

antepartum care were provided culminating in delivery or the beneficiary was continuously CHIP eligible for two or more months before delivery and on the delivery date, the global method of billing CHIP for postpartum services provided is used. When less than two months of antepartum care was provided to the Unborn Child program beneficiary or the beneficiary was not CHIP eligible for at least the last two months of the pregnancy, the antepartum/obstetrical care without delivery and the delivery and postpartum care can be billed to CHIP using the itemized billing method.)

- Services that are determined by the physician as medically necessary as, if not provided, could complicate or endanger the eligible Unborn Child program's beneficiary's pregnancy.

E. Healthy Smiles Dental Managed Care Program

The Arkansas Department of Human Services transitioned the Medicaid dental program to a prepaid ambulatory health plan (PAHP) on January 1, 2018. Two vendors were selected to provide state-wide dental benefits:

- a. Delta Dental
- b. Managed Care of North America (MCNA)

In early December 2017, all Arkansas Medicaid and CHIP beneficiaries who are eligible for dental benefits were randomly and evenly assigned to one of the two dental managed care plans. Each plan sent a welcome packet to each member and the members were able to access plan providers starting January 1, 2018, for covered dental services. Both dental vendors will provide the same dental services that were covered under the Medicaid and CHIP fee-for-service program.

Effective November 1, 2024, Arkansas Department of Human Services transitioned the CHIP dental program to the previous fee-for-service arrangement for all covered dental services and is administered by Division of Medical Services.

F. Provider Led Arkansas Shared Savings Entity (PASSE)-MCO Model of care for client with high behavioral health or developmental disabilities service needs.

Effective February 1, 2018, Arkansas included the ARKids-B Title XXI CHIP program beneficiaries as part of its overall 1915(b) waiver implementing a Provider-Led Arkansas Shared Savings Entity (PASSE) Program. As of May 6, 2019, approximately 2,598 children who participate in ARKids-B were also enrolled in a PASSE. More ARKids-B eligible children will be mandatorily enrolled in a PASSE if they are determined to be a Tier 2 or Tier 3 on the Arkansas Independent Assessment (ARIA) for behavioral health or developmental disabilities services.

The PASSE program is an innovative approach to organizing and managing the

SPA # 13, Purpose of SPA:

The state is assuring that it covers age-appropriate vaccines and their administration, without cost sharing.

Proposed effective date: October 1, 2023

Proposed implementation date: October 1, 2023

SPA # 14, Purpose of SPA:

The purpose of this SPA is to improve access to continuous glucose monitors (CGMs) through pharmacy claim submission processing for reimbursement to pharmacies and DME providers. Beneficiaries eligible for CGMs include those with Type 1 diabetes or any other type of diabetes with either insulin use or evidence of level 2 or level 3 hypoglycemia, or beneficiaries diagnosed with glycogen storage disease type 1a. Patch type insulin pumps, blood glucose monitors (BGMs) and testing supplies will be covered in the same manner. Coverage is being extended to comply with Arkansas Act 393 of 2023.

Proposed effective date: April 1, 2024

Proposed implementation date: April 1, 2024

SPA # 15 , Purpose of SPA:

The purpose of this SPA is to end the Healthy Smiles Managed Care waiver for dental services and transition the dental program to fee-for-services (FFS).

Proposed effective date: November 1, 2024

Proposed implementation date: November 1, 2024

1.4- TC

Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this state plan amendment, when it occurred and who was involved.

Not applicable, as there are no Indian Health Programs or Urban Indian Organizations in the State of Arkansas

TN No: Approval Date Effective Date _____

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT

Section 3. Methods of Delivery and Utilization Controls

- ☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. **Delivery Systems** (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 **Choice of Delivery System**

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

- ☐ No, the State does not use a managed care delivery system for any CHIP populations.
- ☐ Yes, the State uses a managed care delivery system for all CHIP populations.

All children enrolled in CHIP will be enrolled in Healthy Smiles. Healthy Smiles dental managed care ended October 31, 2024.

- ☒ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and

For children who are enrolled in the PASSE, the following services are carved-out of the model:

- Nonemergency Medical Transportation
- Dental Benefits
- School-based services provided by school employees
- Services provided to residents of a human development center, a skilled nursing facility, or an assisted living facility
- They are enrolled in ARChoices, Independent Choices, the 1915(c) Autism Waiver, or any successor to these programs.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1

Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)

☒ Capitation payment

Describe population served:

Those individuals who receive behavioral health and developmental disabilities services who are determined to meet the Tier II or Tier III level of need, unless they are residing in a Human Development Center, a skilled nursing facility, or an assisted living facility or they are enrolled in ARChoices, Independent Choices, the 1915(c) Autism Waiver, or a successor to one of these programs.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)

☐ Capitation payment

☐ Other (please explain)

Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

- ☐ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
 - ☐ Capitation payment
 - ☐ Other (please explain)

- ☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
 - ☐ Case management fee
 - ☐ Other (please explain)

- ☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
 - ☐ Case management fee
 - ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
 - ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State
- ☐ Provision of enrollee outreach and education activities
- ☐ Operation of a customer service call center
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement

The Source of State Share Funds:

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation;
 - Assumptions on which the budget is based, including cost per child and expected enrollment;
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.;
 - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees;
- Include a separate budget line to indicate the cost of providing coverage to pregnant women;
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children;
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage;
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility;
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage;
 - Estimate of unborn children covered in year one treatment

Attachment F
FFY 2025 Budget – Transition from Dental Managed Care to Fee-for-Service

CHIP Budget

STATE:	FFY Budget
Federal Fiscal Year	2025
State's enhanced FMAP rate	79.80%
Benefit Costs	
Insurance payments	\$0.00
Managed care	\$1,039,481 (one month of Managed Care)
<u>per member/per month rate</u>	\$22
Fee for Service	\$11,434,295 (eleven months of FFS)
Total Benefit Costs	\$12,473,776 (Total Cost – budget neutral)
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	\$12,473,776
Cost of Proposed SPA Changes – Benefit	\$0.00
Administration Costs	
Personnel	\$0.00
General administration	\$0.00
Contractors/Brokers	\$0.00
Claims Processing	\$0.00
Outreach/marketing costs	\$0.00
Health Services Initiatives	\$0.00
Other	\$0.00
Total Administration Costs	\$0.00
10% Administrative Cap	\$0.00
Cost of Proposed SPA Changes	\$0.00
Federal Share	\$9,954,073
State Share	\$2,519,703
Total Costs of Approved CHIP Plan	\$12,473,776

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT _____
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **EMAIL** _____

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

TITLE OF THIS RULE _____

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

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

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

If no, please explain:

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

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

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

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

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

Current Fiscal Year

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

 Total _____

Next Fiscal Year

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

 Total _____

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

Current Fiscal Year

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

 Total _____

Next Fiscal Year

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

 Total _____

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

\$ _____

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.