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**State/Territory Name: Arkansas**

**State Plan Amendment (SPA) #: 22-0030**

This file contains the following documents in the order listed:


1) Corrected Approval Letter
2) Original Signed Approval Letter
3) CMS Form 179
4) Approved SPA Pages

**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

August 2, 2023

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

Re: Arkansas State Plan Amendment (SPA) AR-22-0030

Dear Director Mann:

Enclosed please find a corrected approval package for your Arkansas State Plan Amendment (SPA) submitted under transmittal number (TN) AR-22-0030. This SPA, AR-22-0030, was originally approved on June 26, 2023. The approval package sent to Arkansas included the following errors:

- The original approval contained the incorrect version of the SPA pages.
- The modules that were not submitted for approval with this SPA have been removed.
- The correct modules that should be in the approval package are Modules 1, 2a, 2c, 3, 4, 5, 8, and 9.

The enclosed corrected package contains the original signed approval letter, summary page, and the correct SPA pages.

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

**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

June 28, 2023

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

Re: Arkansas State Plan Amendment (SPA) AR-22-0030

Dear Director Mann:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) AR-22-0030. This amendment proposes to update the Alternative Benefit Plan population, voluntary benefit package selection process and the process for exempting members from mandatory enrollment.

We conducted our review of your submittal according to section 1902 (a)(10)(A)(i)(VIII) of the Social Security Act and implementing regulations 42 CFR 440.386. This letter is to inform you that Arkansas Medicaid SPA AR-22-0030 was approved on June 26, 2023, with an effective date of April 1, 2023.

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

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

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

# Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

**State/Territory name:** **Arkansas**

**Transmittal Number:**

***Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.***

AR-22-0030

**Proposed Effective Date**

04/01/2023 *(mm/dd/yyyy)*

**Federal Statute/Regulation Citation**

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

**Federal Budget Impact**

| | Federal Fiscal Year | Amount |
|---|---|---|
| **First Year** | 2023 | $ 0.00 |
| **Second Year** | 2024 | $ 0.00 |

**Subject of Amendment**

To amend the Alternative Benefit Plan to define the Alternative Plan population, and define the voluntary benefit package selection process. Also describes the process for exempting people from mandatory enrollment, the

**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:** | **Jun 7, 2023** |
| **Submit Date:** | **Dec 7, 2022** |

# Alternative Benefit Plan

State Name: Arkansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

## 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:

| Add | Eligibility Group: | Enrollment is mandatory or voluntary? | Remove |
|---|---|---|---|
| Add | Adult Group | Mandatory | Remove |

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

**Geographic Area**

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

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

Arkansas will provide access to the Alternative Benefit Plan (ABP) through two mechanisms: premium assistance to support coverage from Qualified Health Plans (QHPs) offered in the individual market and through fee-for-service Medicaid.

Arkansas has received approval under 1115 of the Social Security Act to implement the Arkansas Health and Opportunity For Me (ARHOME) program. Under the ARHOME 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 QHPs offered in the individual market through the Marketplace

Arkansas will also offer all of thebenefits described in this ABP State Plan Amendment through the fee-for-service delivery system. Individuals who are eligible for coverage under the ARHOME program 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.



V.20181119

# Alternative Benefit Plan

State Name: Arkansas  Attachment 3.1-L-  OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

**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

# Alternative Benefit Plan

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 by the State's eligibility system. Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP coverage is effective, the process for accessing supplemental services, the grievance and appeals process, and accessing other ABP delivery mechanisms for those eligible.

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: "Is this person blind, disabled, or need help with daily activities (such as bathing or walking)?", 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.

☐ In the hard copy of the case record.

☐ Other

# Alternative Benefit Plan

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.

V.20160722

# Alternative Benefit Plan

State Name: Arkansas  Attachment 3.1-L-  OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

## 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 at the time of application: children, individuals eligible for the Parent/Caretaker Relative aid category, blind or disabled, terminally ill hospice patients, pregnant women, individuals living in an institution who are required to contribute all but a minimum amount of their income toward the cost of their care, individuals eligible for medical assistance for long-term care services described in Section 1917(c)(1)(C) of the Social Security Act, individuals infected with tuberculosis, individuals covered by Medicaid only for the treatment of an emergency medical condition, individuals determined Medicaid eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical care, foster children, or former foster children.

☒ Self-identification

Describe:

Individuals will be identified as medically frail through one of two mechanisms: (1) the individual responds “yes” to any of the following questions on the integrated application for assistance: "Do you have a disability? Or are you blind? Do you live in a medical facility or nursing home? What type of facility is this? Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc?” or (2) at any time after the application process, the individual requests to be rescreened for medically frail status. The Division of Medical Services will also monitor rescreening requests to ensure policies and processes for medically frail identification continue to identify appropriate beneficiaries.

☐ 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.

# Alternative Benefit 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

Describe:

The medical frailty screening process is a part of the integrated application for assistance, completed at the time of initial eligibility determination. Individuals will be provided with the opportunity to self-identify as medically frail. Those who self-identify as medically frail will have the option of receiving either the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP.

DHS will rely on carriers and providers 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 ARHOME enrollee can notify the DHS at any time to be rescreened for medically frail status.

☑ 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 individuals have been rescreened as medically frail, 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 provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP. The notice will outline the differences in the benefit offerings and will provide information on the process for enrolling in either the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan or the EHB-equivalent ABP. The notice will also include a toll-free number that individuals may call to make their selection. If an affirmative selection is not made, the individual will be placed in the ABP that provides the full Medicaid benefits offered under the approved Arkansas state plan.

Arkansas Medicaid has developed a process for making transitions to medically frail status after initial application for eligibility. As a part of this process, DHS will rely on carriers to monitor claims so that DHS and carriers may identify individuals with emerging

medical needs that indicate a possible need for transition fee for service delivery system.

An ARHOME enrollee can notify DHS at any time to request a rescreening to determine whether they are medically frail. Additionally, rescreening requests will be monitored to ensure policies and processes for medically frail identification continue to identify beneficiaries in need of services that are not available from the qualified health plans.

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

## PRA Disclosure Statement



V.20160722

# Alternative Benefit Plan

State Name: Arkansas  Attachment 3.1-L-  OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

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

Select one of the following:

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

Name of benefit package: Adult Group Alternative Benefit Package

**Selection of the Section 1937 Coverage Option**

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

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

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

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

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

Arkansas's base benchmark plan is composed of benefits offered through the HMO Partners Inc. Open Access POS 13262AR001. For individuals receiving the ABP through a Qualified Health Plan (QHP), ARHOME,the State will provide supplemental services that are required for the ABP but not covered by QHPs—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services. For beneficiaries under age 21 receiving the ABP through a QHP, 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 Essential Health Benefits (EHBs), Arkansas provides supplemental coverage for only a small number of EPSDT benefits, such as pediatric vision and dental services.

QHP 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 delivery system will cover those services.

**Selection of Base Benchmark Plan**

# Alternative Benefit 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

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.20160722

# Alternative Benefit Plan

State Name: Arkansas  Attachment 3.1-L-  OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

## Alternative Benefit Plan Cost-Sharing — ABP4

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

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

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

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

## PRA Disclosure Statement

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

V.20160722

# Alternative Benefit Plan

State Name: Arkansas  Attachment 3.1-L- [ ]  OMB Control Number: 0938-1148

Transmittal Number: AR - 22 - 0030

## 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

# Alternative Benefit Plan

☑ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

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

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

Benefit Provided: Other Practitioner Office Visit (Nurse, PA, etc)
Source: Base Benchmark Small Group
Remove
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.

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

Benefit Provided: Outpatient Facility Fee (Ambulatory Surgery Ctr).
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: See www healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Outpatient Surgery Physician/Surgical Services
Source: Base Benchmark Small Group
Remove
Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: See https://www.healthadvantage-hmo.com for a list of covered services.

Benefit Provided: Hospice 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:

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.

Remove

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

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:

Remove

Benefit Provided:

Infusion Therapy

Source:

Base Benchmark Small Group

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:

Remove

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

Scope Limit: None

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

Benefit Provided: Allergy Treatment

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Dental Surgery for Accidents

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: State Plan & Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: For non diseased teeth.

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

Benefit Provided: Oral Surgery

Source: Base Benchmark Small Group

Remove

# Alternative Benefit Plan

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:
This benefit is in the CHIP Pediatric dental benefit.

Benefit Provided:
Outpatient Surgery

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Chemotherapy

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
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:

# 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

# Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services — Collapse All ☐

Benefit Provided: Urgent Care Centers or Facilities
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Coverage is the same for In Network and Out of Network

Benefit Provided: Emergency Room Services
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Coverage is the same for In Network and Out of Network

Benefit Provided: Emergency Transportation/Ambulance
Source: Base Benchmark Small Group
Remove

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.

Add

# Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: Inpatient Hospital Services (e.g., Hospital Stay)
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Benefit Provided: Transplants
Source: Base Benchmark Small Group
Remove

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:

Add

# Alternative Benefit Plan

☑ 4. Essential Health Benefit: 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

# Alternative Benefit Plan

Collapse All ☐

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

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mental/Behavioral Health 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: None

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

The initial diagnostic services is not subject to pre-authorizion but treatment plans may be subject to pre-authorization.

Remove

Benefit Provided: Mental/Behavioral Health Inpatient 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 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:

Remove

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

# Alternative Benefit Plan

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.

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

☑ 6. Essential Health Benefit: Prescription drugs

☐ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed 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.

# Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided: Home Health Care Services
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: 50 visits per member per contract year.
Scope Limit: None

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

Benefit Provided: Skilled Nursing Facility
Source: Base Benchmark Small Group
Remove

Authorization: Prior Authorization
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: Limited to 60 days per member per contract year
Scope Limit: None

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

Benefit Provided: Outpatient Rehabilitation Services
Source: Base Benchmark Small Group
Remove

Authorization: None
Provider Qualifications: State Plan & Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: 30 aggregate visits per member per contract year.

# Alternative Benefit Plan

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.

Benefit Provided:
Durable Medical Equipment

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prior authorization is required if costs exceed $5,000. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Single replacement of eyeglasses or contacts within the first 6 months following cataract surgery is covered.

Benefit Provided:
Inpatient Rehabilitative

Source:
Base Benchmark Small Group

Remove

Authorization:
None

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
60 days per member per contract year.

Scope Limit:
None

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

Benefit Provided:
Habilitation (Developmental Services)

Source:
Base Benchmark Small Group

Remove

# Alternative Benefit Plan

| Authorization: | Provider Qualifications: |
|---|---|
| Prior Authorization | State Plan & Public Employee/Commercial Plan |
| **Amount Limit:** | **Duration Limit:** |
| None | 180 visits per contract year |

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

# Alternative Benefit Plan

☑ 8. Essential Health Benefit: 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

# Alternative Benefit Plan

☑ 9. Essential Health Benefit: 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

# Alternative Benefit Plan

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

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 Health and Opportunity for Me (ARHOME) program, QHP benefits are supplemented using fee-for-service Medicaid.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

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

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

# Alternative Benefit Plan

☒ 14. 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:

Other 1937 Benefit Provided:
PASSE-1915(i)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
State Plan & Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
PASSE services are provided only to Medicaid clients with a Tier 2 or Tier 3 Behavioral Health Independent Assessment

Other:
See Attachment 3.1-i PASSE program.

Add

☐ 15. 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

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. 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 0938-1188. 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.20190808

# Alternative Benefit Plan

State Name: Arkansas

Attachment 3.1-L-

OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

## Service Delivery Systems — ABP8

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

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

Select one or more service delivery systems:

☒ Managed care.

- ☐ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☒ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☒ Other service delivery system.

### Managed Care Options

**Managed Care Assurance**

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

**Managed Care Implementation**

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

All ARHOME beneficiaries who are medically frail, and are not enrolled in a PASSE, will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medically frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

**PCCM: Primary Care Case Management**

The PCCM delivery system is the same as an already approved PCCM program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Feb 28, 2019

Describe program below:

Through the PCCM program, beneficiaries choose a primary care provider (PCP), who, through an on-going provider/beneficiary relationship, coordinates health care services, including referrals for necessary specialty services, physician's services, hospital care and other services. The PCCM provider assists enrollees with locating medical services and coordinates and monitors their enrollees prescribed medical and rehabilitation services. This program reimburses the PCP a case management fee provided on a per beneficiary per month basis. All ARHOME beneficiaries who are medically frail, and are not enrolled in a PASSE, will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medially frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

☑ The Alternative Benefit Plan will be provided through primary care case management (PCCM) consistent with applicable managed care requirements (42 CFR Part 438, section 1903(m) of the Social Security Act, and section 1932 of the Social Security Act).

**#type# Procurement or Selection Method**

Indicate the method used to select #type#s:

○ Competitive procurement method (RFP, RFA).

◉ Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PCCMs:

All PCP-qualified physicians and clinics must enroll as PCPs with some exceptions.

**Other PCCM-Based Service Delivery System Characteristics**

One or more of the Alternative Benefit Plan benefits or services will be provided apart from the PCCM. No

PCCM service delivery is provided on less than a statewide basis. No

**PCCM Payments**

Specify how payment for services is handled:

◉ Per member/per month case management fee paid to PCCM provider.

○ Other:

**Additional Information: #type# (Optional)**

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

## 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 delivered through a QHP with a notice that informs individuals that they may choose between the EHB-equivalent 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).

All ARHOME beneficiaries who are medically frail will be required to enroll with a mandatory primary care case management (PCCM) provider. The Choice Counseling notice that medically frail beneficiaries receive will include contact information for the Arkansas Medicaid Beneficiary Service Center to assist in locating a Medicaid primary care provider in their area.

Individuals receiving the EHB-equivalent ABP while awaiting QHP enrollment will not be required to enroll with a Medicaid PCCM provider. Arkansas regulations require QHPs to follow the requirements of the Arkansas Patient Centered Medical Home (PCMH) model or develop their own PCMH standards.

**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 QHPs for ARHOME SECTION 1115(a) demonstration

Provide a narrative description of the model:

Under the ARHOME 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. ARHOME QHP beneficiaries will receive the ABP through a QHP.



V.20181119

# Alternative Benefit Plan

State Name: Arkansas  Attachment 3.1-L-  OMB Control Number: 09381148

Transmittal Number: AR - 22 - 0030

## Employer Sponsored Insurance and Payment of Premiums — ABP9

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

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

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 64 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 64 with incomes between the established monthly eligibility income levels for the Parent/Caretaker/Relative Aid Category (currently $124 per month for a one-person household) and 133% FPL who are not enrolled in Medicare (ARHOME beneficiaries). ARHOME beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP available in their region. The state will use the authority granted under its Arkansas Health and Opportunity for Me Section 1115 Demonstration to provide for the payment of premiums.

The State will provide through its fee for service (FFS) ABP Medicaid program supplemental services that are required for the ABP but not covered by QHPs—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) for beneficiaries under age 21 receiving the ABP through 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 about how to access the supplemental services.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

## PRA Disclosure Statement



V.20160722