



Division of Medical Services

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

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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: October 13, 2021

SUBJ: ARHOME Cost Sharing; SPA 21-0010, Section I 3-21

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than November 12th, 2021 .

NOTICE OF RULE MAKING

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

Effective January 1, 2022:

The Director of the Division of Medical Services (DMS) amends the Medicaid State Plan and the Provider Manual to establish rules implementing a new Section 1115 Demonstration Waiver, the Arkansas Health and Opportunity for Me Program (ARHOME). DMS adds clarification concerning individuals identified as American Indian or Alaskan Native (AI/AN) and outlines cost-sharing parameters and limitations. DMS adds to the State Plan that individuals identified as AI/AN will not be required to enroll in a qualified health plan but may choose to opt in. AI/AN individuals that opt in are subject to federal poverty level eligibility determinations and coverage will begin 30 days prior to the date an application is submitted. AI/AN individuals who chose not to opt into a qualified health plan will receive an alternative benefit plan. DMS also adds that individuals with household income above 20% of the federal poverty limit and who are awaiting assignment to a qualified health plan shall pay cost sharing. DMS outlines six bands of cost sharing based on an individual's federal poverty level and that cost-sharing may not exceed 5% of the lowest level of income within each band. Also, individuals below 20% of the federal poverty level, those deemed medically frail, or those identified as American Indian or Alaskan Native, individuals aged 19-20 years who receive EPSDT services, and pregnancy-related services are not subject to cost sharing.

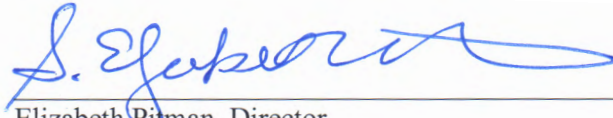
DMS updates the Provider Manual to reflect the ARHOME cost sharing. Beneficiaries with household income above 20% of the federal poverty level shall pay cost shares. The minimum copays for certain services are listed in the manual. A beneficiaries' total copayment obligations are capped each quarter for each of the six cost sharing bands. DMS lists the cap amounts per quarter for each band. Beneficiaries with household income over 100% of the federal poverty level, who are enrolled in a qualified health plan, are subject to a monthly premium. DMS lists the monthly premium amount in the manual.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at <https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/>. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than November 12th, 2021. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on October 27, at 11:00 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at <https://us02web.zoom.us/j/84357627289>. The webinar ID is 843 5762 7289 6203 9587. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed, and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. 4502035775



Elizabeth Piman, Director
Division of Medical Services

TOC required

124.240 Arkansas Health and Opportunity for Me Program (ARHOME)**1-1-22**

The ARHOME aid category covers individuals ages 19-64 who earn up to 138% of the federal poverty level.

Clients with household income above 20% of the federal poverty level shall pay the following cost sharing amounts for each service in calendar year 2022.

	Unit of Service	Copays
<u>All Inpatient Hospital Services (inc MH/SUD)</u>	<u>Day</u>	<u>\$ -</u>
<u>Mental/Behavioral Health and SUD Outpatient Services</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Behavioral Health Professional</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Durable Medical Equipment</u>	<u>Service</u>	<u>\$4.70</u>
<u>Non-Emergency Use of the Emergency Department</u>	<u>Visit</u>	<u>\$9.40</u>
<u>X-rays and Diagnostic Imaging</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Skilled Nursing Facility</u>	<u>Day</u>	<u>\$20.00</u>
<u>Outpatient Facility Fee (e.g., Ambulatory Surgery Center</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Primary Care Visit to Treat and Injury or Illness (exc. Preventive, X-rays)</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Specialist Visit</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Generics</u>	<u>Prescription</u>	<u>\$4.70</u>
<u>Preferred Brand Drugs</u>	<u>Prescription</u>	<u>\$4.70</u>
<u>Non-Preferred Brand Drugs</u>	<u>Prescription</u>	<u>\$9.40</u>
<u>Specialty Drugs (i.e. High-Cost</u>	<u>Prescription</u>	<u>\$9.40</u>
<u>Imaging (CT/Pet Scans, MRIs</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Speech Therapy</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Occupational and Physical Therapy</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Preventative Care/Screening/Immunizations</u>	<u>Visit</u>	<u>\$ -</u>
<u>Laboratory Outpatient and Professional Services</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Outpatient Surgery Physician/Surgical Services</u>	<u>Visit</u>	<u>\$4.70</u>
<u>Pregnancy-Related Services</u>	<u>Visit</u>	<u>\$ -</u>
<u>EPSDT</u>	<u>Visit</u>	<u>\$ -</u>
<u>Other Outpatient Services</u>	<u>Visit</u>	<u>\$4.70</u>

Thereafter, any copayments may not exceed these amounts 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.

There are six levels of cost sharing in this aid category, depending on the individual's federal poverty level. Clients' total copayment obligations are capped each quarter for each level as follows:

21%-40% FPL is \$20.96/quarter

41%-60% FPL is \$40.92/quarter

61%-80% FPL is \$60.89/quarter

81%-100% FPL is \$80.85/quarter

101%-120% FPL is \$95.29/quarter

121%-138% FPL is \$114.15/quarter

Clients at or below 20% FPL are not subject to copayments. ARHOME clients who are deemed medically frail or identified as American Indian or Alaska Native are not subject to copayments. EPSDT services, for clients up to 21 years of age, are not subject to copayments. Pregnancy-related services are not subject to copayments.

Clients with household incomes above 100% of the federal poverty level who are enrolled in a qualified health plan will be subject to a monthly premium. Clients in the following income bands are obligated to pay the following premiums:

101%-120% FPL: \$22.44/month

121%-138% FPL: \$26.88/month

ARHOME clients at or below 100% FPL and those who are not enrolled in a qualified health plan are not subject to monthly premiums. ARHOME clients who are deemed medically frail or identify as American Indian or Alaska Native are not subject to a monthly premium.

133.100 Inpatient Hospital Coinsurance Charge for Medicaid Beneficiaries Clients Without Medicare

**6-1-081-1-
22**

For inpatient admissions, the Medicaid coinsurance charge per admission for non-exempt Medicaid ~~beneficiaries~~ clients aged 18 and older is 10% of the hospital's interim Medicaid per diem, applied on the first Medicaid covered day. (See Section 124.230 for Working Disabled cost-sharing requirements and Section 124.240 for ARHOME clients.)

Example:

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

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

133.400 Co-payment on Prescription Drugs

**6-1-081-1-
22**

Arkansas Medicaid has a ~~beneficiary~~ client co-payment requirement in the Pharmacy Program. The payment is applied per prescription. Non-exempt ~~beneficiaries~~ clients aged 18 and older are responsible for paying the provider a co-payment amount based on the following table: (See Section 124.230 for Working Disabled cost-sharing requirements and Section 124.240 for ARHOME clients. See the ARKids First-B provider manual for ARKids-First B cost-sharing requirements.)

Medicaid Maximum Amount	Beneficiary <u>Client</u> Co-pay
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00



Alternative Benefit Plan

State Name:

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: AR - 21 - 0010

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 through the Federally Facilitated Marketplace (FFM) or via the State's Eligibility and Enrollment Framework (EEF). Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP or ESI enrollment is effective, ESI enrollment, the process for accessing supplemental services, the grievance and appeals process, and outlining the exemption process from the Arkansas Works Alternative Benefit Plan.

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: "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?", the individual will be enrolled in the ABP that is the state plan and will be provided with a Choice Counseling notice. The Choice Counseling notice will outline the differences between traditional fee-for-service state plan (the ABP that is the state plan) or the fee-for-service ABP (the ABP that is aligned with the EHB benchmark plan) and informing them of their right to choose between the two. The notice will also include a toll-free-number that individuals will call to finalize their selection. If an affirmative selection is not made, the individual will remain in the traditional fee-for-service state plan (the ABP that is the state plan). Arkansas Medicaid will provide individuals who are exempt from the ABP with a Choice Counseling notice that informs them that they may choose between the ABP that is the Arkansas state plan or the ABP that is the FFS equivalent of the QHP offering. The notice will also inform them that they will be enrolled in the ABP that is the Arkansas state plan, unless they inform Arkansas Medicaid that they would like to be enrolled in the ABP that is the FFS equivalent of the QHP offering.

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.

Individuals identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in QHP's, but can choose to opt into a QHP. New AI/AN applicants will be subject to FPL eligibility determinations and coverage will begin 30 days prior to the date an application is submitted for coverage. Adults who are AI/AN and who have not opted into a QHP will receive the ABP that is the state plan.

☒ 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)



Alternative Benefit Plan

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

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

- ☒ Copy of correspondence sent to the individual.
- ☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- ☐ Other
- ☒ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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

PRA Disclosure Statement

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

V.20160722



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- ☐

Alternative Benefit Plan Cost-Sharing

ABP4

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

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

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

Yes

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

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

Only individuals with household income above 20% of the federal poverty level (FPL) and who are awaiting assignment to a qualified health plan shall pay cost-sharing, subject to the limitations below and in compliance with CFR 42 §§ 447.50 - 447.57.

There are six (6) levels of cost-sharing depending on the individual's federal poverty level (FPL). Total cost-sharing obligations are capped each quarter for each level as follows: 21%-40% FPL; 41%-60% FPL; 61%-80% FPL; 81%-100% FPL; 101%-120% FPL; and 121%-138% FPL. Cost-sharing may not exceed 5% of the lowest level of income within each FPL band, as updated each January 1.

Individuals at or below 20% FPL, those who are deemed medically frail, those identified as American Indian or Alaska Native, individuals aged 19-20 years who receive EPSDT services, and pregnancy-related services are not subject to cost-sharing. ~~The State will use cost sharing as described in the cost sharing section of the State Plan.~~

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

MARK-UP