ARMedicaid
ARKANSAS DEPARTMENT OF HUMAN SERVICES

# ARKANSAS PHYSICIAN MEDICAID UPDATE

Q1 SFY2023 (July–Sept.)

## What's New for Arkansas Medicaid Providers

- PHE and Medicaid Client Coverage
- New Adult Benefit Limits
- Educational Opportunities

# PHE and Medicaid Continuous Coverage Set to End Soon

## Don't let Clients lose their Medicaid Coverage

The federal government declared a public health emergency when the COVID-19 pandemic began in March 2020, temporarily stopping some Medicaid requirements and conditions. Since then, state agencies have continued health care coverage for all Medicaid assistance programs, even for people who have not renewed their eligibility or are no longer eligible. Arkansas Medicaid only closed cases for people who died, moved out of state, were incarcerated, or asked that their case be closed. This was done to help keep people with Medicaid from losing their health care coverage during the COVID-19 pandemic.

Although a definite date has not been provided, Arkansas will soon be required to review Medicaid eligibility for people whose coverage was extended. This means that many Medicaid clients may lose their coverage if they don't take simple steps now.

It's important for AR Medicaid clients to take the first step in this process by making sure Arkansas Medicaid has up-to-date contact information to receive important notices and be reached if DHS needs more information. Contact information includes mailing address, phone number, and email address. Here's how clients can update their contact information:

- Call the Update Arkansas hotline at **1-844-872-2660**.
- Go online at access.arkansas.gov.
- Visit their local DHS county office to update their information (find local office here)

Clients should be expecting renewal letters and respond quickly about their Medicaid coverage. The completed forms can be mailed back to DHS, or they can be dropped off at their local DHS office. Clients can also renew online at access.arkansas.gov; however, the online option is not currently available for TEFRA clients.

No matter how clients like to communicate, DHS has them covered! Other opportunities available for clients to stay informed about their Medicaid, ARHOME, and

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## CONTINUED FROM COVER: MEDICAID COVERAGE

ARKids coverage include:

- Signing up for email communication and text updates at access.arkansas.gov.
  - › Click HERE to watch a short video on how to sign up for important alerts.
- Follow DHS on social media at www.facebook.com/ArkDHS.
- Visit www.ar.gov/update for updates and more information.
- Does a client need to create a new Access Arkansas account?
  - › Click HERE to watch a short video that shows how.
- Does a client need to link their case to their Access Arkansas account?
  - › Click HERE to watch a short video that shows how.

This mission is too important to do alone. Your help is needed in sharing the message.

The Arkansas Department of Human Services (DHS) is preparing for the end of the COVID-19 Public Health Emergency by working with community partners, advocates, and clients to make sure eligible Arkansans keep getting high quality health care coverage.

DHS has created the Update Arkansas web page which houses resources, toolkits, and materials for clients, partners, and friends and family. The toolkits are available in English, Spanish, and Marshallese. Providers can use the toolkits to make their clients aware of the upcoming eligibility redetermination at the end of the PHE and the need for clients to update their contact information with DHS.

You may know Medicaid clients in your family or in your circle of friends. Your social media circle may include people who are Medicaid or ARHOME clients or who have kids or grandkids with ARKids coverage. We want all eligible Arkansans to keep getting high quality health care coverage.

If clients lose their Medicaid coverage, they will be removed from their assigned Primary Care Provider, and PCCM payments will be affected. Our goal is to utilize all partners and resources to educate Medicaid clients on next steps so that all eligible clients maintain their active Medicaid coverage. If a member no longer qualifies for health coverage from Arkansas Medicaid, they will get:

- Notice of when their Medicaid coverage will end
- Information on how to file an appeal if the member thinks our decision was incorrect
- A referral to the Federal Marketplace and information about buying other health care coverage

Arkansans who do not qualify for Arkansas Medicaid can buy health insurance on the Federal Marketplace on HealthCare.gov:

- Within 60 days after losing health coverage, or
- Anytime during annual open enrollment from November 1 through December 15

Arkansans who do not qualify for health coverage from Medicaid may be able to get financial help to lower the cost of private health insurance through HealthCare.gov. The amount of financial help is based on the cost of insurance where the applicants live, how many people are in their household, and their estimated yearly income. Learn more at HealthCare.gov or **1-800-318-2596**.

If clients have any questions, they can call **1-855-372-1084** or visit access.arkansas.gov ■

Keeping You Informed

# APNs and Certified Nurse Midwives Can Now Enroll as Arkansas Medicaid Primary Care Providers

Enrollment is currently open to APNs and certified nurse midwives who wish to enroll as Arkansas Medicaid Primary Care Providers. Clients can begin selecting an APN or certified nurse midwife as their PCP, pending CMS approval.

To enroll as a PCP, current Medicaid APN and certified nurse midwife providers need to complete and submit to Gainwell Provider Enrollment:

- Both pages of the Arkansas Medicaid Primary Care Physician Managed Care Program Primary Care Physician Participation Agreement form (DMS-2608). Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 2500; and
- The EPSDT Provider Agreement (DMS-831) if you plan to enroll as a PCP who provides EPSDT services to clients ages 0–20.

APNs and certified nurse midwives not enrolled as Medicaid providers will also need to complete a Medicaid provider application in addition to the Arkansas Medicaid Primary Care Physician Managed Care Program Primary Care Physician Participation Agreement form (DMS-2608) and the EPSDT Provider Agreement (DMS-831).

Please contact Gainwell Provider Enrollment with any enrollment questions at **1-800-457-4454**.

The recent webinar on Medicaid Client Eligibility – Post Health Emergency (PHE) and AR Medicaid PCP Enrollment for APNs can be found at this link: Medicaid Client Eligibility Post PHE and AR Medicaid PCP Enrollment for APNs and Certified Nurse Midwives.

Access requirements for PCPs can be found in section 171.510 of all Medicaid manuals. For additional information regarding PCP access requirements, please contact your AFMC Provider Relations outreach specialist. ■

What's New PCMH

# PCMH News and Information

- PCMH Open Enrollment for 2023: 9/26/2022 – 11/11/2022
- PBIP reconsideration for performance period 2021 begins 10/1/2022
- PHM reports will be available the 15th of July, August, and September 2022
- Core Quality Metrics remediation period is 7/1/2022 – 9/30/2022.

PCMH practices wishing to add their clinic APN PCPs to their existing 2022 PCMH provider group can do so by completing the DMS-844 Practice Participation Agreement/Update Change Form and securely emailing the form to ARKPCMH@gainwelltechnologies.com for processing.

The PCMH webinar which was presented by DHS on May 20th webinar is now available at the following link: https://afmc.org/health-care-professionals/arkansas-medicaid-providers/policy-and-education/webinars/pcmh-webinar-may-2022/ ■

**If you have any questions please contact the AFMC Provider Relations team | ProviderRelations@afmc.org | 501-212-8686**

Keeping You Informed

# New Physician Visit Limit for Clients aged 21 and over who are assigned to a PCP

For clients twenty-one (21) years of age or older, pending CMS approval, services provided in a physician's office, advanced practice registered nurse's (APRN) office, a patient's home, or nursing home are limited to twelve (12) visits per state fiscal year (July 1 through June 30) unless the client is assigned to a PCP provider enrolled in the Primary Care Case Management Program (PCCM). If the client is assigned to a PCP provider who is enrolled in the PCCM, the visit limit is sixteen (16) visits per SFY. Clients under twenty-one (21) years of age in the Child Health Services/ Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the sixteen (16) visit SFY benefit limits:

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

# Changes to Diagnostic Laboratory and Radiology Limits for Adult Clients

For clients twenty-one (21) years of age and older, effective 7/1/22, Medicaid has established a maximum amount (benefit limit) of five hundred dollars ($500) per state fiscal year (SFY) for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services. The SFY runs from July 1 through June 30.

There is no benefit limit on laboratory services related to family planning; or on professional components of laboratory or radiology/other services for hospital inpatient treatment; or on laboratory services or radiology/other services performed as emergency services.

Radiology/other services include without limitation: diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG). Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps. The essential health benefit procedure codes can be viewed in the MMIS procedure code tables in the provider manuals.

Magnetic resonance imaging (MRI) services are exempt from the five-hundred-dollar ($500) outpatient radiology/other benefit limit. Medical necessity for each

MRI must be documented in the client's medical record. Cardiac catheterization procedures are exempt from the five-hundred-dollar ($500) SFY benefit limit (each) for outpatient laboratory services and for radiology/other services. Medical necessity for each procedure must be documented in the client's medical record.

The following are not subject to this benefit limit (Physician 225.100)

- Malignant neoplasm (View ICD Codes.)
- HIV infection and AIDS (View ICD Codes.)
- Renal failure (View ICD Codes.)
- Pregnancy (View ICD Codes.)
- Opioid Use Disorder when treated with MAT (View ICD OUD Codes.) Designated lab tests will be automatically overridden when the diagnosis is Opioid Use Disorder. (View Lab and Screening Codes.)

Benefits may be extended for other conditions for documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 229.100 of the Physician manual. (Physician 229.100)

**There are no laboratory or radiology benefit limits for clients under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.** ■

# What's New for Arkansas Medicaid Providers

**TO: ALL PROVIDERS** **RE: EOMB REQUIRED FOR CROSSOVER CLAIMS**

Arkansas Medicaid will begin enforcing the Medicaid policy that requires an Explanation of Medicare Benefits (EOMB) attachment for all Non-COBA (Medicare Coordination of Benefits Agreement) Medicare Crossover claims. Please refer to Section III, Subsections 332.100 through 332.300 for information on Medicare claim submission requirements. An edit will deny claims that are submitted without an EOMB attachment. Medicare Crossover claims submitted without an EOMB on or after 7/1/2022 will begin denying for Edit 3383 (ATTACHMENT REQUIRED FOR NON-COBA CROSSOVER CLAIMS).

**TO: OUTPATIENT BEHAVIORAL HEALTH SERVICES (OBHS), REHABILITATIVE HOSPITAL, AND SCHOOL-BASED MENTAL HEALTH (SBMH) SERVICES PROVIDERS** **RE: MENTAL HEALTH COUNSELING - PCP REQUIRED AFTER 10 VISITS**

Pursuant to ACT 886, the Arkansas Medicaid Program will no longer require a member to obtain a primary care provider referral prior to receiving mental health counseling for the first ten (10) visits. Claims denied between 07/28/2021 and 02/18/2022 will be reprocessed for payment the week of 04/25/2022.

**TO: ALL PROVIDERS** **RE: ARKANSAS MEDICAID REFUND SUBMISSION**

Effective June 8, 2022, all providers who wish to submit a refund check to Arkansas Medicaid for overpayment or retrospective review must mail the check to the following address:
Arkansas Department of Human Services
PO Box 505616
St. Louis, MO 63150-5616

Checks mailed to the incorrect address will delay the refund process and the outstanding amount due to Arkansas Medicaid will be subject to recoupment on upcoming remittance advices.

**If you have any questions please contact the AFMC Provider Relations team | ProviderRelations@afmc.org | 501-212-8686**

Keeping You Informed

# Qualified Medicare Beneficiaries (QMB), Qualifying Individuals-1 (QI-1) and Specified Low-Income Medicare Beneficiaries (SMB) Benefit Plans

QMB, QI-1 and SMB are benefit plans which pay towards certain Medicare related expenses. These benefit plans do not have any Medicaid services coverage.

For clients who have QMB, Medicaid pays the Medicare Part B premium, the Medicare Part B deductible and the Medicare Part B coinsurance, less any Medicaid cost sharing, for Medicare covered medical services. Medicaid also pays the Medicare Part A hospital deductible and the Medicare Part A coinsurance, less any Medicaid cost sharing. Medicaid pays the Medicare Part A premium for QMBs whose employment history is insufficient for Title XVIII to pay it. Certain QMBs may be eligible for other limited Medicaid services if they also have another Medicaid benefit plan which covers Medicaid services.

Individuals eligible as specified low-income Medicare beneficiaries (SMB) are not eligible for the full range of Medicaid services. They are eligible only for Medicaid payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered by Medicaid. SMB individuals do not receive a Medicaid card.

Individuals eligible as QI-1 are not eligible for Medicaid services. They are eligible only for the payment of their Medicare Part B premium. No other Medicare cost sharing charges will be covered by Medicaid. Individuals eligible for QI-1 do not receive a Medicaid card. Additionally, unlike QMBs and SMBs, they may not be certified in another Medicaid category for the same time period. Individuals who meet the eligibility requirements for both QI-1 and Medically Needy Spend Down must choose which of the two benefit plans they want for a particular time period. ■


ACEs22

**2 HOUR WEBINARS IN SEPTEMBER:**

THURS. 8
11 AM

THURS. 15
6 PM

THURS. 22
11 AM and 4 PM

THURS. 29
11 AM


VISIT
**INFO.AFMC.ORG/ACES22**
TO REGISTER!

ARKANSAS ACEs & RESILIENCE COALITION

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Healthy **Communities.**

What's New MQI

# Developmental Screening in the First Three Years of Life

AFMC's Medicaid Quality Improvement (MQI) team, contracted by Arkansas Medicaid, will be providing guidance for your practice(s) to meet the requirements of Quality Measure DEV-CH: Developmental Screening in the First Three Years of Life.

Quality Measure DEV-CH: Developmental Screening in the First Three Years of Life will require providers to perform and document developmental screenings for children. Developmental Screenings must be performed utilizing a validated standardized tool. This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays. It is advised that all children should receive developmental screens at recommended intervals using an evidence-based screening tool at 9, 18, and 30 months, or whenever a concern is expressed.

Documentation in the medical record must include the following: a note indicating the date on which the test was performed, the standardized tool used, and evidence of a screening result or screening score. To aid in reporting, Arkansas Medicaid activated CPT code 96110 for providers to use when performing developmental screenings utilizing a validated standardized tool. Mandatory reporting for all states occurs in 2024.

In preparing to meet the requirements of this measure, we will host a free educational webinar on August 19th. An invitation to this event will be sent via email.

The education objectives are to:

- Learn the importance of utilizing a standardized developmental screening tool as recommended by CMS and Arkansas Medicaid
- Increase knowledge of the specific requirements to meet Quality Measure DEV-CH: Developmental Screening in the First Three Years of Life
- Understand the importance of early identification and intervention for treatment for developmental delays

Please feel free to contact mqi@afmc.org for additional information or questions. ■

2022 ARKANSAS MEDICAID EDUCATIONAL CONFERENCE

Save the Date

REGISTRATION WILL BE AVAILABLE THIS FALL.

#ARMediCon

FOR PHYSICIANS, NURSES, OFFICE MANAGERS, BILLERS, AND HOSPITALS

**In-person conference**

**Dec. 6**

#ArDPSQAcon

FOR BEHAVIORAL HEALTH AND WAIVER PROVIDERS

**Virtual conference**

**Dec. 8**

# Provider Relations Outreach Specialists Information Sheet

1020 W. 4th St., Suite 400 • Little Rock, AR 72201 • **Toll free: 1-877-650-2362** • **Transportation Helpline: 1-888-987-1200**

## AFMC OUTREACH SPECIALISTS

**Refer to the map and the color key below to find your representative.**

### *Manager*

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

### *Supervisor, Provider Relations*

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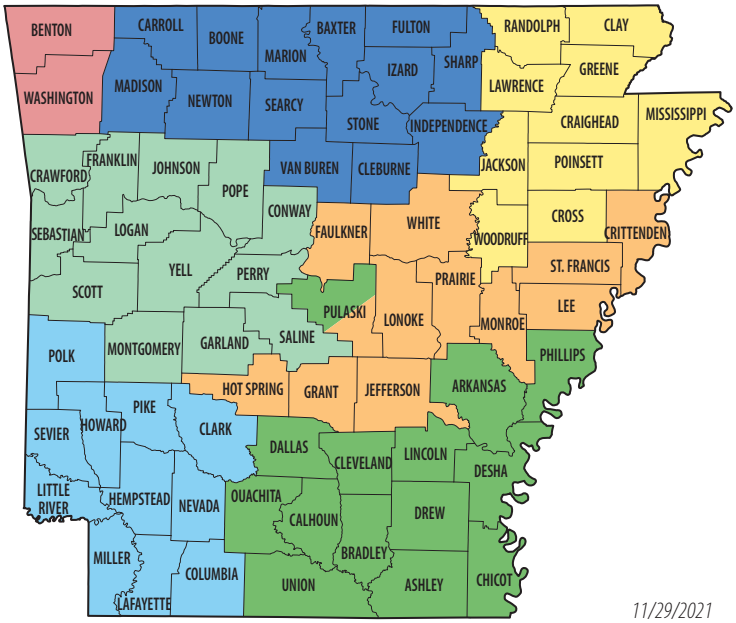
tlong@afmc.org




*11/29/2021*

## GAINWELL TECHNOLOGIES SERVICES *(Claims Processing)*

500 President Clinton Ave., Suite 400 • Little Rock, AR 72201

- ***Gainwell Provider Assistance Center***
  - In-state toll free ..... **800-457-4454**
  - Local / out-of-state... **501-376-2211**

- **Provider Enrollment**

Gainwell Technologies Services
P.O. Box 8105 • Little Rock, AR 72203-8105

- Central Arkansas..... **501-376-2211**
- Fax ..... **501-374-0746**

## ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

ARMedicaid

### ARKIDS FIRST/MEDICAID MEDICAL ASSISTANCE

**https://medicaid.mmis.arkansas.gov**

- ARKids First Enrollment Information ..... **888-474-8275**

### CONNECTCARE

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

### MEDICAID FRAUD CONTROL UNIT (PROVIDERS)

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

### VOICE RESPONSE SYSTEM

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

### AFMC SERVICE CENTER (CLIENTS)

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

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

### MAGELLAN MEDICAID ADMINISTRATION

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

### THIRD PARTY LIABILITY

- Local..... **501-537-1070**
- Fax ..... **501-682-1644**

DHS Division of Medical Services,
TPL Unit • P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

# IN THIS ISSUE OF ARMedicaid

## ARKANSAS PHYSICIAN MEDICAID UPDATE

Q1 SFY2023 (July–Sept.)

- Medicaid coverage client redetermination
- Update Arkansas
- APN enrollment as PCPs
- New SFY physician limit for Adult Clients assigned to a PCP
- New Lab and X-ray limits for Adult Clients

**Additional resources can be found at www.afmc.org/providerrelations**

- Educational Outreach Updates
- PCP Update Packets/Archived PCP Update Packets
- Webinars

**If you have any questions or if you would like additional information regarding any Medicaid topic, please contact the AFMC Provider Relations team**

- ProviderRelations@afmc.org
- 501-212-8686