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State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 20-0013

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

August 12, 2020

Janet Mann, Director
Arkansas Department of Human Services
Division of Medical Services
Office of Rules Promulgation
P.O. Box 1437, Slot S295
Little Rock, AR 72203-1437

Dear Ms. Mann:


On April 14, 2020, the Centers for Medicare & Medicaid Services (CMS) received Arkansas' State Plan Amendment (SPA) transmittal #20-0013, which increases access to medications for Arkansas Medicaid members with opioid use disorder and removes prior authorization requirements for Medication Assisted Treatment.

Based upon the information received, we are now ready to approve SPA #20-0013 as of August 11, 2020, with an effective date of August 1, 2020, as requested by the State.

Enclosed is a copy of the CMS-179 form, as well as the approved page for incorporation into the Kansas State Plan.

If you have any questions regarding this amendment, please contact Michala Walker at (816) 426-5925. We hope this information is helpful. If you have further questions regarding this response, please direct them to Michala Walker of my staff, at Michala.walker@cms.hhs.gov or 816-426-5925.

Sincerely,

 Digitally signed by James
B. Scott -S
Date: 2020.08.12
4:39:17 -05'00'

James Scott, Director
Division of Program Operations


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER <u>2</u> <u>0</u> — <u>0</u> <u>0</u> <u>1</u> <u>3</u>	2. STATE AR
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 8-1-2020	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate transmittal for each amendment</i>)		
6. FEDERAL STATUTE/REGULATION CITATION	7. FEDERAL BUDGET IMPACT a. FFY <u>2020</u> \$ <u>132,083</u> b. FFY <u>2021</u> \$ <u>794,716</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT See attached listing	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) See attached listing	

10. SUBJECT OF AMENDMENT

The Arkansas Title XIX State Plan has been amended to add guidelines for Medication Assisted Treatment

11. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Office of Rules Promulgation PO Box 1437, Slot S295 Little Rock, AR 72203-1437
13. TYPED NAME Janet Mann	Attn: Alexandra Rouse
14. TITLE	
15. DATE SUBMITTED May 14, 2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED	18. DATE APPROVED August 11, 2020
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL August 1, 2020	20. SIGNATURE OF REGIONAL OFFICIAL  James G. Scott - S Date: 2020.08.12 14:42:08 -05'00'
21. TYPED NAME James Scott	22. TITLE Director, Division of Program Operations

23. REMARKS

*Pen and ink change authorized per state email dated 8/3/20 to reflect the elimination of 3.1A pages 2 and 2b from the listing on page 2.

**Pen and ink change authorized per state email dated 8/5/20 to correct superseded TN for 3.1F page 29 on page 2.

**ATTACHED LISTING FOR
ARKANSAS STATE PLAN
TRANSMITTAL #2020-0013**

**8. Number of the Plan
Section or Attachment**

Attachment 3.1-A, Pages 1d

Attachment 3.1-A, Pages 1ee

Attachment 3.1-A, Pages 1f

* Attachment 3.1-A, Pages 2

~~Attachment 3.1-A, Pages 2b~~

Attachment 3.1-A, Pages 5a

Attachment 3.1-B, Pages 2a

Attachment 3.1-B, Pages 2d

Attachment 3.1-B, Pages 2ee

Attachment 3.1-B, Pages 2f

Attachment 3.1-B, Pages 2xxx

Attachment 3.1-B, Pages 4g

Attachment 3.1-F, Pages 29

**9. Number of the Superseded Plan
Section or Attachment**

Attachment 3.1-A, Page 1d
Approved 09-26-06, TN 06-13

Attachment 3.1-A, Page 1ee
Approved 09-06-12, TN 12-10

Attachment 3.1-A, Page 1f
Approved 09-26-06, TN 06-13

~~Attachment 3.1-A, Page 2
Approved 12-27-11, TN 11-09~~

~~Attachment 3.1-A, Page 2b
Approved 12-19-08, TN 08-18~~

Attachment 3.1-A, Page 5a
Approved 01-28-14, TN 13-27

Attachment 3.1-B, Page 2a
Approved 07-01-93, TN 93-22

Attachment 3.1-B, Page 2d
Approved 09-26-06, TN 06-13

Attachment 3.1-B, Page 2ee
Approved 09-06-12, TN 12-10

Attachment 3.1-B, Page 2f
Approved 09-26-06, TN 06-13

Attachment 3.1-B, Page 2xxx
Approved 12-27-11, TN 11-09

Attachment 3.1-B, Page 4g
Approved 01-28-14, TN 13-27

Attachment 3.1-F, Page 29
Approved 11-30-15, TN ~~15-0007~~ **19-0001

TRANSMITTAL Number 2020-0013

EXPLANATION OF FEDERAL BUDGET IMPACT (BLOCK 7)

**TO AMEND ADJUSTMENT FACTOR FOR REIMBURSEMENT CALCULATION
RELATING TO MEDICATION ASSISTED TREATMENT**

Effective for dates of service on or after August 1, 2020, Arkansas Act 964 of 2019 mandates that Arkansas Medicaid may not require prior authorization (PA) nor impose other requirements other than a valid prescription and compliance with MAT guidelines by the Substance Abuse and Mental Health Services Administration (SAMHSA) which may impose a barrier to patients obtaining coverage for buprenorphine, naloxone, naltrexone, methadone and their various formulations and combinations approved by the U.S. Food and Drug Administration (FDA) for the treatment of opioid addiction. This mandate to remove PA requirements pertains to prescriptions drugs for treatment of opioid addiction designated as preferred on the evidence-based preferred drug list (PDL) provided there is at least one of each of the drugs which has the preferred designation on the PDL, or available without PA. In addition, under Act 964, prescriptions for these drugs for this purpose may not count against any prescription limits imposed.

Only providers who have an X-DEA identification number and have obtained an Arkansas Medicaid Specialty designation for MAT may prescribe medication required for the treatment of opioid use disorder for Arkansas Medicaid beneficiaries in conjunction with coordinating all follow-up and referrals for counseling and other services. The expected annual budget impact is estimated to be \$1,109,629.

The FFY 2020 and FFY 2021 budget impacts are identified below.

FFY 2020 (2 months)

Federal Share (71.42%) \$ 132,083

FFY 2021

Federal Share (71.62%) \$ 794,716

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

CATEGORICALLY NEEDY

Revised: August 1, 2020

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; **and**
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; **opioid use disorder when the visit is rendered by an X-DEA waived provider as part of a Medication Assisted Treatment Plan;** and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2020

CATEGORICALLY NEEDY

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners, nurse midwives, and specialized nurse practitioners;
6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and
7. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural Health Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural Health Clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is rendered by an X-DEA waived provider as part of a Medication Assisted Treatment plan.

- 2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4).

Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per beneficiary, per State Fiscal Year (July 1 through June 30) for beneficiaries age **twenty-one** (21) and older. For federally qualified health center core services beyond the 12-visit limit, extensions will be provided if medically necessary. Beneficiaries under age **twenty-one** (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is rendered by an X-DEA waived provider as part of a Medication Assisted Treatment plan.

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised:

August 1, 2020

CATEGORICALLY NEEDY

3. Other Laboratory and X-Ray Services

Other **medically necessary** laboratory and X-ray services **are covered** when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII. **Services are limited to five hundred dollars (\$500) per State Fiscal Year (July 1 – June 30), unless specifically exempt from the limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary. The five hundred dollars (\$500) per State Fiscal Year benefit limit does not apply to services provided to recipients under age twenty-one (21) enrolled in the Child Health Services (EPSDT) Program.**

- (1) The following diagnoses **are specifically exempt from the five hundred dollars (\$500) per State Fiscal Year laboratory and X-ray services health benefit limit:** Malignant neoplasm; HIV infection; and renal failure. **The cost of related laboratory and X-ray services will not be included in the calculation of the recipient's five hundred dollars (\$500) laboratory and X-ray services health benefit limit. Drug screening will be specifically exempt from the five hundred dollars (\$500) per State Fiscal Year laboratory and X-ray services health benefit limit when the diagnosis is for opioid use disorder and the screening is ordered by an X-DEA waived provider as part of a Medication Assisted Treatment plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars (\$500) laboratory and X-ray services health benefit limit.**
- (2) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are **specifically exempt from the five hundred dollars (\$500) per State Fiscal Year laboratory and X-ray services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars (\$500) laboratory and X-ray services health benefit limit.**
- (3) Portable X-Ray Services are **subject to the five hundred dollars (\$500) benefit limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in his or her place of residence upon the written order of the recipient's physician. Services are limited to the following:**
 - a. Skeletal films **which involve** arms and legs, pelvis, vertebral column, and skull;
 - b. Chest films which do not involve the use of contrast media; and
 - c. Abdominal films which do not involve the use of contrast media.
- (4) **Two (2) chiropractic X-rays are covered per state fiscal year. Chiropractic X-Ray Services are subject to the five hundred dollars (\$500) benefit limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary.**

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2020

CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
- a. Prescribed Drugs
- (1) Each recipient age twenty-one (21) or older may have up to six (6) prescriptions each month under the program. The first three (3) prescriptions do not require prior authorization. The three (3) additional prescriptions must be prior authorized. Family Planning, tobacco cessation, **oral prescription drugs for opioid use disorder prescribed by an X-DEA waived provider as part of a Medication Assisted Treatment plan**, and EPSDT prescriptions do not count against the prescription limit.
 - (2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
 - (3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the [Arkansas Medicaid Pharmacy Vendor's Website](#), are covered:

- a. select agents when used for weight gain:
Androgenic Agents;
 - b. select agents when used for the symptomatic relief of cough and colds:
Antitussives; Antitussive-Decongestants; and Antitussive-Expectorants;
 - c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
B 12; Folic Acid; and Vitamin K;
 - d. select nonprescription drugs:
Antiarthritics; Antibacterials and Antiseptics; Antitussives; Antitussives-Expectorants; Analgesics; Antipyretics; Antacids; Antihistamines; Antihistamine-Decongestants; Antiemetic/Vertigo Agents; Gastrointestinal Agents; Hematinics; Laxatives; Ophthalmic Agents; Sympathomimetics; Topical Antibiotics; Topical Antifungals; Topical Antiparasitics; and Vaginal Antifungals; and
 - e. non-prescription products for smoking cessation.
- (4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991 will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a seventy-two (72) hour supply of drugs in emergency situations.

State/Territory: ARKANSAS

**AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY
GROUP(S):**

4.d. Tobacco cessation counseling services for pregnant women

Provided: No limitations with limitations*

e. Medication-Assisted Treatment for opioid use disorders when provided by an X-DEA waived provider as part of a Medication Assisted Treatment plan

Provided: No limitations with limitations*

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: No limitations with limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations with limitations*

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2020
MEDICALLY NEEDY

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. Outpatient hospital services include the following:

- non-emergency outpatient hospital and related physician and nurse practitioner services; and
- outpatient hospital therapy and treatment services and related physician and nurse practitioner services.

For services beyond the 12-visit limit, an extension of benefits will be provided if medically necessary. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; **opioid use disorder when the visit is rendered by an X-DEA waived provider as part of a Medication Assisted Treatment plan**, and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.

Outpatient hospital services are not benefit limited for recipients in the Child Health Services (EPSDT) Program.

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED
MEDICALLY NEEDY

Revised: August 1, 2020

2.b. Rural Health Clinic Services

5. Services of physician assistants, nurse practitioners; nurse midwives; and specialized nurse practitioners;
6. Services and supplies furnished as an incident to a nurse practitioner's or physician assistant's services; and
7. Visiting nurse services on a part-time or intermittent basis to home-bound patients) limited to areas in which there is a shortage of home health agencies).

Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural Health Clinic offers such a service (e.g. dental, visual, etc.). The "other ambulatory services" that are provided by the Rural Health Clinic will count against the limit established in the plan for that service.

Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is rendered by an X-DEA waived provider as part of a Medication Assisted Treatment plan.

- 2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) NCFA – Pub. 45-4).

Effective for claims with dates of service on or after July 1, 1995, federally qualified health center (FQHC) services are limited to twelve (12) encounters per beneficiary, per State Fiscal Year (July 1 through June 30) for beneficiaries age **twenty-one** (21) and older. For federally qualified health center core services beyond the 12-visit limit, extensions will be provided if medically necessary. Beneficiaries under age **twenty-one** (21) in the Child Health Services (EPSDT) Program are not benefit limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is rendered by an X-DEA waived provider as part of a Medication Assisted Treatment plan.

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2020

MEDICALLY NEEDY

3. Other Laboratory and X-Ray Services

Other **medically necessary** laboratory and X-ray services **are covered** when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII. **Services are limited to five hundred dollars (\$500) per State Fiscal Year (July 1-June 30), unless specifically exempt from the limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary. The five hundred dollars (\$500) per State Fiscal Year benefit limit does not apply to services provided to recipients under age twenty-one (21) enrolled in the Child Health Services (EPSDT) Program.**

The following diagnoses are specifically exempt from the five hundred dollars (\$500) per State Fiscal Year laboratory and X-ray services health benefit limit: Malignant neoplasm; HIV infection; and renal failure. The cost of related laboratory and X-ray services will not be included in the calculation of the recipient's five hundred dollars (\$500) laboratory and X-ray services health benefit limit.

- (1) **Drug screening will be specifically exempt from the five hundred dollars (\$500) per State Fiscal Year laboratory and X-ray services health benefit limit when the diagnosis is for opioid use disorder and the screening is ordered by an X-DEA waived provider as part of a Medication Assisted Treatment plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars (\$500) laboratory and X-ray services health benefit limit.**
- (2) **Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars (\$500) per State Fiscal Year outpatient laboratory and X-ray services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars (\$500) laboratory and X-ray services health benefit limit.**
- (3) **Portable X-Ray Services are subject to the five hundred dollars (\$500) benefit limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in his or her place of residence upon the written order of the recipient's physician. Services are limited to the following:**
 - a. **Skeletal films which involve arms and legs, pelvis, vertebral column, and skull;**
 - b. **Chest films which do not involve the use of contrast media; and**
 - c. **Abdominal films which do not involve the use of contrast media.**
- (4) **Two (2) chiropractic X-rays are covered per state fiscal year. Chiropractic X-Ray Services are subject to the five hundred dollars (\$500) benefit limit. Extensions of the benefit limit for recipients age twenty-one (21) or older will be provided through prior authorization, if medically necessary.**

4.a. Nursing Facility Services - Not Provided

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2020

MEDICALLY NEEDY

4.c. Family Planning Services

- (1) Comprehensive family planning services are limited to an original examination and up to three (3) follow-up visits annually. This limit is based on the state fiscal year (July 1 through June 30).

4.d. (1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time)

*describe if there are any limits on who can provide these counseling services

(2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: No limitations With limitations*

*Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

Please describe any limitations:

Face-to-face tobacco cessation counseling services are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per state fiscal year.

4.e. Prescription drugs for treatment of opioid use disorder

- a. **Oral preferred prescription drugs (preferred on the PDL) used for treatment of opioid use disorder require no prior authorization and do not count against the monthly prescription limits when prescribed by an X-DEA waived provider as part of a Medication Assisted Treatment plan.**

5.a. Physicians' services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere

- (1) Physicians' services in a physician's office, patient's home, or nursing home are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for recipients age twenty-one (21) and older.

AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2020

MEDICALLY NEEDY

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed Drugs

- (1) Each recipient age **twenty-one** (21) or older may have up to six (6) prescriptions each month under the program. The first three (3) prescriptions do not require prior authorization. The three (3) additional prescriptions must be prior authorized. Family Planning, tobacco cessation, **oral prescription drugs for opioid use disorder when prescribed by an X-DEA waived provider as part of a Medication Assisted Treatment plan**, and EPSDT prescriptions do not count against the prescription limit.
- (2) Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
- (3) The Medicaid agency provides coverage, to the same extent that it provides coverage for all Medicaid recipients, for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses – with the exception of those covered by Part D plans as supplemental benefits through enhanced alternative coverage as provided in 42 C.F.R. §423.104 (f) (1) (ii) (A) – to full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

The following excluded drugs, set forth on the [Arkansas Medicaid Pharmacy Vendor's Website](#), are covered:

- a. select agents when used for weight gain:
Androgenic Agents;
 - b. select agents when used for the symptomatic relief of cough and colds:
Antitussives; Antitussive-Decongestants; **and** Antitussive-Expectorants;
 - c. select prescription vitamins and mineral products, except prenatal vitamins and fluoride:
B 12; Folic Acid; **and** Vitamin K;
 - d. select nonprescription drugs:
Antiarthritics; Antibacterials and Antiseptics; Antitussives; Antitussives-Expectorants; Analgesics; Antipyretics; Antacids; Antihistamines; Antihistamine-Decongestants; Antiemetic/Vertigo Agents; Gastrointestinal Agents; Hematinics; Laxatives; Ophthalmic Agents; Sympathomimetics; Topical Antibiotics; Topical Antifungals; Topical Antiparasitics; and Vaginal Antifungals; **and**
 - e. non-prescription products for smoking cessation.
- (4) The State will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3), or 1927(d) apply. The State permits coverage of participating manufacturers' drugs, even though it may be using a formulary or other restrictions. Utilization controls will include prior authorization and may include drug utilization reviews. Any prior authorization program instituted after July 1, 1991, will provide for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for at least a 72-hour supply of drugs in emergency situations.

State: ARKANSAS

Citation	Condition or Requirement
	1. Describe any additional circumstances of “cause” for disenrollment (if any).
	K. <u>Information requirements for beneficiaries</u> Place a check mark to affirm state compliance.
1932(a)(5) CFR 438.50 42 CFR 438.10	<input checked="" type="checkbox"/> The state assures that its state plan program complies with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. <u>List all services that are excluded for each model (MCO & PCCM)</u> The following PCCM exempt services do not require PCP authorization: Dental Services Emergency hospital care Developmental Disabilities Services Community and Employment Support Family Planning Anesthesia Alternative Waiver Programs Adult Developmental Day Treatment Services Core Services only Disease Control Services for Communicable Diseases ARChoices waiver services Gynecological care Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment Medication-Assisted Treatment Services for opioid use disorder when rendered by X-DEA waived provider as part of a Medication Assisted Treatment plan Mental health services as follows: a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner b. Rehabilitative Services for Youth and Children Nurse Midwife services ICF/IID Services Nursing Facility services Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment. Ophthalmology and Optometry services Obstetric (antepartum, delivery , and postpartum) services Pharmacy Physician Services for inpatients acute care Transportation