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State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 17-0002

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

June 23, 2017

Our Reference: SPA AR 17-002

Ms. Dawn Stehle
State Medicaid Director
Arkansas Department of Health and Human Services
Division of Medical Services
P.O. Box 1437
Little Rock, Arkansas 72203-1437

Dear Ms. Stehle:

Attached is a copy of approved Arkansas State Plan Amendment (SPA) No. 17-002, with an effective date of January 1, 2017. This amendment was submitted to amend the state's Alternative Benefit Plan (ABP) to reflect changes in the method of determining medically frail. This change of determination will result in a budget neutral Federal Fiscal Impact for Federal Fiscal Year (FFY) 2017 and 2018.

This letter affirms that AR 17-002 is approved effective January 1, 2017 as requested by the State.

We are attaching the HCFA-179 and the following amended plan pages:

- ABP1 – Alternative Benefit Plan Populations
- ABP2a – Voluntary Benefit Package Selection Assurances – Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act
- ABP2c – Enrollment Assurances – Mandatory Participants
- ABP3 – Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package
- ABP5 – Benefits Description
- ABP8 – Service Delivery Systems
- ABP9 – Employer Sponsored Insurance and Payment of Premiums

If you have any questions regarding this matter you may contact Stacey Shuman at 214-767-6479, or by email at stacey.shuman@cms.hhs.gov.

Sincerely,

Bill Brooks
Associate Regional Administrator

CC: Billy Bob Farrell, DMCH Dallas
Stacey Shuman, DMCH Dallas
Jan Covello, DEHPG Baltimore

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.

AR-17-0002

Proposed Effective Date

01/01/2017 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

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

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2017	$ 0.00
Second Year	2018	$ 0.00

Subject of Amendment

To amend the Alternative Benefit Plan that is equivalent to the Qualified Health Plan offerings in Arkansas Works Act 1 of 2015 to reflect changes in the method of determining medically frail.

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:	**Becky Murphy**
Last Revision Date:	**Jun 19, 2017**
Submit Date:	**Mar 31, 2017**

DATE RECEIVED: 31 March, 2017
DATE APPROVED: 23 June, 2017
SIGNATURE OF REGIONAL ADMINISTRATOR: [redacted]

PRINTED NAME AND TITLE: Bill Brooks
Associate Regional Administrator (ARA)
Division of Medicaid and Children's Health (DMCH)

Alternative Benefit Plan

State: ARKANSAS
Date Received: 31 March, 2017
Date Approved: 23 June, 2017
Effective Date: 1 January, 2017
Transmittal Number: 17-002

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

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

Arkansas will also offer all of the benefits described in this ABP State Plan Amendment through the fee-for-service delivery system. Individuals who are eligible for coverage under Arkansas Works will receive the ABP through fee-for-service prior to the effective date of their QHP coverage. Exempt populations will have the option to receive the ABP that is the approved Arkansas state plan or the ABP that is described in these SPA pages. Exempt individuals choosing to receive the ABP that is described in these SPA pages will receive those benefits through the fee-for-service delivery system, except for those individuals age 21 or over who have access to cost-effective ESI.

Alternative Benefit Plan

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

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

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

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

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

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

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

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

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

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

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

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

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

☒ Letter

☐ Email

☐ Other

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

An attachment is submitted.

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

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

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

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

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

☑ 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.

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☐ In the hard copy of the case record.

☐ Other

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

☒ Copy of correspondence sent to the individual.

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

☐ Other

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

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

PRA Disclosure Statement

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

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State: ARKANSAS
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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.

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:

Individuals will be identified as medically frail through one of two mechanisms: (1) the individual responds “yes” to the following question on the single streamlined application : "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home?” or (2) notifies the Division of Medical Services that they are medically frail. The Division of Medical Services will also monitor appeals to identify individuals who may be medically frail, and the Division of Medical Services will reach out to such individuals to remind them of their right to self-identify as medically frail.

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☐ 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

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

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ○ Ad hoc basis
- ◉ Other

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Describe:

The medical frailty screening process is a part of the single-streamlined application, completed at the time of initial eligibility determination. Individuals will be provided with the opportunity to self-identify as medically frail. 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 to assist DHS in identifying individuals with emerging medical needs that lead to a need for transition to the Medicaid program during the plan year.

An Arkansas Works enrollee can notify Division of Medical Services at any time to request a determination of whether they are exempt from participation in Arkansas Works. Additionally, appeals will be monitored to determine whether an individual is in need of services that are not available from the qualified health plans.

☑ 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 to monitor claims so that DHS may identify individuals with emerging medical needs that lead to a need for transition to the Medicaid program during the plan year.

An Arkansas Works enrollee can notify Division of Medical Services at any time to request a determination of whether they are exempt from participation in Arkansas Works. Additionally, appeals will be monitored to determine whether an individual is in need of services that are not available from the qualified health plans.

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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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

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Selection of the Section 1937 Coverage Option

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

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

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

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

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

Arkansas's base benchmark plan is composed of benefits offered through the HMO Partners inc Open Access POS 13262AR001 . For individuals receiving the ABP through Arkansas Works, 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.

Arkansas Works 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.

Alternative Benefit Plan

Selection of Base Benchmark Plan

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

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

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

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

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

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

PRA Disclosure Statement

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Benefits Description ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

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

Secretary-Approved

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☑ 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

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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 Plan

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

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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

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

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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

Alternative Benefit Plan

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:

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Benefit Provided: Oral Surgery

Source: Base Benchmark Small Group

Alternative Benefit Plan

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

State: ARKANSAS
Date Received: 31 March, 2017
Date Approved: 23 June, 2017
Effective Date: 1 January, 2017
Transmittal Number: 17-002

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: 31 March, 2017
Date Approved: 23 June, 2017
Effective Date: 1 January, 2017
Transmittal Number: 17-002

Alternative Benefit Plan

☑ 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

State: ARKANSAS
Date Received: 31 March, 2017
Date Approved: 23 June, 2017
Effective Date: 1 January, 2017
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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: 31 March, 2017
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Transmittal Number: 17-002

Alternative Benefit Plan

■ 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

State: ARKANSAS
Date Received: 31 March, 2017
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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
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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
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Alternative Benefit Plan

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

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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

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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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Alternative Benefit Plan

☑ 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:

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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.

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

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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

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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

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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

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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 Arkansas Works, QHP benefits are supplemented using fee-for-service Medicaid.

Add

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Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

State: ARKANSAS
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Alternative Benefit Plan

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

State: ARKANSAS
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Alternative Benefit Plan

☐ Other Base Benchmark Benefits Not Covered

Collapse All ☐

State: ARKANSAS
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Alternative Benefit Plan

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

Other 1937 Benefit Provided:

Non-Emergency Medical Transportation

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Other:

Add

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Alternative Benefit Plan

☐ 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: 31 March, 2017
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Transmittal Number: 17-002

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:

State: ARKANSAS
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☐ 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).

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

Additional Information: Fee-For-Service (Optional)

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

Other Service Delivery Model

Name of service delivery system:

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

Provide a narrative description of the model:

QHP: Under the Arkansas Works SECTION 1115(a) demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group under the state plan, to support the purchase of coverage from QHPs offered in the individual market through the Marketplace. In Arkansas, individuals eligible for coverage under the new adult group are both (1) childless adults ages 19 through 64 with incomes at or below 133 percent of the federal poverty limit (FPL) or (2) parents and other caretakers between the ages of 19 through 64 with incomes between 17 percent and 133 percent of the FPL (collectively Arkansas Works QHP beneficiaries). Arkansas expects approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.

Alternative Benefit Plan

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

Arkansas Works also includes an ESI premium assistance component. Medicaid eligible individuals age 21 and over with an employer who chooses to participate in the Arkansas Works ESI program must receive ABP coverage through their employer's ESI, unless the individual is medically frail.

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.20130718

State: ARKANSAS
Date Received: 31 March, 2017
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Effective Date: 1 January, 2017
Transmittal Number: 17-002

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. **Yes**

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

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

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

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

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 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:

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

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