ARKANSAS REGISTER

Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

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Statutory Authority for Promulgating Rules Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing

Intended Effective Date (Check One)

- ☐ Emergency (ACA 25-15-204)
- ☑ 10 Days After Filing (ACA 25-15-204)
- ☐ Other _____ (Must be more than 10 days after filing date.)

	Date
Legal Notice Published	October 14, 2022
Final Date for Public Comment	November 13, 2022
Reviewed by Legislative Council	December 16, 2022
Adopted by State Agency	July 31, 2023

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Lisa Teague (Contact Person) Lisa.Teague@dhs.arkansas.gov (E-mail Address) July 31, 2023 (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

on behalf of:
Signature

501-244-3944 (Phone Number) Elizabeth.Pitman@dhs.arkansas.gov (E-mail Address)

Director, Division of Medical Services
Title

July 31, 2023
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

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
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 <u>any</u> 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	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 1-1-23

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 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.

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

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;

■ 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

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V.20160722

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

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

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

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

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

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

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

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

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):

- [x] 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

- [x] 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

- [x] 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

- [x] 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

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V.20160722

Alternative Benefit Plan

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

Transmittal Number: AR - 22 - 0030

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 all of thebenefits described in this ABP State Plan Amendment through the fee-for-service delivery system. Individuals who are eligible for coverage under the ARHOME program 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.

V.20181119

Alternative Benefit Plan

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

Transmittal Number: AR - 22 - 0030

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

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 application process, if a member answers "yes" to the following question: "Is this person blind, disabled, or need help with daily activities (such as bathing or walking)?", 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.

All individuals not identified as medically frail based on their responses on the single streamlined application 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 at any time and can discuss coverage options with their doctor, contact Member Services 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.

☑ 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

Alternative Benefit Plan

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

V.20160722

Alternative Benefit Plan

State Name: Arkansas

Attachment 3.1-L- [ ]

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0030

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, individuals 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):

V.20160722

Alternative Benefit Plan

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

Transmittal Number: AR - 22 - 0030

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

V.20160722

Alternative Benefit Plan

State Name: Arkansas

Attachment 3.1-L- [ ]

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0030

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.

V.20160722

Alternative Benefit Plan

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

Transmittal Number: AR - 22 - 0030

Benefits Description — ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Arkansas's EHB base benchmark plan is composed of benefits offered through the HMO Partners, Inc. - Small Group Gold 1000-1 and the CHIP plans for pediatric dental and vision. The State will provide through its fee-for-service Medicaid program supplemental benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and, for beneficiaries up to age 21 receiving the ABP through Qualified Health Plans (QHPs) under Arkansas's 1115 demonstration waiver, Arkansas 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 EHBs, we anticipate that Arkansas will provide supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.
For benefits provided by Qualified Health Plans, the state also authorizes benefit packages substantially equivalent/actuarially equivalent to the benefit package articulated in this document".

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services — Collapse All ☐

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Practitioner Office Visit (Nurse, PA, etc)
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Includes but not limited to Nurse or Physician Assistants. An APN may not be able to perform certain services that a practitioner would subject to the Arkansas scope of practice and appropriate licensure requirements.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Facility Fee (Ambulatory Surgery Ctr).

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

See www.healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

See https://www.healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Hospice Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

In accordance with section 2302 of the Affordable Care Act, individuals under the age of 21, will receive hospice care concurrently with curative care. For individuals over age 21, individuals will not receive curative care concurrent with hospice services. Hospice care is multi-disciplinary and may include case management.

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Infusion Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Renal Dialysis/Hemodialysis

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Allergy Treatment

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Dental Surgery for Accidents

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: For non diseased teeth.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Oral Surgery

Source: Base Benchmark Small Group

Remove

Alternative Benefit Plan

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This benefit is in the CHIP Pediatric dental benefit.

Benefit Provided: Outpatient Surgery

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Chemotherapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Alternative Benefit Plan

Benefit Provided: Cochlear Implants

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: Lifetime maximum of one per ear.

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Diabetic Supplies

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Urgent Care Centers or Facilities
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Coverage is the same for In Network and Out of Network

Benefit Provided: Emergency Room Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Coverage is the same for In Network and Out of Network

Benefit Provided: Emergency Transportation/Ambulance
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: Ground $1000 per trip. Air $5000 per trip.
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

While there is an amount limit per trip, there is no annual or lifetime limit or limit on number of services.

Add

Alternative Benefit Plan

■ 3. Essential Health Benefit: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient Hospital Services (e.g., Hospital Stay)
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Transplants
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: Certain transplants are allowed and some require prior authorization. Not needed for kidney and cornea.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care — Collapse All ☐

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Treatment of infertility, including prescription drugs, is not a covered benefit. Infertility testing is a covered benefit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient Services

Source: Base Benchmark Federal Employees

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The initial diagnostic services is not subject to pre-authorizion but treatment plans may be subject to pre-authorization.

Remove

Benefit Provided: Mental/Behavioral Health Inpatient Services

Source: Base Benchmark Federal Employees

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: The treating facility must be a hospital

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark Federal Employees

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

The initial diagnostic services is not subject to pre-authorizion but treatment plans may be subject to pre-authorization.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Must have treatment plan pre-approved.

Benefit Provided:

Substance Abuse Disorder Inpatient Services

Source:

Base Benchmark Federal Employees

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

The treating facility must be a hospital.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 6. Essential Health Benefit: Prescription drugs

☐ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Prior authorization applies only to drugs not on the formulary and specialty drugs. New prescription medications approved by the FDA are not covered under the evidence of coverage unless or until the medication is placed on the formulary.

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided: Home Health Care Services
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: 50 visits per member per contract year.
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Skilled Nursing Facility
Source: Base Benchmark Small Group
Remove
Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: Limited to 60 days per member per contract year
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Outpatient Rehabilitation Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: 30 aggregate visits per member per contract year.

Alternative Benefit Plan

Scope Limit:

All therapies (speech, occupational, physical and chiropractic) combined in the limits.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Outpatient Therapy. Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Member per Contract Year.

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required if costs exceed $5,000. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Single replacement of eyeglasses or contacts within the first 6 months following cataract surgery is covered.

Benefit Provided: Inpatient Rehabilitative

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 60 days per member per contract year.

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Habilitation (Developmental Services)

Source: Base Benchmark Small Group

Remove

Alternative Benefit Plan

Authorization:	Provider Qualifications:
Prior Authorization	State Plan & Public Employee/Commercial Plan
Amount Limit:	Duration Limit:
None	180 visits per contract year

Scope Limit:

Habilitation services are available to all individuals meeting the medical necessity criteria, not just those with an intellectual or developmental disability.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services — Collapse All ☐

Benefit Provided: Outpatient Diagnostic Test (X-Ray and Lab Work)
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Advanced Diagnostic Imaging CT Scan, PET, MRI
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Preventative Care/Screening/Immunization

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 1 visit per year

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Diabetic Education Management

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: $250 per program

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For individuals receiving coverage through the Arkansas Health and Opportunity for Me (ARHOME) program, QHP benefits are supplemented using fee-for-service Medicaid.

Add

Alternative Benefit Plan

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

☐ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Alternative Benefit Plan

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Non-Emergency Medical Transportation

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit: Authorization above the 8 legs may be exceeded through a prior authorization process. The 8 leg limit does not apply to individuals determined to be medically frail.

Other:

Other 1937 Benefit Provided: PASSE-1915(i)

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: PASSE services are provided only to Medicaid clients with a Tier 2 or Tier 3 Behavioral Health Independent Assessment

Other: See Attachment 3.1-i PASSE program.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.20190808

Alternative Benefit Plan

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

Transmittal Number: AR - 22 - 0030

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.
  - ☐ Managed Care Organizations (MCO).
  - ☐ Prepaid Inpatient Health Plans (PIHP).
  - ☐ Prepaid Ambulatory Health Plans (PAHP).
  - ☒ Primary Care Case Management (PCCM).
- ☒ Fee-for-service.
- ☒ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

All ARHOME beneficiaries who are medically frail, and are not enrolled in a PASSE, 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.

PCCM: Primary Care Case Management

The PCCM delivery system is the same as an already approved PCCM program. Yes

The PCCM program is operating under (select one):

- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Feb 28, 2019

Describe program below:

Through the PCCM program, beneficiaries choose a primary care provider (PCP), who, through an on-going provider/ beneficiary relationship, coordinates health care services, including referrals for necessary specialty services, physician's services, hospital care and other services. The PCCM provider assists enrollees with locating medical services and coordinates and monitors their enrollees prescribed medical and rehabilitation services. This program reimburses the PCP a case management fee provided on a per beneficiary per month basis. All ARHOME beneficiaries who are medically frail, and are not enrolled in a PASSE, will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medially 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.

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

PCCM Procurement or Selection Method

Indicate the method used to select PCCMs:

○ Competitive procurement method (RFP, RFA).

◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PCCMs:

All PCP-qualified physicians and clinics must enroll as PCPs with some exceptions.

Other PCCM-Based Service Delivery System Characteristics

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. No

PCCM service delivery is provided on less than a statewide basis. No

PCCM Payments

Specify how payment for services is handled:

◉ Per member/per month case management fee paid to PCCM provider.

○ Other:

Additional Information: PCCM (Optional)

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

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 individuals who are exempt from the ABP delivered through a QHP with a notice that informs individuals that they may choose between the EHB-equivalent 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).

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.

V.20181119

Alternative Benefit Plan

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

Transmittal Number: AR - 22 - 0030

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 use the authority granted under its Arkansas Health and Opportunity for Me Section 1115 Demonstration to provide for the payment of premiums.

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:

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.**

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 Outpatient Mental and Behavioral Health	 25% of 1st day's Medicaid per diem $10 per visit
Nurse Services: Certified Nurse Midwife Nurse Practitioner Private Duty Nursing	$10 per visit $10 per visit $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 Physical Speech	 $10 per visit $10 per visit $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.	

TN # _____ Effective Date _____

Supersedes TN # _____ Approval Date _____

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	Deduct.	Type Charge 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	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 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.

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: