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State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 15-30 ABP

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

December 19, 2014

Our Reference: SPA AR 13-030

Dawn Stehle
Arkansas Medicaid Director
700 Main Street,
PO Box 1437
Little Rock, Arkansas 72203-1437

Dear Mrs. Stehle:

The Centers for Medicare and Medicaid Services (CMS) has reviewed the State's proposed amendment to the Arkansas Medicaid State Plan submitted November 20, 2013 under Transmittal Number 13-30. This State Plan Amendment (SPA) revises Arkansas' Medicaid State Plan with an Alternative Benefit Plan (ABP). The ABP defines the benefits available to the new eligibility group established under 1902(a)(10)(A)(i)(VIII) of the Social Security Act. This SPA also lifts inpatient hospital days reimbursement limit for days after 24 to $400 per day.

Enclosed for your records is an approved copy of Arkansas' proposed Alternative Benefit Plan (ABP) State Plan Amendment (SPA) TN# 13-30. This ABP meets all federal statutory and regulatory requirements for establishing an ABP.

All requirements pertaining to Alternative Benefit Plans must be met, including payment rates and reimbursement methodologies, cost-sharing state plan pages, and (if applicable) managed care service delivery systems. These must be updated as necessary to reflect other changes required by federal statute and regulation within allowable parameters.

This ABP SPA is approved effective January 1, 2014 as requested by your state. If you have any questions, please contact Lynn Ward at (214) 767-6327 or Lynn.ward@cms.hhs.gov

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health

Enclosures

Cc: Glenda Higgs

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name:
Arkansas
Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

13-0030

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1902(a)(10)(A)(i)(VIII)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 87695.00
Second Year	2015	$ 118228.00

Subject of Amendment

To add the new adult group established under 1902(a)(10)(A)(i)(VIII) of the Social Security Act to the State Plan and to define the benefits available to this eligibility group.

Governor's Office Review

- (•) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:

- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:
Glenda Higgs
Last Revision Date:
Dec 18, 2014
Submit Date:
Nov 20, 2013

Date Received: 20 November, 2013
Date Approved: 19 December, 2014
Date Effective: 1 January, 2014
Signature of Approving Official:
Printed Name and Title: Bill Brooks, Associate Regional Administrator
Division of Medicaid & Children's Health

Alternative Benefit P

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

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

Attachment 3.1-C-

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: Arkansas Newly Eligible Adult Group

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

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

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

Geographic Area

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

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

Arkansas will provide access to the Alternative Benefit Plan (ABP) through two mechanisms: the Arkansas Health Care Independence Program and through fee-for-service Medicaid.

Arkansas has received approval under 1115 of the Social Security Act to implement the Arkansas Health Care Independence Program (Private Option). Under the Private Option 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. Arkansas expects 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 the Private Option will receive the ABP through fee-for-service prior to the effective date of their QHP coverage. Exempt populations including medically frail individuals have a choice of the ABP that is the Arkansas state plan or the ABP that is the FFS equivalent of the QHP offering. Exempt populations, including medically frail individuals who elect to receive the ABP operated in fee-for-service will receive all of the benefits described in this ABP State Plan Amendment.

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

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

An attachment is submitted.

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

The State will provide a notice informing individuals of their eligibility under the Section 1902(a)(10)(A)(i)(VIII) eligibility group once they have been determined eligible through the Federally Facilitated Marketplace (FFM) or via the State's Eligibility and Enrollment Framework (EEF). Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP enrollment is effective, the process for accessing supplemental services, the grievance and appeals process, and outlining the exemption process from the Private Option Alternative Benefit Plan.
Further, the State engaged in the SNAP facilitated enrollment strategy afforded by CMS. Letters were sent to SNAP beneficiaries the first two weeks in September 2013. Please see attached sample SNAP letter and notices.

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.

Upon completion of the questionnaire and finding that the person is exempt from the ABP, the individual will be enrolled in the ABP that is the state plan and will be provided with a Choice Counseling notice, outlining 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. Initially, all individuals will be coded in the system as receiving the ABP that is the Arkansas state plan, and individuals who choose to receive the ABP that is the FFS equivalent of the QHP offering will have claims for services not covered under the ABP that is the Arkansas state plan handled through a manual process, until system changes are made to automate the ABP that is the FFS equivalent of the QHP offering.

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

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

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

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

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

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other

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

Alternative Benefit Plan

☒ Copy of correspondence sent to the individual.

☐ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

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

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

PRA Disclosure Statement

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

V.20130807

State: Arkansas
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Alternative Benefit Plan

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

Attachment 3.1-C- ☐

Enrollment Assurances - Mandatory Participants — ABP2c

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

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

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

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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: children, parents below 17% FPL; blind or disabled; terminally ill hospice patients; pregnant women; or, foster children.

☒ Self-identification

Describe:

For individuals who are eligible for the Private Option, enrollment in a Qualified Health Plan (QHP) will be mandatory. Individuals will receive a notice informing them of the opportunity to be screened to determine whether they are exempt form mandatory participation in the Private Option alternative benefit plan. Upon a determination that they screen exempt, the individual 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).

Individuals who are determined to be medically frail are not eligible for the Private Option demonstration and such individuals will be excluded from enrolling in QHPs. The term "medically frail" is inclusive of both individuals who meet the medically frail definition in 42 CFR 440.315(f) and individuals who have exceptional medical needs as determined through the Arkansas health care needs questionnaire.

Arkansas has instituted a process to determine whether an individual is medically frail or has exceptional health care needs. Arkansas worked with researchers from the University of Michigan and the Agency for Healthcare Research & Quality to develop a Health Care Needs questionnaire which contains twelve questions to assess whether an individual is medically frail ("the Screening Tool"). The screening tool includes the following domains: health self-assessment; living situation; assistance with activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs); overnight hospital stays (both acute and psychiatric); and number of physician, physician extender or mental health professional visits. The Screening Tool is conducted online (unless an individual requests a paper copy) and consists of yes/no and multiple choice answers. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional needs criteria. The screening tool methodology is a combination of threshold qualifying characteristics, such as the presence of an ADL or IADL, and a weighted scoring algorithm based on applicant responses to other screening questions. Downstream refinements to the questionnaire algorithm may occur as data accumulates and individual screening results are compared with actual utilization patterns.

The medical frailty screening process is meant to be prospective at the time of enrollment and will be conducted annually by

Arkansas Medicaid. Self-attestation to the questions in the Screening Tool will be accepted in year one.

Arkansas Medicaid has developed a process for making mid-year transitions to 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 in plan year 2014 to monitor claims so that DHS may identify individuals with emerging medical needs that lead to a transition to the Medicaid program during the plan year.

A Private Option enrollee can notify Division of Medical Services at any time to request a determination of whether they are exempt from participation in the Private Option. Arkansas Division of Medical Services has developed a provider referral form to identify individuals who need services (such as long-term services and supports) that are not available from qualified health plans, but are offered under fee-for-service Medicaid. Lastly, appeals will be monitored to determine whether an individual is in need of services that are not available from the qualified health plans.

Once exempt individuals have been identified, 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 is the Arkansas State Plan or the 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 individual may also call a toll-free-number if they have questions regrading the Health Care Needs questionnaire if they need assistance or additional information regarding this process.

☐ Other

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

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

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

☒ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☒ Change in eligibility group

☐ Other

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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

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○ Ad hoc basis

◉ Other

Describe:

The medical frailty screening process is meant to be prospective at the time of enrollment and will be conducted annually by Arkansas Medicaid. Self-attestation to the questions in the Screening Tool will be accepted in year one. Individuals will be provided with the opportunity to be screened to determine whether they are exempt from mandatory participation in the alternative benefit plan. 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 in plan year 2014 to assist DHS in identifying individuals with emerging medical needs that lead to a transition to the Medicaid program during the plan year.

A Private Option enrollee can notify Division of Medical Services at any time to request a determination of whether they are exempt from participation in the Private Option. Arkansas Division of Medical Services has developed a provider referral form to identify individuals who need services (such as long-term services and supports) that are not available from qualified health plans, but are offered under fee-for-service Medicaid. Lastly, appeals will be monitored to determine whether an individual is in need of services that are not available from the qualified health plans.

☑ 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, 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 is the Arkansas State Plan or the 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 call to finalize their selection. If an affirmative selection is not made, the individual will be placed in the traditional fee-for-service state plan.

Arkansas Medicaid has developed a process for making mid-year transitions to 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 in plan year 2014 to monitor claims so that DHS may identify individuals with emerging medical needs that lead to a transition to the Medicaid program during the plan year.

A Private Option enrollee can notify Division of Medical Services at any time to request a determination of whether they are exempt from participation in the Private Option. Arkansas Division of Medical Services has developed a provider referral form to identify individuals who need services (such as long-term services and supports) that are not available from qualified health plans, but are offered under fee-for-service Medicaid. Lastly, appeals will be monitored to determine whether an individual is in need of services that are not available from the qualified health plans.

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

As stated in ABP1, Alternative Benefit Plan Populations, Arkansas will provide the full range of benefits covered under the ABP, as listed in this State Plan Amendment, through both the Private Option and the fee-for-service delivery system beginning on January 1,

2014.

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.

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State: Arkansas
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OMB Control Number: 0938-1148
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Attachment 3.1-C- ☐

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

Select one of the following:

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

Name of benefit package: Adult Group Alternative Benefit Package

Selection of the Section 1937 Coverage Option

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

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

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

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

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

Arkansas's base benchmark plan is composed of benefits offered through the Arkansas Blue Cross Blue Shield Health Advantage Point of Service (POS) Plan and is supplemented with the mental health and substance abuse benefits from the QualChoice Federal Plan. For individuals receiving the ABP through the Private Option, the State will provide through its fee-for-service Alternative Benefit Program supplemental services that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services. For beneficiaries up to age 21 receiving the ABP through 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 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 provide supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.

Private Option 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 ABP will cover those services.

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. Open Access POS, 13262AR001

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

PRA Disclosure Statement

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Attachment 3.1-C- ☐

Alternative Benefit Plan Cost-Sharing — ABP4

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

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

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

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

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

The State will use cost-sharing as described in the cost sharing section of the State Plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 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.

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OMB Control Number: 0938-1148
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Attachment 3.1-C-

Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Arkansas's EHB base benchmark plan is composed of benefits offered through the Arkansas Blue Cross Blue Shield Health Advantage Point of Service (POS) Plan and is supplemented with the mental health and substance abuse benefits from the Second Largest Federal Employee Health Benefit plan (the QualChoice Federal Plan) and the CHIP plans for pediatric dental and vision. The State will provide through its fee-for-service Medicaid program supplemental benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and, for beneficiaries up to age 21 receiving the ABP through Qualified Health Plans (QHPs) under Arkansas's 1115 demonstration waiver, Arkansas Medicaid will provide supplemental coverage for EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them of how to access the supplemental benefits. Since the QHPs must cover all EHBs, we anticipate that Arkansas will provide supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.

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

Secretary-Approved

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

Alternative Benefit

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

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

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

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

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

Alternative Benefit

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

Remove

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: See www.healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: See www.healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Hospice Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit

Scope Limit:

None

Remove

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

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

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Infusion Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Renal Dialysis/Hemodialysis

Source:

Base Benchmark Small Group

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

Amount Limit:
None

Duration Limit:
None

Remove

Scope Limit:
None

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

Benefit Provided:
Allergy Treatment

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Dental Surgery for Accidents

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
For non diseased teeth.

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

Benefit Provided:
Oral Surgery

Source:
Base Benchmark Small Group

Alternative Benefit

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Remove

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

This benefit is in the CHIP Pediatric dental benefit.

Benefit Provided: Outpatient Surgery

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Chemotherapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Alternative Benefit Plan

Benefit Provided: Cochlear Implants

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: Lifetime maximum of one per ear.

Scope Limit: None

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

Benefit Provided: Diabetic Supplies

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

Alternative Benefit

■ Essential Health Benefit 2: Emergency services — Collapse All ☐

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

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

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

Alternative Benefit Plan

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

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

Remove

Add

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

Alternative Benefit

■ Essential Health Benefit 3: Hospitalization Collapse All ☐

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

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

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

Alternative Benefit Plan

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

Remove

Add

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

Alternative Benefit Plan

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

Benefit Provided: Prenatal and Postnatal Care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Delivery and All Inpatient Services for Maternity

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

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

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

Add

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

Alternative Benefit

Collapse All ☐

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

Benefit Provided: Mental/Behavioral Health Outpatient Services
Source: Base Benchmark Federal Employees
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: The initial diagnostic services is not subject to pre-authorizion but treatment plans may be subject to pre-authorization.

Benefit Provided: Mental/Behavioral Health Inpatient Services
Source: Base Benchmark Federal Employees
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: The treating facility must be a hospital
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Substance Abuse Disorder Outpatient Services
Source: Base Benchmark Federal Employees
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: The initial diagnostic services is not subject to pre-authorizion but treatment plans may be subject to pre-

authorization.

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

Must have treatment plan pre-approved.

Remove

Benefit Provided:

Substance Abuse Disorder Inpatient Services

Source:

Base Benchmark Federal Employees

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

The treating facility must be a hospital.

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

Add

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
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Alternative Benefit Plan

☑ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

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

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Date Received: 11-20-13
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Alternative Benefit

☑ Essential Health Benefit 7: Rehabilitative and habilitative services and devices Collapse All ☐

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

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

Benefit Provided: Outpatient Rehabilitation Services
Source: Base Benchmark Small Group
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: 30 aggregate visits per member per contract year.
Scope Limit: All therapies (speech, occupational, physical and chiropractic) combined in the limits.

Alternative Benefit

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

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

Remove

Benefit Provided: Durable Medical Equipment

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Inpatient Rehabilitative

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 60 days per member per contract year.

Scope Limit: None

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

Benefit Provided: Habilitation (Developmental Services)

Source: Base Benchmark Small Group

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

180 visits per contract year

Remove

Scope Limit:

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

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

Add

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

Alternative Benefit Plan

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

Benefit Provided: Outpatient Diagnostic Test (X-Ray and Lab Work)

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Advanced Diagnostic Imaging CT Scan, PET, MRI

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

State: Arkansas
Date Received: 11-20-13
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Alternative Benefit Plan

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

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

Benefit Provided: Preventative Care/Screening/Immunization

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: 1 visit per year

Scope Limit: None

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

Benefit Provided: Diabetic Education Management

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: $250 per program

Duration Limit: None

Scope Limit: None

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

Add

State: Arkansas
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Alternative Benefit Plan

☑ Essential Health Benefit 10: Pediatric services including oral and vision care Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan Other

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For individuals receiving coverage through the Private Option, QHP benefits are supplemented using fee-for-service Medicaid.

Add

State: Arkansas
Date Received: 11-20-13
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☐ Other Covered Benefits from Base Benchmark Collapse All ☐

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
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Alternative Benefit Plan

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

State: Arkansas
Date Received: 11-20-13
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Date Effective: 1-1-14
Transmittal Number: AR 13-30

Alternative Benefit Plan

☐ Other Base Benchmark Benefits Not Covered Collapse All ☐

State: Arkansas
Date Received: 11-20-13
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Transmittal Number: AR 13-30

Alternative Benefit Plan

☐ Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

State: Arkansas
Date Received: 11-20-13
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☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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.20130814

State: Arkansas
Date Received: 11-20-13
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Alternative Benefit Plan

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
Date Effective: 1-1-14
Transmittal Number: AR 13-30

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 age 21 will receive the full range of EPSDT benefits. For beneficiaries up to 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 provide supplemental coverage for a small number of EPSDT benefits, such as pediatric vision and dental services. For beneficiaries up to 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.

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

State: Arkansas
Date Received: 11-20-13
Date Approved: 12-19-14
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Transmittal Number: AR 13-30

V.20130807

Alternative Benefit Plan

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

Attachment 3.1-C- ☐

Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☒ Other service delivery system.

Fee-For-Service Options

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

◉ Traditional state-managed fee-for-service

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

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

Arkansas Medicaid will provide individuals who are exempt from the ABP 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).

The notice will also inform them that they will be enrolled in the standard fee-for-service benefit package, unless they inform Arkansas Medicaid that they would like to be enrolled in the FFS ABP. Initially, all individuals will be coded in the system as receiving the Standard fee-for-service benefit package, and individuals who choose to receive the fee-for-service ABP will have claims for services not covered under the standard fee-for-service benefit package handled through a manual process, until system changes are made to automate the fee-for-service Alternative Benefit Plan.

During the first year of this State Plan Amendment, the beneficiary will not 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.

Additional Information: Fee-For-Service (Optional)

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

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Other Service Delivery Model

Name of service delivery system:

Premium Assistance for Qualified Health Plans (QHPs) for Private Option SECTION 1115(a) demonstration

Alternative Benefit Plan

Provide a narrative description of the model:

Under the Private Option 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 Private Option beneficiaries). Arkansas expects approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.

Private Option beneficiaries will receive the State plan Alternative Benefit Plan (ABP) through a qualified health plan (QHP).

PRA Disclosure Statement

V.20130718

State: Arkansas
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Alternative Benefit Plan

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

Attachment 3.1-C-

Employer Sponsored Insurance and Payment of Premiums — ABP9

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

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

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with incomes between 17 and 133% FPL who are not enrolled in Medicare (collectively "Private Option beneficiaries"). 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 qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) for beneficiaries up to age 21 receiving the ABP through 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:

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Attachment 3.1-C- [ ]

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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Attachment 3.1-C- ☐

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

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

State: Arkansas
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5. Alternative Benefit Plan (ABP)

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover inpatient acute hospital days in excess of twenty-four days (during a state fiscal year) for those beneficiaries covered under the Alternative Benefit Plan (APB). The per diem rate for ABP inpatient acute hospital days twenty-five and above will be 400 dollars per day. The intent of the policy change is to increase access to care in all hospitals in the state of Arkansas. Inpatient Acute hospital days under twenty-five will be reimbursed in accordance with the methodology set forth in Attachment 4.19A page 1. Except as otherwise noted in the Plan, this rate is the same for both governmental and private providers of inpatient acute hospital services.

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover inpatient rehabilitation hospital days in excess of twenty-four days (during a state fiscal year) for those beneficiaries covered under the Alternative Benefit Plan (ABP). The per diem rate for ABP inpatient rehabilitation hospital days twenty–five and above will be 400 dollars per day. The intent of the policy change is to increase access to care in all hospitals in the state of Arkansas. Inpatient rehabilitation hospital days under twenty-five will be reimbursed in accordance with the methodology set forth in Attachment 4.19A page 9a. Except as otherwise noted in the State Plan, this rate is the same for both government and private providers of inpatient rehabilitation hospital services.

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29. Alternative Benefit Plan (ABP)

All required ABP services and immunizations not specifically identified in the following are covered and reimbursed in accordance with the methodologies described elsewhere in the State Plan. The state's reimbursement methodologies otherwise set forth in the State Plan meet the minimum ABP requirements under the Affordable Care Act (ACA). All APB and non-ABP rates are published on the agency's website (www.medicaid.state.ar.us/download/provider/provdocs/manuals/). Fee schedules are located on the appropriate provider manual page. Except as otherwise noted in the Plan, the rates are the same for both governmental and private providers.

A. Cochlear Implants, Auditory Brain Stem Implants and Osseointegrated Hearing Aid Implants

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover these implants for all age ABP beneficiaries. Reimbursement will be the same as is currently covered for under age 21 non-ABP beneficiaries.

B. Diabetic Self-Management Training

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover Diabetic self-management training by a qualified health care professional for all age ABP beneficiaries. These services will only be provided in the outpatient hospital setting. Reimbursement will be based on the January 1, 2014 Medicare rates for these services.

C. Diagnosis and Treatment of Alcoholism and Drug Abuse, Including Detoxification Treatment and Counseling

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover Diagnosis and treatment of alcoholism and drug abuse, including detoxification treatment and counseling for all age ABP beneficiaries. Reimbursement will be the same as is currently covered for under age 21 non-ABP beneficiaries

D. Shingles Immunization

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover shingles immunization for ABP beneficiaries. These immunizations will be covered for age groups as recommended by the Centers for Disease Control (CDC). Reimbursement will be based on 80% of the 2014 Arkansas Blue Cross Blue Shield rate for this immunization.

29. Alternative Benefit Plan (ABP) (continued)

E. Human Papillomavirus (HPV) immunization

Effective for dates of service on or after January 1, 2014, the Arkansas Medicaid program will cover HPV immunization for ABP beneficiaries. These immunizations will be covered for age groups as recommended by the Centers for Disease Control (CDC).

Reimbursement for ages 19 and over will be based on 80% of the 2014 Arkansas Blue Cross Blue Shield rate for this immunization. Reimbursement for ages 18 and under will be based on the Arkansas Medicaid Vaccines for Children (VFC) reimbursement rate for non-ABP beneficiaries as of January 1, 2014.

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