishing individual providers within the FQHC of practice is essential for beneficiaries to make an informed choice pertaining to their overall healthcare.

These changes were brought about as the result of a Payment Error Rate Measurement (PERM) audit to bring AR Medicaid into compliance with the Affordable Care Act (ACA). The ACA requires the National Provider Identifier (NPI) of the Ordering, Referring, Prescribing (ORP) provider be on the claim of service. Therefore, each ORP provider must be enrolled as an individual (Entity Type 1) in the Medicaid program for the claim date of service. Managed Care Organizations must also comply with the ACA regulations.

This means a Medicaid beneficiary needs to be assigned to an individual provider, not a provider group as previously allowed. This does not mean the individual provider is the only one the beneficiary is allowed to see for services within the practice. Medicaid does allow for PCP Substitutes. Under Section 171.601, 171.610, and 171.620 of Section I – General Policy, beneficiaries may see other providers within the practice if the assigned PCP's schedule is full and for several other acceptable reasons.