ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: July 18, 2024

SUBJ: Transition of Dental Services

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov 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.

If you have any comments, please submit those comments no later than August 17, 2024.

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: Proposed Rules & Public Notices.

NOTICE OF RULEMAKING

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: §§ 25-10-129, 20-76-201, and 20-77-107. The proposed effective date of the rule is November 1, 2024.

The Director of the Division of Medical Services (DMS) amends the Arkansas Medicaid Children's Health Insurance Program (CHIP) State Plan. After careful consideration of dental service utilization, total program cost, and a holistic, efficient, and sustainable Medicaid delivery system for all Arkansans, Arkansas Medicaid will end the Healthy Smiles Dental Managed Care program and transition to Fee-for-Service (FFS) dental services as they existed prior to creation of Healthy Smiles. This rule amends the CHIP State Plan to reflect the new FFS program. There is no fiscal impact.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than August 17, 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 will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502201653

Elizabeth Pitman, Director
Division of Medical Services

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 Medicaid 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

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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

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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

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~~For children who are **not** enrolled in the PASSE, they will only receive dental services through the Healthy Smiles Dental Managed Care program. All other services will still be provided in the fee-for-service system.~~

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)

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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)

    ~~Describe population served: All children who are enrolled in CHIP will be mandatorily enrolled in the Healthy Smiles PAHP.~~

- ☐ 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

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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

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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)
per member/per month rate	$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

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