7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(5) Aerochamber Device

Effective for dates of service on or after October 1, 1997, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX (Medicaid) maximum established was based on a 1997 survey of Durable Medical Equipment (DME) providers. The information obtained in the survey indicated there is only one major manufacturer and distributor of the aerochamber devices (with or without mask) to providers enrolled in the Arkansas Medicaid Program. It was determined the aerochamber devices are sold to each provider for the same price. As a result, the current Title XIX (Medicaid) maximum for the aerochamber devices (with or without mask) was established based on the actual manufacturer=s list prices. Thereafter, adjustments will be made based on the consumer price index factor to be implemented at the beginning of the appropriate State Fiscal Year, July 1.

(6) Specialized Wheelchairs, Seating and Rehab Items

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. Effective for claims with dates of service on or after May 1, 1995, the Title XIX (Medicaid) maximums were established utilizing the manufacturer's current published suggested retail price less 15%. The 15% is the median of Oklahoma Medicaid which is currently retail less 12% and Texas Medicaid which is currently retail less 18%. Effective for claims with dates of service on or after September 1, 1995, the following Kaye Products, procedure codes Z2059, Z2060, Z2061 and Z2062, are reimbursed at the manufacturer's current published suggested retail price. The State Agency and affected provider association representatives will review the rates annually and negotiate any adjustments.

(7) DME/Continuous Glucose Monitors.

Procedure Codes and Rates.

A. Rates. Effective for dates of service on or after January 1, 2022, reimbursement for Continuous Glucose Monitors (CGM) and related supplies is based on the Medicare non-rural rate for the State of Arkansas (effective as of July 28, 2021, and subject to change when Medicare rates are adjusted) for the allowable procedure codes. All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

B. Effective for dates of service on or after April 1, 2024, reimbursement for Continuous Glucose Monitors (CGM) and related Diabetic Supplies including patch type insulin pumps is based on Wholesale Acquisition Cost (WAC) plus applicable professional dispensing fee. Traditional insulin pumps will remain at the Medicare non-rural rate as stated in A. above.

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

6.2 The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

ARKids-B Program

The Title XXI CHIP ARKids-B program's benefit package includes inpatient and outpatient hospital services, physician, surgical and medical services, laboratory and x-ray services, well baby care, including age-appropriate immunizations. Enrollees in ARKids-B are not eligible for the full range of Medicaid State Plan services. The chart below provides a description of the coverage and the amount, duration, and scope of services covered in certain services included in the ARKids-B benefit package, as well as any exclusions or limitations. The services checked below in the pre- print are included in the ARKids-B benefit package.

Ambulance (Emergency Only)
Ambulatory Surgical Center
Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9)
Certified Nurse Midwife
Chiropractor
Dental Care (routine dental care & orthodontia)

Durable Medical Equipment (DME) (Limited to $500 per State Fiscal Year (SFY) July 1 – June 30, excluding CGMs, Drugs, and diabetic supplies)
Emergency Dept. Services (Emergent, non-emergent, assessment)
Family Planning
Federally Qualified Health Center (FQHC)
Home Health (10 visits per SFY (July 1 – June 30))
Hospital, Inpatient
Hospital, Outpatient
Inpatient Psychiatric Hospital & Psychiatric Residential Treatment Facility
Immunizations (All per protocol)
Laboratory & X-Ray
Medical Supplies (Limited to $125/month unless benefit extension is approved)
Mental & Behavioral Health, Outpatient
School-Based Mental Health
Nurse Practitioner
Physician
Podiatry

Prenatal Care
Prescription Drugs, CGMs, and diabetic supplies
Preventive Health Screenings (All per protocol)
Rural Health Clinic
Speech Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved
Physical Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved
Occupational Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved
Substance Abuse Treatment Services (SATS), Outpatient
Vision (Eye exam – One routine eye exam (refraction) every 12 months Eyeglasses) – One pair every 12 months

*The Prescription Drugs and diabetic supplies category includes prescription drugs, Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution).

6.2.12.[X] Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

The diabetic supplies category requires a co-pay rather than inclusion in the DME $500 per State

Fiscal Year (SFY) July 1 – June 30 limitation. While these products are reimbursable to both pharmacies and DME providers, pricing methodology and billing processes have been aligned for both categories.

8.2.3 [X] Coinsurance or copayments:Co-payments and co-insurance apply for all services with the exception of immunizations, preventive health screenings, family planning, and prenatal care. The Title XXI CHIP ARKids-B schedule of co-payments and co-insurance is outlined in the following table. The annual cumulative cost-sharing maximum cannot exceed 5% of the ARKids-B beneficiary's family's income.

Benefits/Limits	**Co-Pay/Co-Insurance**
Ambulance (Emergency Only)	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9)	None
Certified Nurse Midwife	$10 per visit
Chiropractor	$10 per visit
Dental Care (routine dental care & orthodontia)	$10 per visit
Durable Medical Equipment (DME) (Limited to $500 per State Fiscal Year (SFY) July 1 – June 30)	10% of Medicaid allowed per DME item, excluding CGMs and diabetic supplies which are included in the Prescription Drugs and Diabetic Supplies co-payments.
Emergency Dept. Services (Emergent, non-emergent, assessment)	$10 per visit
Family Planning	None
Federally Qualified Health Center (FQHC)	$10 per visit
Home Health (10 visits per SFY (July 1 – June 30))	$10 per visit
Hospital, Inpatient	10% of first inpatient day
Hospital, Outpatient	$10 per visit
Inpatient Psychiatric Hospital & Psychiatric Residential Treatment Facility	10% of first inpatient day
Immunizations (All per protocol)	None
Laboratory & X-Ray	$10 per visit
Medical Supplies (Limited to $125/month unless benefit extension is approved	None
Mental & Behavioral Health, Outpatient	$10 per visit
School-Based Mental Health	$10 per visit

Nurse Practitioner	$10 per visit
Physician	$10 per visit
Podiatry	$10 per visit
Prenatal Care	None
Prescription Drugs and diabetic supplies*	$5 per prescription (Must use generic, if available)
Preventive Health Screenings (All per protocol)	None
Rural Health Clinic	$10 per visit
Speech Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is	
approved Therapy – Four 15 minute units/day unless benefit extension is approved	$10 per visit
Physical Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved	$10 per visit
Occupational Therapy Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved	$10 per visit
Substance Abuse Treatment Services (SATS), outpatient	$10 per visit
Vision (Eye exam, Eyeglasses)	$10 per visit No co-pay for eyeglasses

*The Prescription Drugs and diabetic supplies category includes prescription drugs, Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution). Inclusion in the prescription drugs and diabetic supplies category requires a $5 co-pay rather than the DME $500 limitation per State Fiscal Year (SFY) July 1 – June 30, and the 10% coinsurance required for DME products. These products are reimbursable to both pharmacies and DME providers, and pricing methodology and billing processes have been aligned for both categories. Pharmacy and DME provider billing procedures for diabetic supplies would be aligned with the payment of a copay rather than ten percent (10%) coinsurance.

Only the traditional insulin pumps requiring a canula and tubing would have applicable 10 % coinsurance, as those will remain billed only through the DME benefit.

During the Federal COVID-19 public health emergency, cost sharing shall be waived for any in vitro diagnostic product described in section 2103(c)(10) of the Social Security Act and any other COVID-19 testing-related services regardless of setting type. In addition, the state will waive copayments for COVID treatment.

The Source of State Share Funds:

Please See ATTACHMENT E for State's projected one-year CHIP budget for revising rate methodology and member coinsurance requirements for Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution).

- 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

Please See ATTACHMENT E for State's projected one-year budget for revising rate methodology and member coinsurance requirements for Continuous Glucose Monitors (CGMs) with CGM supplies, patch type insulin pumps, and blood glucose monitors (BGMs) with blood glucose testing supplies (test strips, calibration solution).

CHIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate	
Fee for Service	
Total Benefit Costs	
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	

General administration	
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	
Other	
Total Administration Costs	
10% Administrative Cap	
Cost of Proposed SPA Changes	
Federal Share	
State Share	
Total Costs of Approved CHIP Plan	

NOTE: Include the costs associated with the current SPA.