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State/Territory Name: Arkansas

State Plan Amendment (SPA) #: 22-0008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

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

Medicaid and CHIP Operations Group

February 8, 2023

Janet Mann
Deputy Director of Health and Medicaid Director
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

Re: Arkansas State Plan Amendment (SPA) AR-22-0008

Dear Director Mann:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) AR-22-0008. This amendment proposes to establish rules for cost sharing in Arkansas.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 1916 and 1916A of the Social Security Act, and 42 CFR 447.50 through 447.57. This letter is to inform you that Arkansas Medicaid SPA AR-22-0008 was approved on February 8, 2023, with an effective date of January 1, 2023.

If you have any questions, please contact Lee Herko at 570-230-4048 or via email at lee.herko@cms.hhs.gov .

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Elizabeth Pitman
David Jones
Jack Tiner
Lisa Teague
Mac Golden

Medicaid Premiums and Cost Sharing: 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-22-0008

Proposed Effective Date

01/01/2023 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1916 and 1916A of the Social Security Act, and 42 CFR 447.50 through 447.57

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2023	$ -6136.00
Second Year	2024	$ -8181.00

Subject of Amendment

To establish rules for cost sharing in Arkansas.

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:	**Lisa Teague**
Last Revision Date:	**Jan 30, 2023**
Submit Date:	**Nov 15, 2022**

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Requirements G1

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

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

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

General Provisions

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

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

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

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

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

☒ The state includes an indicator in the Eligibility Verification System

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

☐ Other process

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

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

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

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

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

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

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

■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and

■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The state relies on monographs developed by its designated utilization management contractor to assess whether a hospital's triage protocols are sufficiently effective to ensure the correct level of treatment is determined. Because emergency department services are part of the overall retrospective review process, if non-emergency services are billed at the higher emergency level incorrectly, the entire service would be recouped and the emergency department could bill Medicaid for the non-emergency level and be paid the amount minus the cost share. They would not be allowed to charge the beneficiary for the cost share because the hospital is responsible for the error in claims processing.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. Yes

■ The state identifies which drugs are considered to be non-preferred.

☑ The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

Cost sharing requirements are published in the provider manuals and a hyperlink is used to send the provider to the coinciding table housing the amount of the cost share, which is also published on the Arkansas Medicaid Website. Division of Provider Services and Quality Assurance (DPSQA) maintains the Choices in
Living Resource Center, where Arkansas citizens can call for assistance, including telephone information and brochures for the Workers with Disabilities program. Various brochures are available at the DHS website:
https://humanservices.arkansas.gov/, and are distributed throughout the state in the county offices where the

Division of County Operations are housed.

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 09381148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C42605, Baltimore, Maryland 212441850.

V.20160722

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Categorically Needy Individuals	G2a
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals.	No

PRA Disclosure Statement

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 09381148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C42605, Baltimore, Maryland 212441850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09381148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C42605, Baltimore, Maryland 212441850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

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

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

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

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

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

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

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Allergy Testing	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Non-Emergency Use of the Emergency Department	9.40	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Urgent Care Centers or Facilities	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Durable Medical Equipment	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Prosthetic Devices	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Orthotic Appliances	4.70	$	Item	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Mental/Behavioral Health and SUD Outpatient Services	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rehabilitative Occupational Therapy	4.70	$	Visit	The state has aligned cost sharing for Workers with Disabilities, Transitional Medicaid and Interim Alternative Benefit Program with the copays calculated for Alternative Benefit Plan members.	Remove
Add	Rehabilitative Speech Therapy	4.70	$	Visit		Remove

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

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

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

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

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

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

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

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

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

Remove Population

Add Population

PRA Disclosure Statement

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V.20181119

Medicaid Premiums and Cost Sharing

State Name: Arkansas

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0008

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

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

Exemptions

Groups of Individuals - Mandatory Exemptions

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

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

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - ☐ Other procedure

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

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

- [x] The MMIS system flags recipients who are exempt
- [ ] The Eligibility and Enrollment System flags recipients who are exempt
- [ ] The Medicaid card indicates if beneficiary is exempt
- [ ] The Eligibility Verification System notifies providers when a beneficiary is exempt
- [ ] Other procedure

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

Payments to Providers

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

Payments to Managed Care Organizations

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

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

Aggregate Limits

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

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

- (•) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

☑ The state calculates family income for the purpose of the aggregate limit on the following basis:

◉ Quarterly

○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

☑ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☐ Other process:

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The DHS eligibility system identifies and sends notice to beneficiaries of the initial aggregate family limit when applicable. The MMIS system sends beneficiary letters regarding incurred cost sharing and when the family limit has been met. The provider is notified via the eligibility verification system and upon explanation of benefits when limit has been met.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. Yes

Describe the appeals process used:

The state uses its standard Medicaid fair hearing process.

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

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

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

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

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

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V.20160722