DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

December 11, 2014

Dawn Stehle
Director, Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot S-401
700 Main Street
Little Rock, AR 72203

Dear Ms. Stehle:

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of Arkansas' ARKids B section 1115 demonstration (Project Nos. 11-W-00115/6 and 21-W-00063/6) until May 31, 2015. The demonstration is currently due to expire on December 31, 2014.

The ARKids B demonstration will continue to operate under the authority of section 1115(a) of the Social Security Act. Additionally, the current list of waiver and expenditure authorities and special terms and conditions will continue to apply to the ARKids B demonstration through May 31, 2015. This temporary extension is being approved to allow the state additional time to create authority to transition ARKids B demonstration children from 142 to 211 percent of the Federal poverty level to the separate Children's Health Insurance Program (CHIP) state plan.

We are in receipt of the state's December 9, 2014, request to extend the ARKids B demonstration through May 31, 2015. Thank you for providing additional information about the legislative review and approval process required to move forward with the ARKids B transition to the CHIP state plan.

If you have any questions, please do not hesitate to contact your project officer, Mr. Martin Burian. He can be reached at (410) 786-3246, or at martin.burian@cms.hhs.gov. We look forward to continuing to work with you and your staff on the ARKids B program.

Sincerely,

/s/

Eliot Fishman
Director

cc:
Bill Brooks, Associate Regional Administrator, Region VI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

July 31, 2014

Dawn Zekis
Interim Director, Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot S-401
700 Main Street
Little Rock, AR 72203

Dear Ms. Zekis:

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of Arkansas' ARKids B section 1115 demonstration (Project Nos. 11-W-00115/6 and 21-W-00063/6) until December 31, 2014. The demonstration is currently due to expire on July 31, 2014.

The ARKids B demonstration will continue to operate under the authority of section 1115(a) of the Social Security Act. Additionally, the current list of waiver and expenditure authorities and special terms and conditions will continue to apply to the ARKids B demonstration through December 31, 2014. This temporary extension is being approved to allow the state additional time to create authority to transition ARKids B demonstration children from 142 to 211 percent of the Federal poverty level to the separate Children's Health Insurance Program (CHIP) state plan.

We are in receipt of the state's July 28, 2014, request to extend the ARKids B demonstration through December 31, 2014. Thank you for providing a detailed explanation of the specific challenges associated with moving children from the demonstration to the state plan sooner than the end of the year. By December 31, 2014, our understanding is that the state will implement the following changes:

Necessary Changes for the ARKids B Transition:	**Date by which changes will be completed:**
Governor's approval of the budget	August 15, 2014
9 state plan amendments (SPAs) associated with the transition of the ARKids-B children to a separate CHIP	In progress
State promulgation process for the CHIP SPA	December 15, 2014
Completion of required MMIS and contract system changes	December 31, 2014
Completion of all required CDC vaccine processes	December 31, 2014
Full shift of children to the CHIP State Plan	January 1, 2015

If you have any questions, please do not hesitate to contact your project officer, Mr. Martin Burian. He can be reached at (410) 786-3246, or at martin.burian@cms.hhs.gov. We look forward to continuing to work with you and your staff on the ARKids B program.

Sincerely,

/s/

Eliot Fishman
Director

cc:
Bill Brooks, Associate Regional Administrator, Region VI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

June 26, 2014

Dawn Zekis
Interim Director, Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437, Slot S-401
700 Main Street
Little Rock, AR 72203

Dear Ms. Zekis:

With this letter, the Centers for Medicare & Medicaid Services (CMS) is granting a temporary extension of Arkansas' ARKids B section 1115 demonstration (Project Nos. 11-W-00115/6 and 21-W-00063/6) until July 31, 2014. The demonstration is currently due to expire on June 30, 2014.

The ARKids B demonstration will continue to operate under the authority of section 1115(a) of the Social Security Act. Additionally, the current list of waiver and expenditure authorities and special terms and conditions will continue to apply to the ARKids B demonstration through July 31, 2014. This temporary extension is being approved to allow the state additional time to create authority to transition ARKids B demonstration children from 142 to 211 percent of the Federal poverty level to the separate Children's Health Insurance Program (CHIP) state plan.

We are in receipt of the state's June 16, 2014, request to extend the ARKids B demonstration through September 30, 2014. However, this request, which only notes "unforeseen logistics" associated with the transition of ARKids B demonstration children to a separate CHIP, is not sufficient for CMS to consider an additional extension. Should Arkansas wish to request a further demonstration extension beyond July 31, 2014, we ask that the state provide a request in writing with a detailed explanation of the specific challenges associated with moving children from the demonstration to the state plan by August 1, 2014.

If you have any questions, please do not hesitate to contact your project officer, Mr. Martin Burian. He can be reached at (410) 786-3246, or at martin.burian@cms.hhs.gov. We look forward to continuing to work with you and your staff on the ARKids B program.

Sincerely,

/s/

Eliot Fishman
Director

Cc:

Bill Brooks, Associate Regional Administrator, Region VI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

Mr. Eugene Gessow
Director
Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437, Slot S401
Little Rock, Arkansas 72203-1437

Dear Mr. Gessow:

This is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to renew the ARKids B section 1115 Demonstration (No. 11-W-00115/6 and 21-W-00063/6). This renewal is effective January 1, 2011, through December 31, 2013, upon which date, unless reauthorized, all authorities granted to operate this Demonstration will expire. The extension is granted under the authority of section 1115(a) of the Social Security Act.

Our approval of this renewal is subject to the limitations specified in the enclosed list of expenditure authorities. The State may deviate from the Medicaid or Children's Health Insurance Program (CHIP) State plan requirements to the extent those requirements have been listed as not applicable to expenditures for Demonstration populations and other services not covered under the Medicaid or CHIP State plan.

The State is receiving approval to increase eligibility for uninsured children age 0 through 18 with family incomes above 200 percent up to and including 250 percent of the Federal poverty level. CMS intends to consider modifying the Demonstration to limit or remove the State's authority to expand eligibility if the State has not fully expanded eligibility to these children within 18 months of the date of the renewal.

This renewal is conditional upon acceptance and compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and the acceptance of the STCs, and waiver and expenditure authorities within 30 days of the date of this letter.

Your project officer is Andrea Casart and she is available to answer any questions concerning your section 1115 demonstration. Ms. Casart's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey and Certification
Division of State Children's Health Insurance Program
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-0742
Facsimile: (410) 786-5882
E-mail: Andrea.Casart@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Casart and to Mr. Bill Brooks, Associate Regional Administrator in our Dallas Regional Office. Mr. Brook's contact information is as follows:

Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202
Telephone: (214) 767-4461
E-mail: Bill.Brooks@cms.hhs.gov

If you have questions regarding this correspondence, please contact Ms. Victoria Wachino, Director, Family and Children's Health Programs Group, Center for Medicaid, CHIP & Survey and Certification, at (410) 786-5647**.** We look forward to continuing to work with you and your staff.

Sincerely,

Cindy Mann
Director

Enclosure

cc: Mr. Bill Brooks
Associate Regional Administrator
Dallas Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
COSTS NOT OTHERWISE MATCHABLE AUTHORITIES

NUMBER: **11-W-00115/6 (Title XIX)**
21-W-00063/6 (Title XXI)

TITLE: **ARKids B Section 1115 Demonstration**

AWARDEE: **Arkansas Department of Human Services**

Title XIX Costs Not Otherwise Matchable

All requirements of the Medicaid and Children's Health Insurance Program (CHIP) programs not identified as not applicable in this list, shall apply to the demonstration expenditures listed below.

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under title XIX or XXI shall), for the period of this extension, January 1, 2011, through December 31, 2013, in accordance with the special terms and conditions, be regarded as matchable expenditures under the State's title XIX or XXI plan:

Demonstration Population I: Expenditures for extending health benefits coverage through the Medicaid program for uninsured children, ages 0 through 5, in families with income (net of State income disregards under 45 CFR 233.20(a)(iv)(G) and 233.20(a)(4)(ii)) above 133 percent of the Federal poverty level (FPL) up to and including 200 percent of the FPL and ages 6 through 18 in families with income above 100 percent of the FPL up to and including 200 percent of the FPL.

For Demonstration Population I, all Medicaid requirements shall apply, except those specifically identified as not applicable below.

Title XIX Requirements Not Applicable to Demonstration Population I

1. Amount, Duration and Scope of Services **Section 1902(a)(10)(B)**

To enable the State to offer a different benefit package to demonstration participants than is being offered to the traditional Medicaid population.

2. Freedom-of-Choice **Section 1902(a)(23)**

To enable the State to restrict freedom of choice of provider for demonstration participants and to the extent that it incorporates the provisions of 1932(a)(4) pertaining to changing providers in a primary care case management program.

3. Reasonable Promptness **Section 1902(a)(8)**

To enable the State to not furnish medical assistance with reasonable promptness, to the extent that the State excludes individuals from eligibility until at least six months have passed since the expiration of their private health insurance coverage.

4. Retroactive Eligibility **Section 1902(a)(34)**

To enable the State to not provide retroactive eligibility for those who had private health insurance within six months of applying for State Medicaid expansion.

5. Methods of Administration: Transportation **Section 1902(a)(4) and 42 CFR 431.53**

The State is not required to assure transportation to and from providers for Demonstration Population I.

6. Copayments **Section 1902(a)(14) insofar as it incorporates sections 1916(a)(2)(A) and 1916(a)(3)**

To enable the State to impose copayments that are above nominal.

Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903 or section 2107(e)(2)(A) shall, for the period of this extension in accordance with these special terms and conditions, be regarded as matchable expenditures under the State's title XXI plan:

Demonstration Population II: Expenditures for extending health insurance coverage through the CHIP program for those uninsured children, ages 0 through 18, in families with income (net of State income disregards under 45 CFR 233.20(a)(iv)(G) and 233.20(a)(4)(ii)) above 200 percent of the FPL up to and including 250 percent of the FPL.

All requirements of the CHIP program apply to Demonstration Population II except those specifically identified as not applicable below.

Title XXI Requirements Not Applicable to Demonstration Population II

1. Benefit Package Requirements **Section 2103**

The State may offer a benefit package that does not meet the requirements of section 2103 of the Act, as implemented at 42 CFR 457.410(b)(1) for Demonstration Population II.

2. Cost Sharing **Section 2103(e)**

Cost sharing for the Demonstration Population II population may exceed the limitations on cost sharing under section 2103(e) of the Act except for the application of the 5 percent cap under 2103(e)(3)(B).

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00115/6 (Title XIX)**
21-W-00063/6 (Title XXI)

TITLE: **ARKids B**

AWARDEE: **Arkansas Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Arkansas' ARKids B section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Arkansas Department of Human Services Division of Medical Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration renewal is approved for the period January 1, 2011 through December 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Cost Sharing; Delivery System; General Reporting Requirements; General Financial Requirements Under Title XIX; General Financial Requirements Under Title XXI; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension Period.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Arkansas implemented the ARKids B Demonstration on September 1, 1997. The Demonstration provides coverage for uninsured children through age 18 with family income (net of State income disregards under 45 CFR 233.20(a)(4)(ii)) and not exceeding 250 percent of the Federal Poverty Level (FPL). ARKids B offers a less comprehensive benefit package than the State's traditional Medicaid program (which is referred to as ARKids A), and requires co-payments.

The ARKids B Demonstration utilizes the same provider system as ARKids A and operates under a Primary Care Case Management (PCCM) model. The objectives of the Demonstration are to integrate uninsured children into the health care delivery system and to provide a Secretary-approved benefit package, comparable to the State Employees and State Teachers Insurance Program.

With this renewal effective January 1, 2011, claims for children covered under the ARKids B Demonstration are eligible for the enhanced title XXI match. Upon renewal, children eligible for coverage under Medicaid will no longer be an eligibility group under this demonstration.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

   b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the Federal law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State

Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c) An up-to-date CHIP allotment neutrality worksheet;

   d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

   e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS

either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

a) Demonstration Summary and Objectives: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

b) Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

c) Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

d) Quality: The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e) Draft report with Evaluation Status and Findings: The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. Demonstration Phase-Out. The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10, a phase-out plan shall not be shorter than six months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project

is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last six months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of titles XIX or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

13. After 18 months from the approval date of this renewal, CMS intends to review the State's implementation of the eligibility expansion under the Demonstration that is described in paragraph 17. If the review indicates that the State has not fully expanded eligibility as it is described in paragraph 17, CMS intends to consider modifying the Demonstration to limit or remove the State's authority to expand eligibility under paragraph 17. In that case, CMS may require the State to submit an amended Demonstration budget reflecting the impact of these changes.

    After 6 months from the approval date of this renewal, CMS intends to review the States' implementation of the cost sharing protections described in 42 CFR Part 447. If the review indicates that the State has not fully implemented changes necessary to the cost sharing amounts described in paragraph 21, CMS intends to consider modifying the Demonstration to limit or remove the State's authority to impose cost sharing under

paragraph 21. In that case, CMS may require the State to submit an amended Demonstration budget that would remove the cost-sharing budget offset.

14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6 are proposed by the State.

16. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND COST SHARING

The ARKids B Demonstration provides coverage for uninsured children ages 0 through 5, in families with income above 133 percent of the FPL and ages 6 through 18 in families with income (net of State income disregards under 45 CFR 233.20(a)(4)(ii)) above 100 percent FPL and not exceeding 250 percent of the FPL. ARKids B offers a less comprehensive benefit package than the State's traditional Medicaid Program, (which is referred to as ARKids A), and requires co-pays.

The Demonstration utilizes the same provider system as ARKids A and operates as a PCCM model.

17. **Eligibility.** Children ages 0 through 5, in families with income above 133 percent up to and not exceeding 250 percent of the FPL, and ages 6 through 18 in families with income (net of State income disregards under 45 CFR 233.20(a)(4)(ii)) above 100 percent FPL up to and not exceeding 250 percent of the FPL, are eligible under the Demonstration, and are funded through the title XXI allotment at the enhanced CHIP matching rate.

    Uninsured children of State employees, ages 0 through 18, who have access to but who are not covered by State-funded State employee health benefits, with family income (net of State income disregards under 45 CFR 233.20(a)(4)(ii)) from 200 percent up to but not exceeding 250 percent of the FPL are eligible for ARKids B coverage. The State will follow the requirements of sections 2110(b)(2)(B) and 2110(b)(6) of the Social

Security Act (the Act), as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), (Public Law 111-148) as amended by the Medicare and Medicaid Extenders Act of 2010 (Public Law 111-309).

The populations are defined below.

Demonstration Expansion Groups	**FPL and/or Other Qualifying Criteria**	**Title XIX Requirements Not Applicable**
Children ages 0-5 **Demonstration Population I**	Above 133 percent up to and including 200 percent FPL	Amount , Duration and Scope, Freedom of Choice, Reasonable Promptness, Retroactive Eligibility, Methods of Administration: Transportation, Copayments
Children age 6-18 **Demonstration Population I**	Above 100 percent up to and including 200 percent FPL	As Above
Demonstration Expansion Groups	**FPL and/or Other Qualifying Criteria**	**Title XXI Requirements Not Applicable**
Children ages 0-18 **Demonstration Population II**	Above 200 percent and not exceeding 250 percent FPL	Benefit Package Requirements and Cost Sharing

18. **CHIP Coverage Authority.** Children with family income (net of State income disregards under 45 CFR 233.20(a)(4)(ii)) up to and including 200 percent of the FPL are covered as a Medicaid expansion population; and children with family income (net of State income disregards under 45 CFR 233.20(a)(4)(ii)) from 200 percent and not exceeding 250 percent of the FPL will be covered as a separate CHIP population.

19. **Eligibility Criteria.** The State must maintain qualifying criteria for ARKids B that includes income criteria and the caveat that all ARKids B enrollees must not have had employer-sponsored or group health insurance for six months prior to program enrollment. There is no presumptive eligibility. Retroactive eligibility may be determined up to three months prior to the date of application.

20. **Enrollees Desiring a Primary Care Provider (PCP) Change.** Enrollees are entitled to change their PCP selection at any time, without limitation. As part of the enrollment materials, enrollees are provided with information concerning their disenrollment rights.

21. **Benefit Package and Cost Sharing.** The State must offer an ARKids B benefit package that meets or exceeds a benefit package that would be approved under CHIP as "Secretary-approved coverage," pursuant to 42 C.F.R. 457.450. The benefit package must include inpatient and outpatient hospital services, physician surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age-appropriate immunizations. Enrollees in ARKids B are not eligible for the full range of State Medicaid services. The ARKids B schedule of benefits is outlined in the table below.

    Co-payments and co-insurance apply for all services with the exception of immunizations, preventive health screenings, family planning, and prenatal care. The ARKids B schedule of co-payments and co-insurance is outlined in the following table may change after the State reviews the provisions of 42 CFR Part 447 and takes the necessary compliance actions outlined in paragraph 13 The annual cumulative cost-sharing maximum cannot exceed 5 percent of the ARKids B family's income (net of State income disregards under 45 CFR 233.20(a)(4)(ii)).

Benefit/Limits	**Co-Pay/Coinsurance**
Ambulance (Emergency Only)	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9)	None
Certified Nurse Midwife	$10 per visit
Chiropractor	$10 per visit
Dental Care (Limited to routine dental care, no Orthodontia)	$10 per visit
Durable Medical Equipment (Limited to $500 per State Fiscal Year (SFY) July 1 – June 30)	20 percent of Medicaid allowed per DME item
Emergency Dept Services (Emergent, non-emergent, assessment)	$10 per visit
Family Planning	None
Federally Qualified Health Center (FQHC)	$10 per visit
Home Health (10 visits per SFY)	$10 per visit

Hospital, Inpatient (including psychiatric services except for services in an inpatient psychiatric hospital and a Psychiatric Residential Treatment Facility)	20 percent of first inpatient day
Hospital, Outpatient	$10 per visit
Immunizations (All per protocol)	None
Laboratory and X-Ray	$10 per visit
Medical Supplies (Limited to $125/mo unless benefit extension is approved)	None
Mental and Behavioral Health, Outpatient	$10 per visit
Nurse Practitioner	$10 per visit
Physician	$10 per visit
Podiatry	$10 per visit
Prenatal Care	None
Prescription Drugs	$5 per prescription (Must use generic and rebate manufacturer, if available)
Preventive Health Screenings (All per protocol)	None
Rural Health Clinic	$10 per visit
Speech Therapy Evaluation – Four 30 minute units/SFY unless benefit extension is approved Therapy – Four 15 minute units/day unless benefit extension is approved	$10 per visit
Vision (Eye exam, eyeglasses)	$10 per visit (no co-pay for eyeglasses)

The following services are not covered under ARKids B.

Medicaid Services not Covered for ARKids B Enrollees
Audiological Services (exception: Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9)
Child Health Management Services
Developmental Day Treatment Clinic Services
Diapers, underpads and incontinence supplies
Domiciliary Care
EPSDT (All treatment services may not be provided)
End Stage Renal Disease Services
Hearing Aids
Hospice

Hyperalimentation
Services in an Inpatient Psychiatric hospital or a Psychiatric Residential Treatment Facility
Non-emergency transportation
Nursing facilities
Occupational and Physical Therapies
Orthodontia
Orthotic Appliances and Prosthetic Devices
Personal Care
Private Duty Nursing Services
Rehabilitative Services for Children
Rehabilitative Services for Persons with Physical Disabilities
School-Based Mental Health Services
Targeted Case Management
Ventilator Services

V. DELIVERY SYSTEM

22. Access and Delivery System. The Demonstration utilizes the same provider system as ARKids A and operates under a PCCM model. ARKids B beneficiaries select or are aligned with a PCP responsible for furnishing primary and preventive services and making medically necessary referrals.

23. Contracts. Procurement and the subsequent final contracts developed to implement the Demonstration by the State with any provider group or vendor shall be subject to CMS approval prior to implementation.

24. Linkage Agreements. The State must monitor: A) PCP linkage agreements; B) PCPs care coordination for their beneficiaries with other medical assistance providers such as behavioral health providers, public health agencies, school-based health clinics, and family planning clinics; and C) the processes for exchanging patient-specific information while protecting the confidentiality of the enrollee.

VI. GENERAL REPORTING REQUIREMENTS

25. General Financial Requirements. The State must comply with all general financial requirements under title XIX set forth in Section VII**,** and all general financial requirements under title XXI set forth in Section VIII.

26. Eligibility Reporting. The State must continue to have processes and reporting systems in place to ensure that title XXI matching funds are not claimed for ARKids B enrollees

who are eligible for traditional Medicaid. The State must submit summary reports of its monitoring and analysis of its eligibility determinations to CMS as part of the quarterly reports.

27. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section IX.

28. **Monthly Call.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall use and discuss quarterly expenditure reports submitted by the State to monitor budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

29. **Quarterly Operational Reports.** The State must submit progress reports in the format specified in Attachment A, no later than 60 days following the end of each quarter. The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:

    a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including benefits, enrollment, grievances, quality of care, access, health plan financial performance that is relevant to the Demonstration, pertinent legislative activity, the methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative annual cost-sharing maximum of 5 percent, and other operational issues;

    b) Action plans for addressing any policy and administrative issues identified; and,

    c) Evaluation activities and interim findings.

    Notwithstanding this requirement, the fourth-quarter Quarterly Report may be submitted as a combined report with the Annual Report required in paragraph 30.

30. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, Maintenance of Effort/data set analysis, data regarding the

number of children who have met the cost-sharing cap of 5 percent, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the operational reports required under paragraph 29. The State must submit the draft annual report no later than 120 days after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, the State must submit a final annual report.

31. **Title XXI Enrollment Reporting.** The State will provide CMS with an enrollment report showing end of quarter actual and unduplicated ever enrolled figures. The enrollment data for the title XXI population will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.

VII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

All children covered under the ARKids B Demonstration are eligible to receive the enhanced title XXI match. Subsequent to the renewal, children eligible for Medicaid will no longer be an eligibility group under this demonstration and no additional member months will be reported or counted for title XIX budget neutrality with the exception of member months for medical claims paid for title XIX enrollees with a date of service prior to January 1, 2011. The State will only receive Title XIX matching funds for Medicaid-eligible children enrolled in AR Kids B with dates of service prior to January 1, 2011. The title XIX requirements in STCs 33 through 40 apply to medical claims with a date of service prior to January 1, 2011.

32. **Quarterly Expenditure Reports.** The State shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only to the extent that the expenditures do not exceed the pre-defined limits on the costs incurred as specified in Section IX.

33. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this Demonstration, Arkansas must report Demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. The State must report all Demonstration expenditures claimed under the authority of title XIX of the Act each quarter on separate Forms CMS-64.9 Waiver and 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were paid).

    a) For each Demonstration year, the State must complete a Form CMS-64.9 Waiver

and CMS-64.9P Waiver using the waiver name "Title XIX children," to report expenditures for the following Demonstration population.

Title XIX Children: Expenditures for Title XIX children as approved under the demonstration agreement operating with dates of service prior to January 1, 2011.

b) The sum of the quarterly expenditures for all Demonstration years will represent the expenditures subject to the budget neutrality agreement as defined in paragraph 47.

c) For purposes of this section, the term "expenditures subject to the budget neutrality agreement" must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration as defined in paragraph 33a. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

d) Administrative costs are not subject to the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

e) The State must make all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the State made the expenditures. The State must make all claims for services during the Demonstration period (including any cost settlements) within two years after the conclusion or termination of the Demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

f) The State must report premiums and other applicable cost sharing contributions that are collected by the State from enrollees under the Demonstration to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the Demonstration must be separately reported on the CMS-64 Narrative.

34. Reporting Member Months. The following describes the reporting of member months for the Demonstration population:

a) For the purpose of calculating the budget neutrality expenditure agreement and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 29, the actual number of eligible member months for the Eligibility Group (EG) defined in paragraph 33. The State must attach to the quarterly report a statement certifying the accuracy of the reported information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions for an additional 180 days after the end of each quarter.

b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

35. Standard Medicaid Funding Process. The State must use the standard Medicaid funding process during the Demonstration. Arkansas must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure agreement and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

36. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section IX:

a) Administrative costs, including those associated with the administration of the Demonstration;

b) Net expenditures and prior period adjustments that are paid in accordance with the approved Medicaid State plan; and

c) Net medical assistance expenditures made under Section 1115 Demonstration authority, with dates of service prior to January 1, 2011.

37. Sources of Non-Federal Share. The State certifies that the matching non-Federal share of funds for the Demonstration is State/local monies. Arkansas further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. Premiums paid by enrollees and collected by the State shall not be used as a source of non-Federal share for the Demonstration. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. Arkansas agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS; and

b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

38. State Certification of Funding Conditions. The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration;

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures;

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match; and

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent

of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and local government to return and redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments), are not considered returning and redirecting a Medicaid payment.

e) Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

39. Monitoring the Demonstration. The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

VIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

40. Quarterly Expenditure Reports. The State must report State Plan and Demonstration expenditures using the Medicaid and Children's health Insurance Program Budget and Expenditure System (MBES/CBES), following the routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid manual. The State shall report on separate forms, CMS-64.21U Waiver and/or CMS-64.21UP Waiver, and CMS-21 Waiver for Title XXI Demonstration expenditures for the children eligible for title XXI funding. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable ARKids B Demonstration expenditures that do not exceed the State's available title XXI funding.

41. State Employee Affordability Test, Maintenance of Effort and Matching of State-Funded Program. Federal financial participation (FFP) is available as matching funds for the coverage of uninsured children of State employees who have access to but who are not covered by State-funded State employee health benefits. The State will enroll uninsured children of State employees according to the requirements of sections 2110(b)(2)(B) and 2110(b)(6) of the Act as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), (Public Law 111-148) as amended by the Medicare and Medicaid Extenders Act of 2010 (Public Law 111-309).

42. Reporting Expenditures Under the Demonstration. In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures through the MBES/CBES, following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid manual and routine CMS-64 reporting instructions as

outlined in section 2500 of the State Medicaid manual. The State will report Title XXI Demonstration expenditures on separate Forms CMS-21 Waiver, CMS-21P Waiver, CMS-64.21U Waiver and CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the State must identify the program code and coverage.

a) The State must submit all claims for expenditures related to the Demonstration (including any cost settlements) within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, the State must submit all claims for services during the Demonstration period (including cost settlements) within 2 years after the conclusion or termination of the Demonstration. During the 2-year period, the State must continue to identify separately, on the Form CMS-21, net expenditures related to dates of service during the operation of the Demonstration.

b) The State will use standard CHIP funding process during the Demonstration. Arkansas must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c) The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

43. Limitations on Title XXI Funding. Arkansas will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI separate child health program or Demonstration until the next allotment becomes available.

a) Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this Demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

b) Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the Demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

c) If the State exhausts the available title XXI Federal funds in a Federal fiscal year during the period of the Demonstration, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and the demonstration populations with State funds until further title XXI Federal funds become available. CMS will provide Title XIX Federal matching funds for Demonstration Population I enrollees (as identified in paragraph 16) if the title XXI allotment is exhausted, only after a budget neutrality agreement with CMS is reached.

d) If title XXI allocations are expended, Arkansas may submit an amendment requesting a Title XIX section 1115 demonstration (including budget neutrality) for demonstration population 1.

e) All Federal rules shall continue to apply during the period of the Demonstration that State or title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the demonstration populations. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

IX. MONITORING BUDGET NEUTRALITY

Subsequent to the renewal, the monitoring of budget neutrality will be limited to the impact of medical claims paid for title XIX enrollees with a date of service prior to January 1, 2011. The title XIX budget neutrality requirements in STCs 46 through 51 apply to medical claims for title XIX enrollees with a date of service prior to January 1, 2011.

44. Limit on Title XIX Funding. Arkansas shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

45. Risk. Arkansas shall be at risk for the per capita cost for Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, Arkansas will

not be at risk for changing economic conditions which impact enrollment levels. However, by placing Arkansas at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

46. Demonstration Populations Subject to the Budget Neutrality Agreement. The following Demonstration populations are subject to the budget neutrality agreement and are incorporated into the Demonstration EGs used to calculate budget neutrality.

Title XIX Children: Expenditures for Title XIX children as approved under the demonstration agreement operating from October 1, 2005 through December 31, 2010 with dates of service prior to January 1, 2011.

47. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration:

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for the EG described in paragraph 46 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 34, for each EG, multiplied by the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below.

ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.

iii. The PMPM costs for the EG used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

Category	DY 2009 PMPM	Trend Rate	DY 2010 PMPM	Trend Rate	DY 2011 PMPM	Trend Rate
Population 1	$125.93	1.6%	127.94	1.6%	$129.99	N/A

b) The overall budget neutrality expenditure limit for the three-year Demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a) above for each of the three years. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations and expenditures described in paragraph 46 during the Demonstration period.

48. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target	Percentage
Year 12	Year 12 budget neutrality cap plus	0 percent
Year 13	Years 12 and 13 combined budget neutrality cap plus	0 percent
Year 14	Years 12 through 14 combined budget neutrality cap plus	0 percent

49. Exceeding Budget Neutrality. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

X. EVALUATION OF THE DEMONSTRATION

50. Submission of Draft Evaluation Design. The State must submit an updated evaluation design to CMS for approval within 120 days from the award of the Demonstration. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested through this demonstration, including those that focus specifically on the target population for the Demonstration, i.e. uninsured children with access to the State health benefits plan. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

51. Interim Evaluation Reports. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

52. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 50, within 60 days of

receipt of CMS comments. The State must implement the evaluation design and report its progress in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days after the expiration of the current Demonstration period. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report no later than 60 days after the receipt of the comments from CMS.

53. Cooperation with Federal Evaluators. Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

XI. SCHEDULE OF STATE MANDATORY DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

	Deliverable	STC Reference
Annual	By January 31st - Draft Annual Report	Section VI, paragraph 30
Quarterly		
	Quarterly Operational Reports	Section VI, paragraph 29
	Quarterly Enrollment Reports	Section VI, paragraph 31
	CMS-64 Reports CMS -64.21 and CMS-21	Section VII, paragraph 33 Section VIII, paragraph 42
	Eligible Member Months	Section VII, paragraph 34

ATTACHMENT A

Under Section VI paragraph 29 of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an update on budget neutrality monitoring.

NARRATIVE REPORT FORMAT

Title Line One – ARKids B

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 12 (10/1/2008 – 9/30/2009)
Federal Fiscal Quarter: 1/2008 (10/08 - 12/08)

Introduction

Please provide information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".
Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard coded in the CMS 64, 64.21 or 21 waiver forms)	**Current Enrollees** (to date)
Population I	
Uninsured Children of State Employees in Population I	
Population II	
Uninsured Children of State Employees in Population II	

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64, 64.21 and 21 reporting for the current quarter. Identify the State's actions to address these issues.

Member Month Reporting
Enter the member months for each of the demonstration populations for the quarter.

For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX Children				

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS