



Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Jose R. Romero, MD, Secretary of Health

MEMORANDUM OF AGREEMENT

This Memorandum of Agreement (MOA) is entered by and between the Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) as the State Medicaid Agency, the DHS Division of Developmental Disabilities Services (DDS), and the Arkansas Department of Health (ADH) for the purpose of carrying out provisions of Titles V and XIX of the Social Security Act, as amended. This agreement is set forth to define each agency's responsibilities in order to effectively administer the coverage of medical services through ADH's Title XIX Program and to ensure Medicaid coverage for Title V (Maternal and Child Health Block Grant) services provided to eligible individuals receiving Title V services, and to facilitate data sharing that will enable ADH and DMS to improve Title V and Title XIX program administration and outcomes.

The DHS/DMS administrator for this Agreement will be: Elizabeth Pitman, DMS Director, 501-244-3944; Elizabeth.Pitman@dhs.arkansas.gov; P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437.

The DHS/DDS administrator for this Agreement will be: Melissa Stone, DDS Director, 501-683-0870, Melissa.stone@dhs.arkansas.gov; P.O. Box 1437, Slot N501, Little Rock, AR 72203.

The ADH administrator for this Agreement will be: Jo C. Thompson, ADH Chief Financial Officer, 501-280-4157, Jo.Thompson@arkansas.gov; 4815 West Markham Street, Slot 51, Little Rock, AR 72205-3867.

I. PRINCIPLES

This Agreement is based on the following principles:

- A. Both parties have a common and concurrent interest in providing eligible Medicaid recipients with access to family planning, immunization, maternity and infant care, sexually transmitted disease services, and other clinical services, while ensuring that the integrity of the Medicaid Program is maintained.
- B. Both parties agree that the basis for this Agreement is:
 1. To allow ADH to gain access to Medicaid reimbursement, and for certain specified services, reimbursement is contingent upon ADH providing the state match portion of the expenditures.
 2. To ensure Medicaid coverage of services provided to Medicaid-eligible individuals receiving Title V services, including the Title V Children and Youth with Special Health Care Needs (CYSHCN) Program administered through DHS' Division of Development Disabilities (DDS) Children's Services.

3. To delineate coordination and collaboration responsibilities for ADH Title V programs and DDS First Connections and CYSHCN programs.
4. To allow ADH to gain access to demographic data summaries which are to fulfill Title V federal reporting requirements.

C. This agreement is in no way intended to modify the responsibilities or authority delegated to the parties.

II. TERM OF AGREEMENT

This Agreement will become effective on the date of execution, when all parties affix signatures thereto. Changes made during its effective life will be added as formal amendments which all parties must acknowledge by signature. This Agreement will continue in effect until terminated by ADH or DMS. This Agreement may be terminated, without cause, by either party upon thirty (30) days written notice, which notice shall be delivered by email or certified mail to all parties.

III. AUTHORITY

Federal laws and regulations mandate cooperation between state agencies responsible for the administration and/or supervision of Title V and title XIX of the Social Security Act. The following legislation and regulations delineate the authority and the intent of this agreement:

A. Legislative

1. Title V of the SSA [§505(5)(F)] and (SSA § 1902(a)(11)(A)) provides for entering into cooperative agreements with the State agencies responsible for administering and/or supervising the administration of services to ensure maximum utilization of such services. Section 1902 (a)(11)(B) requires provision of appropriate reimbursement to any Title funded project by Title XIX for services and care provided to Medicaid consumers;
2. Title V of the SSA [§505(5)(F)] provides for : 9a) participation in the coordination of activities between such programs and the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program under section 1905(a)(4)(B) (including the establishment of periodicity and content standards for EPSDT services), to ensure that such programs are carried out without duplication of effort; (b) participation in the arrangement and carrying out of coordination of care and services available under this title and Title XIX; (c) participation in the coordination of activities within the State with programs carried out under this title and related federal grant programs (including supplemental food programs for mothers, infants, and children; related education programs; and other health, developmental disability, and family planning programs); and (d) provision, directly and through their providers and institutional contractors, for services to identify pregnant women and infants who are eligible for Medicaid, under subparagraph (A) or (B) of section 1902(1)(1) and, once identified, to assist them in applying for such assistance.
3. All federal statues relating to nondiscrimination which may apply to Title V and Title XIX of the Social Security Act and the terms of this agreement. These include but are not limited to:

- a. Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin;
- b. Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex;
- c. Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C §794), which prohibits discrimination on the basis of handicaps;
- d. Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- e. Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse;
- f. Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism;
- g. §§523 and 527 of the Public Health Services Act of 1912 (42 U.S.C. §§290dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records.

B. Regulatory

1. 42 CFR 431.615 requires that the State Title XIX plan include written cooperative agreements with the State health agencies and Title V grantees to ensure that Title V recipients eligible for Medicaid receive services with particular emphasis on EPSDT services.
2. 34 CFR Part 303, Early Intervention Program for Infants and toddlers with Disabilities requires coordination, cooperation, and prevents unnecessary duplication with Title XIX in several areas, including; (a) comprehensive child find system; (b) all available resources; (c) non-substitution of funds; and (d) non-reduction of benefits. See 34 CFR 303.321;522; and 527.

IV. SERVICES

The Arkansas Department of Health agrees to provide the following services for eligible individuals:

A. Family Planning Services

1. Initial Visit (Annual)

Medical history; medical examination, including head, neck, breast, chest, bimanual examination and cervical inspection, abdomen, height, weight and body mass index (BMI), extremities; vital signs as indicated, including but not limited to blood pressure; and contraceptive counseling.

2. Subsequent/Follow-up Visit

Follow-up medical history; height, weight and body mass index (BMI), vital signs as indicated, including but not limited to blood pressure; Intrauterine Contraceptive follow-up; Implantable Capsule follow-up; and contraceptive counseling.

3. Other Services, as appropriate, including but not limited to:

Colposcopy, including biopsy (may include multiple specimens on the same date of service); Implantable Capsule insertion, removal, and removal with re-insertion; IUD system, insertion and removal; Intrauterine Systems (IUS), insertion and removal; Depo-Provera; Rocephin injections; Tdap immunization; MMR immunization; Varicella immunization; vasectomy examination; tobacco cessation counseling services; and topical fluoride varnish application (2 units per calendar year for individuals under age 21).

4. Laboratory Services, as appropriate, and eligible under the Arkansas Medical Assistance Program including but not limited to:

- a. All laboratory services for which we are currently being reimbursed;
- b. Fecal Occult Blood test;
- c. Hemoglobin A1C test;
- d. Syphilis serology;
- e. Papanicolaou Test;
- f. Gonorrhea culture;
- g. Sickle Cell screen;
- h. Hemoglobin/hematocrit;
- i. Pregnancy test;
- j. Urinalysis;
- k. X-ray/ultrasonography;
- l. Chlamydia screen;
- m. Wet prep;
- n. HIV – Rapid Test;
- o. HIV 2 – Antibody test.

B. Well Woman Services

1. Initial Visit (Annual)

Medical history; medical examination, including head, neck, breast, chest, bimanual examination and cervical inspection, abdomen, height, weight, body mass index (BMI), extremities; vital signs as indicated, including but not limited to blood pressure.

2. Subsequent/Follow-up Visit

Follow-up medical history; height, weight and body mass index (BMI); vital signs as indicated, including but not limited to blood pressure.

3. Other Services, if appropriate, including but not limited to:

Colposcopy, including biopsy (may include multiple specimens on the same date of service);

Tdap immunization; MMR immunization; Varicella immunization; and tobacco cessation counseling services.

4. Laboratory Services, as appropriate, and eligible under the Arkansas Medical Assistance Program including but not limited to:
 - a. All laboratory services for which we are currently being reimbursed;
 - b. Fecal Occult Blood test;
 - c. Hemoglobin A1C test;
 - d. HIV – Rapid test;
 - e. HIV 2 – Antibody test

C. Maternity and Infant Services

1. Clinic Visits (per pregnancy)

Prenatal visits should begin as early as possible and continue every four weeks until the 28th week, every two weeks until the 36th week, and weekly thereafter. High risk patients may require more visits.

- a. Initial prenatal visit: medical, obstetrical, menstrual and contraceptive history; complete physical examination; measurements (e.g. blood pressure, height, weight, and BMI). Maximum billed: One initial visit per three years.
- b. Subsequent prenatal visits: interval history; measurements (e.g. blood pressure, weight, BMI, recording of fundal height, recording of fetal movements, fetal heart tones auscultated, presentation and position determined); counseling.
- c. Postpartum clinic visits: interval history (e.g. labor and delivery, noting complications, newborn weight at birth, postpartum events, level of activity); physical assessment; measurements (e.g. blood pressure, Weight, BMI); rubella immunization, if indicated; family planning counseling; newborn care counseling.

2. Additional Services

a. Risk Assessment

The medical, nutritional, and psychological assessment by the physician, Advanced Practice Registered Nurse (APRN) or registered nurse to designate patients as high risk or low risk; Medical assessment to include medical, menstrual, pregnancy history, and tobacco use status; Nutritional assessment to include screening for anemia and BMI or weight history; Socioeconomic assessment to include criteria for identification of psychosocial problems which may adversely affect the patient's health status.

Maximum: Two per pregnancy

b. Perinatal Education

Education classes provided by a health professional (Public Health Nurse, Nutritionist, or Health Educator) on the following topics: pregnancy, labor and delivery, reproductive health, postpartum care, nutrition in pregnancy, breastfeeding, infant care, and feeding.

Maximum: Six classes (units) per pregnancy

c. Nutrition Consultation

Services provided for high risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration to include at least one of the following: Evaluation to determine health risks due to nutrition factors with development of a nutritional care plan; or nutritional care plan follow-up and re-assessment as indicated.

Maximum: Nine nutrition consultation sessions per pregnancy

d. Case Management

Coordination of care by a physician or registered nurse, including activities to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational, and other services. Examples: Life 360 program, locating a source of service, making an appointment for service; arranging transportation, arranging hospital admission, locating physician to deliver a newborn, follow-up to verify patient kept appointment, re-scheduling appointment.

Maximum Billed: one unit per month.

e. Early Intervention

Coordination of care by the Infant Hearing Program (IHP), First Connections, and CYSHCN programs; including referral, follow-up, and coordination of early hearing detection and intervention (EHDI) services for infants and toddlers (0-3) who are at risk of and/or diagnosed with a hearing condition.

f. Other

Tobacco cessation counseling services, Tdap immunization, if indicated, topical fluoride varnish application (2 units per calendar year for individuals under age 21).

3. Laboratory Services, as appropriate, and eligible under the Arkansas Medical Assistance Program including but not limited to:

- a. All laboratory services for which we are currently being reimbursed;
- b. HIV – Rapid test;
- c. HIV 2 – Antibody test;
- d. IGRA test.

D. Immunization Services

1. Immunizations, as indicated, as per the current recommended immunization schedule approved by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (Vaccines for eligible individuals under the age of 18 are provided by the Vaccines for Children Program.). Vaccination administration also includes:
 - a. Immunization counseling and post-vaccination observation for complications;
 - b. Medical history update.
2. Other Services, if appropriate, including but not limited to: tobacco cessation counseling services; topical fluoride varnish application (2 units per calendar year for individuals under age 21).

E. Sexually Transmitted Disease Services

1. STD/HIV Initial Visit

This includes the first or initial visit per episode of disease or patient complaint. Based upon the patient's complaint/symptoms, appropriate services include intake, physical assessment, laboratory specimen collection, counseling, treatment, referral, and/or disease intervention.

Maximum Billed: Three first or initial visits per three years

2. STD/HIV Follow-up Visit

Includes follow-up services related to the initial STD/HIV visit. Appropriate services include rescreens, test of cure, positive/negative test result counseling, follow-up serology, and/or administration of medications.

3. Other Services, if appropriate, including but not limited to: Immunizations offered based on Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, if indicated; tobacco cessation counseling services; topical fluoride varnish application (2 units per calendar year for individuals under age 21)

4. Laboratory Services, as appropriate, and eligible under the Arkansas Medical Assistance Program including but not limited to:

- a. All laboratory services for which we are currently being reimbursed;
- b. HIV 2 - antibody testing.

V. REIMBURSEMENT TERMS

- A. For the following services, DMS shall reimburse ADH at a rate equal to the physicians' fee schedule. The rates are subject to change according to revisions made to that schedule.

1. Family Planning Services

57454

Colposcopic examination with biopsy and endocervical

	currettage
57455	Colposcopy with biopsy
57452	Colposcopic examination (no biopsy)
88305	Cervical Biopsy Pathology
J7307	Nexplanon
11981	Nexplanon Insertion
11983	Removal with Reinsertion of Nexplanon
J7298	Mirena Intrauterine System
J2797	Liletta Intrauterine System
J7300	Paragard Intrauterine System
58300	IUD Insertion
58301	IUD Removal
J0696	Rocephin Injection
99401	Subsequent visit
99402	Annual exam
99406,SE	Tobacco Cessation Counseling (15 minutes)
99407,SE	Tobacco Cessation Counseling (30 minutes)
99188	Topical Application of Fluoride Varnish

Laboratory services, as appropriate and eligible under the Arkansas Medical Assistance Plan

99205	Initial Visit
99215	Follow-up Visit Laboratory services as appropriate and eligible.

B. ADH state general revenue (SGR) will be utilized in the reimbursement of the following specified services supported through the Title XIX Program. Coverage under Title XIX is contingent upon the ability of ADH to provide the required state match of the expenditures:

1. Family Planning Services

99401	Initial/Annual/Basic Visit
99402	Subsequent/Follow-up/Periodic Visit

2. Immunizations

All immunizations as eligible under the Arkansas Medical Assistance Program.

When the federal Vaccines for Children (VFC) Program is implemented and Medicaid reimbursement for immunizations is changed to an administrative fee, ADH will no longer be responsible for the state match for immunizations.

3. Sexually Transmitted Disease Services

99205	STD/HIV Initial Visit
99215	STD/HIV Follow-Up Visit

Laboratory services, as appropriate and eligible under the Arkansas Medical Assistance Plan

4. Maternity and Infant Services

For the following services, ADH shall pay the state match requirement.

99402,U1,UA Risk Assessment

99402,U4,UA Case Management – Low Risk

99402,U5,UA Case Management – High Risk

99402, UA Prenatal Ed Classes

VI. RESPONSIBILITIES

A. Responsibilities of the Arkansas Department of Health (ADH)

1. ADH must maintain written policies to ensure adequate staff training and skills to support the administration of ADH services that are not performed by a physician.
2. When ADH services are not performed by a physician, a physician must be immediately available for consultation to the staff performing the services. The physician is not required to be physically present (under the same roof) at all times during the service delivery.
3. Fluoride varnish application will be provided by physicians or other licensed health care professionals who have completed the ADH Office of Oral Health's fluoride varnish application online training program and received a certificate certifying successful completion of the training. Physicians who have completed the training may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. Physicians and other licensed healthcare providers who have completed the training will maintain documentation to establish his or her successful completion of the training and submit a copy of their fluoride varnish certification to HP Provider Enrollment.
4. ADH will certify by memo each year the anticipated Medicaid match requirement for each program as specified in this agreement. Upon receipt of the Medicaid Match Utilization Report, ADH will forward payment for the Medicaid match utilized for services as specified.
5. ADH will provide DMS with a memo outlining projected expenditures for each forthcoming quarter as follows:

<u>Due Date</u>	<u>For the Period</u>
i. July 1	October, November, December
ii. October 1	January, February, March
iii. January 1	April, May, June
iv. April 1	July, August, September

6. ADH will periodically review the rate at which Medicaid funds are being utilized. Even though DMS will monitor the state general revenue, all claims

received after the general revenue has been depleted will be the financial responsibility of ADH, regardless of whether ADH has received a reminder/notification.

7. If Federal Financial Participation is disallowed regarding coverage of the services described in this agreement, ADH is responsible for the repayment of all disallowed funds.
8. ADH will identify, track, and assist infants and toddlers (0-3) at risk of and/or diagnosed with a hearing condition as the lead agency for the state's EHDI program. ADH will fulfill this by:
 - a. Providing a comprehensive list of federal reporting criteria (Attachment A).
 - b. Referring infants/toddlers who have been diagnosed with a confirmed hearing condition and/or chronic health condition to First Connections and/or CYSHCN within two (2) days of detection or suspicion of a developmental delay through the link in the EHDI Information System.
 - c. Providing a report detailing children referred from the IHP to First Connections or CYSHCN, for quality assurance and follow-up measures.
 - d. Providing a bi-monthly report to CYSHCN detailing children identified with risk factors during initial hearing screening.
 - e. Providing training for designated First Connections and CYSHCN staff in the use of the EHDI Information System for the completion of the infant's/toddler's electronic record.
9. It is the responsibility of both parties, whenever possible, to identify Arkansans who may be eligible for Medicaid and/or who have not received appropriate screenings or services. ADH will fulfill this by:
 - a. Providing information to families about Medicaid benefits at Local Health Units and other appropriate venues, when possible;
 - b. Assisting individuals receiving services at ADH Local Health Units with determining Medicaid-eligibility and helping them with the Medicaid application process, when possible.

B. Responsibilities of the Arkansas Department of Human Services

1. DMS will periodically review the rate at which funds are being utilized, and upon determining that the state general revenue reserved for coverage of ADH services will be exhausted prior to the end of the state fiscal year, will initiate the following actions:
 - a. Thirty days prior to the estimated depletion of the general revenue, ADH will be sent a reminder requesting that additional funding be obtained. All claims submitted to DMS after this date will be placed on a prior authorization status;

- b. If no additional funding is obtained, ADH will be sent a notification of the date that the general revenue was exhausted, noting that all claims received for the duration of the state fiscal year will be non-reimbursable under Title XIX.
2. Title XIX (Medicaid) will reimburse ADH for Title V services covered under the State Medicaid Plan for Medicaid-eligible consumers based in accordance to the rates established in this Agreement. Title XIX funds shall be the first and primary source of payment for medical services provided to mutual beneficiaries of the Title V and Medicaid Programs, including individuals receiving Title V Children and Youth with Special Health Care Needs Program services administered through DHS' Division of Development Disabilities Children's Services.
3. DDS will direct early intervention enrollment and care coordination for children who are at risk of and/or diagnosed with a hearing condition through varied agencies. DDS will fulfill this by:
 - a. Including the IHP in the parental authorization for release of information which allows the IHP access to information in the early intervention, CYSHCN care coordination plan, related services, and medical records for infants/toddlers referred to First Connections and/or CYSHCN by the IHP.
 - b. Providing specific, individualized information based on EHDI federal reporting criteria to the IHP.
 - c. Providing a copy of the child's/family's Individualized Family Service Plan (IFSP) and CYSHCN care plan for referred children with a hearing condition to the IHP, if requested.
 - d. Providing a report to the IHP listing infants/toddlers referred with a hearing condition with documentation of early intervention services or services selected by the IFSP team and demographic information (i.e. primary care physician or phone number) for infants/toddlers referred to CYSHCN as part of quality assurance to ensure all infants/toddlers referred to First Connections or CYSHCN have been accounted for.
 - e. Providing targeted case management services to assist families of CYSHCN eligible children in accessing all medical, social, education, and other services appropriate to the child's special health care needs.
 - f. Collaborating with IHP to schedule training for identified program staff in the use of the EHID Information System.
4. It is the responsibility of both parties, whenever possible, to identify Arkansans who may be eligible for Medicaid and/or who have not received appropriate screenings or services. DMS will fulfill this by:
 - a. Providing information for families about Medicaid benefits through various venues such as online, at health fairs, local county DHS offices, offices of health care providers, and hospitals;

- b. Conducting outreach to ensure that families are benefiting from Medicaid services;
- c. Maintaining a toll-free number and website to help people who have Medicaid and/or ARKids First find a medical home by locating a primary care doctor and dental care.

C. Shared Responsibilities of All Parties

1. Work in partnership and to ensure the quality of Medicaid reimbursable ADH clinical health services;
2. Make timely referrals for services not directly rendered by their respective agencies, but are essential to meeting the individual's needs;
3. Coordinate plans to address: 1) the scope of services covered under Title XIX and Title V programs that may impact DMS or ADH's plans and/or budgets; and 2) Title V activities that may impact Medicaid service requirements and the cost of services. ADH and DMS jointly agree to work collaboratively to:
 - a. Prevent duplication of efforts among Title V and Title XIX programs;
 - b. Improve the cost effectiveness of the health care delivery system;
 - c. Improve the availability of services;
 - d. Ensure services focus on targeted population groups and/or geographical areas;
4. Maximize efficiency of services delivery.
5. Provide access to any pertinent financial reports, documents, papers, and records for the purpose of completing audits, examinations, and transcripts of transactions related to this agreement;
6. Retain financial records, supporting documents, statistical records, and all other pertinent records for a period of three years after the date expenditures are reported under this agreement.

VII. REPORTING DATA

Data sharing between ADH and DMS is vital to ensure mandatory data reporting as required by the Title V MCH Block Grant federal funder. The agreed upon exchange of data will also enable ADH and DMS to improve Title V and Title XIX program administration and outcomes, develop performance measures that rely on shared data, and facilitate joint planning efforts to identify service delivery gaps to improve delivery of services.

A. Responsibilities of the Arkansas Department of Health

1. Collect and analyze demographic data regarding Title V services rendered for the purpose of submitting all required reports and documents to the Title V federal funding entity, including programmatic and fiduciary reports based on aggregate data;

2. Request needed data from DMS in a timely manner.

B. Responsibilities of DHS' Department of Medical Services

1. Provide demographic data summaries, within thirty days of request, which are necessary to fulfill Title V federal reporting requirements, including but not limited to:
 - a. Percent of Medicaid enrolled children under 1 year of age receiving at least 1 initial EPSDT screen in previous calendar year;
 - b. Percent of State Children's Health Insurance Program (SCHIP) enrolled children under 1 year of age receiving at least 1 initial EPSDT screen in previous calendar year;
 - c. Percent of all Medicaid enrolled children receiving a service paid by the Medicaid program in previous calendar year;
 - d. Percent of Medicaid enrolled children 6 - 9 years receiving a dental service paid by the Medicaid program in previous calendar year;
 - e. Number of Medicaid eligible of all ages enrolled anytime in previous calendar year.
 - f. Number of Medicaid eligibles 23 years of age or over enrolled anytime in previous calendar year.
 - g. Unduplicated number of eligibles by race for previous calendar year for:
 - i. Medicaid eligible ages 0-19 (excludes ARKids B);
 - ii. SCHIP eligible ages 0-19;
 - iii. Foster care eligible ages 0-19.
2. Collaborate to provide HIPAA-compliant information and records necessary to facilitate program administration and evaluation.

C. Mutual Services

1. Work together with the goal of improving the State's capacity to integrate data, link data files, and to utilize program data to improve program administration and outcomes.
2. Share and disseminate data necessary for program administration, policy development, and to carry out responsibilities listed in this Agreement.
3. Designate individuals to accept and coordinate all data requests from each respective agency in accordance with individual program's policies and procedures.
4. To maintain policies and procedures that ensure data sharing is in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), specifically 45 CFR Parts 160 and 164 (the "Privacy Rule" and "Security Rule"); the Health Information Technology for Economic and Clinical Health Act (HITECH Act); and applicable federal and Arkansas laws that protect the privacy and provide for the security of protected health information and electronic protected health information;

5. To uphold the confidentiality of shared data in accordance with the following requirements:
 - a. The data will not be used in any way except for the purpose stated above;
 - b. The data will not be released, wholly or partially, to any person that is not required to use it as part of their job duties for the purpose stated above;
 - c. The data will be kept in a secure environment and not be transported on an unencrypted mobile device such as a laptop, cellphone or flash drive; only the authorized user will have access to the data;
 - d. The confidentiality requirements shall continue in full effect until the data have been destroyed from their system and any backups.

VIII. AGENCY LIAISONS

Each agency will designate an individual to serve as a liaison for the purpose of implementing this Agreement and ensuring that ongoing communication and coordination takes place between the agencies. The designated liaison for each agency will be:

Arkansas Department of Health (ADH) Liaison

Tamara Baker, MCH Director and Branch Chief, Arkansas Department of Health,
Center for Health Advancement, Family Health Branch

Arkansas Department of Human Services/Division of Medical Services Liaison

Elizabeth Pitman, Division of Medical Services Director, Arkansas Department of
Human Services

IX. REVIEW

This Agreement will be reviewed prior to July 1 of each year in a joint meeting of all parties, or at the request of either party by the designated agency liaison, to determine if revisions are required.

Amendments can be requested at any time; in the event that changes are sought, the designated agency liaisons may coordinate and make formal amendments to be agreed upon by both parties. Amendments shall be in writing, signed by the authorized representative of each party, and will comprise an official component of the document from that time forward.

If no revisions are requested by any party, no action of renewal is necessary and the effective life of this Agreement continues. As listed in section II, "this Agreement may be terminated, without cause, by either party upon thirty (30) days written notice, which notice shall be delivered by email, by hand, or certified mail to all parties."

The following parties agree to this Memorandum of Agreement:

L. Elizabeth Pitman

DHS DMS Administrator

Elizabeth Pitman, DMS Director
Printed Name

7/13/21
Date

Melissa Stone

DHS DDS Administrator

Melissa Stone, DDS Director
Printed Name

7/13/21
Date

Mary Franklin

DHS OEC Administrator

Mary Franklin, DHS OEC Director
Printed Name DCO

7/15/2021
Date

Tamara Baker

ADH MCH Director

Tamara Baker, MCH Director
Printed Name

6/17/21
Date

Renee Mallory

ADH Interim Chief of Staff

Renee Mallory
Printed Name

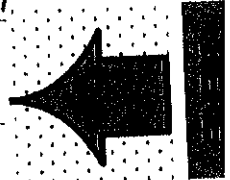
6/29/21
Date

Jo C. Thompson

ADH Administrator

Jo C. Thompson, CFO
Printed Name

6/28/21
Date



Attachment A

Early Intervention Data

A. Referrals to Part C Early Intervention (EI)

Total Number of Referrals (that have primary or secondary condition of hearing loss from all entities that reported). Of the total number, the number that are:

- 1) Eligible for Part C
- 2) Not eligible for Part C
- 3) Eligibility unknown

B. Enrolled in Part C Early Intervention (EI)

Total number Enrolled in Part C EI Of the total number, the number those are:

- 1) Enrolled before 6 months of age
- 2) Enrolled after 6 months but before 12months of age
- 3) Enrolled after 12 months of age
- 4) Enrolled: age unknown

C. No services

Total reported that are not receiving services. Of the total numbers that are not receiving services, the number not receiving services due to the following reasons:

- 1) Infant died/parents declined services
- 2) Non-resident or moved out of jurisdiction
- 3) Unable to contact, unresponsive, unknown
- 4) Not eligible for Part C Services
- 5) Parent/Family Declined Services
- 6) Homebirths
- 7) Unable to receive EI due to Medical reasons
- 8) Receiving EI Services Elsewhere (Non-Part C Services)

D. Date that Child was enrolled in EI

- 1) IFSP date
- 2) Notification of Receiving EI Services Elsewhere

E. Number of Families referred to parent-to-parent support groups

F. Copy of Child's IFSP

To obtain the following information:

- 1) Child's Name (as a unique identified with IHP data)
- 2) Intervention or service start date
- 3) Type of Evaluation(s), Service, or Intervention
- 4) Date of Evaluation(s), Service, or Intervention
- 5) Where services received (home-based), school-based, etc.)
- 6) *Receptive Language Level
- 7) *Expressive Language Level
- 8) *Cognitive Inventory Used
- 9) *Cognitive Development Score
- 10) *Social Development Inventory Used
- 11) *Social Development Score

*Indicates future CDC data collection

Children and Youth with Special Health Care Needs Program Data

G. Referrals to Title V

Total Number of Referrals (that have primary or secondary condition of hearing loss from all entities that reported). Of the total number, the number that are:

- 1) Eligible for Title V
- 2) Not eligible for Title V
- 3) Eligibility Unknown

H. Enrolled in Title V

Total number Enrolled in Title V. Of the total number, the number that are:

- 1) Enrolled before 6 months of age
- 2) Enrolled after 6 months but before 12 months of age
- 3) Enrolled after 12 months of age
- 4) Enrolled: age unknown

I. No services

Total reported that are not receiving services. Of the total numbers that are not receiving services, the number not receiving services due to the following reasons:

- 1) Infant died
- 2) Non-resident or moved out of jurisdiction
- 3) Unable to contact, unresponsive, unknown
- 4) Not eligible for Title V Services
- 5) Parent/Family Declined Services

J. Date that Child was enrolled Title V

- 1) Begin Date

K. Number of Families referred to parent-to-parent support groups (i.e. Parent Advisory Council)

L. Child's Family Contact Information

- 1) Parent's name
- 2) Mailing Address
- 3) Phone Number
- 4) Primary Care Physician

BUSINESS ASSOCIATE AGREEMENT

Between

ARKANSAS DEPT. OF HUMAN SERVICES

and

Arkansas Department of Health
(Business Name and Tax Id Number)

This Business Associate Agreement ("Agreement") is made effective on November 16, 2020, (the "Effective Date") by and between the Arkansas Department of Human Services ("Covered Entity") and Arkansas Department of Health, ("Business Associate,") (collectively, the "Parties").

Background

(a) Covered Entity has been designated as a hybrid entity for the purposes of the HIPAA Privacy Rule, and it has designated several of its component agencies as health care components.

(b) In accordance with the laws of Arkansas, Business Associate provides services for Covered Entity unrelated to treatment, payment, or healthcare operations; therefore, the Parties believe a Business Associate agreement is required. The provision of such services may involve the disclosure of individually identifiable health information from Covered Entity to Business Associate.

(c) The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "Business Associate" within the meaning of the HIPAA Privacy Rule.

(d) The Parties enter into the Agreement with the intention of complying with the HIPAA Privacy and Security Rule provisions and the Health Information Technology for Economic and Clinical Health (HITECH) Act, that a Covered Entity may disclose protected health information to a Business Associate, and may allow a Business Associate to create or receive protected health information on its behalf, if the Covered Entity obtains satisfactory assurances that the Business Associate will appropriately safeguard the information.

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) "Breach" shall have the meaning set out in its definition at 45 C.F.R. 164.402, as such provision is

currently drafted and as it is subsequently updated, amended, or revised.

(b) "Business Associate" shall generally have the same meaning as the term "Business Associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Arkansas Department of Health

(c) "Covered Entity" shall generally have the same meaning as the term "Covered Entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Arkansas Department of Human Services.

(d) "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(e) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(f) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.

(g) "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his/her designee.

(h) "Unsecured Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. 164.402; protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the U.S. Secretary of DHHS in the guidance issued under section 13402(h)(2) of Pub. L. 111-5; as such provision is currently drafted and as it is subsequently updated, amended, or revised.

Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the HIPAA Privacy Rule.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to Covered Entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) Business Associate agrees to report to Covered Entity any unauthorized acquisition, access, use, or disclosure of unsecured PHI the Business Associate holds on behalf of the Covered Entity, including

the identity of each individual who is the subject of the unsecured PHI of which it becomes aware, no later than three calendar days after the discovery of the breach;

(e) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information;

(f) Make available protected health information in a designated record set to the Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.524;

(g) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the Covered Entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy Covered Entity's obligations under 45 CFR 164.526;

(h) Maintain and make available the information required to provide an accounting of disclosures to the Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.528;

(i) To the extent the Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s); and

(j) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

Permitted Uses and Disclosures by Business Associate

(a) Business Associate may only use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in:

Contract # MOA # 200-262, dated November, 2020

(known as "the Contract") between the parties, provided that such use or disclosure does not violate the policies and procedures of all HIPAA rules.

(b) Business Associate may use or disclose protected health information as required by law.

(c) Business Associate agrees to make uses and disclosures and requests for protected health information consistent with Covered Entity's Privacy and Security policies and procedures.

(d) Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity, except for the specific uses and disclosures set forth below.

(e) Business Associate may disclose protected health information for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used

or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached. The Business Associate will notify Covered Entity within three calendar days of such a disclosure.

(l) Business Associate may provide data aggregation services relating to the health care operations of the Covered Entity.

Discovery and Notification of Breach or Incident

(a) Business Associate shall implement reasonable systems, policies, and procedures for discovery of possible HIPAA violations and breaches (as defined by HIPAA rules) and shall ensure that its workplace members and other agents are adequately trained and aware of the importance of timely reporting of possible breaches.

(b) Upon the discovery of any HIPAA violation by the Business Associate or any member of its workforce, (which includes, without limitation, employees, subcontractors and agents), with respect to PHI, the Business Associate shall promptly perform a risk assessment to determine whether a breach of unsecured PHI has occurred and whether or not the breach has resulted in any harm to the owner of the PHI as required by the HITECH Act.

(c) The Business Associate shall take immediate steps to mitigate any HIPAA violation with respect to the Covered Entity's PHI that is discovered and shall provide the Covered Entity with written documentation of such steps.

(d) If the Business Associate determines that an incident or breach of unsecured PHI may have occurred, the Business Associate shall notify the Covered Entity of such incident or breach within two calendar days. The Business Associate will specifically notify the DHS Privacy Officer in writing via posted mail, as well as email, and will confirm receipt of the email immediately by phone. The email shall be sent to DHSPrivacy-Security@dhs.arkansas.gov.

Such notice shall include:

1. A brief description of the occurrence, including the date of the incident or breach and the date of discovery, if known;
2. To the extent possible, the identity of each individual whose unsecured PHI has been, or is reasonably believed to have been, breached;
3. A description of the types of unsecured PHI involved;
4. A brief description of what the owners of the PHI can do to protect themselves;
5. A brief description of what the Business Associate is doing to investigate the breach, mitigate harm to affected individuals, and protect against further breaches; and;
6. Any other information that the Covered Entity reasonably believes necessary to enable it to comply with its obligations under HIPAA.

(c) The Business Associate shall continue to provide the Covered Entity with any additional information related to the required disclosures that becomes available following initial notice of the breach. The Business Associate will fully cooperate with the Covered Entity's investigation, including:

1. Providing Covered Entity with a copy of the letter Business Associate will send to affected individuals, pursuant to 45 CFR §§ 164.404;
2. For a breach involving unsecured PHI of more than 500 individuals of a state or jurisdiction, the Business Associate shall promptly provide notice of such breach to the Covered Entity, the U.S. Secretary of Health and Human Services, and to the media, as required by 45 CFR §§ 164.406;
3. Agreeing to maintain documentation of all breaches of unsecured PHI for a minimum of six years after the creation of the documentation and shall make such documentation available to the U.S. Secretary of Health and Human Services upon request.

Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by Covered Entity.

Term and Termination

(a) Term. This Agreement shall be effective as of the effective date stated above and shall terminate when all of the protected health information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to the Covered Entity, or if it infeasible to return or destroy the protected health information protections acceptable to Covered Entity are extended to such information in accordance with the termination provisions below, or on the date Covered Entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business Associate authorizes termination of this Agreement by Covered Entity, if Covered Entity determines Business Associate has violated a material term of the Agreement and Business Associate has not cured the breach or ended the violation within the time specified by Covered Entity.

(c) Obligations of Business Associate Upon Termination. Upon termination of this agreement for any reason, Business Associate shall return to Covered Entity or, if agreed to by Covered Entity, destroy all protected health information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, that the Business Associate still maintains in any form. Business Associate shall retain no copies of the protected health information.

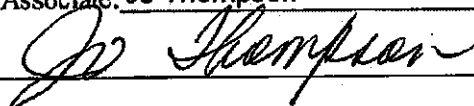
(d) Survival. The obligations of Business Associate under this Section shall survive the termination of this Agreement.

Miscellaneous

- (a) Regulatory References. A reference in this agreement to a section in the HIPAA Rules means the section as in effect or as amended.
- (b) Amendment. The Parties agree to take such action as is necessary to amend this agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.
- (c) Interpretation. Any ambiguity in this agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be executed in its name and on its behalf effective as of the Effective Date at the top of this document.

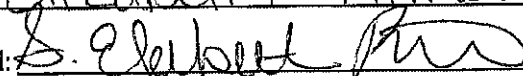
Business Associate: Jo Thompson

Signed: 

Title: Chief Financial Officer

Date: 3-24-2021

DHS: Elizabeth Pitman

Signed: 

Title: DMS Director

Date: 9-22-21