EXHIBIT H

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing

DESCRIPTION:

Statement of Necessity

Arkansas previously submitted State Plan Amendments (SPA) to CMS that require cost sharing updates. During the approval of the SPAs, CMS noted problems relating to cost sharing charges imposed on traditional Medicaid clients. CMS has also requested that traditional SPA pages be removed and cost sharing updates be submitted through the Medicaid Model Data Lab (MMDL) system. A rule change and SPA is also necessary to revise copayment amounts and limits for the ARHOME Program, Workers with Disabilities, and Transitional Medicaid.

Rule Summary

The rule has been updated to correct the following issues:

- Co-pays for emergency services have been removed. Sections 1916(a)(2)(D), 1916(b)(2)(D), and 1916A(b)(3)(vi) of the Social Security Act prohibit copays on emergency services.
- Non-emergency copayments have been revised and rules mandating hospital compliance with screening requirements updated. Previously, there were inconsistent amounts for nonemergency copays for income group ranging from 100-150% FPL and no evidence of hospitals complying with screening requirement rules.
- Outpatient copay amounts have been updated. Previously, some outpatient service copay amounts exceeded the federally allowed percentages of 10% for 100-150% FPL and 20% for over 150% FPL.
- Inpatient hospital stay coinsurance has been eliminated. The limit on the coinsurance amount that can be charged for hospital inpatient stay changed to no more than $75/stay in July 2013 and has subsequently changed in the calendar years since.
- System updates will be implemented for calculation of the 5% aggregate cap across all Medicaid populations. Currently, Arkansas does not collect information on income in determining eligibility for the Workers with Disabilities program, therefore the aggregate cap of 5% of family income on cost sharing cannot be calculated.

This rule change repeals various state plan pages and amends others to define cost-sharing requirements, amounts, limitations, exemptions, and payments.

Section I of the Medicaid Provider Manual is amended to provide information about Transitional Medicaid and the ARHOME Program, add a hyperlink to a table containing the eligibility aid categories, and clean up language and formatting.

Section II of the Medicaid Visual Provider Manual is amended to clarify copays and change “beneficiaries” to “clients.”

Section A of the Medical Services Policy Manual is amended to remove business processes, add information regarding copays and exemptions, update cost information for EPSDT, and clean up language and dates.

The ARHOME State Plan Amendment implements copayment requirements and quarterly copayment limits for the ARHOME program. It changes service-specific copayment amounts and limits for ARHOME clients in a qualified health plan and introduces new copayment amounts and limits for ARHOME clients receiving services through fee for service while they await enrollment in a QHP. The SPA also limits the amount of quarterly copayments individual ARHOME clients may incur, and it limits the amount of quarterly copayments their entire household may incur.

PUBLIC COMMENT: A public hearing was held on this rule on October 27, 2022. The public comment period expired on November 13, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, this rule will result in reduced costs of $743,040 for the current fiscal year ($210,875 in general revenue and $532,165 in federal funds) and $1,486,080 for the next fiscal year ($421,749 in general revenue and $1,064,330 in federal funds). The total estimated cost reduction by fiscal year to state, county, and municipal government is $210,875 for the current fiscal year and $421,749 for the next fiscal year.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Act 530 of 2021. The Act, sponsored by Senator Missy Irvin, created the Arkansas Health and Opportunity for Me Act of 2021 and the Arkansas Health and Opportunity for Me Program. "The Department of Human Services shall adopt rules necessary to implement" the Health and Opportunity for Me Act. *See* Ark. Code Ann. § 23-61-1012, *as created by* Act 530.

RECEIVED
DEC 7 2022
BUREAU OF
LEGISLATIVE RESEARCH

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437
P: 501.682.8292 F: 501.682.1197

October 12, 2022

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact Mac Golden, Office of Rules Promulgation at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Elizabeth Pitman
Director

EP: lt

Attachments

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Human Services

DIVISION Medical Services

DIVISION DIRECTOR Elizabeth Pitman

CONTACT PERSON Mac Golden

ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437

PHONE NO. 501-320-6383 **FAX NO.** 501-404-4619 **E-MAIL** Mac.E.Golden @dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Elizabeth Pitman

PRESENTER E-MAIL Elizabeth.Pitman@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing

2. What is the subject of the proposed rule? See Attached.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

   If yes, please provide the federal rule, regulation, and/or statute citation. 1916 and1916A of the SSA Act; 42 CFR 447.50 through 447.57 (excluding 447.55)

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?

   Yes ☐ No ☒

   If yes, what is the effective date of the emergency rule? _____

   When does the emergency rule expire? _____

   Will this emergency rule be promulgated under the permanent provisions of the Administrative

Procedure Act?

Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

23-61-1004(e)(1)

7. What is the purpose of this proposed rule? Why is it necessary?
See Attached

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).
https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: October 27, 2022
Time: 1:00 p.m.
Place: Zoom meeting:
https://us02web.zoom.us/j/89650093645
Webinar ID: 896 5009 3645

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
November 13, 2022

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
1/1/2023

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice.
See Attached

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e).

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known : Unknown

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, 23-61-1004, and 25-10-129.

Effective January 1, 2023:

The Director of the Division of Medical Services amends the State Plan, Sections 124.000, 124.220, 124.230, 124.240, 124.250, 133.000, 134.000, and 135.000 of the Medicaid Provider Manual, Sections 213.200, 213.300, and 214.200 of the Medicaid Visual Provider Manual, and Medical Services Policy Section A to comply with CMS requested changes and to revise copayment amounts and limits for the ARHOME Program, Workers with Disabilities, and Traditional Medicaid.

The ARHOME QHP Cost Share Schedule and the Adult Medicaid Cost Share Schedule copays range from $0.00 to $9.40, with the specific amount dependent on the covered service. DMS adds that exclusions from cost sharing policy will apply to individuals enrolled in a Provider-led Arkansas Shared Savings Entity (PASS), individuals receiving hospice care, and individuals at or below 20% of the federal poverty level. DMS also adds that the following services are excluded from the client cost sharing requirement: emergency services, pregnancy related services, preventative services, and services for provider-preventable conditions. DMS adds information concerning the collection of coinsurance/co-payments that detail hospital compliance with updated screening requirements. DMS has eliminated coinsurance for inpatient hospital stays. There are no changes to the Early Periodic Screening, Diagnosis, and Treatment services.

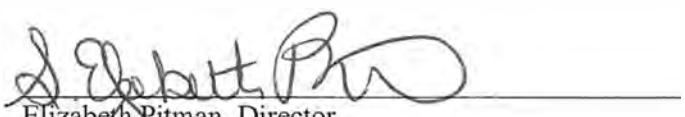
The proposed rule estimates a financial impact of $ ($743,040) (($532,165) of which is federal funds) for state fiscal year (SYF) 2023 and ($1,486,080) (($1,064,330) of which is federal funds) for SYF 2024.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than November 13, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on October 27, 2022, at 1:00 p.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/89650093645. The webinar ID is 896 5009 3645. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502100209



Elizabeth Pitman, Director
Division of Medical Services

From:	legalads@arkansasonline.com
To:	Jack Tiner
Cc:	Mac Golden; Simone Blagg (DHS); Elaine Stafford; Lakeya Gipson; Kate Chagnon; Lisa Teague
Subject:	Re: FULL RUN AD--Rule-171
Date:	Wednesday, October 12, 2022 9:57:15 AM
Attachments:	image001.png image002.png

[EXTERNAL SENDER]

Will run Fri 10/14, Fri 10/15, and Sun 10/16.

Thank you.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>
To: legalads@arkansasonline.com
Cc: "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Simone Blagg, DHS" <Simone.A.Blagg@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Kate Chagnon" <Kate.Chagnon@dhs.arkansas.gov>, "Lisa Teague" <Lisa.Teague@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>
Sent: Wednesday, October 12, 2022 9:21:04 AM
Subject: FULL RUN AD--Rule-171

Please run the attached Notice of Rulemaking in the *Arkansas Democrat-Gazette* on the following days:

- Friday, October 14, 2022
- Saturday, October 15, 2022
- Sunday, October 16, 2022

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**
P.O. Box 1437
Slot S535
Little Rock, AR 72203

From:	Lisa Teague
To:	Arkansas Register
Cc:	Mac Golden; Jack Tiner; Simone Blagg (DHS); JAMIE EWING
Subject:	DHS/DMS Proposed Rule - ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing (r171)
Date:	Wednesday, October 12, 2022 2:24:00 PM
Attachments:	SOS Initial ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing 10-12-22.pdf image001.png image002.png image003.png image004.png image005.png image009.png image012.png image013.png image014.png image015.png

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The attached proposed rule will run in the Arkansas Democrat-Gazette October 14th, 15th, and 16th, 2022. The Public comment period ends November 13th, 2022.

Please post.

Thank you,

DHS
Lisa Teague
Office of Rules Promulgation
DHS Program Administrator
Phone: 501-396-6428
700 Main St./Slot S295
Little Rock, AR 72203
lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** 501-682-8155 **EMAIL:** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing

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

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

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

   If an agency is proposing a more costly rule, please state the following:

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

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

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	

Other (Identify)		Other (Identify)	
Total	$	Total	$

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

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	($210,875)	General Revenue	($421,749)
Federal Funds	($532,165)	Federal Funds	($1,064,330)
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	($743,040)	Total	($1,486,080)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ (210,875)	$ (421,749)

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose; -

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute**;** -

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and -

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs; -

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; -

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule; -

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives; -
(b) the benefits of the rule continue to justify its costs; and -
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives. -

Statement of Necessity and Rule Summary
ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing

Why is this change necessary? Please provide the circumstances that necessitate the change.

Arkansas previously submitted State Plan Amendments (SPA) to CMS that require cost sharing updates. During the approval of the SPAs, CMS noted problems relating to cost sharing charges imposed on traditional Medicaid clients. CMS has also requested that traditional SPA pages be removedand cost sharing updates be submitted through the Medicaid Model Data Lab (MMDL) system. A rule change and SPA is also necessary to revise copayment amounts and limits for the ARHOME Program, Workers with Disabilities, and Transitional Medicaid.

What is the change? Please provide a summary of the change.

Specific Issues:

Issue	Provision cited	Arkansas response
Prohibited copay on emergency services	1916(a)(2)(D), 1916(b)(2)(D), and 1916A(b)(3)(vi) of the Social Security Act	Co-pays for emergency services have been removed
Inconsistent amount for non-emergency copay for income group ranging from 100-150% FPL, and no evidence of hospitals complying with screening requirement rules	1916(a)(3), 1916(b)(3), and 1916A(e) of the Social Security Act, as implemented at 42 CFR §447.54 1916(a)(3), 1916(b)(3) and 1916A(e) of the Social Security Act	Non-emergency co-payments have been revised and rules mandating hospital compliance with screening requirements updated.
Some outpatient service copay amounts exceed the federally allowed percentages of 10% for 100-150% FPL and 20% for over 150% FPL	1916A(b)(1)(B) and 1916(b)(2)(B) of the Social Security Act	Out-patient co-pay amounts have been updated.
The limit on the coinsurance amount that can be charged for hospital inpatient stay changed to no more than $75/stay in July 2013 and has subsequently changed in the Calendar years since.	42 CFR §447.52(b)(2)	Inpatient hospital stay coinsurance has been eliminated.

Arkansas does not collect information on income in determining eligibility for the Workers with Disabilities program, therefore the aggregate cap of 5% of family income on cost sharing cannot be calculated	1916A(a)(2)(B), (b)(1)(B)(ii) and (b)(2)(A) of the Social Security Act, implemented at 42 CFR §447.56(f), and 42 CFR §447.56(f)(2)	System updates will be implemented for calculation of the 5% aggregate cap across all Medicaid populations..

Repealed the following State Plan pages.

- Attachment 4.18-A page 1a
- Attachment 4.18-A page 2
- Attachment 4.18-A page 3
- Attachment 4.18-A page 4
- Attachment 4.18-A page 5
- Attachment 4.18-C page 1
- Attachment 4.18-C page 1a
- Attachment 4.18-C page 2
- Attachment 4.18-C page 3
- Attachment 4.18-C page 4
- Attachment 4.18-C page 5
- Attachment 2.6-A page 12p1
- Attachment 2.6-A page 12p2
- Page 54
- Page 55
- Page 56

State Plan Pages that will be submitted through the MMDL system include the following:

- G1- defines cost sharing requirements
- G2a- defines cost sharing amounts for categorically needy individuals
- G2b- defines cost sharing amounts for medically needy individuals
- G2c- defines targeted cost sharing amounts
- G3- defines cost sharing limitations, optional exemptions, mandatory exemptions, enforceability of exemptions, payments to providers, payments to managed care organizations, and aggregate limits.

State Plan Pages submitted through traditional method:

- Attachment 2.6A page 12p- defines the cost sharing for members of the Workers with Disabilities, Transitional Medicaid, and Interim Alternative Benefits Plan Medicaid Categories.

Medicaid Provider Manual Section I:

- Section 124.000 updated to add a hyperlink to a table containing the eligibility aid categories consistent with Division of County Operations.
- Section 124.200- removed the word “co-insurance”.
- Section 124.220 changed the word “contains” to “covers”.
- Section 124.230 updated category name from “Working Disabled” to “Workers with Disabilities”. Added Adult Medicaid Cost Share Fee Schedule. Added Transitional Medicaid to the exception stating that temporary nursing home placements will be exempt from co-pays.
- Section 124.240 updated to provide information about Transitional Medicaid for Adults and references Section 124.230 for co-pay amounts.
- Section 124.250 added to give information about the New Adult Group/Arkansas Health and Opportunity for Me Program (ARHOME) and adds the ARHOME QHP Cost Share amounts.
- Section 133.000 through Section 133.500 were deleted
- Section 134.000 was updated to reformat and align the exclusions to cost-sharing.
- Section 135.000 added a paragraph explaining hospital requirements regarding federal rules for non-emergency co-pays.

Medicaid Visual Provider Manual Section II

Section 213.200

- Changes beneficiaries to client
- Removes the statement “One prescription service fee every 12 months from the last date of service”
- Removes the statement “Medicaid eligible beneficiaries, with the exception of nursing home residents, who are 21 or older, will pay a $2.00 co-payment to the visual care provider for prescription services. Beneficiaries who are in nursing facilities or in group homes will have no co-pays. All co-pays will be applied to examination codes rather than to tests or procedures.”

Section 213.300

- Removes the statement “There will be no co-payment for replacement glasses for post cataract patients.”
- Changes beneficiary to client

Section 214.200

- Removes the statement “There will be no co-payment assessed for replacement glasses requiring prior authorization.”
- Removes the statement “EPSDT beneficiaries will have no co-pays.

Medical Services Policy Section A:

1. Global Change- changing Medicaid to Health Care Program.
2. Removal of MS Manual updated dates. Uses 01/01/23 throughout document
3. Removal of information out of Policy is reflected in the Business Process Manual.
4. A-100 General Program Information
    a. Adding acronyms DHS and DCO for clarification
    b. Removed “but are not limited to the following”
    c. Wrote out the numbers next to the numerical number
    d. Removed irrelevant reference information
5. A-110 Cost Sharing Coinsurance/Copayment
    a. Added information regarding copay exemptions
    b. Added wording to make the amounts of the prescriptions more general to prevent policy updates yearly if co-pays change
    c. Updated exemption list
6. A-115 Cost Sharing for Workers with Disabilities
    a. Updated percentages that are affected to pay the copays amounts
    b. Removed specific number amounts to prevent policy updates yearly
7. A-116 Premiums for the Adult Expansion Group is being deleted.
8. A-163 Child Health Services Program (EPSDT)
    a. Updated cost information.

Separate State Plan amendment for ARHOME:

This SPA implements copayment requirements and quarterly copayment limits for the ARHOME program. It changes service-specific copayment amounts and limits for ARHOME clients in a qualified health plan and introduces new copayment amounts and limits for ARHOME clients receiving services through fee for service while they await enrollment in a QHP.

The SPA also limits the amount of quarterly copayments individual ARHOME clients may incur, and it limits the amount of quarterly copayments their entire household may incur.

Replaces the following state plan pages:

- ABP1: defines the Alternative Benefit Plan populations
- ABP2a: describes the voluntary benefit package selection process
- ABP2c: describes the process for exempting populations from mandatory enrollment
- ABP3: describes the state’s selection of Benchmark Benefit Package
- ABP4: describes the implementation of cost sharing in the Alternative Benefit Plan

- ABP8: describes the service delivery system
- ABP9: describes the process for payment of premium assistance

TOC required

124.000 Beneficiary Aid Categories

~~2-1-17~~1-1-23

~~The following is the~~A full list of ~~beneficiary~~ client aid categories is available online. **View or print the Client Aid Category list**. ~~Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. The following codes describe each level of coverage.~~

~~**FR** full range~~

~~**LB** limited benefits~~

~~**AC** additional cost sharing~~

~~**MNLB** medically needy limited benefits~~

~~**MP/MF** market place/medically frail~~

~~Category~~	~~Description~~	~~Code~~
~~01 ARKIDS B~~	~~ARKids CHIP Separate Child Health Program~~	~~LB, AC~~
~~06~~	~~New Adult Group~~	~~MP/MF~~
~~09 SSI~~	~~Program of All-Inclusive Care for the Elderly (PACE)~~	~~FR~~
~~10 N WD NewCo~~	~~Working Disabled – New Cost Sharing (N)~~	~~FR, AC~~
~~10 R WD RegCo~~	~~Working Disabled – Regular Medicaid Cost Sharing I~~	~~FR, AC~~
~~11 AABD~~	~~AABD~~	~~FR~~
~~13 SSI~~	~~SSI~~	~~FR~~
~~14 SSI~~	~~SSI~~	~~FR~~
~~15~~	~~Program of All-Inclusive Care for the Elderly (PACE)~~	~~FR~~
~~16 AA-EC~~	~~AA-EC~~	~~MNLB~~
~~17 AA-SD~~	~~Aid to the Aged Medically Needy Spend Down~~	~~MNLB~~
~~18 QMB-AA~~	~~Aid to the Aged-Qualified Medicare Beneficiary (QMB)~~	~~LB~~
~~18 S AR Seniors~~	~~ARSeniors~~	~~FR~~
~~20 AFDC-GRANT~~	~~Parent Caretaker Relative~~	~~FR~~
~~25 TM~~	~~Transitional Medicaid~~	~~FR~~
~~26 AFDC-EC~~	~~AFDC Medically Needy Exceptional Category~~	~~MNLB~~
~~27 AFDC-SD~~	~~AFDC Medically Needy Spend Down~~	~~MNLB~~
~~31 AAAB~~	~~Aid to the Blind~~	~~FR~~
~~33 SSI~~	~~SSI Blind Individual~~	~~FR~~
~~34 SSI~~	~~SSI Blind Spouse~~	~~FR~~
~~35 SSI~~	~~SSI Blind Child~~	~~FR~~
~~36 AB-EC~~	~~Aid to the Blind-Medically Needy Exceptional Category~~	~~MNLB~~
~~37 AB-SD~~	~~Aid to the Blind-Medically Needy Spend Down~~	~~MNLB~~
~~38 QMB-AB~~	~~Aid to the Blind-Qualified Medicare Beneficiary (QMB)~~	~~LB~~

Category	Description	Code
41 AABD	Aid to the Disabled	FR
43 SSI	SSI Disabled Individual	FR
44 SSI	SSI Disabled Spouse	FR
45 SSI	SSI Disabled Child	FR
46 AD-EC	Aid to the Disabled-Medically Needy Exceptional Category	MNLB
47 AD-SD	Aid to the Disabled-Medically Needy Spend Down	MNLB
48 QMB- AD	Aid to the Disabled-Qualified Medicare Beneficiary (QMB)	LB
49 TEFRA	TEFRA Waiver for Disabled Child	FR, AC
51 U-18	Under Age 18 No Grant	FR
52 ARKIDS A	Newborn	FR
56 U-18 EC	Under Age 18 Medically Needy Exceptional Category	MNLB
57 U-18 SD	Under Age 18 Medically Needy Spend Down	MNLB
58 QI-1	Qualifying Individual-1 (Medicaid pays only the Medicare premium.)	LB
61 PW-PL	Women's Health Waiver - Pregnant Women, Infants & Children Poverty Level (SOBRA). A 100 series suffix (the last 3 digits of the ID number) is a pregnant woman; a 200 series suffix is an ARKids First A child.	LB (for the pregnant woman only) FR (for SOBRA children)
61 PW "Unborn Child"	Pregnant Women PW Unborn CH no Ster cov – Does not cover sterilization or any other family planning services.	LB (for the pregnant woman only)
63 ARKIDS A	SOBRA Newborn	FR
65 PW-NG	Pregnant Women No Grant	FR
66 PW-EC	Pregnant Women Medically Needy Exceptional Category	MNLB
67 PW-SD	Pregnant Women Medically Needy Spend Down	MNLB
76 UP-EC	Unemployed Parent Medically Needy Exceptional Category	MNLB
77 UP-SD	Unemployed Parent Medically Needy Spend Down	MNLB
80 RRP-GR	Refugee Resettlement Grant	FR
81 RRP-NG	Refugee Resettlement No Grant	FR
86 RRP-EC	Refugee Resettlement Medically Needy Exceptional Category	MNLB
87 RRP-SD	Refugee Resettlement Medically Needy Spend Down	MNLB
88 SLI-QMB	Specified Low Income Qualified Medicare Beneficiary (SMB) (Medicaid pays only the Medicare premium.)	LB
91 FC	Foster Care	FR
92 IVE-FC	IV-E Foster Care	FR
93	Former Foster Care	FR

~~Category~~	~~Description~~	~~Code~~
~~96 FC-EC~~	~~Foster Care Medically Needy Exceptional Category~~	~~MNLB~~
~~97 FC-SD~~	~~Foster Care Medically Needy Spend Down~~	~~MNLB~~

124.100 ~~Beneficiary~~ Client Aid Categories with Limited Benefits ~~4-1-06~~1-1-23

Most Medicaid categories provide the full range of Medicaid services as specified in the Arkansas Medicaid State Plan. However, certain categories offer a limited benefit package. These categories are discussed below. **View or print the Client Aid Category list.**

124.200 ~~Beneficiary~~ Client Aid Categories with Additional Cost Sharing ~~6-1-08~~1-1-23

Certain programs require additional cost sharing for Medicaid services. **View or print the Client Aid Category list.**

The forms of cost sharing in the Medicaid Program are co-payment and premiums. These programs are discussed in Sections 124.210 through 124.2~~3~~50.

Copayments may not exceed the amounts listed in the cost sharing schedules, as updated each January 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

A family's total annual out-of-pocket cost sharing cannot exceed five percent (5%) of the family's gross income.

124.220 TEFRA ~~2-1-17~~1-1-23

Eligibility category 49 ~~contains~~ covers children under age 19 who are eligible for Medicaid services as authorized by Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and amended by the Omnibus Budget Reduction Act. Children in category 49 receive the full range of Medicaid services. However, there are cost sharing requirements. Families will be charged a sliding scale monthly premium based on the income of the custodial parents. Custodial parents with incomes above 150 percent of the federal poverty level (FPL) and in excess of $25,000 annually will be subject to a sliding scale monthly premium. The monthly premium, described in the following chart, can only be assessed if the family income is in excess of ~~150~~ one-hundred and fifty percent (150%) of the federal poverty level.

The premiums listed ~~above~~ in the TEFRA Cost Share Schedule below represent family responsibility. They will not increase if a family has more than one TEFRA-eligible child. ~~There are no c~~Co-payments are not charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed five ~~(5)~~ percent (5%) of the family's gross income.

TEFRA Cost Share Schedule
Effective July 1, 2022

Family Income		Monthly Premiums		
From	**To**	**%**	**From**	**To**
$0	$25,000	0%	$0	$0
$25,001	$50,000	1.00%	$20	$41
$50,001	$75,000	1.25%	$52	$78

TEFRA Cost Share Schedule
Effective July 1, 2022

Family Income		Monthly Premiums		
From	To	%	From	To
$75,001	$100,000	1.50%	$93	$125
$100,001	$125,000	1.75%	$145	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$364	$416
$200,001	No limit	2.75%	$458	$458

The maximum premium is $5,500 per year ($458 per month) for income levels of $200,001 and above.

124.230 ~~Working Disabled~~Workers with Disabilities ~~12-1-19~~1-1-23

The ~~Working Disabled~~Workers with Disabilities (WD) category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are ages sixteen (16) through sixty-four (64), with a disability as defined by Supplemental Security Income (SSI) criteria and who meet the income and resource criteria may be eligible in this category.

Co-payments are required for the following services:

~~There are two levels of cost sharing in this aid category, depending on the individual's income:~~

~~A. Regular Medicaid cost sharing.~~

~~Beneficiaries with gross income below 100% of the Federal Poverty Level (FPL) are responsible for the regular Medicaid cost sharing (pharmacy, inpatient hospital and prescription services for eyeglasses). They are designated in the system as "WD RegCO."~~

~~B. New cost sharing requirements.~~

~~Beneficiaries with gross income equal to or greater than 100% FPL have cost sharing for more services and are designated in the system as "WD NewCo".~~

~~The cost sharing amounts for the "WD NewCo" eligibles are listed in the chart below:~~

Adult Medicaid Cost Share Schedule	
Service	**Copay**
Office Visits and Outpatient Services	
Physician visit (including PCP/specialist/audiologist/podiatrist visit, excluding preventive services and X-ray)	$4.70
Preventative Care/Screening/Immunizations/EPSDT	$0.00
Other Practitioner Office Visit (Nurse, Physician Assistant)	$4.70
Federally Qualified Health Center (FQHC)	$4.70
Rural Health Clinic	$4.70

Ambulatory Surgical Center	$4.70
Family planning services and supplies (including contraceptives)	$0.00
Chiropractor	$4.70
Acupuncture	Not covered
Pharmacy	
Generics	$4.70
Preferred Brand Drugs	$4.70
Non-Preferred Brand Drugs	$9.40
Specialty Drugs (i.e., High-Cost)	$9.40
Testing and Imaging	
X-rays and Diagnostic Imaging	$4.70
Imaging (CT/Pet Scans, MRIs)	$4.70
Laboratory Outpatient and Professional Services	$4.70
Allergy Testing	$4.70
Inpatient Services	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Emergency and Urgent Care	
Emergency Room Services	$0.00
Non-Emergency Use of the Emergency Department	$9.40
Emergency Transportation/Ambulance	$0.00
Urgent Care Centers or Facilities	$4.70
Durable Medical Equipment	
Durable Medical Equipment	$4.70
Prosthetic Devices	$4.70
Orthotic Appliances	$4.70
Mental and Behavioral Health and Substance Abuse	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Mental/Behavioral Health and SUD Outpatient Services	$4.70
Rehabilitation and Habilitation	
Rehabilitative Occupational Therapy	$4.70
Rehabilitative Speech Therapy	$4.70
Rehabilitative Physical Therapy	$4.70
Outpatient Rehabilitation Services	$4.70
Habilitation Services	$4.70
Surgery	
Inpatient Physician and Surgical Services	$0.00
Outpatient Surgery Physician/Surgical Services	$4.70

Treatments and Therapies	
Chemotherapy	$4.70
Radiation	$4.70
Infertility Treatment	Not covered
Infusion Therapy	$4.70
Vision	
Dental	
Accidental Dental	$4.70
Women's Services	
Delivery and all Inpatient services for maternity care	$0.00
Prenatal and postnatal care	$0.00
Other	
Home health Care Services	$4.70
Hospice Services	$0.00
End Stage Renal Disease Services (Dialysis)	$0.00
Personal Care	Not covered

~~Program Services~~	~~New Co-Payment*~~
~~Adult Developmental Day Treatment Services~~	~~$10 per day~~
~~ARChoices Waiver Services~~	~~None~~
~~Ambulance~~	~~$10 per trip~~
~~Ambulatory Surgical Center~~	~~$10 per visit~~
~~Audiological Services~~	~~$10 per visit~~
~~Augmentative Communication Devices~~	~~10% of the Medicaid maximum allowable amount~~
~~Chiropractor~~	~~$10 per visit~~
~~Dental~~	~~$10 per visit (no co-pay on EPSDT dental screens)~~
~~Diapers, Underpads and Incontinence Supplies~~	~~None~~
~~Durable Medical Equipment (DME)~~	~~20% of Medicaid maximum allowable amount per DME item~~
~~Early Intervention Day Treatment~~	~~$10 per day~~
~~Emergency Department: Emergency Services~~	~~$10 per visit~~
~~Emergency Department: Non-emergency Services~~	~~$10 per visit~~
~~End Stage Renal Disease Services~~	~~None~~
~~Early and Periodic Screening, Diagnosis and Treatment~~	~~None~~

Program Services	New Co-Payment*
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals ages 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient	25% of the hospital's Medicaid per diem for the first Medicaid-covered inpatient day
Hospital: Outpatient	$10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per encounter, regardless of the number of services per encounter
Medical Supplies	None
Inpatient Psychiatric Services for Under Age 21	25% of the facility's Medicaid per diem for the first Medicaid-covered day
Outpatient Behavioral Health	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Certified Nurse Midwife	$10 per visit
Orthodontia (not covered for individuals ages 21 and older)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of the first covered day's Medicaid inpatient per diem
Rural Health Clinic	$10 per core service encounter
Targeted Case Management	10% of Medicaid maximum allowable rate per unit

~~Program Services~~	~~New Co-Payment*~~
~~Occupational Therapy (Age 21 and older have limited coverage**)~~	~~$10 per visit~~
~~Physical Therapy (Age 21 and older have limited coverage**)~~	~~$10 per visit~~
~~Speech-Language Therapy (Age 21 and older have limited coverage**)~~	~~$10 per visit~~
~~Transportation (non-emergency)~~	~~None~~
~~Ventilator Services~~	~~None~~
~~Visual Care~~	~~$10 per visit~~

*** Exception:** Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD ~~beneficiaries~~ clients (Aid Category 10) and Transitional Medicaid clients (Aid Category 25) who temporarily enter a nursing home and continue to meet WD or TM eligibility criteria will be exempt from the co-payments listed above.

~~**** Exception:** This service is NOT covered for individuals within the Occupational, Physical and Speech-Language Therapy Program for individuals ages 21 and older.~~

~~**NOTE: Providers must consult the appropriate provider manual to determine coverage and benefits.**~~

124.240 Transitional Medicaid Adult 1-1-23

The Transitional Medicaid program extends Medicaid coverage to families up to 185% of FPL that, due to earned income, lost eligibility for the Parents/Caretaker-Relative (PCR) Aid Category. The Transitional Medicaid program provides up to twelve (12) months of extended coverage after losing PCR eligibility.

Pertinent co-payment amounts for clients covered by Adult Transitional Medicaid are the same as those listed in Section 124.230.

124.250 Arkansas Health and Opportunity for Me (ARHOME) 1-1-23

The ARHOME program operates as a demonstration waiver under Section 1115 of the Social Security Act. It provides premium assistance to allow clients eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to enroll in qualified health plans. The ARHOME aid category covers adults ages 19-64 who earn up to 138% of the federal poverty level and are not eligible for Medicare. Under ARHOME, clients receive services either through a qualified health plan (QHP) or through three other benefit plans delivered through fee for service. Cost sharing applies only to ARHOME clients who are enrolled in a QHP or who are awaiting enrollment in a QHP (IABP benefit plan). ARHOME clients in a benefit plan based on their status as medically frail (FRAIL) or alternative benefit plan (ABP) will not be subject to any cost sharing.

ARHOME QHP Cost Share amounts for clients enrolled in a QHP are as follows:

ARHOME QHP Cost Share Schedule	
Service	**Copay**
Office Visits and Outpatient Services	
Physician visit (including PCP/specialist/audiologist/podiatrist visit, excluding preventive services and X-ray)	$4.70

Preventative Care/Screening/Immunizations/EPSDT	$0.00
Other Practitioner Office Visit (Nurse, Physician Assistant)	$4.70
Federally Qualified Health Center (FQHC)	$4.70
Rural Health Clinic	$4.70
Ambulatory Surgical Center	$4.70
Family planning services and supplies (including contraceptives)	$0.00
Chiropractor	$4.70
Acupuncture	Not covered
Nutritional Counseling	$4.70
Pharmacy	
Generics	$4.70
Preferred Brand Drugs	$4.70
Non-Preferred Brand Drugs	$9.40
Specialty Drugs (i.e., High-Cost)	$9.40
Testing and Imaging	
X-rays and Diagnostic Imaging	$4.70
Imaging (CT/Pet Scans, MRIs)	$4.70
Laboratory Outpatient and Professional Services	$4.70
Allergy Testing	$4.70
Inpatient Services	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Emergency and Urgent Care	
Emergency Room Services	$0.00
Non-Emergency Use of the Emergency Department	$9.40
Emergency Transportation/Ambulance	$0.00
Urgent Care Centers or Facilities	$4.70
Durable Medical Equipment	
Durable Medical Equipment	$4.70
Prosthetic Devices	$4.70
Orthotic Appliances	$4.70
Mental and Behavioral Health and Substance Abuse	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Mental/Behavioral Health and SUD Outpatient Services	$4.70
Rehabilitation and Habilitation	
Rehabilitative Occupational Therapy	$4.70
Rehabilitative Speech Therapy	$4.70
Rehabilitative Physical Therapy	$4.70

Outpatient Rehabilitation Services	$4.70
Habilitation Services	$4.70
Surgery	
Inpatient Physician and Surgical Services	$0.00
Outpatient Surgery Physician/Surgical Services	$4.70
Treatments and Therapies	
Chemotherapy	$4.70
Radiation	$4.70
Infertility Treatment	Not covered
Infusion Therapy	$4.70
Vision	
Routine Eye Exam	Not covered
Dental	
Basic Dental Services	Not covered
Accidental Dental	$4.70
Orthodontia	Not covered
Women's Services	
Delivery and all Inpatient services for maternity care	$0.00
Prenatal and postnatal care	$0.00
Other	
Eyeglasses for Adults	Not covered
Diabetes Education	$0.00
Skilled Nursing Facility	$20.00
Home Health Care Services	$4.70
Private-Duty Nursing	Not covered
Hospice Services	$0.00
End Stage Renal Disease Services (Dialysis)	$0.00
Personal Care	Not covered

~~**133.000 Cost Sharing** **9-15-09**~~

~~The forms of cost sharing in the Medicaid Program are coinsurance, co-payment, deductibles and premiums. Each are detailed in the following Sections 133.100 through 133.500.~~

~~**133.100 Inpatient Hospital Coinsurance Charge for Medicaid Beneficiaries Without Medicare** **6-1-08**~~

~~For inpatient admissions, the Medicaid coinsurance charge per admission for non-exempt Medicaid beneficiaries aged 18 and older is 10% of the hospital's interim Medicaid per diem, applied on the first Medicaid covered day. (See Section 124.230 for Working Disabled cost-sharing requirements.)~~

Example:

A Medicaid beneficiary is an inpatient for 4 days in a hospital whose Arkansas Medicaid interim per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00; the beneficiary will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).
2. Ten percent (10% Medicaid coinsurance rate) of $500.00 = $50.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (coinsurance) = $1950.00 (Medicaid payment).

133.300 Inpatient Hospital Coinsurance Charge to Medicare-Medicaid Dually Eligible Beneficiaries 9-15-09

The coinsurance charge per admission for Medicaid beneficiaries, who are also Medicare Part A beneficiaries, is 10% of the hospital's Arkansas Medicaid per diem amount, applied on the first Medicare covered day only.

Example:

A Medicare beneficiary, also eligible for Medicaid, is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00.

1. This is the patient's first hospitalization for the Medicare benefit year; so the patient has not met their Medicare Part A deductible.
2. Medicare pays the hospital its allowed Part A charges, less the current (federal fiscal year) Medicare deductible, and forwards the payment information to Medicaid.
3. Ten percent (10% Medicaid coinsurance rate) of $500.00 (the Arkansas Medicaid hospital per diem) = $50.00 (Medicaid coinsurance). Medicaid coinsurance is due for the first day only of each admission covered by Medicare Part A.
4. Medicaid's payment is the current (federal fiscal year) Medicare Part A deductible minus $50.00 Medicaid coinsurance.

If, on a subsequent admission, Medicare Part A assesses coinsurance, Medicaid will deduct from the Medicaid payment an amount equal to 10% of the hospital's Medicaid per diem for one day. The patient will be responsible for the amount deducted from the Medicaid payment.

133.400 Co-payment on Prescription Drugs 6-1-08

Arkansas Medicaid has a beneficiary co-payment requirement in the Pharmacy Program. The payment is applied per prescription. Non-exempt beneficiaries aged 18 and older are responsible for paying the provider a co-payment amount based on the following table: (See Section 124.230 for Working Disabled cost-sharing requirements. See the ARKids First-B provider manual for ARKids First-B cost-sharing requirements.)

Medicaid Maximum Amount	Beneficiary Co-pay
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

~~133.500 Co-Payment of Eyeglasses for Beneficiaries Aged 21 and Older~~ ~~6-1-08~~

~~Arkansas Medicaid has a beneficiary co-payment requirement in the Visual Care Program. Medicaid beneficiaries 21 years of age and older must pay a $2.00 co-payment for Visual Care prescription services. Nursing home residents are exempt from the co-pay requirement.~~

134.000 Exclusions from Cost Sharing Policy

~~9-15-09~~1-1-23

~~As required by 42 C.F.R. § 447.53(b), t~~The following ~~services~~ populations are excluded from the ~~beneficiary~~ client cost sharing requirement:

A. ~~Services provided to i~~Individuals under twenty-one (21~~18~~) years of age, except:

1. ~~Services for~~ ARKids First-B ~~beneficiaries~~ clients (see the ARKids First-B manual for cost share and more information about this program).

~~2. Services for individuals under age 18 in the Working Disabled category.~~

B. ~~Services provided to p~~Pregnant women.

C. Individuals who are American Indian or Native Alaskan~~Emergency services - services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:~~

~~1. Placing the patient's health in serious jeopardy,~~

~~2. Serious impairment to bodily functions, or~~

~~3. Serious dysfunction of any bodily organ or part.~~

D. ~~Services provided to i~~Individuals who are inpatients in a long~~-~~term care facility (nursing facility (NF) and intermediate care for individuals with intellectual disabilities (ICF/IID) facility) when, as a condition for receiving the institutional services, the individual is required to spend all but a minimal amount (for personal needs) of his or her income for medical care costs.

The fact that a ~~beneficiary~~ client is a resident of a nursing facility does not on its own exclude the Medicaid services provided to the ~~beneficiary~~ client from the cost sharing requirement. Unless a Medicaid ~~beneficiary~~ client has been found eligible for long term care assistance through the Arkansas Medicaid Program, and Medicaid is making a vendor payment to the nursing facility (NF or ICF/IID) for the ~~beneficiary~~client, the ~~beneficiary~~ client is not exempt from the cost sharing requirement.

E. Individuals who are enrolled in a Provider-led Arkansas Shared Savings Entity (PASSE).

F. Individuals receiving hospice care.

G. Individuals who are at or below 20% of the federal poverty level.

The following services are excluded from the client cost sharing requirement:

A. Emergency services - services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy,

2. Serious impairment to bodily functions, or

3. Serious dysfunction of any bodily organ or part.

B. Pregnancy-related services

C. Preventive services

D. Services for provider-preventable conditions

E. Family planning services and supplies.

The provider must maintain sufficient documentation in the ~~beneficiary's~~ client's medical record to substantiate any exemption from the ~~beneficiary~~ client cost sharing requirement.

135.000 Collection of Coinsurance/Co-payment

~~6-1-08~~1-1-23

The method of collecting the coinsurance/co-payment amount from the ~~beneficiary~~ client is the provider's responsibility. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing (coinsurance or co-payment) from the ~~beneficiary~~ client remains the provider's responsibility.

The provider may not deny services to a Medicaid ~~beneficiary~~ client because of the individual's inability to pay the coinsurance or co-payment. However, the individual's inability to pay does not eliminate his or her liability for the coinsurance or co-payment charge.

The ~~beneficiary's~~ client's inability to pay the coinsurance or co-payment does not alter the Medicaid reimbursement for the claim. Unless the ~~beneficiary~~ client or the service is exempt from cost sharing requirements as listed in Section 134.000, Medicaid reimbursement is made in accordance with the current reimbursement methodology and when applicable cost sharing amounts are deducted from the maximum allowable fee before payment.

Hospitals are required to comply with certain federal rules before assessing non-emergency copays. Hospitals are expected to comply with emergency room screening requirements, help locate alternate providers when screening determines the patient's need to be non-emergent, and inform clients of treatment options that have a lesser co-pay before the hospital and the state can charge the non-emergency use of the emergency room co-pay.

Hospitals must develop written policies and tracking mechanisms to identify how they comply with the requirement and produce data on member choice and expenditures. Policies and data must be available upon request of DHS and its designees.

The Medicaid cost-sharing amount for clients who use hospital emergency department services for non-emergency reasons can be found in the ARHOME QHP Cost Share Schedule for clients enrolled in a QHP **or** the Adult Medicaid Cost Share Schedule. (See Sections 124.230 and 124.250)

This cost-sharing amount will only apply to Medicaid clients who are subject to a copay. There will not be any cost-sharing required from clients who need emergency services or treatment.

The first step in the process will be for hospital emergency departments to conduct an appropriate medical screening to determine whether the client needs emergency services.

If the screening determines that emergency services are needed, hospitals should tell the client what the cost-sharing amount will be for the emergency services provided in the emergency department ($0.00). Hospitals should then provide needed emergency services per their established protocols.

If the screening determines that emergency services are not needed, hospitals may provide non-emergency services in the emergency department. Before providing non-emergency services and imposing client cost sharing for such services, however, the hospital must:

- Tell the client what the cost-sharing amount will be for the non-emergency services provided in the emergency department,
- Give the client the option of paying for and receiving services in the emergency department, or
- Give the client the name and location of an alternate non-emergency services provider that can provide the needed services in a timely manner and at a lower cost than the hospital emergency department, and
- Refer the client to the alternate provider, who will then coordinate scheduling for treatment.

TOC required

124.000 Beneficiary Aid Categories 1-1-23

A full list of client aid categories is available online. **View or print the Client Aid Category list**.

124.100 Client Aid Categories with Limited Benefits 1-1-23

Most Medicaid categories provide the full range of Medicaid services as specified in the Arkansas Medicaid State Plan. However, certain categories offer a limited benefit package. These categories are discussed below. **View or print the Client Aid Category list**.

124.200 Client Aid Categories with Additional Cost Sharing 1-1-23

Certain programs require additional cost sharing for Medicaid services. **View or print the Client Aid Category list.**

The forms of cost sharing in the Medicaid Program are co-payment and premiums. These programs are discussed in Sections 124.210 through 124.250.

Copayments may not exceed the amounts listed in the cost sharing schedules, as updated each January 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

A family's total annual out-of-pocket cost sharing cannot exceed five percent (5%) of the family's gross income.

124.220 TEFRA 1-1-23

Eligibility category 49 covers children under age 19 who are eligible for Medicaid services as authorized by Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and amended by the Omnibus Budget Reduction Act. Children in category 49 receive the full range of Medicaid services. However, there are cost sharing requirements. Families will be charged a sliding scale monthly premium based on the income of the custodial parents. Custodial parents with incomes above 150 percent of the federal poverty level (FPL) and in excess of $25,000 annually will be subject to a sliding scale monthly premium. The monthly premium, described in the following chart, can only be assessed if the family income is in excess of one-hundred and fifty percent (150%) of the federal poverty level.

The premiums listed in the TEFRA Cost Share Schedule below represent family responsibility. They will not increase if a family has more than one TEFRA-eligible child. Co-payments are not charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed five percent (5%) of the family's gross income.

TEFRA Cost Share Schedule
Effective July 1, 2022

Family Income		Monthly Premiums		
From	To	%	From	To
$0	$25,000	0%	$0	$0
$25,001	$50,000	1.00%	$20	$41
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$93	$125

TEFRA Cost Share Schedule
Effective July 1, 2022

Family Income		Monthly Premiums		
From	**To**	**%**	**From**	**To**
$100,001	$125,000	1.75%	$145	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$364	$416
$200,001	No limit	2.75%	$458	$458

The maximum premium is $5,500 per year ($458 per month) for income levels of $200,001 and above.

124.230 Workers with Disabilities 1-1-23

The Workers with Disabilities (WD) category is an employment initiative designed to enable people with disabilities to gain employment without losing medical benefits. Individuals who are ages sixteen (16) through sixty-four (64), with a disability as defined by Supplemental Security Income (SSI) criteria and who meet the income and resource criteria may be eligible in this category.

Co-payments are required for the following services:

Adult Medicaid Cost Share Schedule	
Service	**Copay**
Office Visits and Outpatient Services	
Physician visit (including PCP/specialist/audiologist/podiatrist visit, excluding preventive services and X-ray)	$4.70
Preventative Care/Screening/Immunizations/EPSDT	$0.00
Other Practitioner Office Visit (Nurse, Physician Assistant)	$4.70
Federally Qualified Health Center (FQHC)	$4.70
Rural Health Clinic	$4.70
Ambulatory Surgical Center	$4.70
Family planning services and supplies (including contraceptives)	$0.00
Chiropractor	$4.70
Acupuncture	Not covered
Pharmacy	
Generics	$4.70
Preferred Brand Drugs	$4.70
Non-Preferred Brand Drugs	$9.40
Specialty Drugs (i.e., High-Cost)	$9.40
Testing and Imaging	

X-rays and Diagnostic Imaging	$4.70
Imaging (CT/Pet Scans, MRIs)	$4.70
Laboratory Outpatient and Professional Services	$4.70
Allergy Testing	$4.70
Inpatient Services	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Emergency and Urgent Care	
Emergency Room Services	$0.00
Non-Emergency Use of the Emergency Department	$9.40
Emergency Transportation/Ambulance	$0.00
Urgent Care Centers or Facilities	$4.70
Durable Medical Equipment	
Durable Medical Equipment	$4.70
Prosthetic Devices	$4.70
Orthotic Appliances	$4.70
Mental and Behavioral Health and Substance Abuse	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Mental/Behavioral Health and SUD Outpatient Services	$4.70
Rehabilitation and Habilitation	
Rehabilitative Occupational Therapy	$4.70
Rehabilitative Speech Therapy	$4.70
Rehabilitative Physical Therapy	$4.70
Outpatient Rehabilitation Services	$4.70
Habilitation Services	$4.70
Surgery	
Inpatient Physician and Surgical Services	$0.00
Outpatient Surgery Physician/Surgical Services	$4.70
Treatments and Therapies	
Chemotherapy	$4.70
Radiation	$4.70
Infertility Treatment	Not covered
Infusion Therapy	$4.70
Vision	
Dental	
Accidental Dental	$4.70
Women's Services	
Delivery and all Inpatient services for maternity care	$0.00

Prenatal and postnatal care	$0.00
Other	
Home health Care Services	$4.70
Hospice Services	$0.00
End Stage Renal Disease Services (Dialysis)	$0.00
Personal Care	Not covered

*** Exception:** Cost sharing for nursing facility services is in the form of "patient liability" which generally requires that patients contribute most of their monthly income toward their nursing facility care. Therefore, WD clients (Aid Category 10) and Transitional Medicaid clients (Aid Category 25) who temporarily enter a nursing home and continue to meet WD or TM eligibility criteria will be exempt from the co-payments listed above.

124.240 Transitional Medicaid Adult 1-1-23

The Transitional Medicaid program extends Medicaid coverage to families up to 185% of FPL that, due to earned income, lost eligibility for the Parents/Caretaker-Relative (PCR) Aid Category. The Transitional Medicaid program provides up to twelve (12) months of extended coverage after losing PCR eligibility.

Pertinent co-payment amounts for clients covered by Adult Transitional Medicaid are the same as those listed in Section 124.230.

124.250 Arkansas Health and Opportunity for Me (ARHOME) 1-1-23

The ARHOME program operates as a demonstration waiver under Section 1115 of the Social Security Act. It provides premium assistance to allow clients eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act to enroll in qualified health plans. The ARHOME aid category covers adults ages 19-64 who earn up to 138% of the federal poverty level and are not eligible for Medicare. Under ARHOME, clients receive services either through a qualified health plan (QHP) or through three other benefit plans delivered through fee for service. Cost sharing applies only to ARHOME clients who are enrolled in a QHP or who are awaiting enrollment in a QHP (IABP benefit plan). ARHOME clients in a benefit plan based on their status as medically frail (FRAIL) or alternative benefit plan (ABP) will not be subject to any cost sharing.

ARHOME QHP Cost Share amounts for clients enrolled in a QHP are as follows:

ARHOME QHP Cost Share Schedule	
Service	**Copay**
Office Visits and Outpatient Services	
Physician visit (including PCP/specialist/audiologist/podiatrist visit, excluding preventive services and X-ray)	$4.70
Preventative Care/Screening/Immunizations/EPSDT	$0.00
Other Practitioner Office Visit (Nurse, Physician Assistant)	$4.70
Federally Qualified Health Center (FQHC)	$4.70
Rural Health Clinic	$4.70
Ambulatory Surgical Center	$4.70
Family planning services and supplies (including contraceptives)	$0.00

Chiropractor	$4.70
Acupuncture	Not covered
Nutritional Counseling	$4.70
Pharmacy	
Generics	$4.70
Preferred Brand Drugs	$4.70
Non-Preferred Brand Drugs	$9.40
Specialty Drugs (i.e., High-Cost)	$9.40
Testing and Imaging	
X-rays and Diagnostic Imaging	$4.70
Imaging (CT/Pet Scans, MRIs)	$4.70
Laboratory Outpatient and Professional Services	$4.70
Allergy Testing	$4.70
Inpatient Services	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Emergency and Urgent Care	
Emergency Room Services	$0.00
Non-Emergency Use of the Emergency Department	$9.40
Emergency Transportation/Ambulance	$0.00
Urgent Care Centers or Facilities	$4.70
Durable Medical Equipment	
Durable Medical Equipment	$4.70
Prosthetic Devices	$4.70
Orthotic Appliances	$4.70
Mental and Behavioral Health and Substance Abuse	
All Inpatient Hospital Services (including MH/SUD)	$0.00
Mental/Behavioral Health and SUD Outpatient Services	$4.70
Rehabilitation and Habilitation	
Rehabilitative Occupational Therapy	$4.70
Rehabilitative Speech Therapy	$4.70
Rehabilitative Physical Therapy	$4.70
Outpatient Rehabilitation Services	$4.70
Habilitation Services	$4.70
Surgery	
Inpatient Physician and Surgical Services	$0.00
Outpatient Surgery Physician/Surgical Services	$4.70
Treatments and Therapies	

Chemotherapy	$4.70
Radiation	$4.70
Infertility Treatment	Not covered
Infusion Therapy	$4.70
Vision	
Routine Eye Exam	Not covered
Dental	
Basic Dental Services	Not covered
Accidental Dental	$4.70
Orthodontia	Not covered
Women's Services	
Delivery and all Inpatient services for maternity care	$0.00
Prenatal and postnatal care	$0.00
Other	
Eyeglasses for Adults	Not covered
Diabetes Education	$0.00
Skilled Nursing Facility	$20.00
Home Health Care Services	$4.70
Private-Duty Nursing	Not covered
Hospice Services	$0.00
End Stage Renal Disease Services (Dialysis)	$0.00
Personal Care	Not covered

134.000 Exclusions from Cost Sharing Policy 1-1-23

The following populations are excluded from the client cost sharing requirement:

A. Individuals under twenty-one (21) years of age, except:

1. ARKids First-B clients (see the ARKids First-B manual for cost share and more information about this program).

B. Pregnant women.

C. Individuals who are American Indian or Native Alaskan

D. Individuals who are inpatients in a long-term care facility (nursing facility (NF) and intermediate care for individuals with intellectual disabilities (ICF/IID) facility) when, as a condition for receiving the institutional services, the individual is required to spend all but a minimal amount (for personal needs) of his or her income for medical care costs.

The fact that a client is a resident of a nursing facility does not on its own exclude the Medicaid services provided to the client from the cost sharing requirement. Unless a Medicaid client has been found eligible for long term care assistance through the Arkansas Medicaid Program, and Medicaid is making a vendor payment to the nursing facility (NF or ICF/IID) for the client, the client is not exempt from the cost sharing requirement.

E. Individuals who are enrolled in a Provider-led Arkansas Shared Savings Entity (PASSE).

F. Individuals receiving hospice care.

G. Individuals who are at or below 20% of the federal poverty level.

The following services are excluded from the client cost sharing requirement:

A. Emergency services - services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

B. Pregnancy-related services

C. Preventive services

D. Services for provider-preventable conditions

E. Family planning services and supplies.

The provider must maintain sufficient documentation in the client's medical record to substantiate any exemption from the client cost sharing requirement.

135.000 Collection of Coinsurance/Co-payment 1-1-23

The method of collecting the coinsurance/co-payment amount from the client is the provider's responsibility. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing (coinsurance or co-payment) from the client remains the provider's responsibility.

The provider may not deny services to a Medicaid client because of the individual's inability to pay the coinsurance or co-payment. However, the individual's inability to pay does not eliminate his or her liability for the coinsurance or co-payment charge.

The client's inability to pay the coinsurance or co-payment does not alter the Medicaid reimbursement for the claim. Unless the client or the service is exempt from cost sharing requirements as listed in Section 134.000, Medicaid reimbursement is made in accordance with the current reimbursement methodology and when applicable cost sharing amounts are deducted from the maximum allowable fee before payment.

Hospitals are required to comply with certain federal rules before assessing non-emergency copays. Hospitals are expected to comply with emergency room screening requirements, help locate alternate providers when screening determines the patient's need to be non-emergent, and inform clients of treatment options that have a lesser co-pay before the hospital and the state can charge the non-emergency use of the emergency room co-pay.

Hospitals must develop written policies and tracking mechanisms to identify how they comply with the requirement and produce data on member choice and expenditures. Policies and data must be available upon request of DHS and its designees.

The Medicaid cost-sharing amount for clients who use hospital emergency department services for non-emergency reasons can be found in the ARHOME QHP Cost Share Schedule for clients enrolled in a QHP **or** the Adult Medicaid Cost Share Schedule. (See Sections 124.230 and 124.250)

This cost-sharing amount will only apply to Medicaid clients who are subject to a copay. There will not be any cost-sharing required from clients who need emergency services or treatment.

The first step in the process will be for hospital emergency departments to conduct an appropriate medical screening to determine whether the client needs emergency services.

If the screening determines that emergency services are needed, hospitals should tell the client what the cost-sharing amount will be for the emergency services provided in the emergency department ($0.00). Hospitals should then provide needed emergency services per their established protocols.

If the screening determines that emergency services are not needed, hospitals may provide non-emergency services in the emergency department. Before providing non-emergency services and imposing client cost sharing for such services, however, the hospital must:

- Tell the client what the cost-sharing amount will be for the non-emergency services provided in the emergency department,
- Give the client the option of paying for and receiving services in the emergency department, or
- Give the client the name and location of an alternate non-emergency services provider that can provide the needed services in a timely manner and at a lower cost than the hospital emergency department, and
- Refer the client to the alternate provider, who will then coordinate scheduling for treatment.

Beneficiary Aid Category List

Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. The following codes describe each level of coverage.

FR	full range
LB	limited benefits
AC	additional cost sharing
MNLB	medically needy limited benefits
QHP/IABP/MF	Qualified Health Plan/awaiting QHP assignment/medically frail

Category	Category Name	Description	Code
01	ARKIDS B	CHIP Separate Child Health Program	LB, AC
06	ARHOME	New Adult Expansion Group	QHP, AC IABP, AC MF, FR
10	WD	Workers with Disabilities	FR, AC
11	Assisted Individual - Aged	Assisted Living Facility- Individual is >= 65 years old	FR
11	ARChoices - Aged	ARChoices waiver -Individual is >= 65 years old	FR
13	SSI Aged Individual	SSI Medicaid	FR
14	SSI Aged Spouse	SSI Medicaid	FR
15	PACE	Program of All-Inclusive Care for the Elderly (PACE)	FR
16	AA-EC Aged Individual	Medically Needy, Exceptional Category-Individual is >= 65 years old	MNLB
17	AA-SD – Aged	Medically Needy Spend Down- Individual is >= 65 years old	MNLB
18 QMB	AA Aged Individual	Qualified Medicare Beneficiary (QMB)-Individual is >= 65 years old	LB
19	ARSeniors	ARSeniors	FR
20	PCR	Parent Caretaker Relative	FR
25	TM	Transitional Medicaid	FR, AC
26	AFDC Medically Needy-EC	AFDC Medically Needy Exceptional Category	MNLB
27	AFDC Medically Needy-SD	AFDC Medically Needy Spend Down	MNLB
31	Pickle	Disregard COLA Increase	FR
33	SSI Blind Individual	SSI Medicaid	FR
34	SSI Blind Spouse	SSI Medicaid	FR

Category	Category Name	Description	Code
35	SSI Blind Child	SSI Medicaid	FR
36	Blind Medically Needy-EC**	AABD Medically Needy - Individual is Blind as indicated on the Disability screen	MNLB
37	Blind Medically Needy-SD-	Aid to the Blind-Medically Needy Spend Down-Individual has disability type of blind	MNLB
38	Blind – QMB	Aid to the Blind-Qualified Medicare Beneficiary (QMB) - Individual is Blind as indicated on the Disability screen	LB
40	Nursing Facility – Aged	Nursing Facility - Individual age is >= 65 years old	FR
40	Nursing Facility – Blind	Nursing Facility- Individual is Blind as indicated on the Disability screen	FR
40	Nursing Facility – Disabled	Nursing Facility – Individual has a disability	FR
41	Disabled Widow/er Surviving Divorced Spouse	Widows/Widowers and Surviving Divorced Spouses with a Disability (COBRA 90)	FR
41	Assisted Living	Assisted Living Facility-Individual has a disability of any type-	FR
41	ARChoices	ARChoices-Individual has disability type of physical or blind-	FR
41	DAC	Disabled Adult Child	FR
41	Autism	Autism Waiver	FR
41	DDS	DDS Waiver	FR
41	Disregard (1984) Widow/Widow/er	Disabled Widower 50-59 (COBRA)	FR
41	Disregard SSA Disabled Widow/er	Disabled Widower 60-65 (OBRA 87)	FR
41	Disregard SSA Disabled Widow/e	OBRA 90	FR
43	SSI Disabled Individual	SSI Medicaid	FR
44	SSI Disabled Spouse	SSI Medicaid	FR
45	SSI Disabled Child	SSI Medicaid	FR
46	Disabled Medically Needy - EC	AABD Medically Needy - Individual has disability of any type other than blind	MNLB
47	Disabled Medically Needy - SD	AABD Medically Needy Spenddown - Individual has any other disability type other than Blind	MNLB

Category	Category Name	Description	Code
48	Disabled QMB	Qualified Medicare Beneficiary (QMB) - Individual has any other disability type other than Blind	LB
49	TEFRA	TEFRA Waiver for Disabled Child	FR, AC
52	Newborn	Newborn	FR
56 U-18 EC		Under Age 18 Medically Needy Exceptional Category	MNLB
57	U-18 Medically Needy - SD	AFDC U18 Medically Needy Spend Down	MNLB
58	Qualifying Individual (QI-1)	Qualifying Individual-1 (Medicaid pays only the Medicare premium.)	LB
61	ARKids A	ARKids A	FR
~~61~~	~~Pregnant Women-Limited~~	~~Pregnant Women-Limited~~	~~LB~~
61	Unborn	Pregnant Wom~~ae~~n - Unborn Child (No family planning benefits allowed)	LB
65	Pregnant Women – Full	Pregnant Women – Full	FR
66	Pregnant Women Medically Needy - EC	AFDC Pregnant Women Medically Needy	MNLB
67	Pregnant Women Medically Needy - SD	AFDC Pregnant Women Medically Needy Spend Down	MNLB
68	Qualified Disabled and Working individual (QDWI)	Qualified Disabled and Working individual (QDWI) - (Medicaid pays only the Medicare Part A premium.)	LB
76	AFDC UP Medically Needy - EC	Unemployed Parent Medically Needy	MNLB
77	AFDC UP Medically Needy Spenddown	Unemployed Parent Medically Needy Spend Down	MNLB
81	RMA	Refugee Resettlement	FR
87	RMA Spenddown	Refugee Resettlement- Medically Needy Spend Down	MNLB
88	SLMB	Specified Low Income Qualified Medicare Beneficiary (SLMB) (Medicaid pays only the Medicare premium.)	LB
91	Foster Care Non-IV-E	Non IV-E Foster Care - User selection based on Child in Placement screen	FR
92	Foster Care IV-E	IV-E Foster Care - User selection based on Child in Placement screen	FR

Category	Category Name	Description	Code
92	Foster Care ICPC IV-E	ICPC IV-E Foster Care - User selection based on Child in Placement screen	FR
93	Former Foster Care	Former Foster Care Up to Age 26	FR
94	Adoption	Non- IV-E- User selection based on Child in Placement screen	FR
94	Adoption	ICAMA Non- IV-E- User selection based on Child in Placement screen	FR
94	Adoption	IV-E- User selection based on Child in Placement screen	FR
94	Adoption	ICAMA IV-E- User selection based on Child in Placement screen	FR
95	Guardianship (GAP)	Guardianship Non-IV-E - User selection based on Child in Placement screen	FR
95	Guardianship (GAP)	Guardianship IV-E- User selection based on Child in Placement screen	FR
96	Foster Care Exceptional Category	Foster Care Medically Needy Exceptional Category - Individual fails Foster Care Non-IVE Income Test and is eligible for FC EC	MNLB
97 FC-SD	Foster Care Spend Down	Foster Care Medically Needy Spend Down- Individual fails FC EC Income Test/or Income Test of any other higher category and has medical bills to be eligible on spenddown.	MNLB

Beneficiary Aid Category List

Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. The following codes describe each level of coverage.

FR	full range
LB	limited benefits
AC	additional cost sharing
MNLB	medically needy limited benefits
QHP/IABP/MF	Qualified Health Plan/awaiting QHP assignment/medically frail

Category	Category Name	Description	Code
01	ARKIDS B	CHIP Separate Child Health Program	LB, AC
06	ARHOME	New Adult Expansion Group	QHP, AC IABP, AC MF, FR
10	WD	Workers with Disabilities	FR, AC
11	Assisted Individual - Aged	Assisted Living Facility- Individual is >= 65 years old	FR
11	ARChoices - Aged	ARChoices waiver -Individual is >= 65 years old	FR
13	SSI Aged Individual	SSI Medicaid	FR
14	SSI Aged Spouse	SSI Medicaid	FR
15	PACE	Program of All-Inclusive Care for the Elderly (PACE)	FR
16	AA-EC Aged Individual	Medically Needy, Exceptional Category-Individual is >= 65 years old	MNLB
17	AA-SD – Aged	Medically Needy Spend Down- Individual is >= 65 years old	MNLB
18 QMB	AA Aged Individual	Qualified Medicare Beneficiary (QMB)-Individual is >= 65 years old	LB
19	ARSeniors	ARSeniors	FR
20	PCR	Parent Caretaker Relative	FR
25	TM	Transitional Medicaid	FR, AC
26	AFDC Medically Needy-EC	AFDC Medically Needy Exceptional Category	MNLB
27	AFDC Medically Needy-SD	AFDC Medically Needy Spend Down	MNLB
31	Pickle	Disregard COLA Increase	FR
33	SSI Blind Individual	SSI Medicaid	FR
34	SSI Blind Spouse	SSI Medicaid	FR

Category	Category Name	Description	Code
35	SSI Blind Child	SSI Medicaid	FR
36	Blind Medically Needy-EC**	AABD Medically Needy - Individual is Blind as indicated on the Disability screen	MNLB
37	Blind Medically Needy-SD-	Aid to the Blind-Medically Needy Spend Down-Individual has disability type of blind	MNLB
38	Blind – QMB	Aid to the Blind-Qualified Medicare Beneficiary (QMB) - Individual is Blind as indicated on the Disability screen	LB
40	Nursing Facility – Aged	Nursing Facility - Individual age is >= 65 years old	FR
40	Nursing Facility – Blind	Nursing Facility- Individual is Blind as indicated on the Disability screen	FR
40	Nursing Facility – Disabled	Nursing Facility – Individual has a disability	FR
41	Disabled Widow/er Surviving Divorced Spouse	Widows/Widowers and Surviving Divorced Spouses with a Disability (COBRA 90)	FR
41	Assisted Living	Assisted Living Facility-Individual has a disability of any type	FR
41	ARChoices	ARChoices-Individual has disability type of physical or blind	FR
41	DAC	Disabled Adult Child	FR
41	Autism	Autism Waiver	FR
41	DDS	DDS Waiver	FR
41	Disregard (1984) Widow/Widow/er	Disabled Widower 50-59 (COBRA)	FR
41	Disregard SSA Disabled Widow/er	Disabled Widower 60-65 (OBRA 87)	FR
41	Disregard SSA Disabled Widow/e	OBRA 90	FR
43	SSI Disabled Individual	SSI Medicaid	FR
44	SSI Disabled Spouse	SSI Medicaid	FR
45	SSI Disabled Child	SSI Medicaid	FR
46	Disabled Medically Needy - EC	AABD Medically Needy - Individual has disability of any type other than blind	MNLB
47	Disabled Medically Needy - SD	AABD Medically Needy Spenddown - Individual has any other disability type other than Blind	MNLB

Category	Category Name	Description	Code
48	Disabled QMB	Qualified Medicare Beneficiary (QMB) - Individual has any other disability type other than Blind	LB
49	TEFRA	TEFRA Waiver for Disabled Child	FR, AC
52	Newborn	Newborn	FR
56 U-18 EC		Under Age 18 Medically Needy Exceptional Category	MNLB
57	U-18 Medically Needy - SD	AFDC U18 Medically Needy Spend Down	MNLB
58	Qualifying Individual (QI-1)	Qualifying Individual-1 (Medicaid pays only the Medicare premium)	LB
61	ARKids A	ARKids A	FR
61	Unborn	Pregnant Women - Unborn Child (No family planning benefits allowed)	LB
65	Pregnant Women – Full	Pregnant Women – Full	FR
66	Pregnant Women Medically Needy - EC	AFDC Pregnant Women Medically Needy	MNLB
67	Pregnant Women Medically Needy - SD	AFDC Pregnant Women Medically Needy Spend Down	MNLB
68	Qualified Disabled and Working individual (QDWI)	Qualified Disabled and Working individual (QDWI) - (Medicaid pays only the Medicare Part A premium)	LB
76	AFDC UP Medically Needy - EC	Unemployed Parent Medically Needy	MNLB
77	AFDC UP Medically Needy Spenddown	Unemployed Parent Medically Needy Spend Down	MNLB
81	RMA	Refugee Resettlement	FR
87	RMA Spenddown	Refugee Resettlement- Medically Needy Spend Down	MNLB
88	SLMB	Specified Low Income Qualified Medicare Beneficiary (SLMB) (Medicaid pays only the Medicare premium)	LB
91	Foster Care Non-IV-E	Non IV-E Foster Care - User selection based on Child in Placement screen	FR
92	Foster Care IV-E	IV-E Foster Care - User selection based on Child in Placement screen	FR
92	Foster Care ICPC IV-E	ICPC IV-E Foster Care - User selection based on Child in Placement screen	FR
93	Former Foster Care	Former Foster Care Up to Age 26	FR

Category	Category Name	Description	Code
94	Adoption	Non- IV-E- User selection based on Child in Placement screen	FR
94	Adoption	ICAMA Non- IV-E- User selection based on Child in Placement screen	FR
94	Adoption	IV-E- User selection based on Child in Placement screen	FR
94	Adoption	ICAMA IV-E- User selection based on Child in Placement screen	FR
95	Guardianship (GAP)	Guardianship Non-IV-E - User selection based on Child in Placement screen	FR
95	Guardianship (GAP)	Guardianship IV-E- User selection based on Child in Placement screen	FR
96	Foster Care Exceptional Category	Foster Care Medically Needy Exceptional Category - Individual fails Foster Care Non-IVE Income Test and is eligible for FC EC	MNLB
97 FC-SD	Foster Care Spend Down	Foster Care Medically Needy Spend Down- Individual fails FC EC Income Test/or Income Test of any other higher category and has medical bills to be eligible on spenddown	MNLB

TOC not required

213.200 Coverage and Limitations of the Adult Program ~~1~~1-1-~~23~~09

A. One visual examination and one pair of glasses are available to eligible Medicaid ~~beneficiaries~~ clients every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program ~~in order~~ for repairs to be made.
2. All repairs will be made by the optical laboratory.

~~B. One prescription services fee every 12 months from the last date of service~~

~~C~~B. Lens replacement as medically necessary with prior authorization

~~D~~C. Lens power for single vision must be a minimum of:

1. +1.00 OR -0.75 sphere
2. -0.75 axis 90 or 0.75 axis 180 cylinder or at any axis

~~E~~D. Tinted lenses, photogray lenses or sunglasses are limited to post-operative cataract or albino patients

~~F~~E. Bifocals for presbyopia must have a power of +1.00 and any changes in bifocals must be in increments of at least +0.50

~~G~~F. Bifocal lenses are limited to:

1. D-28 and
2. Kryptok

~~H~~G. For ~~beneficiaries~~ clients who are eligible for both Medicare and Medicaid, see Section I for coinsurance and deductible information.

~~I~~H. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

~~J~~I. Low vision aids are covered on a prior authorization basis.

~~K. Medicaid eligible beneficiaries, with the exception of nursing home residents, who are 21 or older, will pay a $2.00 co-payment to the visual care provider for prescription services. Beneficiaries who are in nursing facilities or in group homes will have no co-pays. All co-pays will be applied to examination codes rather than to tests or procedures.~~

~~L~~J. Adult diabetics are eligible (with prior authorization) to receive a second pair of eyeglasses within the twelve (12) month period if their prescription changes more than one diopter.

~~M~~K. One visual prosthetic device every twenty-four (24) months from the last date of service

~~N~~L. Eye prosthesis and polishing services are covered with a prior authorization.

~~O~~M. Trifocals are covered if medically necessary with a prior authorization.

~~P~~N. Progressive lenses are covered if medically necessary with a prior authorization.

~~Q~~O. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

213.300 Exclusions in the Adult Program ~~11-1-09~~1-1-23

A. The Medicaid Program will not reimburse for replacement glasses, with the exception of post-cataract patients, which will require prior authorization. ~~There will be no co-pay for replacement glasses for post-cataract patients.~~

B. Lenses may not be purchased separately from the frames. If the ~~beneficiary~~ client desires frames other than the frames approved by Medicaid, he or she will be responsible for the lenses also. Medicaid will reimburse the provider for the examination in these situations.

C. Medicaid will not pay the prescription service charges in situations where the patient buys the eyeglasses.

D. Medicaid does not cover charges incurred due to errors made by doctors or optical laboratories.

E. Tinted lenses for cosmetics purposes are not covered.

F. Glass lenses are NOT covered by Medicaid.

214.200 Coverage and Limitations of the Under Age 21 Program ~~2-1-22~~1-1-23

A. One examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.
2. If the glasses are lost or broken beyond repair within the twelve (12)-month benefit limit period, one additional pair will be available through the optical laboratory. After the first replacement pair, any additional pair will require prior authorization. ~~There will be no co-payment assessed for replacement glasses requiring prior authorization~~.
3. All replacements will be made by the optical laboratory and the doctor's office may make repairs only when necessary.
4. ~~EPSDT beneficiaries will have no co-pays.~~ Only ARKids First-B beneficiaries will be assessed a ten-dollar ($10.00) co-pay. All co-pays will be applied to examination codes rather than to tests or procedures.

B. Prescriptive and acuity minimums must be met before glasses will be furnished. Glasses should be prescribed only if the following conditions apply:

1. The strength of the prescribed lens (for the poorer eye) should be a minimum of -.75D + 1.00D spherical or a minimum of .75 cylindrical or the unaided visual acuity of the poorer eye should be worse than 20/30 at a distance.
2. Reading glasses may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

C. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

D. When the prescription has met the prescriptive and acuity minimum qualifications, Medicaid will purchase eyeglasses through a negotiated contract with an optical laboratory.

E. The eyeglasses will be forwarded to the doctor's office where he or she will be required to verify the prescription and fit or adjust them to the patient's needs.

F. Eye prosthesis and polishing services require a prior authorization.

G. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

H. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses.

1. Ptosis (droopy lid)
2. Congenital cataracts
3. Exotropia or vertical tropia
4. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia

I. Prior authorized orthoptic and/or pleoptic training may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under.

1. The initial prior authorization request must include objective and subjective measurements and tests used to indicate diagnosis.
2. The initial prior authorization approved for this treatment will consist of sixteen (16) treatments in a twelve (12)-month period with no more than one treatment per seven (7) calendar days.
3. An extension of benefits may be requested for medical necessity.
4. Requests for extension of benefits must include the initial objective and subjective measures with diagnosis along with subjective and objective measures after the initial sixteen (16) treatments are completed to show progress and the need for, or benefit of, further treatment.
5. For a list of diagnoses that are covered for orthoptic and/or pleoptic training **(View ICD Codes.)**.

J. Prior authorized sensorimotor examination may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) sensorimotor examination in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for sensorimotor examination **(View ICD Codes.)**.

K. Prior authorized developmental testing may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) developmental testing in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for developmental testing **(View ICD Codes)**.

View or print the procedure codes for Vision services.

TOC not required

213.200 Coverage and Limitations of the Adult Program 1-1-23

A. One visual examination and one pair of glasses are available to eligible Medicaid clients every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program for repairs to be made.
2. All repairs will be made by the optical laboratory.

B. Lens replacement as medically necessary with prior authorization

C. Lens power for single vision must be a minimum of:

1. +1.00 OR -0.75 sphere
2. -0.75 axis 90 or 0.75 axis 180 cylinder or at any axis

D. Tinted lenses, photogray lenses or sunglasses are limited to post-operative cataract or albino patients

E. Bifocals for presbyopia must have a power of +1.00 and any changes in bifocals must be in increments of at least +0.50

F. Bifocal lenses are limited to:

1. D-28 and
2. Kryptok

G. For clients who are eligible for both Medicare and Medicaid, see Section I for coinsurance and deductible information.

H. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

I. Low vision aids are covered on a prior authorization basis.

J. Adult diabetics are eligible (with prior authorization) to receive a second pair of eyeglasses within the twelve (12) month period if their prescription changes more than one diopter.

K. One visual prosthetic device every twenty-four (24) months from the last date of service

L. Eye prosthesis and polishing services are covered with a prior authorization.

M. Trifocals are covered if medically necessary with a prior authorization.

N. Progressive lenses are covered if medically necessary with a prior authorization.

O. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

213.300 Exclusions in the Adult Program 1-1-23

A. The Medicaid Program will not reimburse for replacement glasses, with the exception of post-cataract patients, which will require prior authorization.

B. Lenses may not be purchased separately from the frames. If the client desires frames other than the frames approved by Medicaid, he or she will be responsible for the lenses also. Medicaid will reimburse the provider for the examination in these situations.

C. Medicaid will not pay the prescription service charges in situations where the patient buys the eyeglasses.

D. Medicaid does not cover charges incurred due to errors made by doctors or optical laboratories.

E. Tinted lenses for cosmetics purposes are not covered.

F. Glass lenses are NOT covered by Medicaid.

214.200 Coverage and Limitations of the Under Age 21 Program 1-1-23

A. One examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.
2. If the glasses are lost or broken beyond repair within the twelve (12)-month benefit limit period, one additional pair will be available through the optical laboratory. After the first replacement pair, any additional pair will require prior authorization..
3. All replacements will be made by the optical laboratory and the doctor's office may make repairs only when necessary.
4. Only ARKids First-B beneficiaries will be assessed a ten-dollar ($10.00) co-pay. All co-pays will be applied to examination codes rather than to tests or procedures.

B. Prescriptive and acuity minimums must be met before glasses will be furnished. Glasses should be prescribed only if the following conditions apply:

1. The strength of the prescribed lens (for the poorer eye) should be a minimum of -.75D + 1.00D spherical or a minimum of .75 cylindrical or the unaided visual acuity of the poorer eye should be worse than 20/30 at a distance.
2. Reading glasses may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

C. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

D. When the prescription has met the prescriptive and acuity minimum qualifications, Medicaid will purchase eyeglasses through a negotiated contract with an optical laboratory.

E. The eyeglasses will be forwarded to the doctor's office where he or she will be required to verify the prescription and fit or adjust them to the patient's needs.

F. Eye prosthesis and polishing services require a prior authorization.

G. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

H. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses.

1. Ptosis (droopy lid)
2. Congenital cataracts
3. Exotropia or vertical tropia
4. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia

I. Prior authorized orthoptic and/or pleoptic training may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under.

1. The initial prior authorization request must include objective and subjective measurements and tests used to indicate diagnosis.
2. The initial prior authorization approved for this treatment will consist of sixteen (16) treatments in a twelve (12)-month period with no more than one treatment per seven (7) calendar days.
3. An extension of benefits may be requested for medical necessity.
4. Requests for extension of benefits must include the initial objective and subjective measures with diagnosis along with subjective and objective measures after the initial sixteen (16) treatments are completed to show progress and the need for, or benefit of, further treatment.
5. For a list of diagnoses that are covered for orthoptic and/or pleoptic training **(View ICD Codes.)**.

J. Prior authorized sensorimotor examination may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) sensorimotor examination in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for sensorimotor examination **(View ICD Codes.)**.

K. Prior authorized developmental testing may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) developmental testing in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for developmental testing **(View ICD Codes)**.

View or print the procedure codes for Vision services.

A-100 General Program Information

MS Manual ~~07/01/20~~01/01/23

The ~~Medicaid~~ Health Care Program (Medicaid) is a Federal-State Program designed to meet the financial expense of medical services for eligible individuals in Arkansas. The Department of Human Services (DHS), Divisions of County Operations (DCO) and Medical Services have the responsibility for administration of the ~~Medicaid~~ Health Care Program. The purpose of Medical Services is to provide medical assistance to low income individuals and families and to insure proper utilization of such services. ~~The Division of County Operations~~DCO will accept all applications, verification documents, ~~etc.~~ and ~~will~~ make eligibility determinations.

Benefits for the Arkansas Medicaid and ARKids Programs include~~, but are not limited to the following~~:

- Emergency Services;
- Home Health and Hospice;
- Hospitalization;
- Long Term Care;
- Physician Services;
- Prescription Drugs; and
- Transportation ~~(~~Refer to Appendix B for a description of Transportation Services~~).~~

Generally, there is no limit on benefits to individuals under ~~age~~ twenty-one (21) years of age who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over ~~age~~ twenty-one (21) years of age.
~~Consult "Arkansas Medicaid, ARKids First & You, Arkansas Medicaid Beneficiary Handbook" (PUB-040) for specific information and covered services.~~

The Adult Expansion Group coverage for most individuals will be provided through a private insurance plan, ~~i.e.,~~ this is, a Qualified Health Plan (QHP). QHP coverage will include:

- Outpatient Services;
- Emergency Services;
- Hospitalization;
- Maternity and Newborn Care;

- Mental Health and Substance Abuse;
- Prescription Drugs;
- Rehabilitative and Habilitative Services;
- Laboratory Services;
- Preventive and Wellness Services and Chronic Disease Management; and
- Pediatric Services, including Dental and Vision Care;

EXCEPTION: Individuals eligible for the Adult Expansion Group who have health care needs that make coverage through a QHP impractical, or overly complex, or who would undermine continuity or effectiveness of care, will not enroll in a private QHP plan but will remain in ~~Medicaid~~Health Care.

A-110 Cost Sharing Coinsurance/Copayment

MS Manual ~~01/01/17~~01/01/23

Health Care Programs could include out-of-pocket spending (cost sharing) on covered services that follow 42 CFR § 447.50. Examples of cost sharing can include; ~~The types of cost sharing in the Medicaid Program are~~ coinsurance, co-payments, ~~deductibles and~~ premiums, and prescription costs. ~~.Medicaid recipients are responsible for paying a coinsurance amount equal to 10% of the per diem charge for the first Medicaid covered day per inpation hospital admission. Medicaid recipients are also responsible for paying a copayment amount per prescription based on a graduated payment scale, not to exceed $3.00 per prescription.~~

The coinsurance and copayment policy does not apply to the following recipients and/or services:

1. Individuals under twenty-one (~~the age of 18~~21) years of age receiving coverage through ARKids A or Newborn;

2. Pregnant women;

~~2.~~3. Family Planning services and supplies;

~~3.~~4. ~~Individuals residing in a nursing or ICF/IID (Intermediate Care Facilities/Individuals with Intellectual Disabilities) facility who are approved for vendor payment~~Individuals receiving Medically Frail or Alternative Benefit Plan (ABP);

5. Emergency services;

~~4.~~6. Services that are considered preventative or provider-preventable diseases;

~~5.~~7. Health Maintenance Organization (HMO) enrollees;

8. Services provided to individuals receiving hospice care;

9. PASSE enrollees;

~~6.~~10. American Indian/ Alaska Natives; and

~~7.~~11. ~~Adult Expansion Group~~Individuals that are at or below twenty (20) percent of the FPL ~~enrollees with household income below 100% FPL for their household size are not required to pay co-pays or other cost-sharing.~~

A-115 Cost Sharing for Workers with Disabilities

MS Manual ~~07/01/20~~01/01/23

Recipients of Medicaid for Workers with Disabilities (WD) with gross income up to one hundred and fifty percent (~~under~~ 1~~0~~50~~% percent (100%~~) of the ~~Federal Poverty Level~~FPL for their family size will be subject to paying ~~the usual Medicaid~~ Health Care co-~~-~~pays. Recipients with income greater than one hundred and fifty percent (150%) of the FPL will be assessed for co-payments up to twenty percent (20%) of Health Care maximum allowable, up to ten dollars ($10) per visit.~~Recipients with gross income equal to or greater than 100 percent (100%) of the FPL will be assessed co-payments at the point of service for medical visits and prescription drugs according to the following schedule:~~

NOTE: Transitional Medicaid will follow the same cost share guidelines as Workers with Disabilities.

~~1. Physician's visits - $10.00 per visit;~~

~~2. Prescription drugs - $10.00 for generic, $15.00 for brand name;~~

~~3. Inpatient Hospital - 25% of the first day's Medicaid per diemrate;~~

~~4. Orthotic appliances, prosthetic devices and augmentative communication devices - 10% of the Medicaid maximum allowable amount;~~

~~5. Durable medical equipment – 20% of Medicaid maximum allowable amount per item;~~

~~6. Occupational, physical and speech therapy, & private duty nursing - $10.00 per visit, with a cap of $10.00 per day.~~

~~A-116 Premiums for the Adult Expansion Group~~

~~MS Manual 01/01/17~~

~~A program participant who has income of at least (138~~00%~~)~~ ~~of the federal poverty level~~FPL ~~will pay a premium of no more than 2% of~~to ~~their income to a health insurance carrier.~~.

~~**NOTE:** Individuals who are medically frail and receiving~~ Ttraditional ~~Medicaid will not be required to pay a premium.~~

~~Failure to pay the premium for three (3) consecutive months will result in a dept to the State of Arkansas.~~

A-163 Child Health Services Program (EPSDT)

MS Manual ~~07/01/20~~01/01/23

The Child Health Services Program (EPSDT) is a program designed to provide early and periodic screening, diagnosis, and treatment services ~~at no cost to Medicaid eligible individuals under age 21 (including parents under age 21)~~.

A-100 General Program Information

MS Manual 01/01/23

The Health Care Program (Medicaid) is a Federal-State Program designed to meet the financial expense of medical services for eligible individuals in Arkansas. The Department of Human Services (DHS), Divisions of County Operations (DCO) and Medical Services have the responsibility for administration of the Health Care Program. The purpose of Medical Services is to provide medical assistance to low income individuals and families and to insure proper utilization of such services. DCO will accept all applications, verification documents, and make eligibility determinations.

Benefits for the Arkansas Medicaid and ARKids Programs include:

- Emergency Services;
- Home Health and Hospice;
- Hospitalization;
- Long Term Care;
- Physician Services;
- Prescription Drugs; and
- Transportation-(Refer to Appendix B for a description of Transportation Services).

Generally, there is no limit on benefits to individuals under twenty-one (21) years of age who are enrolled in the Child Health Services Program (EPSDT). There may be benefit limits to individuals over twenty-one (21) years of age.

The Adult Expansion Group coverage for most individuals will be provided through a private insurance plan, this is, a Qualified Health Plan (QHP). QHP coverage will include:

- Outpatient Services;
- Emergency Services;
- Hospitalization;
- Maternity and Newborn Care;

- Mental Health and Substance Abuse;
- Prescription Drugs;
- Rehabilitative and Habilitative Services;
- Laboratory Services;
- Preventive and Wellness Services and Chronic Disease Management; and
- Pediatric Services, including Dental and Vision Care;

EXCEPTION: Individuals eligible for the Adult Expansion Group who have health care needs that make coverage through a QHP impractical, or overly complex, or who would undermine continuity or effectiveness of care, will not enroll in a private QHP plan but will remain in Health Care.

A-110 Cost Sharing Coinsurance/Copayment

MS Manual 01/01/23

Health Care Programs could include out-of-pocket spending (cost sharing) on covered services that follow 42 CFR § 447.50. Examples of cost sharing can include: coinsurance, co-payments, premiums, and prescription costs.

The coinsurance and copayment policy does not apply to the following recipients and/or services:

1. Individuals under twenty-one (21) years of age receiving coverage through ARKids A or Newborn;
2. Pregnant women;
3. Family Planning services and supplies;
4. Individuals receiving Medically Frail or Alternative Benefit Plan (ABP);
5. Emergency services;
6. Services that are considered preventative or provider-preventable diseases;
7. Health Maintenance Organization (HMO) enrollees;
8. Services provided to individuals receiving hospice care;
9. PASSE enrollees;
10. American Indian/ Alaska Natives; and
11. Individuals that are at or below twenty (20) percent of the FPL.

A-115 Cost Sharing for Workers with Disabilities

MS Manual 01/01/23

Recipients of Medicaid for Workers with Disabilities (WD) with gross income up to one hundred and fifty percent (150%) of the FPL for their family size will be subject to paying Health Care co-pays. Recipients with income greater than one hundred and fifty percent (150%) of the FPL will be assessed for co-payments up to twenty percent (20%) of Health Care maximum allowable, up to ten dollars ($10) per visit.

NOTE: Transitional Medicaid will follow the same cost share guidelines as Workers with Disabilities.

A-163 Child Health Services Program (EPSDT)

MS Manual 01/01/23

The Child Health Services Program (EPSDT) is a program designed to provide early and periodic screening, diagnosis, and treatment services.

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- [ ]

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Arkansas Newly Eligible Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Arkansas will provide access to the Alternative Benefit Plan (ABP) through two ~~three~~ mechanisms: premium assistance to support coverage from Qualified Health Plans (QHPs) offered in the individual market, ~~premium assistance to support cost-effective employer-sponsored insurance (ESI) through an employer participating in the Arkansas Works program~~ and through fee-for-service Medicaid.

Arkansas has received approval under 1115 of the Social Security Act to implement the Arkansas ~~Works~~ Health and Opportunity for Me (ARHOME) program. Under the ARHOME ~~Arkansas Works~~ demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group established under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to support the purchase of coverage from Qualified Health Plans offered in the individual market through the Marketplace; ~~additionally, individuals ages 21 and over with access to cost-effective ESI through an employer who has elected to participate in the Arkansas Works ESI program will be required to enroll in ESI. Arkansas expected approximately 200,000 beneficiaries to be enrolled in coverage offered through the Marketplace through this demonstration program.~~

Arkansas will also offer ~~all of the~~ benefits described in this ABP State Plan Amendment through the fee-for-service delivery system. ~~Individuals who are eligible for coverage under Arkansas Works will receive the ABP through fee-for-service prior to the effective date of their QHP coverage. Exempt populations will have the option to receive the ABP that is the approved Arkansas state plan or the ABP that is described in these SPA pages. Exempt individuals choosing to receive the ABP that is described in these SPA pages will receive those benefits through the fee-for-service delivery system, except for those individuals age 21 or over who have access to cost-effective ESI.~~ The State will offer two types of fee for service ABP plans: an ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan and an ABP that covers the Essential Health Benefits provided by QHPs (EHB-equivalent ABP). Individuals who are eligible for coverage under ARHOME will receive the EHB-equivalent ABP through fee-for-service temporarily prior to the effective date of their QHP coverage. Exempt populations will have the option of receiving the ABP that offers approved Arkansas state plan benefits or the EHB-equivalent ABP.

MARK-UP

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☐ Other

MARK-UP

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

The State will provide a notice informing individuals of their eligibility under the Section 1902(a)(10)(A)(i)(VIII) eligibility group once they have been determined eligible by ~~through the Federally Facilitated Marketplace (FFM) or via~~ the State's ~~E~~ eligibility ~~and Enrollment Framework (EEF)~~ system. Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP ~~or ESI enrollment~~ coverage is effective, ~~ESI enrollment~~, the process for accessing supplemental services, the grievance and appeals process, ~~and outlining the exemption process from the Arkansas Works Alternative Benefit Plan.~~ and accessing other ABP delivery mechanisms for those eligible.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the eligibility application process, ~~if~~ a member who answers "yes" to the following questions will be considered medically frail or eligible for Medicaid through another Aid Category: "Do you have a disability? Or are you blind? Do you live in a medical facility or nursing home? What type of facility is this? Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) ?" ~~or live in a medical facility or nursing home?", the individual will be enrolled in the ABP that is the state plan and will be provided with a Choice Counseling notice. The Choice Counseling notice will outline the differences between traditional fee-for service state plan (the ABP that is the state plan) or the fee-for-service ABP (the ABP that is aligned with the EHB benchmark plan) and informing them of their right to choose between the two. The notice will also include a toll-free number that individuals will call to finalize their selection. If an affirmative selection is not made, the individual will remain in the traditional fee-for-service state plan (the ABP that is the state plan). Arkansas Medicaid will provide individuals who are exempt from the ABP with a Choice Counseling notice that informs them that they may choose between the ABP that is the Arkansas state plan or the ABP that is the FFS equivalent of the QHP offering. The notice will also inform them that they will be enrolled in the ABP that is the Arkansas state plan, unless they inform Arkansas Medicaid that they would like to be enrolled in the ABP that is the FFS equivalent of the QHP offering.~~ Individuals screened as medically frail will be enrolled in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan and will be provided with a Choice Counseling notice that will inform them about their benefit plan options.

The Choice Counseling notice will inform medically frail clients of their right to choose the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP and will describe the differences between the two. The notice will also include a toll-free number that individuals can call to make their selection. If an affirmative selection is not made, the individual will remain in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan.

Medically frail clients with a serious mental illness or a substance use disorder who assess as a Tier 2 or Tier 3 on the independent assessment will be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program.

☐ All individuals not ~~identified~~ screened as medically frail based on their responses on the ~~single streamlined~~ integrated application for assistance will receive a general Medicaid eligibility notice. That eligibility notice will include, ~~among other things~~, information about an individual's ability to identify as medically frail at a later time. The notice will define a medically frail individual as a person who has a physical or behavioral health condition that limits what he or she is able to do (like bathing, dressing, daily chores, etc.), a person who lives in a medical facility or nursing home, a person who has a serious mental illness, a person who has a long-term problem with drugs or alcohol, a person with intellectual or developmental disabilities, or a person with some other serious health condition. The document will inform all enrollees that they may ~~identify as medically frail~~ screen for medically frailty at any time and can discuss coverage options with their doctor, contact Member Services or or visit the Medicaid website for additional information. ~~Once an individual identifies as medically frail, they will receive a Choice Counseling notice and proceed through the steps identified above~~.

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MARK-UP

Alternative Benefit Plan

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☐ Individuals identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in a QHP but can choose to opt into a QHP. Individuals identified as AI/AN will receive a Choice Counseling notice that will inform them of their right to choose between a QHP and the EHB-equivalent ABP and will describe the differences between the two. The notice will also include a link to

☑ a webpage and a toll-free number that individuals can use to make their selection. If an affirmative selection is not made, the individual will remain in the EHB-equivalent ABP.

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Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

The state will review to ensure the person is newly eligible under section 1902(a)(10)(A)(i)(VIII) and is not in any of the following eligibility categories at the time of application: children, adults eligible for the Parent/Caretaker Relative aid category ~~parents below 17% FPL~~; blind or disabled; terminally ill hospice patients; pregnant women, individuals living in an institution who are required to contribute all but a minimum amount of their income toward the cost of their care, individuals eligible for medical assistance for long-term care services describe in Section 1917(c)(1)(C) of the Social Security Act,

☒

individuals infected with tuberculosis, individuals covered by Medicaid only for the treatment of an emergency medical condition, individuals determined Medicaid eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical care, ~~or,~~ foster children, or former foster children.

i.

☒ Self-identification

Describe:

Individuals will be identified as medically frail through one of two mechanisms: (1) the individual responds “yes” to the following question on the ~~single streamlined~~ integrated application for assistance : "Do you have a disablity? Or are you blind? Do you live in a medical facility nursing home? What type of facility is this? "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) ~~or live in a medical facility or nursing home?”~~ or (2) at any time after the application process, the individual requests to be rescreened for medically frail status. The Division of Medical Services will also monitor rescreening requests to ensure policies and processes for medically frail identification continue to identify appropriate beneficiaries. ~~notifies the Division of Medical Services that they are medically frail. The Division of Medical Services will also monitor appeals to identify individuals who may be medically frail and the Division of Medical Services will reach out to such individuals to remind them of their right to self-identify as medically frail.~~

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☒ Review of claims data -this box now unchecked
- ☒ Self-identification
- ☒ Review at the time of eligibility redetermination
- ☒ Provider identification
- ☒ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

The medical frailty screening process is a part of the ~~single-streamlined~~ integrated application for assistance, completed at the time of initial eligibility determination. Individuals will be provided with the opportunity to self-identify as medically frail. Those who self-identify as medically frail will have the option of receiving either the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP. ~~Upon a determination that they screen exempt, the individual will be transferred from the alternative benefit plan and will have the option of receiving either the ABP operated through fee-for-service or the ABP that is the Medicaid State plan (which in Arkansas is the standard Medicaid benefit package).~~

DHS will rely on carriers and providers to assist DHS in identifying individuals with emerging medical needs that lead to a need for transition to the Medicaid program during the plan year.

An ~~Arkansas Works~~ ARHOME enrollee can notify ~~Division of Medical Services~~ DHS at any time to be rescreened for frailty ~~and identify~~ us.

☐

~~request a determination of whether they are exempt from participation in Arkansas Works. Additionally, appeals will be monitored to determine whether an individual is in need of services that are not available from the qualified health plans.~~

MARK-UP

Alternative Benefit Plan

x The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Once ~~exempt~~ individuals ~~have been identified~~ have been rescreened as medically frail, they will be sent a notice informing them of their exempt status. This notice will inform them of their right to choose between the ABP that provides the full Medicaid benefits under the approved ~~is the~~ Arkansas State Plan or the EHB-equivalent ABP ~~that is the FFS equivalent of the QHP offering~~. ~~The notice will outline the differences in the benefit offerings and will provide information on the process for enrolling in either the ABP that is the Arkansas State Plan or the ABP that is the FFS equivalent of the QHP offering.~~ The notice will also include a toll-free number that individuals ~~will~~ may call to ~~finalize~~ make their selection. If an affirmative selection is not made, the individual will be placed in the ABP that provides the full Medicaid benefits offered under the approved Arkansas State Plan. ~~traditional fee-for-service state plan.~~

Arkansas Medicaid has developed a process for making ~~mid-year~~ transitions to medically frail status after initial application for eligibility. ~~either the ABP that is operated through fee-for-service or the ABP that is the Medicaid State plan (which in Arkansas is the standard Medicaid benefit package).~~ As a part of this process, DHS will rely on carriers to monitor claims so that DHS and carriers may identify individuals with emerging medical needs that indicate a possible ~~lead to a~~ need for transition to fee for service delivery system.~~the Medicaid program during the plan year.~~

An ARHOME ~~Arkansas Works~~ enrollee can notify ~~Division of Medical Services~~ DHS at any time to request a rescreening to determine whether they are medially frail. ~~determination of whether they are exempt from participation in Arkansas Works.~~ Additionally, rescreening requests will be monitored to ensure policies and processes for medically frail identification continue to identify beneficiaries in need of services that are not available from qualified health plans. ~~appeals will be monitored to determine whether an individual is in need of services that are not available from the qualified health plans.~~

E

MARK-UP

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Arkansas's base benchmark plan is composed of benefits offered through the HMO Partners inc Open Access POS 13262AR001 . For individuals receiving the ABP through a Qualified Health Plan (QHP), ~~Arkansas Works~~ ARHOME, the State will provide ~~through its fee-for-service Alternative Benefit Program~~ supplemental services that are required for the ABP but not covered by QHPs ~~qualified health plans~~ —namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services. For beneficiaries ~~up to~~ under age 21 receiving the ABP through a QHP, ~~Qualified Health Plans (QHPs)~~ Medicaid will provide supplemental coverage for EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid ~~ABP~~, and beneficiaries will receive notices informing them of how to access the supplemental benefits. Since the QHPs must cover all Essential Health Benefits (EHB), ~~we anticipate that~~ Arkansas ~~will~~ provides supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.

~~Arkansas Works~~ QHP enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC and/or RHC.

If family planning services are accessed at a facility that the QHP considers to be an out-of-network provider, the State's fee-for-service delivery system ~~ABP~~ will cover those services.

MARK-UP

Alternative Benefit Plan

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (•) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: HMO Partners, Inc. - Small Group Gold 1000-1

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

V.20130801

MARK-UP

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Alternative Benefit Plan Cost-Sharing ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A.

~~Ye~~ ~~s~~ NO

☐

The state/territory has completed and attached to this submission Attachment 4.18-F to indicate the Alternative Benefit Plan's cost-sharing provisions that are different from those otherwise approved in the state plan.

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

The State will use cost-sharing as described in the cost sharing section of the State Plan with one exception. Individuals enrolled in a QHP will pay a copay of $20 a day for skilled nursing facilities. These amounts will increase with the medical component of the CPI-U.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☒ Other service delivery system.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Arkansas Medicaid will provide coverage through the Medicaid fee-for-service delivery system in three ways. Individuals who are medically frail will be allowed to choose between FFS Medicaid delivered either through ~~exempt from the~~ an ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or through the EHB- equivalent ABP. Arkansas Medicaid will also provide temporary coverage through an EHB-equivalent ABP for individuals while they await enrollment in a qualified health plan (QHP). ~~with a notice that informs individuals that they may choose between the ABP that is operated through fee-for-service or the ABP that is the Medicaid State plan (which in Arkansas is the standard Medicaid benefit package).~~

~~Arkansas Works beneficiaries will be required to enroll with a mandatory primary care case management (PCCM) provider. The notice will give the recipient contact information to the Arkansas Medicaid Beneficiary Service Center, managed by Arkansas Foundation for Medical Care (AFMC) for help in choosing between the ABP that is the Arkansas State Plan or the ABP that is the FFS equivalent to the QHP offering. The notice also states AFMC will assist the beneficiary in locating a Medicaid provider in their area.~~

All ARHOME beneficiaries who are medically frail will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medically frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

Individuals receiving the EHB-equivalent ABP while awaiting QHP enrollment will not be required to enroll with a Medicaid ~~PCCM provider. Arkansas regulations require QHPs to follow the requirements of the Arkansas Patient Centered Medical~~ Home (PCMH) model or develop their own PCMH standards.

MARK-UP

Alternative Benefit Plan

Other Service Delivery Model

Name of service delivery system:

Premium Assistance for Qualified Health Plans (QHPs) for ~~Arkansas Works~~ ARHOME SECTION 1115(a) demonstration;
Employer Sponsored Insurance Premium Assistance

Provide a narrative description of the model:

QHP: Under the ~~Arkansas Works~~ ARHOME SECTION 1115(a) demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group under the state plan, to support the purchase of coverage from QHPs offered in the individual market through the Marketplace. ~~In Arkansas, individuals eligible for coverage under the new adult group are both (1) childless adults ages 19 through 64 with incomes at or below 133 percent of the federal poverty limit (FPL) or (2) parents and other caretakers between the ages of 19 through 64 with incomes between 17 percent and 133 percent of the FPL (collectively Arkansas Works QHP beneficiaries). Arkansas expects approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.~~

~~Arkansas Works~~ ARHOME QHP beneficiaries will receive the ABP through a QHP. ~~State plan Alternative Benefit Plan (ABP) through a qualified health plan (QHP).~~

~~Arkansas Works also includes an ESI premium assistance component. Medicaid eligible individuals age 21 and over with an employer who chooses to participate in the Arkansas Works ESI program must receive ABP coverage through their employer's ESI, unless the individual is medically frail.~~

MARK-UP

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

~~Yes~~ NO

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

~~The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.~~

The state/territory otherwise provides for payment of premiums.

Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and ~~65~~ 64 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and ~~65~~ 64 with incomes between ~~17~~ the established monthly eligibility income levels for the Parent/Caretaker/Relative Aid Category (currently $124 per month for a one-person household) and 133% FPL who are not enrolled in Medicare (ARHOME beneficiaries). ~~(collectively "Private Option beneficiaries").~~ ARHOME ~~Private Option~~ beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP available in their region.

The State will provide through its FFS ABP Medicaid program supplemental services that are required for the ABP but not covered by QHPs ~~qualified health plans~~ —namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) for beneficiaries ~~up to~~ under age 21 receiving the ABP through QHPs ~~Qualified Health Plans (QHPs)~~ , Medicaid will provide supplemental EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through ~~fee for~~ Medicaid, and beneficiaries will receive notices informing them of how to access the supplemental services.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

~~Starting in plan year 2017, Arkansas is also providing premium assistance for new adults age 21 and over with access to cost-effective ESI. If a new adult age 21 and over has an employer who chooses to participate in the ESI program, that individual will be required to participate in the ESI program, unless medically frail.~~

MARK-UP

Alternative Benefit Plan

State Name: Arkansas Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0007

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Arkansas Newly Eligible Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

Add	Eligibility Group:	Enrollment is mandatory or voluntary?	Remove
Add	Adult Group	Mandatory	Remove

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

Arkansas will provide access to the Alternative Benefit Plan (ABP) through two mechanisms: premium assistance to support coverage from Qualified Health Plans (QHPs) offered in the individual market and through fee-for-service Medicaid.

Arkansas has received approval under 1115 of the Social Security Act to implement the Arkansas Health and Opportunity For Me (ARHOME) program. Under the ARHOME demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group established under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to support the purchase of coverage from QHPs offered in the individual market through the Marketplace

Arkansas will also offer benefits described in this ABP State Plan Amendment through the fee-for-service delivery system. The State will offer two types of fee for service ABP plans: an ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan and an ABP that covers the Essential Health Benefits provided by QHPs (EHB-equivalent ABP). Individuals who are eligible for coverage under ARHOME will receive the EHB-equivalent ABP through fee-for-service temporarily prior to the effective date of their QHP coverage. Exempt populations will have the option of receiving the ABP that offers approved Arkansas state plan benefits or the EHB-equivalent ABP.

PROPOSED

V.20181119

Alternative Benefit Plan

State Name: Arkansas | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0007

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act — ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan. [No]

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☐ Other

PROPOSED

Alternative Benefit Plan

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

The State will provide a notice informing individuals of their eligibility under the Section 1902(a)(10)(A)(i)(VIII) eligibility group once they have been determined eligible by the State's eligibility system. Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP coverage is effective, the process for accessing supplemental services, the grievance and appeals process, and accessing other ABP delivery mechanisms for those eligible.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

During the eligibility application process, a member who answers "yes" to the following questions will be considered medically frail or eligible for Medicaid through another Aid Category: "Do you have a disability? Or are you blind? Do you live in a medical facility or nursing home? What type of facility is this? Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.)?" Individuals screened as medically frail will be enrolled in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan and will be provided with a Choice Counseling notice that will inform them about their benefit plan options.

The Choice Counseling notice will inform medically frail clients of their right to choose the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP and will describe the differences between the two. The notice will also include a toll-free number that individuals can call to make their selection. If an affirmative selection is not made, the individual will remain in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan.

Medically frail clients with a serious mental illness or a substance use disorder who assess as a Tier 2 or Tier 3 on the independent assessment will be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program.

All individuals not screened as medically frail based on their responses on the integrated application for assistance will receive a general Medicaid eligibility notice. That eligibility notice will include information about an individual's ability to identify as medically frail at a later time. The notice will define a medically frail individual as a person who has a physical or behavioral health condition that limits what he or she is able to do (like bathing, dressing, daily chores, etc.), a person who lives in a medical facility or nursing home, a person who has a serious mental illness, a person who has a long-term problem with drugs or alcohol, a person with intellectual or developmental disabilities, or a person with some other serious health condition. The document will inform all enrollees that they may screen for medically frailty at any time and can discuss coverage options with their doctor, contact Member Services or visit the Medicaid website for additional information.

Individuals identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in a QHP but can choose to opt into a QHP. Individuals identified as AI/AN will receive a Choice Counseling notice that will inform them of their right to choose between a QHP and the EHB-equivalent ABP and will describe the differences between the two. The notice will also include a link to a webpage and a toll-free number that individuals can use to make their selection. If an affirmative selection is not made, the individual will remain in the EHB-equivalent ABP.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Where will the information be documented? (Check all that apply)

- ☒ In the eligibility system.
- ☐ In the hard copy of the case record.
- ☐ Other

What documentation will be maintained in the eligibility file? (Check all that apply)

- ☒ Copy of correspondence sent to the individual.
- ☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- ☐ Other

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

Alternative Benefit Plan

State Name: Arkansas | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0007

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

The state will review to ensure the person is newly eligible under section 1902(a)(10)(A)(i)(VIII) and is not in any of the following eligibility categories at the time of application: children, adults eligible for the Parent/Caretaker Relative aid category, blind or disabled, terminally ill hospice patients, pregnant women, individuals living in an institution who are required to contribute all but a minimum amount of their income toward the cost of their care, individuals eligible for medical assistance for long-term care services described in Section 1917(c)(1)(C) of the Social Security Act, individuals infected with tuberculosis, individuals covered by Medicaid only for the treatment of an emergency medical condition, individuals determined Medicaid eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical care, foster children, or former foster children.

☒ Self-identification

Describe:

Individuals will be identified as medically frail through one of two mechanisms: (1) the individual responds "yes" to any of the following questions on the integrated application for assistance: "Do you have a disability? Or are you blind? Do you live in a medical facility or nursing home? What type of facility is this? Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc?" or (2) at any time after the application process, the individual requests to be rescreened for medically frail status. The Division of Medical Services will also monitor rescreening requests to ensure policies and processes for medically frail identification continue to identify appropriate beneficiaries.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Alternative Benefit Plan

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☐ Review of claims data
- ☒ Self-identification
- ☒ Review at the time of eligibility redetermination
- ☒ Provider identification
- ☒ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

Describe:

The medical frailty screening process is a part of the integrated application for assistance, completed at the time of initial eligibility determination. Individuals will be provided with the opportunity to self-identify as medically frail. Those who self-identify as medically frail will have the option of receiving either the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP.

DHS will rely on carriers and providers to assist DHS in identifying individuals with emerging medical needs that lead to a need for transition to the Medicaid program during the plan year.

An ARHOME enrollee can notify the DHS at any time to be rescreened for medically frail status.

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Once individuals have been rescreened as medically frail, they will be sent a notice informing them of their exempt status. This notice will inform them of their right to choose between the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP. The notice will outline the differences in the benefit offerings and will provide information on the process for enrolling in either the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP. The notice will also include a toll-free number that individuals may call to make their selection. If an affirmative selection is not made, the individual will be placed in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan.

Arkansas Medicaid has developed a process for making transitions to medically frail status after initial application for eligibility. As a part of this process, DHS will rely on carriers to monitor claims so that DHS and carriers may identify individuals with emerging medical needs that indicate a possible need for transition fee for service delivery system.

An ARHOME enrollee can notify DHS at any time to request a rescreening to determine whether they are medically frail. Additionally, rescreening requests will be monitored to ensure policies and processes for medically frail identification continue to identify beneficiaries in need of services that are not available from the qualified health plans.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

Alternative Benefit Plan

State Name: Arkansas Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0007

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ○ The state/territory offers benefits based on the approved state plan.
  - ◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

Please briefly identify the benefits, the source of benefits and any limitations:

Arkansas's base benchmark plan is composed of benefits offered through the HMO Partners Inc. Open Access POS 13262AR001. For individuals receiving the ABP through a Qualified Health Plan (QHP), ARHOME,the State will provide supplemental services that are required for the ABP but not covered by QHPs—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services. For beneficiaries under age 21 receiving the ABP through a QHP, Medicaid will provide supplemental coverage for EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them of how to access the supplemental benefits. Since the QHPs must cover all Essential Health Benefits (EHBs), Arkansas provides supplemental coverage for only a small number of EPSDT benefits, such as pediatric vision and dental services.

QHP enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC and/or RHC.

If family planning services are accessed at a facility that the QHP considers to be an out-of-network provider, the State's fee-for-service delivery system will cover those services.

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (•) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: HMO Partners, Inc. - Small Group Gold 1000-1

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

PRA Disclosure Statement

PROPOSED

Alternative Benefit Plan

State Name: Arkansas | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0007

Alternative Benefit Plan Cost-Sharing — ABP4

☐ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. **No**

Other Information Related to Cost Sharing Requirements (optional):

The State will use cost-sharing as described in the cost sharing section of the State Plan with one exception. Individuals enrolled in a QHP will pay a copay of $20 a day for skilled nursing facilities. These amounts will increase with the medical component of the CPI-U.

V.20160722

Alternative Benefit Plan

State Name: Arkansas | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0007

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☒ Other service delivery system.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Arkansas Medicaid will provide coverage through the Medicaid fee for service delivery system in three ways. Individuals who are medically frail will be allowed to choose between FFS Medicaid delivered either through an ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or through the EHB-equivalent ABP. Arkansas Medicaid will also provide temporary coverage through an EHB-equivalent ABP for individuals while they await enrollment in a qualified health plan (QHP).

All ARHOME beneficiaries who are medically frail will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medically frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

Individuals receiving the EHB-equivalent ABP while awaiting QHP enrollment will not be required to enroll with a Medicaid PCCM provider. Arkansas regulations require QHPs to follow the requirements of the Arkansas Patient Centered Medical Home (PCMH) model or develop their own PCMH standards.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Other Service Delivery Model

Name of service delivery system:

Premium Assistance for QHPs for ARHOME SECTION 1115(a) demonstration

Provide a narrative description of the model:

Under the ARHOME SECTION 1115(a) demonstration, the State will provide premium assistance for beneficiaries eligible under the

new adult group under the state plan, to support the purchase of coverage from QHPs offered in the individual market through the Marketplace. ARHOME QHP beneficiaries will receive the ABP through a QHP.

PRA Disclosure Statement

V.20181119

Alternative Benefit Plan

State Name: Arkansas | Attachment 3.1-L- | OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0007

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **No**

The state/territory otherwise provides for payment of premiums. **Yes**

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 64 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 64 with incomes between the established monthly eligibility income levels for the Parent/ Caretaker/Relative Aid Category (currently $124 per month for a one-person household) and 133% FPL who are not enrolled in Medicare (ARHOME beneficiaries). ARHOME beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP available in their region.

The State will provide through its fee for service (FFS) ABP Medicaid program supplemental services that are required for the ABP but not covered by QHPs—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) for beneficiaries under age 21 receiving the ABP through QHPs, Medicaid will provide supplemental EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them about how to access the supplemental services.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PROPOSED

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Requirements	G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

PROPSED

- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The state relies on monographs developed by its designated utilization management contractor to assess whether a hospital's triage protocols are sufficiently effective to ensure the correct level of treatment is determined. Because emergency department services are part of the overall retrospective review process, if non-emergency services are billed at the higher emergency level incorrectly, the entire service would be recouped and the emergency department could bill Medicaid for the non-emergency level and be paid the amount minus the cost share. They would not be allowed to charge the beneficiary for the cost share because the hospital is responsible for the error in claims processing.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. Yes

- ■ The state identifies which drugs are considered to be non-preferred.
- ☑ The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

Cost sharing requirements are published in the provider manuals and a hyperlink is used to send the provider to the coinciding table housing the amount of the cost share, which is also published on the Arkansas Medicaid Website. Division of Provider Services and Quality Assurance (DPSQA) maintains the Choices in
Living Resource Center, where Arkansas citizens can call for assistance, including telephone information and brochures for the Workers with Disabilities program. Various brochures are available at the DHS website:
https://humanservices.arkansas.gov/, and are distributed throughout the state in the county offices where the

Division of County Operations are housed.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Categorically Needy Individuals	G2a
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

PROPSED

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional): Workers with Disabilities, Interim Alternative Benefits Plan, and Transitional Medicaid

Eligibility Group(s) Included: 1902(a)(10)(A)(ii)(XV); 1902(a)(10)(A)(i)(VIII); and 408(a)(11)(A), 1902(a)(52), 1902(e)(1), 1925, 1931(c)(2)

Incomes Greater than 20% TO Incomes Less than or Equal to

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physician visit (including PCP/ specialist/audiologist/podiatrist visit, excluding preventive service	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Other Practitioner Office Visit (Nurse, Physician Assistant)	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Federally Qualified Health Center (FQHC)	4.70	$	Encounter	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rural Health Clinic	4.70	$	Encounter	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Ambulatory Surgical Center	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Chiropractor	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Generics	4.70	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Preferred Brand Drugs	4.70	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Non-Preferred Brand Drugs	9.40	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Pharmacy/Specialty Drugs (i.e., High-Cost)	9.40	$	Prescription	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	X-rays and Diagnostic Imaging	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Imaging (CT/Pet Scans, MRIs)	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Laboratory Outpatient and Professional Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

PROPSED

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Allergy Testing	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Non-Emergency Use of the Emergency Department	9.40	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Urgent Care Centers or Facilities	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Durable Medical Equipment	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Prosthetic Devices	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Orthotic Appliances	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Mental/Behavioral Health and SUD Outpatient Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rehabilitative Occupational Therapy	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rehabilitative Speech Therapy	4.70	$	Visit		Remove

Medicaid Premiums and Cost Sharing

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Rehabilitative Physical Therapy	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Outpatient Rehabilitation Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Habilitation Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Outpatient Surgery Physician/ Surgical Services	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Chemotherapy	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Radiation	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Infusion Therapy	4.70	$	Procedure	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Accidental Dental	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Home health Care Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. No

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Add Population

PRA Disclosure Statement

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Limitations	G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

The percentage of family income used for the aggregate limit is:

- (•) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

[■] The state calculates family income for the purpose of the aggregate limit on the following basis:

- (•) Quarterly
- ( ) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

[■] Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

- [☒] As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.
- [ ] Managed care organization(s) track each family's incurred cost sharing, as follows:
- [ ] Other process:

[■] Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The DHS eligibility system identifies and sends notice to beneficiaries of the initial aggregate family limit when applicable. The MMIS system sends beneficiary letters regarding incurred cost sharing and when the family limit has been met. The provider is notified via the eligibility verification system and upon explanation of benefits when limit has been met.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

The state uses its standard Medicaid fair hearing process.

[■] Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The MMIS system stops deducting the cost sharing amount once met. The provider is required to refund any cost sharing it has collected upon notification via MMIS that cost sharing was met.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Beneficiaries may notify their local eligibility office of changes in circumstances adversely affecting their family aggregate limit.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

State/Territory: ARKANSAS

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cont.)	Premiums and Other Cost-Sharing Charges For the Basic Insurance Group and/or the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described ~~below~~ in Medicaid Premiums and Cost Sharing pages G1 through G3. In future years, cost share amounts will change with the medical component of the CPI-U. ~~The premium for this program is assessed at zero.~~ ~~Regular Medicaid cost sharing (pharmacy and inpatient hospital) applies for eligibles whose gross income is below 100% of the Federal Poverty Level (FPL).~~ ~~There will be a co-payment, as listed in the chart on pages 12p-1 and 12p-2, for Medicaid-covered services for eligibles whose gross income is equal to or greater than 100% of the FPL.~~

There will be a co-payment for Medicaid-covered services, as listed below, for WD eligibles, whose gross income is equal to greater than 100% of the Federal Poverty Level.

PROGRAM SERVICES	**"New" COPAYMENT**
Adult Developmental Day Treatment	**$10 per day**
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiology Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Chiropractor	$10 per visit
Dental (very limited benefits for individuals age 21 and over)	$10 per visit (no co-pay on EPSDT dental screens)
Diapers, Underpads and Incontinence Supplies	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Early Intervention Day Treatment (not covered for age 21 and over)	**$10 per day**
Emergency Department Services: Emergency Services Non-emergency	$10 per visit $10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (not available for individuals over age 21)	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals age 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient Outpatient	25% of 1st inpatient day (Medicaid per diem) $10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per visit
Medical Supplies	None

PROGRAM SERVICES	"New" COPAYMENT
Mental Health Services	
Inpatient Psychiatric Services for Under Age 21	25% of 1st day's Medicaid per diem
Outpatient Mental and Behavioral Health	$10 per visit
Nurse Services: Certified Nurse Midwife	$10 per visit
Nurse Practitioner	$10 per visit
Private Duty Nursing	$10 per visit
Orthodontia (not covered for individuals age 21 and over)	None
Orthotic Appliances	10% of Medicaid maximum allowable amount
Personal Care	None
Physician	$10 per visit
Podiatry	$10 per visit
Prescription Drugs	$10 for generic drugs; $15 for brand name
Prosthetic Devices	10% of Medicaid maximum allowable amount
Rehabilitation Services for Persons with Physical Disabilities (RSPD)	25% of 1st day's Medicaid in patient per diem
Rural Health Clinic	$10 per visit
Targeted Case Management	10% of Medicaid maximum allowable rate per unit
Therapy (age 21 and over have very limited coverage)	
Occupational	$10 per visit
Physical	$10 per visit
Speech	$10 per visit
Transportation (non-emergency)	None
Ventilator Services	None
Vision Care	$10 per visit

Revised: September 300, 2003

State/Territory: [Arkansas]

Citation 42 CFR 447.51 through 447.58	4.18 (a)	Recipient Cost Sharing and Similar Charges Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916(a) and (b) of the Act	(b)	Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

No enrollment fee, premium, or similar charge is imposed under the plan.

No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

Services to individuals under age 18, or

under

[ ] Age 19

[ ] Age 20

[ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

TN # Effective:

Supersedes TN # Approval Date

Revised: September 30, 2003

State/Territory: [Arkansas]

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[ ] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[ ] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991
Revised: September 1, 1992

State/Territory: ARKANSAS

Citation	4.18(b)	(Continued)
42 CFR 447.51 through 447.48	(3)	Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above. ☐ Not applicable. No such charges are imposed. (i) For any service, no more than one type of charge is imposed. (ii) Charges apply to services furnished to the following age groups: ☒ 18 or older ☐ 19 or older ☐ 20 or older ☐ 21 or older ☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: ARKANSAS

A. The following charges are imposed on the categorically needy for services: (Continued)

Service	Type Charge Deduct.	Coins.	Copay	Amount and Basis for Determination
Prescribed Drugs			x	For each prescription reimbursed by Medicaid, the recipient will be responsible for paying a copayment amount based on the following table as set out at 42 CFR 447.54:

State Payment for the Service	Copay to Recipient
$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

~~Supersedes TN No. _____ Approval Date _____ Effective Date _____~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals:

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

In the absence of knowledge or indication to the contrary, the provider may accept the recipient's assertion that he/she cannot afford to pay the cost sharing amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

D. The procedure for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The Arkansas Medicaid Program notified Medicaid providers of the exclusions via an Official Notice.

For recipients who are excluded from the cost sharing policy for reasons other than age or residence, the provider must enter one of the following diagnosis codes as the secondary diagnosis on the claim form to avoid the cost sharing amount from being deducted from the total paid claim amount:

Diagnosis Code	Reason for Exclusion
A1000	Pregnant Women
A2000	Emergency Services
A3000	Family Planning Services and Supplies (entry on claim form is required for nurse practitioner only)
A4000	Health Maintenance Organization (HMO) Enrollee
A5000	Hospice Care Recipient

The provider must maintain sufficient documentation in the recipient's medical record which substantiates the exclusion from cost sharing. These procedures apply to the following services:

Ambulatory Surgical Center
Federally Qualified Health Center
Home Health
Hospital
Nurse Practitioner
Optometrist
Personal Care
Physician
Podiatrist
Private Duty Nursing
Prosthetic
Rural Health Clinic

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

D. The procedure for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below: (Continued)

Public Transportation

For recipients who are excluded from the copayment policy for reasons other than age of residence, the provider must check the "NO" block in Field 9 on the EMS-3 claim form to avoid the copayment amount from being deducted from the total paid claim amount.

Prescribed Drugs

When prescribing pharmaceuticals to Medicaid recipients who are excluded from the prescribed drug copayment policy due to the services provided to pregnant women, emergency services or HMO enrollees, the dentist or physician must write "Excluded From Copay" on the face of the prescription. The provider must maintain sufficient documentation in the recipient's medical record which substantiates the exclusion from cost sharing.

For recipients excluded from the copayment policy due to pregnancy, emergency services or HMO enrollee, pharmacy providers must enter "4" in Field 17 of the pharmacy claim form. If "4" is not entered and the recipient is not identified in the system as meeting one of the exclusion groups, the copayment policy will be applied prior to payment to the provider.

Individuals under age 18 or individuals receiving hospice care or institutionalized individuals are also excluded from cost sharing. Individuals under age 18 and the institutionalized individuals are readily identifiable through the current MMIS. No additional information is necessary from the provider in order to exclude these individuals from the cost sharing policy. A separate code has been assigned for providers to use in billing to identify services provided to recipients receiving hospice care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

E. Cumulative maximums on charges:

[x] State policy does not provide for cumulative maximums.

[ ] Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: ARKANSAS

A. The following charges are imposed on the categorically needy for services:

Service	Type Charge Deduct.	Coins.	Copay	Amount and Basis for Determination
Inpatient Hospital		x		10% of the hospital's per diem applied on the first Medicaid covered day of each admission. [The maximum coinsurance for each admission does not exceed the limit specified in 42 CFR 447.54(c).]
Prescription Services for Eyeglasses			x	**$2.00 on the dispensing fee for prescription services.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: ARKANSAS

A. The following charges are imposed on the categorically needy: (Continued)

Service	Deduct.	Coins.	Copay	Type Charge	Amount and Basis for Determination
Prescribed Drugs			x		For each prescription reimbursed by Medicaid, the recipient will be responsible for paying a copayment amount based on the following table as set out at 42 CFR 447.54:

State Payment for the Service	Copay to Recipient
$10.00 or less	$ .50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

~~Supersedes TN No. _____ Approval Date _____ Effective Date _____~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

B. The method used to collect cost sharing charges for medically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

In the absence of knowledge or indication to the contrary, the provider may accept the recipient's assertion that he/she can not afford to pay the cost sharing amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

D. The procedure for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The Arkansas Medicaid Program notified Medicaid providers of the exclusions via an Official Notice.

For recipients who are excluded from the cost sharing policy for reasons other than age or residence, the provider must enter one of the following diagnosis codes as the secondary diagnosis on the claim form to avoid the cost sharing amount from being deducted from the total paid claim amount:

Diagnosis Code	Reason for Exclusion
A1000	Pregnant Women
A2000	Emergency Services
A3000	Family Planning Services and Supplies (entry on claim form is required for nurse practitioner only)
A4000	Health Maintenance Organization (HMO) Enrollee
A5000	Hospice Care Recipient

The provider must maintain sufficient documentation in the recipient's medical record which substantiates the exclusion from cost sharing. These procedures apply to the following services:

- **Ambulatory Surgical Center**
- Federally Qualified Health Center
- Home Health
- Hospital
- Nurse Practitioner
- Optometrist
- Personal Care
- Physician
- Podiatrist
- Private Duty Nursing
- Prosthetic
- Rural Health Clinic

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

D. The procedure for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below: (Continued)

Public Transportation

For recipients who are excluded from the copayment policy for reasons other than age of residence, the provider must check the "NO" block in Field 9 on the EMS-3 claim form to avoid the copayment amount from being deducted from the total paid claim amount.

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When prescribing pharmaceuticals to Medicaid recipients who are excluded from the prescribed drug copayment policy due to the services provided to pregnant women, emergency services or HMO enrollees, the dentist or physician must write "Excluded From Copay" on the face of the prescription. The provider must maintain sufficient documentation in the recipient's medical record which substantiates the exclusion from cost sharing.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARKANSAS

E. Cumulative maximums on charges:

[x] State policy does not provide for cumulative maximums.

[ ] Cumulative maximums have been established as described below:

State/Territory: ARKANSAS

Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cont.)	Premiums and Other Cost-Sharing Charges For the Basic Insurance Group and/or the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described **in Medicaid Premiums and Cost Sharing pages G1 through G3. In future years, cost share amounts will change with the medical component of the CPI-U.**

State of Arkansas *As Engrossed: S3/8/21*
93rd General Assembly **A Bill**
Regular Session, 2021 SENATE BILL 410

By: Senator Irvin
By: Representative M. Gray

For An Act To Be Entitled

AN ACT TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; TO PROMOTE ECONOMIC AND PERSONAL HEALTH, PERSONAL INDEPENDENCE, AND OPPORTUNITY FOR ARKANSANS THROUGH PROGRAM PLANNING AND INITIATIVES; TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND TITLE 23 OF THE ARKANSAS CODE TO ENSURE THE STABILITY OF THE INSURANCE MARKET IN ARKANSAS; AND TO CREATE THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME ACT OF 2021 AND THE ARKANSAS HEALTH AND OPPORTUNITY FOR ME PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 61, Subchapter 10 is amended to read as follows:

Subchapter 10 — ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021

23-61-1001. Title.

This subchapter shall be known and may be cited as the "~~Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021".

23-61-1002. Legislative intent.

Notwithstanding any general or specific laws to the contrary, it is the intent of the General Assembly for the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program to be a fiscally sustainable, cost-effective, and opportunity-driven program that:

~~(1) Empowers individuals to improve their economic security and achieve self-reliance;~~

~~(2) Builds on private insurance market competition and value-based insurance purchasing models;~~

~~(3) Strengthens the ability of employers to recruit and retain productive employees; and~~

~~(4)~~(1) Achieves comprehensive and innovative healthcare reform that reduces the rate of growth in state and federal obligations for ~~entitlement spending~~ providing healthcare coverage to low-income adults in Arkansas;

(2) Reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies;

(3) Promotes the health, welfare, and stability of mothers and their infants after birth through hospital-based community bridge organizations;

(4) Encourages personal responsibility for individuals to demonstrate that they value healthcare coverage and understand their roles and obligations in maintaining private insurance coverage;

(5) Increases opportunities for full-time work and attainment of economic independence, especially for certain young adults, to reduce long-term poverty that is associated with additional risk for disease and premature death;

(6) Addresses health-related social needs of Arkansans in rural counties through hospital-based community bridge organizations and reduces the additional risk for disease and premature death associated with living in a rural county;

(7) Strengthens the financial stability of the critical access hospitals and other small, rural hospitals; and

(8) Fills gaps in the continuum of care for individuals in need of services for serious mental illness and substance use disorders.

23-61-1003. Definitions.

As used in this subchapter:

~~(1) "Cost-effective" means that the cost of covering employees who are:~~

~~(A) Program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through individual qualified health insurance plans; or~~

~~(B) Eligible individuals who are not program participants, either individually or together within an employer health insurance coverage, is the same or less than the cost of providing comparable coverage through a program authorized under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., as it existed on January 1, 2016;~~

(1) "Acute care hospital" means a hospital that:

(A) Is licensed by the Department of Health under § 20-9-201 et seq., as a general hospital or a surgery and general medical care hospital; and

(B) Is enrolled as a provider with the Arkansas Medicaid Program;

(2) "Birthing hospital" means a hospital in this state or in a border state that:

(A) Is licensed as a general hospital;

(B) Provides obstetrics services; and

(C) Is enrolled as a provider with the Arkansas Medicaid Program;

(3) "Community bridge organization" means an organization that is authorized by the Department of Human Services to participate in the economic independence initiative or the health improvement initiative to:

(A) Screen and refer Arkansans to resources available in their communities to address health-related social needs; and

(B) Assist eligible individuals identified as target populations most at risk of disease and premature death and who need a higher level of intervention to improve their health outcomes and succeed in meeting

their long-term goals to achieve independence, including economic independence;

~~(2)~~(4) "Cost sharing" means the portion of the cost of a covered medical service that is required to be paid by or on behalf of an eligible individual;

(5) "Critical access hospital" means an acute care hospital that is:

(A) Designated by the Centers for Medicare and Medicaid Services as a critical access hospital; and

(B) Is enrolled as a provider in the Arkansas Medicaid Program;

(6) "Economic independence initiative" means an initiative developed by the Department of Human Services that is designed to promote economic stability by encouraging participation of program participants to engage in full-time, full-year work, and to demonstrate the value of enrollment in an individual qualified health insurance plan through incentives and disincentives;

~~(3)~~(7) "Eligible individual" means an individual who is in the eligibility category created by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a;

~~(4)~~(8) "Employer health insurance coverage" means a health insurance benefit plan offered by an employer or, as authorized by this subchapter, an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended;

(9) "Health improvement initiative" means an initiative developed by an individual qualified health insurance plan or the Department of Human Services that is designed to encourage the participation of eligible individuals in health assessments and wellness programs, including fitness programs and smoking or tobacco cessation programs;

~~(5)~~(10) "Health insurance benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, but not including excepted benefits as defined under 42 U.S.C. § 300gg-91(c), as it existed on ~~January 1, 2016~~ January 1, 2021;

~~(6)~~(11) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in

Arkansas shop for and select health insurance benefit plans in a way that permits comparison of available plans based upon price, benefits, services, and quality, and refers to either:

(A) The Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or a successor entity; or

(B) The federal health insurance marketplace or federal health benefit exchange created under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148;

~~(7)~~(12) "Health insurer" means an insurer authorized by the State Insurance Department to provide health insurance or a health insurance benefit plan in the State of Arkansas, including without limitation:

(A) An insurance company;

(B) A medical services plan;

(C) A hospital plan;

(D) A hospital medical service corporation;

(E) A health maintenance organization;

(F) A fraternal benefits society; ~~or~~

(G) Any other entity providing health insurance or a health insurance benefit plan subject to state insurance regulation; or

(H) A risk-based provider organization licensed by the Insurance Commissioner under § 20-77-2704;

(13) "Healthcare coverage" means coverage provided under this subchapter through either an individual qualified health insurance plan, a risk-based provider organization, employer health insurance coverage, or the fee-for-service Arkansas Medicaid Program;

~~(8)~~(14) "Individual qualified health insurance plan" means an individual health insurance benefit plan offered by a health insurer ~~through~~ that participates in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations, as they existed on ~~January 1, 2016~~ January 1, 2021;

(15) "Member" means a program participant who is enrolled in an individual qualified health insurance plan;

~~(9)~~(16) "Premium" means a monthly fee that is required to be paid by or on behalf of an eligible individual to maintain some or all health

insurance benefits;

~~(10)~~(17) "Program participant" means an eligible individual who:

(A) Is at least nineteen (19) years of age and no more than sixty-four (64) years of age with an income that meets the income eligibility standards established by rule of the Department of Human Services;

(B) Is authenticated to be a United States citizen or documented qualified alien according to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193;

(C) Is not eligible for Medicare or advanced premium tax credits through the health insurance marketplace; and

(D) Is not determined ~~to be more effectively covered through the traditional Arkansas Medicaid Program, including without limitation:~~ by the Department of Human Services to be medically frail or eligible for services through a risk-based provider organization;

~~(i) An individual who is medically frail; or~~

~~(ii) An individual who has exceptional medical needs for whom coverage offered through the health insurance marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care; and~~

~~(11)(A) "Small group plan" means a health insurance benefit plan for a small employer that employed an average of at least two (2) but no more than fifty (50) employees during the preceding calendar year.~~

~~(B) "Small group plan" does not include a grandfathered health insurance plan as defined in 45 C.F.R. § 147.140(a)(1)(i), as it existed on January 1, 2016~~

(18) "Risk-based provider organization" means the same as defined in § 20-77-2703; and

(19) "Small rural hospital" means a critical access hospital or a general hospital that:

(A) Is located in a rural area;

(B) Has fifty (50) or fewer staffed beds; and

(C) Is enrolled as a provider in the Arkansas Medicaid Program.

23-61-1004. Administration ~~of Arkansas Works Program~~.

(a)(1) The Department of Human Services, in coordination with the State Insurance Department and other ~~necessary~~ state agencies, as necessary, shall:

(A) Provide ~~health insurance or medical assistance~~ healthcare coverage under this subchapter to eligible individuals;

(B) Create and administer the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program by:~~;~~

~~(C)~~(i) ~~Submit and apply~~ Applying for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program in a manner consistent with this subchapter; and

(ii) Administering the Arkansas Health and Opportunity for Me Program as approved by the Centers for Medicare and Medicaid Services;

(C)(i) Administer the economic independence initiative designed to reduce the short-term effects of the work penalty and the long-term effects of poverty on health outcomes among program participants through incentives and disincentives.

(ii) The Department of Human Services shall align the economic independence initiative with other state-administered work-related programs to the extent practicable;

(D) Screen, refer, and assist eligible individuals through community bridge organizations under agreements with the Department of Human Services;

~~(D)~~(E) Offer ~~incentive benefits~~ incentives to promote personal responsibility, individual health, and economic independence through individual qualified health insurance plans and community bridge organizations; and

~~(E)~~(F) Seek a waiver to ~~eliminate~~ reduce the period of retroactive eligibility for an eligible individual under this subchapter to thirty (30) days before the date of the application.

(2) The Governor shall request the assistance and involvement of other state agencies that he or she deems necessary for the implementation of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

(b) ~~Health insurance benefits~~ Healthcare coverage under this subchapter shall be provided through enrollment in:

~~(1) Individual premium assistance for enrollment of Arkansas Works Program participants in~~ An individual qualified health insurance ~~plans~~ plan through a health insurer; ~~and~~

~~(2) Supplemental benefits to incentivize personal responsibility~~ A risk-based provider organization;

(3) An employer-sponsored health insurance coverage; or

(4) Fee-for-service Medicaid program.

(c) ~~The~~ Annually, the Department of Human Services~~, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall promulgate and administer rules to implement the Arkansas Works Program.~~ shall develop purchasing guidelines that:

(1) Describe which individual qualified health insurance plans are suitable for purchase in the next demonstration year, including without limitation:

(A) The level of the plan;

(B) The amounts of allowable premiums;

(C) Cost sharing;

(D) Auto-assignment methodology; and

(E) The total per-member-per-month enrollment range; and

(2) Ensure that:

(A) Payments to an individual qualified health insurance plan do not exceed budget neutrality limitations in each demonstration year;

(B) The total payments to all of the individual qualified health insurance plans offered by the health insurers for eligible individuals combined do not exceed budget targets for the Arkansas Health and Opportunity for Me Program in each demonstration year that the Department of Human Services may achieve by:

(i) Setting in advance an enrollment range to represent the minimum and a maximum total monthly number of enrollees into all individual qualified health insurance plans no later than April 30 of each demonstration year in order for the individual qualified health insurance plans to file rates for the following demonstration year;

(ii) Temporarily suspending auto-assignment into the individual qualified health insurance plans at any time in a demonstration year if necessary, to remain within the enrollment range and budget targets for the demonstration year; and

(iii) Developing a methodology for random auto-assignment of program participants into the individual qualified health insurance plans after a suspension period has ended;

(C) Individual qualified health insurance plans meet and report quality and performance measurement targets set by the Department of Human Services; and

(D) At least two (2) health insurers offer individual qualified health insurance plans in each county in the state.

(d)(1) The Department of Human Services, the State Insurance Department, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Arkansas Health and Opportunity for Me Program, including provisions necessary to effectuate the purchasing guidelines and reporting requirements, at least thirty (30) calendar days before the annual open enrollment period.

(2) If a memorandum of understanding is not fully executed with a health insurer by January 1 of each new demonstration year, the Department of Human Services shall suspend auto-assignment of new members to the health insurers until the first day of the month after the new memorandum of understanding is fully executed.

(3) The memorandum of understanding shall include financial sanctions determined appropriate by the Department of Human Services that may be applied if the Department of Human Services determines that an individual qualified health insurance plan has not met the quality and performance measurement targets or any other condition of the memorandum of *understanding.*

(4)(A) If the Department of Human Services determines that the individual qualified health insurance plans have not met the quality and health performance targets for two (2) years, the Department of Human Services shall develop additional reforms to achieve the quality and health performance targets.

(B) If legislative action is required to implement the additional reforms described in subdivision (d)(4)(A) of this section, the Department of Human Services may take the action to the Legislative Council or the Executive Subcommittee of the Legislative Council for immediate action.

(e) The Department of Human Services shall:

(1) Adopt premiums and cost sharing levels for individuals enrolled in the Arkansas Health and Opportunity for Me Program, not to exceed aggregate limits under 42 C.F.R. § 447.56;

(2)(A) Establish and maintain a process for premium payments, advanced cost-sharing reduction payments, and reconciliation payments to health insurers.

(B) The process described in subdivision (e)(2)(A) of this section shall attribute any unpaid member liabilities as solely the financial obligation of the individual member.

(C) The Department of Human Services shall not include any unpaid individual member obligation in any payment or financial reconciliation with health insurers or in a future premium rate; and

(3)(A) Calculate a total per-member-per-month amount for each individual qualified health insurance plan based on all payments made by the Department of Human Services on behalf of an individual enrolled in the individual qualified health insurance plan.

(B)(i) The amount described in subdivision (e)(3)(A) of this section shall include premium payments, advanced cost-sharing reduction payments for services provided to covered individuals during the demonstration year, and any other payments accruing to the budget neutrality target for plan-enrolled individuals made during the demonstration year and the member months for each demonstration year.

(ii) The total per-member-per-month upper limit is the budget neutrality per-member-per-month limit established in the approved demonstration for each demonstration year.

(C) If the Department of Human Services calculates that the total per-member-per-month for an individual qualified health insurance plan for that demonstration year exceeds the budget neutrality per-member-per-month limit for that demonstration year, the Department of Human Services shall not make any additional reconciliation payments to the health insurer for that individual qualified health insurance plan.

(D) If the Department of Human Services determines that the budget neutrality limit has been exceeded, the Department of Human Services shall recover the excess funds from the health insurer for that individual qualified health insurance plan.

~~(d)(1)~~(f)(1) ~~If the~~ ~~Within thirty (30) days of a reduction in~~ federal medical assistance percentages ~~as described in this section~~ for the Arkansas Health and Opportunity for Me Program are reduced to below ninety percent (90%), the Department of Human Services shall present to the Centers for Medicare and Medicaid Services a plan within thirty (30) days of the reduction to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and transition eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program within one hundred twenty (120) days of ~~a~~ the reduction ~~in any of the following federal medical assistance percentages:~~

~~(A) Ninety-five percent (95%) in the year 2017;~~

~~(B) Ninety-four percent (94%) in the year 2018;~~

~~(C) Ninety-three percent (93%) in the year 2019; and~~

~~(D) Ninety-percent (90%) in the year 2020 or any year after the year 2020~~.

(2) An eligible individual shall maintain coverage during the process to implement the plan to terminate the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program and the transition of eligible individuals out of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program.

~~(e) State obligations for uncompensated care shall be tracked and reported to identify potential incremental future decreases.~~

~~(f) The Department of Human Services shall track the hospital assessment fee imposed by § 20-77-1902 and report to the General Assembly subsequent decreases based upon reduced uncompensated care.~~

~~(g)(1) On a quarterly basis, the Department of Human Services, the State Insurance Department, the Division of Workforce Services, and other necessary state agencies shall report to the Legislative Council, or to the Joint Budget Committee if the General Assembly is in session, available information regarding the overall Arkansas Works Program, including without limitation:~~

~~(A) Eligibility and enrollment;~~

~~(B) Utilization;~~

~~(C) Premium and cost-sharing reduction costs;~~

~~(D) Health insurer participation and competition;~~

~~(E) Avoided uncompensated care; and~~

~~(F) Participation in job training and job search programs.~~

~~(2)(A)~~(g)(1) A health insurer ~~who~~ that is providing an individual qualified health insurance plan or employer health insurance coverage for an eligible individual shall submit claims and enrollment data to the ~~State Insurance Department~~ Department of Human Services to facilitate reporting required under this subchapter or other state or federally required reporting or evaluation activities.

~~(B)~~(2) A health insurer may utilize existing mechanisms with supplemental enrollment information to fulfill requirements under this subchapter, including without limitation the state's all-payer claims database established under the Arkansas Healthcare Transparency Initiative Act of 2015, § 23-61-901 et seq., for claims and enrollment data submission.

(h)(1) The Governor shall request a block grant under relevant federal law and regulations for the funding of the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a block grant for this purpose.

(2) The Governor shall request a waiver under relevant federal law and regulations for a work requirement as a condition of maintaining coverage in the Arkansas Medicaid Program as soon as practical if the federal law or regulations change to allow the approval of a waiver for this purpose.

23-61-1005. Requirements for eligible individuals.

~~(a)(1) To promote health, wellness, and healthcare education about appropriate healthcare-seeking behaviors, an eligible individual shall receive a wellness visit from a primary care provider within:~~

~~(A) The first year of enrollment in health insurance coverage for an eligible individual who is not a program participant and is enrolled in employer health insurance coverage; and~~

~~(B) The first year of, and thereafter annually:~~

~~(i) Enrollment in an individual qualified health insurance plan or employer health insurance coverage for a program participant; or~~

~~(ii) Notice of eligibility determination for an eligible individual who is not a program participant and is not enrolled in employer health insurance coverage.~~

~~(2) Failure to meet the requirement in subdivision (a)(1) of~~

~~this section shall result in the loss of incentive benefits for a period of up to one (1) year, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(b)(1) An eligible individual who has up to fifty percent (50%) of the federal poverty level at the time of an eligibility determination shall be referred to the Division of Workforce Services to:~~

~~(A) Incentivize and increase work and work training opportunities; and~~

~~(B) Participate in job training and job search programs.~~

~~(2) The Department of Human Services or its designee shall provide work training opportunities, outreach, and education about work and work training opportunities through the Division of Workforce Services to all eligible individuals regardless of income at the time of an eligibility determination.~~

(a) An eligible individual is responsible for all applicable cost-sharing and premium payment requirements as determined by the Department of Human Services.

(b) An eligible individual may participate in a health improvement initiative, as developed and implemented by either the eligible individual's individual qualified health insurance plan or the department.

(c)(1)(A) An eligible individual who is determined by the department to meet the eligibility criteria for a risk-based provider organization due to serious mental illness or substance use disorder shall be enrolled in a risk-based provider organization under criteria established by the department.

(B) An eligible individual who is enrolled in a risk-based provider organization is exempt from the requirements of subsections (a) and (b) of this section.

(2)(A) An eligible individual who is determined by the department to be medically frail shall receive healthcare coverage through fee-for-service Medicaid.

(B) An eligible individual who is enrolled in the fee-for-service Medicaid program is exempt from the requirements of subsection (a) of this section.

~~(c)~~(d) An eligible individual shall receive notice that:

(1) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity

for Me Program is not a perpetual federal or state right or a guaranteed entitlement;

(2) The ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program is subject to cancellation upon appropriate notice; ~~and~~

(3) ~~The Arkansas Works Program is not an entitlement program~~ Enrollment in an individual qualified health insurance plan is not a right; and

(4) If the individual chooses not to participate or fails to meet participation goals in the economic independence initiative, the individual may lose incentives provided through enrollment in an individual qualified health insurance plan or be unenrolled from the individual qualified health insurance plan after notification by the department.

23-61-1006. Requirements for program participants.

~~(a) A program participant who is twenty-one (21) years of age or older shall enroll in employer health insurance coverage if the employer health insurance coverage meets the standards in § 23-61-1008(a).~~

~~(b)(1) A program participant who has income of at least one hundred percent (100%) of the federal poverty level shall pay a premium of no more than two percent (2%) of the income to a health insurer.~~

~~(2) Failure by the program participant to meet the requirement in subdivision (b)(1) of this section may result in:~~

~~(A) The accrual of a debt to the State of Arkansas; and~~

~~(B)(i) The loss of incentive benefits in the event of failure to pay premiums for three (3) consecutive months, as incentive benefits are defined by the Department of Human Services in consultation with the State Insurance Department.~~

~~(ii) However, incentive benefits shall be restored if a program participant pays all premiums owed.~~

(a) The economic independence initiative applies to all program participants in accordance with the implementation schedule of the Department of Human Services.

(b) Incentives established by the department for participation in the economic independence initiative and the health improvement initiative may include, without limitation, the waiver of premium payments and cost-sharing requirements as determined by the department for participation in one (1) or

more initiatives.

(c) Failure by a program participant to meet the cost-sharing and premium payment requirement under § 23-61-1005(a) may result in the accrual of a personal debt to the health insurer or provider.

(d)(1)(A) Failure by the program participant to meet the initiative participation requirements of subsection (b) of this section may result in:

(i) Being unenrolled from the individual qualified health insurance plan; or

(ii) The loss of incentives, as defined by the department.

(B) However, an individual who is unenrolled shall not lose Medicaid healthcare coverage based solely on disenrollment from the individual qualified health insurance plan.

(2) The department shall develop and notify program participants of the criteria for restoring eligibility for incentive benefits that were removed as a result of the program participants' failure to meet the initiative participation requirements of subsection (b) of this section.

(3)(A) A program participant who also meets the criteria of a community bridge organization target population may qualify for additional incentives by successfully completing the economic independence initiative provided through a community bridge organization.

(B) If successfully completing the initiative results in an increase in the program participant's income that exceeds the program's financial eligibility limits, a program participant may receive, for a specified period of time, financial assistance to pay:

(i) The individual's share of employer-sponsored health insurance coverage not to exceed a limit determined by the department; or

(ii) A share of the individual's cost sharing obligation, as determined by the department, if the individual enrolls in a health insurance benefit plan offered through the Arkansas Health Insurance Marketplace.

23-61-1007. Insurance standards for individual qualified health insurance plans.

(a) Insurance coverage for a ~~program participant~~ member enrolled in an

individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 U.S.C. § 18022(d) and § 18071, as they existed on ~~January 1, 2016~~ January 1, 2021, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(b) ~~The Department of Human Services shall pay premiums and supplemental cost sharing reductions directly to a health insurer for a program participant enrolled in an individual qualified health insurance plan~~ As provided under § 23-61-1004(e)(2), health insurers shall track the applicable premium payments and cost sharing collected from members to ensure that the total amount of an individual's payments for premiums and cost sharing does not exceed the aggregate cap imposed by 42 C.F.R. § 447.56.

(c) ~~All participating health insurers offering individual qualified health insurance plans in the health insurance marketplace~~ All health benefit plans purchased by the Department of Human Services shall:

(1)~~(A) Offer individual qualified health insurance plans conforming~~ Conform to the requirements of this section and applicable insurance rules~~.~~;

~~(B)~~(2) Be certified by the State Insurance Department; ~~The individual qualified health insurance plans shall be approved by the State Insurance Department; and~~

~~(2)~~(3)(A) Maintain a medical-loss ratio of at least eighty percent (80%) for an individual qualified health insurance plan as required under 45 C.F.R. § 158.210(c), as it existed on ~~January 1, 2016~~ January 1, 2021, or rebate the difference to the Department of Human Services for ~~program participants~~ members.

(B) However, the Department of Human Services may approve up to one percent (1%) of revenues as community investments and as benefit expenses in calculating the medical-loss ratio of a plan in accordance with 45 C.F.R. § 158.150;

(4) Develop:

(A) An annual quality assessment and performance improvement strategic plan to be approved by the Department of Human Services that aligns with federal quality improvement initiatives and quality and reporting requirements of the Department of Human Services; and

(B) Targeted initiatives based on requirements established

by the Department of Human Services in consultation with the Department of Health; and

(5) Make reports to the Department of Human Service and the Department of Health regarding quality and performance metrics in a manner and frequency established by a memorandum of understanding.

~~(d) The State of Arkansas shall assure that at least two (2) individual qualified health insurance plans are offered in each county in the state.~~

~~(e)~~(d) A health insurer offering individual qualified health insurance plans for ~~program participants~~ members shall participate in the Arkansas Patient-Centered Medical Home Program, including:

(1) Attributing enrollees in individual qualified health insurance plans, including ~~program participants~~ members, to a primary care physician;

(2) Providing financial support to patient-centered medical homes to meet practice transformation milestones; and

(3) Supplying clinical performance data to patient-centered medical homes, including data to enable patient-centered medical homes to assess the relative cost and quality of healthcare providers to whom patient-centered medical homes refer patients.

(e)(1) Each individual qualified health insurance plan shall provide for a health improvement initiative, subject to the review and approval of the Department of Human Services, to provide incentives to its enrolled members to participate in one (1) or more health improvement programs as defined in § 23-61-1003(9).

(2)(A) The Department of Human Services shall work with health insurers offering individual qualified health insurance plans to ensure the economic independence initiative offered by the health insurer includes a robust outreach and communications effort which targets specific health, education, training, employment, and other opportunities appropriate for its enrolled members.

(B) The outreach and communications effort shall recognize that enrolled members receive information from multiple channels, including without limitation:

(i) Community service organizations;

(ii) Local community outreach partners;

(iii) Email;

(iv) Radio;

(v) Religious organizations;

(vi) Social media;

(vii) Television;

(viii) Text message; and

(ix) Traditional methods such as newspaper or mail.

(f) On or before ~~January 1, 2017~~ January 1, 2022, the State Insurance Department and the Department of Human Services may implement through certification requirements or rule, or both, the applicable provisions of this section.

~~23-61-1008. [Expired.]~~

23-61-1009. Sunset.

This subchapter shall expire on ~~December 31, 2021~~ December 31, 2026.

23-61-1010. Community bridge organizations.

(a) The Department of Human Services shall develop requirements and qualifications for community bridge organizations to provide assistance to one (1) or more of the following target populations

(1) Individuals who become pregnant with a high-risk pregnancy and the child, throughout the pregnancy and up to twenty-four (24) months after birth;

(2) Individuals in rural areas of the state in need of treatment for serious mental illness or substance use disorder;

(3) Individuals who are young adults most at risk of poor health due to long-term poverty and who meet criteria established by the Department of Human Services, including without limitation the following:

(A) An individual between nineteen (19) and twenty-four (24) years of age who has been previously placed under the supervision of the:

(i) Division of Youth Services; or

(ii) Department of Corrections;

(B) An individual between nineteen (19) and twenty-seven (27) years of age who has been previously placed under the supervision of the

Division of Children and Family Services; or

(C) An individual between nineteen (19) and thirty (30) years of age who is a veteran; and

(4) Any other target populations identified by the Department of Human Services.

(b)(1) Each community bridge organization shall be administered by a hospital under conditions established by the Department of Human Services.

(2) A hospital is eligible to serve eligible individuals under subdivision (a)(1) of this section if the hospital:

(A) Is a birthing hospital;

(B) Provides or contracts with a qualified entity for the provision of a federally recognized evidence-based home visitation model to a woman during pregnancy and to the woman and child for a period of up to twenty-four (24) months after birth; and

(C) Meets any additional criteria established by the Department of Human Services.

(3)(A) A hospital is eligible to serve eligible individuals under subdivision (a)(2) of this section if the hospital:

(i) Is a small rural hospital;

(ii) Screens all Arkansans who seek services at the hospital for health-related social needs;

(iii) Refers Arkansans identified as having health-related social needs for social services available in the community;

(iv) Employs *local qualified staff* to assist eligible individuals in need of treatment for serious mental illness or substance use disorder in accessing medical treatment from healthcare professionals and supports to meet health-related social needs;

(v) Enrolls with Arkansas Medicaid Program as an acute crisis unit provider; and

(vi) Meets any additional criteria established by the Department of Human Services.

(B) The hospital may use funding available through the Department of Human Services to improve the hospital's ability to deliver care through coordination with other healthcare professionals and with the local emergency response system that may include training of personnel and improvements in equipment to support the delivery of medical services through

telemedicine.

(4) A hospital is eligible to serve eligible individuals under subdivision (a)(3) of this section if the hospital:

(A) Is an acute care hospital;

(B) Administers or contracts for the administration programs using proven models, as defined by the Department of Human Services, to provide employment, training, education, or other social supports; and

(C) Meets any additional criteria established by the Department of Human Services.

(c) An individual is not required or entitled to enroll in a community bridge organization as a condition of Medicaid eligibility.

(d) A hospital is not:

(1) Required to apply to become a community bridge organization; or

(2) Entitled to be selected as a community bridge organization.

23-61-1011. Health and Economic Outcomes Accountability Oversight Advisory Panel.

(a) There is created the Health and Economic Outcomes Accountability Oversight Advisory Panel.

(b) The advisory panel shall be composed of the following members:

(1) The following members of the General Assembly:

(A) The Chair of the Senate Committee on Public Health, Welfare, and Labor;

(B) The Chair of the House Committee on Public Health, Welfare, and Labor;

(C) The Chair of the Senate Committee on Education;

(D) The Chair of the House Committee on Education;

(E) The Chair of the Senate Committee on Insurance and Commerce;

(F) The Chair of the House Committee on Insurance and Commerce;

(G) An at-large member of the Senate appointed by the President Pro Tempore of the Senate;

(H) An at-large member of the House of Representatives appointed by the Speaker of the House of Representatives;

(I) An at-large member of the Senate appointed by the minority leader of the Senate; and

(J) An at-large member of the House of Representatives appointed by the minority leader of the House of Representatives;

(2) The Secretary of the Department of Human Services;

(3) The Arkansas Surgeon General;

(4) The Insurance Commissioner;

(5) The heads of the following executive branch agencies or their designees;

(A) Department of Health;

(B) Department of Education;

(C) Department of Corrections;

(D) Department of Commerce; and

(E) Department of Finance and Administration;

(6) The Director of the Arkansas Minority Health Commission; and

(7)(A) Three (3) community members who represent health, *business, or education, who reflect the broad racial and geographic diversity in the state, and who have demonstrated a commitment to improving the* health and welfare of Arkansans, appointed as follows;

(i) One (1) member shall be appointed by and serve at the will of the Governor;

(ii) One (1) member shall be appointed by and serve at the will of the President Pro Tempore of the Senate; and

(iii) One (1) member shall be appointed by and serve at the will of the Speaker of the House of Representatives.

(B) Members serving under subdivision (b)(6)(A) of this section may receive mileage reimbursement.

(c)(1) The Secretary of the Department of Human Services and one (1) legislative member shall serve as the co-chairs of the Health and Economic Outcomes Accountability Oversight Advisory Panel and shall convene meetings quarterly of the advisory panel.

(2) The legislative member who serves as the co-chair shall be selected by majority vote of all legislative members serving on the advisory panel.

(d)(1) The advisory panel shall review, make nonbinding recommendations, and provide advice concerning the proposed quality

performance targets presented by the Department of Human Services for each participating individual qualified health insurance plan.

(2) The advisory panel shall deliver all nonbinding recommendations to the Secretary of the Department of Human Services.

(3)(A) The Secretary of the Department of Human Services, in consultation with the State Medicaid Director, shall determine all quality performance targets for each participating individual qualified health insurance plan.

(B) The Secretary may consider the nonbinding recommendations of the advisory panel when determining quality performance targets for each participating individual qualified health insurance plan.

(e) The advisory panel shall review:

(1) The annual quality assessment and performance improvement strategic plan for each participating individual qualified health insurance plan;

(2) Financial performance of the Arkansas Health and Opportunity for Me Program against the budget neutrality targets in each demonstration year;

(3) Quarterly reports prepared by the Department of Human Services, in consultation with the Department of Commerce, on progress towards meeting economic independence outcomes and health improvement outcomes, including without limitation:

(A) Community bridge organization outcomes;

(B) Individual qualified health insurance plan health improvement outcomes;

(C) Economic independence initiative outcomes; and

(D) Any sanctions or penalties assessed on participating Individual qualified health insurance plans;

(4) Quarterly reports prepared by the Department of Human Services on the Arkansas Health and Opportunity for Me Program, including without limitation:

(A) Eligibility and enrollment;

(B) Utilization;

(C) Premium and cost-sharing reduction costs; and

(D) Health insurer participation and competition; and

(5) Any other topics as requested by the Secretary of the

Department of Human Services.

(f)(1) The advisory panel may furnish advice, gather information, make recommendations, and publish reports.

(2) However, the advisory panel shall not administer any portion of the Arkansas Health and Opportunity for Me Program or set policy.

(g) The Department of Human Services shall provide administrative support necessary for the advisory panel to perform its duties.

(h) The Department of Human Services shall produce and submit a quarterly report incorporating the advisory panel's findings to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the public on the progress in health and economic improvement resulting from the Arkansas Health and Opportunity for Me Program, including without limitation:

(1) Eligibility and enrollment;

(2) Participation in and the impact of the economic independence initiative and the health improvement initiative of the eligible individuals, health insurers, and community bridge organizations;

(3) Utilization of medical services;

(4) Premium and cost-sharing reduction costs; and

(5) Health insurer participation and completion.

20-61-1012. Rules.

The Department of Human Services shall adopt rules necessary to implement this subchapter.

SECTION 2. Arkansas Code § 19-5-984(b)(2)(D), concerning the Division of Workforce Services Special Fund, is amended to read as follows:

(D) The ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor; and

SECTION 3. Arkansas Code § 19-5-1146 is amended to read as follows:

19-5-1146. ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "~~Arkansas Works Program~~ Arkansas Health and Opportunity for

Me Program Trust Fund".

(b) The fund shall consist of:

(1) Moneys saved and accrued under the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation:

(A) Increases in premium tax collections; and

(B) Other spending reductions resulting from the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.; and

(2) Other revenues and funds authorized by law.

(c) The Department of Human Services shall use the fund to pay for future obligations under the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program created by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.

SECTION 4. Arkansas Code § 23-61-803(h), concerning the creation of the Arkansas Health Insurance Marketplace, is amended to read as follows:

(h) The State Insurance Department and any eligible entity under subdivision ~~(e)(1)~~ (e)(2) of this section shall provide claims and other plan and enrollment data to the Department of Human Services upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program established by the ~~Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., including without limitation the program's quality, cost, and consumer access.

SECTION 5. Arkansas Code § 23-79-1601(2)(A), concerning the definition of "health benefit plan" regarding coverage provided through telemedicine, is amended to read as follows:

(2)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 6. Arkansas Code § 23-79-1801(1)(A), concerning the definition of "health benefit plan" regarding coverage for newborn screening for spinal muscular atrophy, is amended to read as follows:

(1)(A) "Health benefit plan" means:

(i) An individual, blanket, or group plan, policy, or contract for healthcare services issued or delivered by an insurer, health maintenance organization, hospital medical service corporation, or self-insured governmental or church plan in this state; and

(ii) Any health benefit program receiving state or federal appropriations from the State of Arkansas, including the Arkansas Medicaid Program~~, the Health Care Independence Program [expired], commonly referred to as the "Private Option",~~ and the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program, or any successor program.

SECTION 7. Arkansas Code § 26-57-604(a)(1)(B)(ii), concerning the remittance of the insurance premium tax, is amended to read as follows:

(ii) However, the credit shall not be applied as an offset against the premium tax on collections resulting from an eligible individual insured under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003.

SECTION 8. Arkansas Code § 26-57-610(b)(2), concerning the disposition of the insurance premium tax, is amended to read as follows:

(2) The taxes based on premiums collected under the ~~Health Care Independence Act of 2013, § 20-77-2401 et seq. [repealed], the Arkansas Works~~

~~Act of 2016~~ Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., or individual qualified health insurance plans, including without limitation stand-alone dental plans, issued through the health insurance marketplace as defined by § 23-61-1003 shall be:

(A) At the time of deposit, separately certified by the commissioner to the Treasurer of State for classification and distribution under this section; and

(B) Transferred to the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund and used as required by the ~~Arkansas Works Program~~ Arkansas Health and Opportunity for Me Program Trust Fund;

SECTION 9. EFFECTIVE DATE.

This act is effective on and after January 1, 2022.

/s/Irvin

APPROVED: 4/1/21

(b) *Definitions.* ''Claim'' and ''clean claim'' have the meaning given those terms in § 447.45.

(c) *Contract requirements*—(1) *Basic rule.* A contract with an MCO must provide that the organization will meet the requirements of §§ 447.45(d)(2) and (d)(3), and abide by the specifications of §§ 447.45(d)(5) and (d)(6).

(2) *Exception.* The MCO and its providers may, by mutual agreement, establish an alternative payment schedule.

(3) *Alternative schedule.* Any alternative schedule must be stipulated in the contract.

[67 FR 41115, June 14, 2002]

COST SHARING

§ 447.50 Cost sharing: Basis and purpose.

(a) Section 1902(a)(14) of the Act permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. For States that impose cost sharing payments, §§ 447.51 through 447.59 prescribe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.

(b) *Definitions.* For the purposes of this subpart:

(1) *Indian* means any individual defined at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to § 136.12 of this part. This means the individual:

(i) Is a member of a Federally-recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the following four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations promulgated by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(2) *Indian health care provider* means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

[43 FR 45253, Sept. 29, 1978, as amended at 75 FR 30261, May 28, 2010; 75 FR 38749, July 1, 2010]

ENROLLMENT FEE, PREMIUM OR SIMILAR COST SHARING CHARGE

§ 447.51 Requirements and options.

(a) The plan must provide that the Medicaid agency does not impose any enrollment fee, premium, or similar charge for any services available under the plan upon:

(1) Categorically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter, except for the following populations in accordance with sections 1916(c), (d), (g), and (i) of the Act:

(i) A pregnant woman or an infant under one year of age described in subparagraph (A) or (B) of section 1902(l)(1) of the Act, who is receiving medical assistance on the basis of section 1902(a)(10)(A)(ii)(IX) of the Act and whose family income equals or exceeds 150 percent of the Federal poverty level (FPL) applicable to a family of the size involved;

(ii) A qualified disabled and working individual described in section 1905(s) of the Act whose income exceeds 150 percent of the FPL;