Table of Contents

State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 19-001

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

October 31, 2019

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:

This letter is being sent with the Centers for Medicare and Medicaid Services' (CMS) approval of Arkansas's State Plan Amendment (SPA) #19-0001, consistent with the State Medicaid Director letter (SMD) #10-020 published on October 1, 2010 (relating to SPA review process), to address a problem with one of the SPA pages relating to cost sharing charges imposed on individuals who are enrolled in the eligibility group described at section 1902(a)(10)(A)(ii)(XV) of the Social Security Act (the Act), also known as the Ticket to Work and Work Incentives Improvement Act (TWWIIA) group. Arkansas's SPA #19-0001 proposes to drop coverage of domiciliary services from the state plan and drop the copay associated with this service.

During its review of SPA #19-0001, CMS found several cost sharing policies on page 12p-1 of Attachment 2.6 that were not consistent with federal requirements at sections 1916 and 1916A of the Act. Specifically:

- Page 12p-1 includes a copay on emergency services which is explicitly prohibited by statute at sections 1916(a)(2)(D), 1916(b)(2)(D), and 1916A(b)(3)(vi) of the Act.
    - Page 12p-1 also describes an assessment of a $10 non-emergency copay applicable to those members of the TWWIIA group with income over 100% of the FPL. The amount of this copay is not consistent with the limitations described at sections 1916(a)(3), 1916(b)(3), and 1916A(e) of the Act, as implemented at 42 CFR §447.54 for individuals with income between 100-150% of the FPL which limit the non-emergency copay to $8 (inflated to $9.10 for FFY20). Sections 1916(a)(3), 1916(b)(3) and 1916A(e) also require that hospitals comply with certain rules before assessing the non-emergency copay. Hospitals are expected to comply with screening requirements, help locate an alternate provider and inform beneficiaries of treatment options that have a lesser copay before the hospital and the state can assess the non-emergency use of the emergency room copay. CMS will need to review the state's policies to determine whether the state and its hospitals are implementing this copay appropriately.

- Sections 1916A(b)(1)(B) and section 1916(b)(2)(B) of the Act state that the maximum amount that states may assess to individuals with income between 101-150% of the FPL is 10% of the cost to the agency for items or services, while individuals with income greater than 151% of the FPL are permitted to be charged a copay up to 20% of the cost to the agency for items or services. On October 4, 2019, the state supplied a list of the average Medicaid payment rate for each type of service and CMS has identified the following list of copayments which are not compliant with federal requirements:

    - The copay amount associated with audiology services is not compliant;
    - The copay amount associated with chiropractic services is not compliant;
    - The federally qualified health clinic copay is not compliant for beneficiaries with income at 150% of the FPL, but the copay is compliant for beneficiaries with income greater than 150% of the FPL.
    - The copays for lab services is not compliant for beneficiaries with income at 150% of the FPL, but the copay is compliant for beneficiaries with income greater than 150% of the FPL.
    - The copays for durable medical equipment is not compliant for beneficiaries with income at 150% of the FPL, but the copay is compliant for beneficiaries with income greater than 150% of the FPL.

- As part of the rulemaking that went into effect on July 15, 2013, CMS set a limit on the amount that beneficiaries can be charged for a hospital inpatient stay. 42 CFR §447.52(b)(2) prohibits beneficiaries from being charged in excess of $75/stay. CMS will need additional information from the state to determine if the copay described in Attachment 2.6, page 12p-1 is consistent with federal requirements.

- Lastly, notwithstanding a provision in section 1916(g) of the Act that allows states increased flexibility in the amount of premium that may be assessed to the TWWIIA-group[1], sections 1916A(a)(2)(B), (b)(1)(B)(ii) and (b)(2)(A) of the Act, implemented at 42 CFR §447.56(f), set an aggregate cap on the total premiums and cost sharing charged to a given beneficiary (or, in the case of a family with multiple beneficiaries, all beneficiaries in the household) to five percent of the beneficiary's family income. This five percent aggregate cap may be applied, at state option, on either a monthly or quarterly basis ("aggregate cap period"). Under 42 CFR §447.56(f)(2), if the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mechanism that does not rely on beneficiary documentation. CMS will need additional information from the state on how it is meeting these tracking requirements for the TWWIIA-group and other groups subject to cost sharing and/or premiums in the state plan.

During a phone call on October 18, 2019, CMS reiterated the need for the state to describe cost sharing policies that are consistent with statutory and regulatory requirements. The items identified during the review of the state's submission are not integral to the purpose of SPA #19-0001. In accordance with SMD #10-020, CMS explained to the state the option it has to resolve this issue separately from the approval of the SPA. The state informed CMS that it would like to address the

[1] Section 1916(g) permits states to require individuals in the TWWIIA group to pay premiums or other cost-sharing charges set on a sliding scale based on income. The statute also permits states to assess premiums up to 7.5% of the family income for individuals with income up to 450% of the FPL. However, the flexibility only applies to premiums and any assessment of cost sharing must remain within the aggregate cap.

steps needed to comply with federal policy governing cost sharing separately. This letter initiates that separate process.

As discussed, Arkansas will need to submit a new SPA to amend its cost sharing policies articulated on page 12p-1 of Attachment 2.6-A.

Please respond within 90-days of receipt of this letter by submitting a SPA to bring the state plan into compliance. During this 90-day period, CMS welcomes the opportunity to work with you and your staff. Should you or your staff have any questions, please contact Stephanie Kaminsky, Director, Division of Medicaid Eligibility and Policy at Stephanie.Kaminsky@cms.hhs.gov.

Sincerely,

Bill Brooks
Director
Centers for Medicaid and CHIP Services
Regional Operations Group

Cc: Billy Bob Farrell, ROG Dallas
Melissa Musotto, CMS Baltimore
Terri Fraser, CMS Baltimore
Angela Jones, CMS Baltimore
Jack Tiner, AR DHHS
Isaac Linum, AR DHHS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19 — 0001

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2019

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR § 440.170

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $ 0
b. FFY 2021 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See attached listing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See attached listing

10. SUBJECT OF AMENDMENT

The Arkansas Title XIX State Plan has been amended to remove the optional Domiciliary Care service.

11. GOVERNOR'S REVIEW *(Check One)*

■ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Janet Mann

14. TITLE
Director, Division of Medical Services

15. DATE SUBMITTED

16. RETURN TO
Office of Rules Promulgation
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attn: Isaac Linam

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
August 14, 2019

18. DATE APPROVED
October 31, 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
December 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Bill Brooks

22. TITLE
Director, Regional Operations Group,
Division of Medicaid and Children's Health

23. REMARKS

ATTACHED LISTING FOR
ARKANSAS STATE PLAN
TRANSMITTAL #2019-0001

8. Number of the Plan Section or Attachment	9. Number of the Superseded Plan Section or Attachment
Attachment 2.6-A, Page 12p-1	Attachment 2.6-A, Page 12p-1 Approved 01-25-01, TN 00-14
Attachment 3.1-A, Page 9b	Attachment 3.1-A, Page 9b Approved 02-25-00, TN 99-30
Attachment 3.1-B, Page 8c	Attachment 3.1-B, Page 8c Approved 08-03-01, TN 01-14
Attachment 3.1-F, Page 29	Attachment 3.1-F, Page 29 Approved 11-30-15, TN 13-26
Attachment 4.19-B, Page 8aaaa	Attachment 4.19-B, Page 8aaaa Approved 11-13-01, TN 01-22

State: Arkansas
Date Received: 14 August, 2019
Date Approved: 31 October, 2019
Effective Date: 1 December, 2019
Transmittal Number: 19-0001

There will be a co-payment for Medicaid-covered services, as listed below, for WD eligibles, whose gross income is equal to greater than 100% of the Federal Poverty Level.

PROGRAM SERVICES	**"New" COPAYMENT**
Adult Developmental Day Treatment	**$10 per day**
Ambulance	$10 per trip
Ambulatory Surgical Center	$10 per visit
Audiology Services	$10 per visit
Augmentative Communication Devices	10% of the Medicaid maximum allowable amount
Chiropractor	$10 per visit
Dental (very limited benefits for individuals age 21 and over)	$10 per visit (no co-pay on EPSDT dental screens)
Diapers, Underpads and Incontinence Supplies	None
Durable Medical Equipment (DME)	20% of Medicaid maximum allowable amount per DME item
Early Intervention Day Treatment (not covered for age 21 and over)	**$10 per day**
Emergency Department Services: Emergency Services Non-emergency	$10 per visit $10 per visit
End Stage Renal Disease Services	None
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (not available for individuals over age 21)	None
Eyeglasses	None
Family Planning Services	None
Federally Qualified Health Center (FQHC)	$10 per visit
Hearing Aids (not covered for individuals age 21 and over)	10% of Medicaid maximum allowable amount
Home Health Services	$10 per visit
Hospice	None
Hospital: Inpatient Outpatient	25% of 1st inpatient day (Medicaid per diem) $10 per visit
Hyperalimentation	10% of Medicaid maximum allowable amount
Immunizations	None
Laboratory and X-Ray	$10 per visit
Medical Supplies	None

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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Volunteer Transportation

Volunteer carriers are reimbursed for providing transportation to recipients to medical services provided the carriers are registered by the Arkansas Department of Human Services and Medical Services and the medical services are part of the case plan. A General Relief check is issued by local Human Services staff for payment of Medicaid transportation if a licensed carrier is not available.

These services may be billed once per day, per recipient for a maximum of 300 miles per day. The benefit limit does not apply to EPSDT recipients.

b. Services of Christian Science Nurses - Not Provided.

c. Care and services provided in Christian Science sanitoria - Not Provided.

State: Arkansas
Date Received: 14 August, 2019
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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Volunteer Transportation

Volunteer carriers are reimbursed for providing transportation to recipients to medical services provided the carriers are registered by the Arkansas Department of Human Services and Medical Services and the medical services are part of the case plan. A General Relief check is issued by local Human Services staff for payment of Medicaid transportation if a licensed carrier is not available.

These services may be billed once per day, per recipient for a maximum of 300 miles per day. The benefit limit does not apply to EPSDT recipients.

b. Services of Christian Science Nurses - Not Provided.

c. Care and services provided in Christian Science sanitoria - Not Provided.

d. Nursing facility services provided for patients under 21 years of age - Not Provided.

e. Emergency Hospital Services

Limited to immediate treatment and removal of patient to a qualifying hospital as soon as patient's condition warrants.

State: Arkansas
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Citation	Condition or Requirement

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
CFR 438.50
CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 42 438.10(i) for information requirements specific to MCOs and PCCM programs 42 operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:
Dental Services
Emergency hospital care
Developmental Disabilities Services Community and Employment Support
Family Planning Anesthesia
Alternative Waiver Programs
Adult Developmental Day Treatment Core Services only
Disease Control Services for Communicable Diseases
ARChoices waiver services
Gynecological care
Inpatient Hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment
Mental health services as follows:

a. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practice as an individual practitioner
b. Rehabilitative Services for Youth and Children Nurse

Midwife services
ICF/IID Services
Nursing Facility services
Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment.
Ophthalmology and Optometry services
Obstetric (antepartum, deliver and postpartum) services
Pharmacy
Physician Services for inpatients acute care.
Transportation

State: Arkansas
Date Received: 14 August, 2019
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23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Non-Emergency (Continued)

(b) Non-Public Transportation

Effective for dates of service on or after December 1, 2001, Non-Public Transportation Services reimbursement is based on the lesser charges or the Title XIX maximum allowable. The Title XIX maximum is based on the Internal Revenue Service (IRS) reimbursement for private mileage in a business setting, plus an additional allowance for the cost of the driver. The standard mileage private reimbursement is compliant to the 1997 Standard Federal Tax Report, paragraph #8540.011. The calculation of the additional allowance for the cost of the driver is based on the minimum wage per hour, plus 28% of salaries (minimum wage) for fringe benefits, plus a fixed allowance of $2.11 for the provider's overhead and billings, divided by 30 (average number of miles per trip). The average number of miles was determined by utilizing data from SFY 1996 and dividing the number of miles per trip by the number of trips made.

The State Agency will negotiate with the affected provider group representatives should recipients access become an issue.

(5) Volunteer Transportation: Amount of payment is agreed on by County Human Services Office and the Carrier. Medicaid reimburses the County Human Services Office for the agreed amount.

The rate of reimbursement equals the amount of travel reimbursement per mile for a state employee. Medicaid reimbursement will not be made for services provided free of charge.

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