ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: October 13, 2022

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

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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 13, 2022 .

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: Proposed Rules & Public Notices.

NOTICE OF RULE MAKING

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

Effective January 1, 2023:

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

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

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

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

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

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

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

Elizabeth Pitman, Director
Division of Medical Services

TOC required

124.000 Beneficiary Aid Categories ~~2-1-17~~1-1-23

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

~~**FR** full range~~

~~**LB** limited benefits~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TEFRA Cost Share Schedule
Effective July 1, 2022

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

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TEFRA Cost Share Schedule
Effective July 1, 2022

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

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

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

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

Co-payments are required for the following services:

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

~~A. Regular Medicaid cost sharing.~~

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

~~B. New cost sharing requirements.~~

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

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

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

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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

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

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

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

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

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

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

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

124.240 Transitional Medicaid Adult 1-1-23

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

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

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

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

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

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

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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

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

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

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

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

~~For inpatient admissions, the Medicaid coinsurance charge per admission for non-exempt Medicaid beneficiaries aged 18 and older is 10% of the hospital's interim Medicaid per diem,~~

applied on the first Medicaid covered day. (See Section 124.230 for Working Disabled cost-sharing requirements.)

Example:

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

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

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

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

Example:

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

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

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

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

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

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

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

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

134.000 Exclusions from Cost Sharing Policy ~~9-15-09~~1-1-23

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

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

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

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

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

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

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

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

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

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

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

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

F. Individuals receiving hospice care.

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

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

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

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

2. Serious impairment to bodily functions, or

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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 ~~beficiary's~~ client's medical record to substantiate any exemption from the ~~beneficiary~~ client cost sharing requirement.

135.000 Collection of Coinsurance/Co-payment ~~6-1-08~~1-1-23

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

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

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

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

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

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

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

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

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

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

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- 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.

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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

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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

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Category	Category Name	Description	Code
48	Disabled QMB	Qualified Medicare Beneficiary (QMB) - Individual has any other disability type other than Blind	LB
49	TEFRA	TEFRA Waiver for Disabled Child	FR, AC
52	Newborn	Newborn	FR
56 U-18 EC		Under Age 18 Medically Needy Exceptional Category	MNLB
57	U-18 Medically Needy - SD	AFDC U18 Medically Needy Spend Down	MNLB
58	Qualifying Individual (QI-1)	Qualifying Individual-1 (Medicaid pays only the Medicare premium~~.~~)	LB
61	ARKids A	ARKids A	FR
~~61~~	~~Pregnant Women-Limited~~	~~Pregnant Women-Limited~~	~~LB~~
61	Unborn	Pregnant Wom~~a~~en - 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

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

MARKUP

TOC not required

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

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

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

   2. All repairs will be made by the optical laboratory.

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

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

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

   1. +1.00 OR -0.75 sphere

   2. -0.75 axis 90 or 0.75 axis 180 cylinder or at any axis

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

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

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

   1. D-28 and

   2. Kryptok

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Tinted lenses for cosmetics purposes are not covered.

F. Glass lenses are NOT covered by Medicaid.

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

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

   1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.

   2. If the glasses are lost or broken beyond repair within the twelve (12)-month benefit limit period, one additional pair will be available through the optical laboratory. After the first replacement pair, any additional pair will require prior authorization. ~~There will be no co-payment assessed for replacement glasses requiring prior authorization~~.

   3. All replacements will be made by the optical laboratory and the doctor's office may make repairs only when necessary.

   4. ~~EPSDT beneficiaries will have no co-pays.~~ Only ARKids First-B beneficiaries will be assessed a ten-dollar ($10.00) co-pay. All co-pays will be applied to examination codes rather than to tests or procedures.

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

   1. The strength of the prescribed lens (for the poorer eye) should be a minimum of -.75D + 1.00D spherical or a minimum of .75 cylindrical or the unaided visual acuity of the poorer eye should be worse than 20/30 at a distance.

   2. Reading glasses may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

C. Plastic or polycarbonate lenses <u>only</u> 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.

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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.

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Alternative Benefit Plan

Attachment 3.1-C-

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

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: Arkansas Newly Eligible Adult Group

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

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

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

Geographic Area

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

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

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

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

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

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Alternative Benefit Plan

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

Attachment 3.1-C- ☐

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

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

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

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

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

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

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

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

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

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

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

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

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

☒ Letter

☐ Email

☐ Other

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Alternative Benefit Plan

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

An attachment is submitted.

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

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

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

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

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

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

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

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Alternative Benefit Plan

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

V.20130807

Alternative Benefit Plan

Attachment 3.1-C- ☐

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

Enrollment Assurances - Mandatory Participants ABP2c

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

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

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

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

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

Describe:

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

☒

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

i.

☒ Self-identification

Describe:

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

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Alternative Benefit Plan

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

☒ Review of claims data -this box now unchecked

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☒ Change in eligibility group

☐ Other

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

◯ Monthly

◯ Quarterly

◯ Annually

◯ Ad hoc basis

◉ Other

Describe:

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

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

An ~~Arkansas Works~~ ARHOME enrollee can notify ~~Division of Medical Services~~ DHS at any time to be rescreened for frail status.

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

MARK-UP

Alternative Benefit Plan

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

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

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

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

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

E

MARK-UP

Alternative Benefit Plan

Attachment 3.1-C- ☐

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

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

Select one of the following:

○ The state/territory is amending one existing benefit package for the population defined in Section 1.

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

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

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

◉ Benchmark Benefit Package.

○ Benchmark-Equivalent Benefit Package.

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

○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).

○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):

○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):

◉ Secretary-Approved Coverage.

○ The state/territory offers benefits based on the approved state plan.

◉ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.

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

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

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

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

MARK-UP

Alternative Benefit Plan

Selection of Base Benchmark Plan

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

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

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

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

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

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

V.20130801

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Alternative Benefit Plan

Attachment 3.1-C- ☐

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

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~~ NO

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

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

The State will use cost-sharing as described in the cost sharing section of the State Plan with two exceptions. Individuals enrolled in a QHP will pay a copay of $20 a day for skilled nursing facilities and $4.70 for hearing aids. These amounts will increase with the medical component of the CPI-U.

MARK-UP

PRA Disclosure Statement

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

V.20130807

Alternative Benefit Plan

Attachment 3.1-C- ☐

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

Benefits Assurances ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

○ Through an Alternative Benefit Plan.

◉ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Per 42 CFR 440.345, please describe how the additional benefits will be provided, how access to additional benefits will be coordinated and how beneficiaries and providers will be informed of these processes in order to ensure individuals have access to the full EPSDT benefit.

Indicate whether additional EPSDT benefits will be provided through fee-for-service or contracts with a provider:

◉ State/territory provides additional EPSDT benefits through fee-for-service.

○ State/territory contracts with a provider for additional EPSDT services.

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

All beneficiaries ~~up to~~ under age 21 will receive the full range of EPSDT benefits. For beneficiaries ~~up to~~ under age 21 receiving the ABP through Qualified Health Plans (QHPs) under Arkansas's 1115 waiver, Arkansas Medicaid will provide supplemental coverage for any 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 wrapped benefits. Since the QHPs must cover all EHBs, ~~we anticipate that~~ Arkansas ~~will~~ provides supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services. For beneficiaries ~~up to~~ under age 21 receiving the ABP through fee-for-service Medicaid, the beneficiaries will access all benefits, including the full range of EPSDT benefits, through fee-for-service Medicaid.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

MARK-UP

Alternative Benefit Plan

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits 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).

PRA Disclosure Statement

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V.20130807

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Alternative Benefit Plan

Attachment 3.1-C- ☐

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

Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☒ Other service delivery system.

Fee-For-Service Options

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

◉ Traditional state-managed fee-for-service

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

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

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

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

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

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

MARK-UP

Alternative Benefit Plan

Other Service Delivery Model

Name of service delivery system:

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

Provide a narrative description of the model:
QHP: Under the ~~Arkansas Works~~ ARHOME SECTION 1115(a) demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group under the state plan, to support the purchase of coverage from QHPs offered in the individual market through the Marketplace. ~~In Arkansas, individuals eligible for coverage under the new adult group are both (1) childless adults ages 19 through 64 with incomes at or below 133 percent of the federal poverty limit (FPL) or (2) parents and other caretakers between the ages of 19 through 64 with incomes between 17 percent and 133 percent of the FPL (collectively Arkansas Works QHP beneficiaries). Arkansas expects approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.~~
~~Arkansas Works~~ ARHOME QHP beneficiaries will receive the ABP through a QHP. ~~State plan Alternative Benefit Plan (ABP) through a qualified health plan (QHP).~~
~~Arkansas Works also includes an ESI premium assistance component. Medicaid eligible individuals age 21 and over with an employer who chooses to participate in the Arkansas Works ESI program must receive ABP coverage through their employer's ESI, unless the individual is medically frail.~~

MARK-UP

Alternative Benefit Plan

Attachment 3.1-C- ☐

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

Employer Sponsored Insurance and Payment of Premiums — ABP9

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

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

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

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

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

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 6~~5~~ 4with 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 6~~5~~ 4 with incomes between ~~17~~ the established monthly eligibility income levels for the Parent/Caretaker/Relative Aid Category (currently $124 per month for a one-person household) and 133% FPL who are not enrolled in Medicare (ARHOME beneficiaries). ~~(collectively "Private Option beneficiaries").~~ ARHOME ~~Private Option~~ beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP available in their region.

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

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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

MARK-UP

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Requirements — G1

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

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

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

General Provisions

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

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

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

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

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

☒ The state includes an indicator in the Eligibility Verification System

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

☐ Other process

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

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

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

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

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

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

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

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- ■ 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

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Division of County Operations are housed.

PRA Disclosure Statement

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V.20160722

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Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals.	No

PRA Disclosure Statement

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V.20181119

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Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

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

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

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

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

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

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Medicaid Premiums and Cost Sharing

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

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Medicaid Premiums and Cost Sharing

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

PROPSED

Medicaid Premiums and Cost Sharing

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

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

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

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

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

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

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

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

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

Remove Population

Add Population

PRA Disclosure Statement

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

V.20181119

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Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0008

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

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

Exemptions

Groups of Individuals - Mandatory Exemptions

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

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

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Medicaid Premiums and Cost Sharing

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

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☐ Other procedure

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

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

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

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

☐ Other procedure

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

Payments to Providers

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

Payments to Managed Care Organizations

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

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

Aggregate Limits

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

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

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(•) 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:

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

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

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

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

PRA Disclosure Statement

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

V.20160722

PROPSED

A-100 General Program Information

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

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

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

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

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

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

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

MARK-UP

A-100 General Program Information

A-1005 NGeneral Program Informatioondiscriminatioon

- 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 MedicaidHealth Care.

A-110 Cost Sharing Coinsurance/Copayment

MS Manual 01/01/1701/01/23

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

MARK-UP

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

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

2. Pregnant women;

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

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

5. Emergency services;

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

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

8. Services provided to individuals receiving hospice care;

9. PASSE enrollees;

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

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

A-115 Cost Sharing for Workers with Disabilities

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

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

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

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

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

MARK-UP

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

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

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

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

A-116 Premiums for the Adult Expansion Group

MS Manual 01/01/17

A program participant who has income of at least (13800%) of the federal poverty levelFPL will pay a premium of no more than 2% ofto their income to a health insurance carrier..

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

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

A-163 Child Health Services Program (EPSDT)

MS Manual 07/01/2001/01/23

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

MARK-UP

State/Territory: ARKANSAS

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

MARK-UP

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

MARK-UP

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

MARK-UP

Revised: September 300, 2003

State/Territory: [Arkansas]

Citation	4.18	Recipient Cost Sharing and Similar Charges
42 CFR 447.51 through 447.58	(a)	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 ______

MARK-UP

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. 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.

MARK-UP

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.

MARK-UP

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			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
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

MARK-UP

~~Supersedes TN No. ______________________ Approval Date ____________________________ Effective Date _______________________~~

MARK-UP

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.

MARK-UP

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

MARK-UP

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.

MARK-UP

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:

MARK-UP

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

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

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

MARK-UP

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.	Type Charge: Coins.	Type Charge: 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

MARK-UP

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

MARK-UP

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.

MARK-UP

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

MARK-UP

September 1, 1992

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.

Markup

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:

MARK-UP