

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES**

Revised: January 1, 2014

1. Inpatient Hospital Services (Continued)

Arkansas State Operated Teaching Hospitals (Continued)

- (b) Effective with cost reporting periods beginning on or after July 1, 1993, direct medical education costs, including graduate medical education, will be reimbursed using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rule will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments.

Effective for cost reporting periods beginning on or after January 1, 1997 **and for dates of service up through December 31, 2013**, Arkansas Medicaid will begin excluding graduate medical education (GME) cost from the interim rate. A separate payment for GME reimbursement will be made quarterly and will be calculated based on the number of paid days for that quarter, arrived from the Medicaid Management Information System, multiplied by the GME reimbursement per day determined by the previous cost reporting period. A reimbursement settlement for GME will be made at the time the cost settlements are processed. The GME reimbursement will be calculated using the Medicare rules published in the Federal Register dated September 29, 1989. The only exception to the above Medicare rules will be the inclusion of nursery cost in the calculation of the cost per resident for Medicaid and the State will include nursery days for the allocation of cost to Medicaid. The State will use the Medicare base year for the purpose of calculating the State Operated Teaching Hospitals direct graduate medical education payments. GME payments will not be subject to the upper limit.

Effective for dates of service beginning on or after January 1, 2014, Arkansas Medicaid will make a separate payment for GME costs on a quarterly basis. The payments will be equal to the product of (i) the direct GME costs as reported on the State Operated Teaching Hospital's Medicare cost report, and (ii) the Medicaid Ratio. The Medicaid Ratio is the total of Medicaid patient days for traditional Medicaid beneficiaries plus patient days for Medicaid Private Option beneficiaries divided by total hospital patient days. The quarterly payments will be made on an interim basis, estimated using prior year data trended forward to the current year or, where prior year Private Option data is not available, another appropriate proxy. Payments will be subject to an annual settlement to actual costs based on the filed cost report.

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Arkansas State Operated Teaching Hospitals (Continued)

- (c) The base period for the determination of the TEFRA limit will be current year which is the fiscal year ending immediately prior to the first period this change goes into effect. EXAMPLE: The University of Arkansas for Medical Sciences' (UAMS) base period for determination of TEFRA limits will be fiscal year ending June 30, 1989. Only inpatient operating costs are subject to the limit.

Arkansas Medicaid will use the CMS Market Basket Index or the Congressional Set Inflation Factor for hospitals not subject to the Medicare prospective payment system.

Effective for cost reporting periods ending on or after June 30, 2000, the TEFRA rate of increase limit will no longer be applied to Arkansas State Operated Teaching Hospitals.



Medicaid Administration

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority	A1
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42 CFR 431.10

Designation and Authority

State Name:

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency:

Type of Agency:

- Title IV-A Agency
- Health
- Human Resources
- Other

Type of Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

The single state agency supervises the administration of the state plan by local political subdivisions.

- Yes No

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

- Yes No



Medicaid Administration

Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

Yes No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY):

The type of responsibility delegated is (check all that apply):

- Determining eligibility
- Conducting fair hearings
- Other

Name of state agency to which responsibility is delegated:

Arkansas Insurance Department

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

For Private Option enrollees, only, the Arkansas Department of Human Services intends to delegate covered service appeals including appeals related to medical necessity, scope and duration to the Arkansas Insurance Department. The Arkansas Insurance Department has an external review infrastructure in place for individual market appeals that will be extended to all aspects of Private Option appeals. Under the Arkansas Department of Human Services 1115 Waiver to enroll newly eligible individuals in the Private Option, the State has demonstrated to CMS and met approval that all elements of the appeals process provided by the Arkansas Insurance Department meet Medicaid appeals due process requirements with respect to notices; timeframes for granting or denying a request for an appeal; timeframes for issuing a decision; the right to an in-person hearing; the right to provide testimony; and the right to call witnesses and confront adverse witnesses.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The Arkansas Department of Human Services will enter into a written memorandum of understanding with the Arkansas Insurance Department (that will be made available to the Secretary of Human Services upon request) that will include the following provisions: (1) the relationships and respective responsibilities of both entities to effectuate coverage fair hearings; (2) quality control and oversight by the Medicaid agency, including reporting requirements needed to facilitate control and oversight; and (3) assurances that the Arkansas Insurance Department will: (a) comply with all federal and state Medicaid laws, regulations and policies; (b) and prohibit conflicts of interest and improper incentives; and (c) ensure privacy and confidentiality safeguards.

Add

The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:



Medicaid Administration

The Medicaid agency

Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

The Medicaid agency

Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands

An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

Medicaid agency

Title IV-A agency

An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

Medicaid agency

An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

Yes No

State Plan Administration Organization and Administration

A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

See Attached.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.



Medicaid Administration

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

See attached.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Eligibility determination will be made by the FFM.

Remove

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Eligibility will be determined by the Federal agency administering the SSI program.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Fair Hearings will be determined by the FFM.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)



Medicaid Administration

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

Yes No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

Counties

Parishes

Other

Are all of the local subdivisions indicated above used to administer the state plan?

Yes No

State Plan Administration Assurances

A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

- The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- All requirements of 42 CFR 431.10 are met.
- There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement



Medicaid Administration

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 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 C4-26-05, Baltimore, Maryland 21244-1850.



Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage

S32

Adult Group

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

Yes No

Adult Group - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

The state attests that it operates this eligibility group in accordance with the following provisions:

Individuals qualifying under this eligibility group must meet the following criteria:

Have attained age 19 but not age 65.

Are not pregnant.

Are not entitled to or enrolled for Part A or B Medicare benefits.

Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

Have household income at or below 133% FPL.

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

There is no resource test for this eligibility group.

Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is

receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

Under age 19, or

A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

Yes No

PRA Disclosure Statement



Medicaid Eligibility

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage

S55

Individuals with Tuberculosis

1902(a)(10)(A)(ii)(XII)

1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

Yes No

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Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Individuals Eligible for Family Planning Services

S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

Yes 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 0938-1148. 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 C4-26-05, Baltimore, Maryland 21244-1850.



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Alternative Benefit Plan Populations ABP1

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

Alternative Benefit Plan Population Name:

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

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

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

Geographic Area

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

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

Arkansas has submitted a 1115(a) demonstration waiver to the Centers for Medicare & Medicaid Services for the Arkansas Health Care Independence Program (Private Option). Under the Private Option demonstration, the State will provide premium assistance for beneficiaries eligible under the new adult group established under 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to support the purchase of coverage from Qualified Health Plans offered in the individual market through the Marketplace. Arkansas expects approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program. This state plan amendment applies to the demonstration and outlines the benefits available to this eligibility group. The State estimates that approximately 90% of the newly eligible adult group will receive the ABP through the Private Option demonstration, with the remaining 10% of newly eligible adults receiving either the ABP operated through FFS or the ABP that is the Medicaid State Plan (which in Arkansas is the standard Medicaid benefit package).

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.



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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

ABP2a

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

No

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

- The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).
- The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.
- Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:
 - a) Enrollment in the specified Alternative Benefit Plan is voluntary;
 - b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and
 - c) What the process is for transferring to the state plan-based Alternative Benefit Plan.
- The state/territory assures it will inform the individual of:
 - a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and
 - b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

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

- Letter
- Email
- Other



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 through the Federally Facilitated Marketplace (FFM) or via the State's Eligibility and Enrollment Framework (EEF). Additional notices will provide greater detail explaining the process for selecting a Qualified Health Plan (QHP), the process for accessing services until the QHP enrollment is effective, the process for accessing wrapped/supplemental services, the grievance and appeals process, and outlining the exemption process from the Private Option Alternative Benefit Plan. Further, the State engaged in the SNAP facilitated enrollment strategy afforded by CMS. Letters were sent to SNAP beneficiaries the first two weeks in September 2013. Please see attached sample SNAP letter and notices.

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

The State will provide notice to individuals who believe they may be exempt from the section 1937 Alternative Benefit Plan, informing them that they may request a determination of whether they are exempt from the section 1937 Alternative Benefit Plan and eligible for coverage under either the Alternative Benefit Plan either the ABP operated through FFS or the ABP that is the Medicaid State Plan (which in Arkansas is the standard Medicaid benefit package). The individual will be directed to complete a medically frail screening tool. Upon completion of the tool and finding that the person is exempt from the ABP, the individual will be transitioned to Standard Medicaid and noticed of such transition.

- 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

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

- Copy of correspondence sent to the individual.



Alternative Benefit Plan

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

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V.20130807



Division of Medical Services
[INSERT PROGRAM NAME]



HP Enterprise Services
[INSERT CONTACT INFORMATION]
ACCESSIBILITY LANGUAGE REQUIRED: 42 CFR
435.917(a).

You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-855-550-3974 (TTY: 1--800-285-1131)

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos 1-855-550-3974 al Las personas con problemas para oír – (TTY: 1-8800-285-1131)

Month Day, YYYY

CIN/Medicaid Number: xxxxxxxx
[BENEFICIARY NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [BENEFICIARY NAME],

Why you are getting this letter

We are writing to let you know you have been enrolled in health care plan through the Arkansas Health Care Independence Program. Your health plan coverage begins on xx/xx/xxxx. If you want a different plan, you have 30 days to change your plan.

Your insurance carrier will be sending you coverage and plan information prior to the start of your health coverage.

If you would like to choose another plan, go to the Arkansas Health Care Independence Program website at www.insureark.org.

Health services and costs

You can get many health services through your plan, like doctor's visits, hospital care, and prescriptions. Your plan does not pay for emergency room care when it is not an emergency. Do not go to a hospital emergency room unless you must receive immediate emergency hospital care to prevent your death or serious impairment of your health. For all other care, including urgent care that is not an emergency, call your regular doctor or visit an urgent care provider who participates in your plan. If you go to the emergency room when it is not an emergency the hospital will expect you to pay the bill.

Questions? Go to www.medicad.state.ar.us You can also find out how to meet with someone in person.
Protecting the vulnerable, fostering independence and promoting better health

You are also eligible to receive non-emergency transportation, which you may access by calling 1-888-987-1200. If you are under the age of 21, you may be eligible for some additional services, such as dental and vision, and you can access these services by calling 1-855-703-2891.

If you need help with paying for doctor's visits, hospital care or prescriptions now, before your new health plan coverage begins, please call 1-800-482-8988.

You do not have to pay a premium (monthly cost) for your health coverage.

You will have co-payments for some health services. There is a limit to the total amount of co-payments you have to pay. If you need help paying for any of your co-payments, such as if you have a hospitalization, call 1-800-482-8988. Your health plan will send you more information about your services and co-payments.

By enrolling in or using this health insurance coverage, you acknowledge that the Health Care Independence Program is not an entitlement.

You can appeal what health services you get and how much you pay for them through your health plan and information about how to do that will be provided in your health plan member services package.

If you have questions, please see the questions and answers at www.medicaid.state.ar.us.



Division of Medical Services
[INSERT PROGRAM NAME]



HP Enterprise Services
[INSERT CONTACT INFORMATION]
ACCESSIBILITY LANGUAGE REQUIRED: 42 CFR
435.917(a).

You can get this letter in another language, in large print, or
in another way that's best for you. Call us at 1-855-550-3974
(TTY: 1--800-285-1131)

Usted puede obtener esta carta en otro idioma, con
letras más grandes, o en otro formato que sea más
conveniente para usted. Llámenos 1-855-550-3974 al
Las personas con problemas para oír – (TTY: 1-8800-
285-1131)

Month Day, YYYY

CIN/Medicaid Number: xxxxxxxx
[BENEFICIARY NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [BENEFICIARY NAME],

Why you are getting this letter

We are writing to let you know you have been enrolled in health care plan **X** through the Arkansas Health Care Independence Program. Your health plan coverage begins on xx/xx/xxxx. If you want a different plan, you have 30 days to change your plan.

Your insurance carrier will be sending you coverage and plan information prior to the start of your health coverage.

If you would like to choose another plan, go to the Arkansas Health Care Independence Program website at www.insureark.org.

Health services and costs

You can get many health services through your plan, like doctor's visits, hospital care, and prescriptions. Your plan does not pay for emergency room care when it is not an emergency. Do not go to a hospital emergency room unless you must receive immediate emergency hospital care to prevent your death or serious impairment of your health. For all other care, including urgent care that is not an emergency, call your regular doctor or visit an urgent care provider who participates in your plan. If you go to the emergency room when it is not an emergency the hospital will expect you to pay the bill.

**Questions? Go to www.medicad.state.ar.us You can also find out how to meet with someone in person.
Protecting the vulnerable, fostering independence and promoting better health**

You are also eligible to receive non-emergency transportation, which you may access by calling 1-888-987-1200. If you are under the age of 21, you may be eligible for some additional services, such as dental and vision, and you can access these services by calling 1-855-703-2891.

If you need help with paying for doctor's visits, hospital care or prescriptions now, before your new health plan coverage begins, please call 1-800-482-8988.

You do not have to pay a premium (monthly cost) for your health coverage. You will not have co-payments for your health services.

By enrolling in or using this health insurance coverage, you acknowledge that the Health Care Independence Program is not an entitlement.

You can appeal what health services you get and how much you pay for them through your health plan and information about how to do that will be provided in your health plan member services package.

If you have questions, please see the questions and answers at www.medicad.state.ar.us.

**Questions? Go to www.medicad.state.ar.us You can also find out how to meet with someone in person.
Protecting the vulnerable, fostering independence and promoting better health**

DHS Pine Bluff Scanning Center
P.O. Box 5670
Pine Bluff, AR 71611



Date of Notice: **10/01/2013 9:30 AM**

Reference Number: **56545645**

Deadline for Appeal: **11/01/2013**

Client Name
Street Address
Little Rock, AR 72213-6589

Este aviso contiene datos sobre las prestaciones de usted.
Si necesita la traducción en español, favor llame al 1-855-372-1084

Health Care Notice

Health Care Results

Participant	Participant ID #	Effective Date	Action	Program Name
Client Name	22556644	01/01/2014	Denied	Health Care Independence

You do not qualify for the Health Care Independence Program because there are children in your household who do not have health coverage in Medicaid or another insurance program. This decision is based on MS Section B-270.

Additional household members may be on a separate notice.

Please read the back of this notice for information about what to do if you disagree with this action.

This information is available in accessible formats for individuals with disabilities by contacting 1-855-372-1084.

YOUR RIGHT TO A HEARING

If you disagree with the action we plan to take or a decision that has been made regarding your case, you may have a hearing. You have until the DEADLINE FOR APPEAL date shown on the front of this notice to ask for a hearing. If you request a hearing within 10 days from the DATE OF NOTICE shown on the front page, your assistance may be continued at its present level or reinstated to its previous level pending a decision on your appeal.

However, you may be required to repay the additional benefits if the hearing decision is not in your favor. If you wish to discuss your case with a caseworker before deciding to file a hearing, you should contact your County Office immediately.

REQUESTING A HEARING

You may request a hearing by writing or talking to an employee of the County Office, by writing to Appeals & Hearings, P.O. Box 1437, Slot N401, Little Rock, AR 72203 or by checking the request for a fair hearing box below. If you are requesting a hearing by checking the box, please mail this form to the county office address listed on the front of this notice of action or to Appeals & Hearings at the address shown above.

Please check this box if you are requesting a fair hearing with DHS because you disagree with the case action.

If you request a hearing, you have the right to appear in person and to be represented by a lawyer or by another person you have selected. You may contact the Helpline Center for Arkansas Legal Services at 1-800-952-9243 to request free legal aid. (In Pulaski County, you should call 501-376-3423.) You may also log onto their web site at www.arkansaslegalservices.org and click on the Helpline icon.

Prior to the hearing, you and/or your representative have the right to review your record and any other evidence that is to be presented at the hearing. You have the right to present evidence in your own behalf, to bring witnesses, and to question any person who is presented as a witness against you.

YOUR RESPONSIBILITY TO REPORT CHANGES

It is your continuing responsibility to report changes in income or circumstances which might affect your eligibility. You are required to report changes within 10 days of the change. Report changes including:

- Change in your address
- Change in who lives with you
- Income changes that put you over the income limit for your household size.

Failure to report changes may cause an overpayment which is subject to legal action for collection and prosecution for Fraud.

FOR MEDICAID ONLY: If an individual who is receiving Medicaid is applying for other health insurance and needs verification of "creditable coverage," please contact your local DHS office.

DHS Pine Bluff Scanning Center
P.O. Box 5670
Pine Bluff, AR 71611



Date of Notice: **10/01/2013 9:00 AM**
Reference Number: **567891568**
Deadline for Appeal: **11/01/2013**

Client Name
Street Address
Little Rock, AR 72214-6589

Este aviso contiene datos sobre las prestaciones de usted.
Si necesita la traducción en español, favor llame al 1-855-372-1084

Health Care Notice

Health Care Results

Participant	Medicaid ID #	Effective Date	Action	Program Name
Client Name	89562314	01/01/2014	Approved	Health Care Independence

You qualify for the Health Care Independence Program starting on 01/01/2014 based on your monthly household income of \$2500. You will now need to complete the enrollment process for this coverage by answering a few questions at www.insureark.org and then selecting a plan that is right for you. The selection process must be completed by 01/12/2013. If this selection process has not been completed by this date you will be automatically assigned to a health insurance plan. Keep this notice as proof of your eligibility until you receive your insurance card. The Medicaid ID number on this notice can be used for health insurance coverage until you enroll in a Qualified Health Plan. This decision is based on MS Section B.

Additional household members may be on a separate notice.
Please read the back of this notice for information about what to do if you disagree with this action.

This information is available in accessible formats for individuals with disabilities by contacting 1-855-372-1084.

Date of Notice: 10/01/2013 9:00 AM
Reference Number: 567891568

YOUR RIGHT TO A HEARING

If you disagree with the action we plan to take or a decision that has been made regarding your case, you may have a hearing. You have until the DEADLINE FOR APPEAL date shown on the front of this notice to ask for a hearing. If you request a hearing within 10 days from the DATE OF NOTICE shown on the front page, your assistance may be continued at its present level or reinstated to its previous level pending a decision on your appeal.

However, you may be required to repay the additional benefits if the hearing decision is not in your favor. If you wish to discuss your case with a caseworker before deciding to file a hearing, you should contact your County Office immediately.

REQUESTING A HEARING

You may request a hearing by writing or talking to an employee of the County Office, by writing to Appeals & Hearings, P.O. Box 1437, Slot N401, Little Rock, AR 72203 or by checking the request for a fair hearing box below. If you are requesting a hearing by checking the box, please mail this form to the county office address listed on the front of this notice of action or to Appeals & Hearings at the address shown above.

Please check this box if you are requesting a fair hearing with DHS because you disagree with the case action.

If you request a hearing, you have the right to appear in person and to be represented by a lawyer or by another person you have selected. You may contact the Helpline Center for Arkansas Legal Services at 1-800-952-9243 to request free legal aid. (In Pulaski County, you should call 501-376-3423.) You may also log onto their web site at www.arkansaslegalservices.org and click on the Helpline icon.

Prior to the hearing, you and/or your representative have the right to review your record and any other evidence that is to be presented at the hearing. You have the right to present evidence in your own behalf, to bring witnesses, and to question any person who is presented as a witness against you.

YOUR RESPONSIBILITY TO REPORT CHANGES

It is your continuing responsibility to report changes in income or circumstances which might affect your eligibility. You are required to report changes within 10 days of the change. Report changes including:

- Change in your address
- Change in who lives with you
- Income changes that put you over the income limit for your household size.

Failure to report changes may cause an overpayment which is subject to legal action for collection and prosecution for Fraud.

FOR MEDICAID ONLY: If an individual who is receiving Medicaid is applying for other health

insurance and needs verification of "creditable coverage," please contact your local DHS office.



Division of Medical Services
[INSERT PROGRAM NAME]



HP Enterprise Services
[INSERT CONTACT INFORMATION]
ACCESSIBILITY LANGUAGE REQUIRED: 42 CFR
435.917(a).

You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-855-550-3974 (TTY: 1--800-285-1131)

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos 1-855-550-3974 al Las personas con problemas para oír – (TTY: 1-8800-285-1131)

Month Day, YYYY

CIN/Medicaid Number: xxxxxxxx
[BENEFICIARY NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [BENEFICIARY NAME],

Why you are getting this letter

We are writing to let you know that we have found that you will be best served through Arkansas Medicaid and you have been enrolled in the program. Your coverage begins on xx/xx/xxxx. Your Medicaid ID number is XXXXXXXX.

Health services and costs

You can get many health services through Medicaid like doctor's visits, hospital care and prescriptions.

You do not have to pay a premium (a monthly cost) for your health coverage. You will have to pay co-payments for some services. There is a limit to the total amount of co-payments you have to pay. If you need help paying for any of your co-payments, such as if you have a hospitalization, call 1800-482-8988.

By enrolling in or using this health insurance coverage, you acknowledge that the Health Care Independence Program is not an entitlement.

You can learn more about your covered benefits by visiting www.medicaid.state.ar.us.

Questions? Go to www.medicaid.state.ar.us You can also find out how to meet with someone in person.
Protecting the vulnerable, fostering independence and promoting better health

Access Arkansas
Ark. Dept. of Human Services
1095 White Dr.
Batesville, AR 72501-9964



ADDRESS
ADDRESS
ADDRESS
ADDRESS

Case Number _____
Date _____

Opportunity to Enroll in Health Insurance Coverage with No Monthly Premium Costs for You

You may have seen ads about how to “Get In” to the new Health Insurance Marketplace. Here’s an opportunity for the people in your home to get insured if they don’t already have affordable health insurance. Simply sign the form on the back and return to DHS!

Because your household currently receives SNAP benefits, DHS has already confirmed that the people in your home who are listed on the back of this page are income-eligible for either the **Health Care Independence Program** (adults) or **ARKids First** (children). The Health Care Independence Program lets adults pick the health insurance plans that best meets their needs.

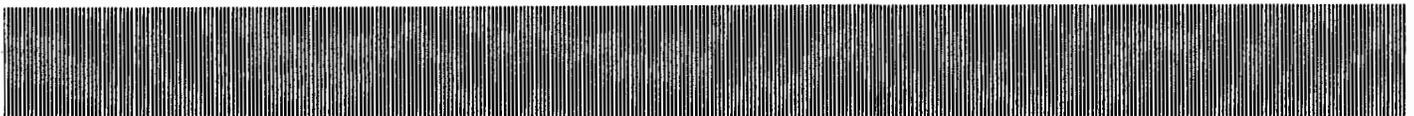
For your household, these programs will pay **100% of your monthly insurance premiums**. You may be responsible for only small copays for appointments, prescriptions, and other medical services.

In order for your household to enroll in the Health Care Independence Program or ARKids First, we **MUST** confirm that you want your household members to receive healthcare coverage. Please complete the form on the back. **DHS must receive the completed “YES” form by September 25, 2013.**

Once you sign and return this form, the following steps will take place:

1. DHS will use the information we have in our computer systems to enroll the listed household members in either the Health Care Independence Program or ARKids First. You will NOT need to fill out any applications for health insurance coverage for these household members.

TURN OVER →



2. DHS will notify you by mail about how and when to choose the health insurance plan that best meets the needs of the adults in your household. Coverage through the Health Care Independence Program will be effective January 1, 2014.
3. For the children in your household, DHS will automatically enroll them in ARKids First and mail an insurance card for each child. Coverage begins once you receive your child's ARKids First card.

If there are other members in your household that need coverage and are not listed on this form, they can apply online beginning October 1, 2013 at www.access.arkansas.gov.

If you have any questions about this special enrollment opportunity, please contact your local DHS office.



Yes, I want the household members listed below to receive health insurance.

1234567890123456789012345678901234567890

Bob Smith
 Bob Smith

Cynthia Smith
 Cynthia Smith
 Cynthia Smith
 Cynthia Smith
 Cynthia Smith
 Cynthia Smith
 Cynthia Smith
 Cynthia Smith

I understand that the Health Care Independence Program is not a federal or state entitlement program and that it may be ended at any time upon appropriate notice.

By receiving benefits from Medicaid, ARKids First, or the Healthcare Independence Program, I assign to DHS my right to receive payment for medical expenses from any legal settlement, judgment, or award paid by any third party, including a health insurer. I must repay DHS, up to the amount that DHS has paid for my medical expenses, whether or not a portion of the third-party payment is designated to pay for medical expenses. I also authorize and request that any payment made by or on behalf of a third party for medical expenses be paid directly to DHS.

Signature: _____ **Date:** _____

**If you want coverage, please sign and return this form in the enclosed envelope.
 This form must be received by September 25, 2013.**

If you do NOT want the household members to receive health insurance, do NOT return this form.



Division of Medical Services
[INSERT PROGRAM NAME]



HP Enterprise Services
[INSERT CONTACT INFORMATION]
ACCESSIBILITY LANGUAGE REQUIRED: 42 CFR
435.917(a).

You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-855-550-3974 (TTY: 1--800-285-1131)

Usted puede obtener esta carta en otro idioma, con letras más grandes, o en otro formato que sea más conveniente para usted. Llámenos 1-855-550-3974 al Las personas con problemas para oír – (TTY: 1-8800-285-1131)

Month Day, YYYY

CIN/Medicaid Number: xxxxxxxx

[BENEFICIARY NAME]

[ADDRESS]

[CITY, STATE ZIP]

Dear [BENEFICIARY NAME],

Why you are getting this letter

We are writing to let you know that you have been enrolled in health care plan X through the Arkansas Health Care Independence Program. Your health plan coverage begins on xx/xx/xxxx. Your insurance carrier will be sending you coverage and plan information prior to the start of your coverage.

Health services and costs

You can get many health services through your plan, such as doctor's visits, hospital care, and prescriptions. Your plan does not pay for emergency room care when it is not an emergency. Do not go to a hospital emergency room unless you must receive immediate emergency hospital care to prevent your death or serious impairment of your health. For all other care, including urgent care that is not an emergency, call your regular doctor or visit an urgent care provider who participates in your plan. If you go to the emergency room when it is not an emergency the hospital will expect you to pay the bill.

You are also eligible to receive non-emergency transportation, which you may access by calling 1-888-987-1200. If you are under the age of 21, you may be eligible for some additional services, such as dental and vision, and you can access these services by calling 1-855-703-2891.

You do not have to pay a premium (monthly cost) for your health coverage. You will have co-payments for some health services. There may be different co-payments for different health services, but there is a limit to your costs each month.

Questions? Go to www.medicad.state.ar.us You can also find out how to meet with someone in person. Protecting the vulnerable, fostering independence and promoting better health

You can appeal what health services you get and how much you pay for them through your health plan. Directions on how to appeal will be included in the information you receive from your health care plan.

By enrolling in or using this health insurance coverage, you acknowledge that the Health Care Independence Program is not an entitlement.

If you need help paying for doctor's visits, hospital care or prescriptions now, before your new health plan coverage begins, please call 1-800-482-8988.

If you have questions, please see the questions and answers at www.medicad.state.ar.us.



Division of Medical Services
[INSERT PROGRAM NAME]



HP Enterprise Services
[INSERT CONTACT INFORMATION]
ACCESSIBILITY LANGUAGE REQUIRED: 42 CFR
435.917(a).

You can get this letter in another language, in large print, or in another way that's best for you. Call us at 1-855-550-3974 (TTY: 1-800-285-1131)

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Month Day, YYYY

CIN/Medicaid Number: xxxxxxx
[BENEFICIARY NAME]
[ADDRESS]
[CITY, STATE ZIP]

Dear [BENEFICIARY NAME],

Why you are getting this letter

We are writing to let you know that you have been enrolled in health care plan X through the Arkansas Health Care Independence Program. Your health plan coverage begins on xx/xx/xxxx. Your insurance carrier will be sending you coverage and plan information prior to the start of your coverage.

Health services and costs

You can get many health services through your plan, such as doctor's visits, hospital care, and prescriptions. Your plan does not pay for emergency room care when it is not an emergency. Do not go to a hospital emergency room unless you must receive immediate emergency hospital care to prevent your death or serious impairment of your health. For all other care, including urgent care that is not an emergency, call your regular doctor or visit an urgent care provider who participates in your plan. If you go to the emergency room when it is not an emergency the hospital will expect you to pay the bill.

You are also eligible to receive non-emergency transportation, which you may access by calling 1-888-987-1200. If you are under the age of 21, you may be eligible for some additional services, such as dental and vision, and you can access these services by calling 1-855-703-2891.

You do not have to pay a premium (monthly cost) for your health coverage. You will not have co-payments for your health services.

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You can appeal what health services you get and how much you pay for them through your health plan. Directions on how to appeal will be included in the information you receive from your health care plan.

By enrolling in or using this health insurance coverage, you acknowledge that the Health Care Independence Program is not an entitlement.

If you need help paying for doctor's visits, hospital care or prescriptions now, before your new health plan coverage begins, please call 1-800-482-8988.

If you have questions, please see the questions and answers at www.medicaid.state.ar.us.



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Enrollment Assurances - Mandatory Participants

ABP2c

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

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

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

How will the state/territory identify these individuals? (Check all that apply)

- Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

The state will review to ensure the person is newly eligible under section 1902(a)(10)(A)(i)(VIII) and is not in any of the following eligibility categories: children, parents below 17% FPL; blind or disabled; terminally ill hospice patients; pregnant women; or, foster children.

- Self-identification

Describe:

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

Individuals excluded from enrolling in QHPs through the Private Option as a result of medical frailty will be eligible for coverage under Title XIX and will have the option of receiving either the ABP operated through fee-for-service or the ABP that is the Medicaid State plan (which in Arkansas is the standard Medicaid benefit package). Arkansas will institute a process to determine whether an individual is medically frail—such as individuals who would benefit from long-term services and supports and targeted outreach and care coordination through the State's emerging plans to establish health homes and to provide services through the Community First Choice state plan option.

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



Alternative Benefit Plan

The medical frailty screening process is meant to be prospective at the time of enrollment and will be conducted annually by Arkansas Medicaid. Self-attestation to the questions in the Screening Tool will be accepted in year one. In the case of false negatives and for individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during the plan year, Medicaid will develop a process for making mid-year transitions to either the ABP that is operated through fee-for-service or the ABP that is the Medicaid State plan (which in Arkansas is the standard Medicaid benefit package). The State may also develop a process to monitor claims experience to identify individuals who were initially identified as medically frail, but no longer appear to meet those criteria.

Other

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

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

- Review of claims data
- Self-identification
- Review at the time of eligibility redetermination
- Provider identification
- Change in eligibility group
- Other

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

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

- 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.



Alternative Benefit Plan

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

Individuals will be provided with the opportunity to be screened to determine whether they are exempt from mandatory participation in the alternative benefit plan. Upon a determination that they screen exempt, the individual will be transferred from the alternative benefit plan and will have the option of receiving either the ABP operated through fee-for-service or the ABP that is the Medicaid State plan (which in Arkansas is the standard Medicaid benefit package).

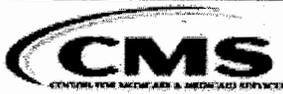
Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

Arkansas plans to use the flexibility outlined by the Secretary in the final ABP regulation. Arkansas will not have a fee-for-service ABP in place by January of 2014, but will work to establish a fee-for-service ABP to be implemented during 2014.

PRA Disclosure Statement

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

V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package

ABP3

Select one of the following:

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

Name of benefit package:

Selection of the Section 1937 Coverage Option

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

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

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

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

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

Arkansas's base benchmark plan is composed of benefits offered through the Arkansas Blue Cross Blue Shield Health Advantage Point of Service (POS) Plan and is supplemented with the mental health and substance abuse benefits from the QualChoice Federal Plan. The State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services. For beneficiaries up to age 21 receiving the ABP through Qualified Health Plans (QHPs) Medicaid will provide wrap around 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 wrapped benefits. Since the QHPs must cover all Essential Health Benefits (EHB), we anticipate that Arkansas will provide wrap around coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.

Selection of Base Benchmark Plan

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



Alternative Benefit Plan

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:

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

Arkansas's EHB benchmark plan is composed of benefits offered through the Arkansas Blue Cross Blue Shield Health Advantage Point of Service (POS) Plan and is supplemented with the mental health and substance abuse benefits from the QualChoice Federal Plan. The State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment services for individuals participating in the Demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT services to the extent such services are not covered under the QHP).

PRA Disclosure Statement

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V.20130801



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Alternative Benefit Plan Cost-Sharing

ABP4

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

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

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

Yes

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

An attachment is submitted.

Other Information Related to Cost Sharing Requirements (optional):

See Appendix D for additional information regarding cost sharing.

PRA Disclosure Statement

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

V.20130807

APPENDIX D

HIGH LEVEL SILVER PLAN COST SHARING VARIATION REQUIREMENT

High-Value Silver Plan	
100% FPL - 150% FPL	

Overall Deductible:	\$150
Service Specific Deductibles:	
Medical	\$0
Brand Drugs	\$0
Dental	\$0
Member Out-of-Pocket Max (all services combined):	\$754

General Service Description	Subject to Deductible	Unit of Service	Copays	Coinsurance
Behavioral Health - IP	Yes	Day	\$ 140	100%
Behavioral Health - OP	No	Visit	\$ 4	100%
Behavioral Health - Professional	No	Visit	\$ 4	100%
Durable Medical Equipment	No	Service	\$ 4	100%
Emergency Room Services	No	Visit	\$ 20	100%
FQHC	No	Visit	\$ 8	100%
Inpatient	Yes	Day	\$ 140	100%
Lab and Radiology	No	Visit	\$ -	100%
Skilled Nursing Facility	Yes	Day	\$ 20	100%
Other	No	Visit	\$ 4	100%
Other Medical Professionals	No	Visit	\$ 4	100%
Outpatient Facility	Yes	Visit	\$ -	91%
Primary Care Physician	No	Visit	\$ 8	100%
Specialty Physician	No	Visit	\$ 10	100%
Pharmacy - Generics	No	Prescription	\$ 4	100%
Pharmacy - Preferred Brand Drugs	No	Prescription	\$ 4	100%
Pharmacy - Non-Preferred Brand Drugs	No	Prescription	\$ 8	100%
Pharmacy - Specialty Drugs (i.e. high-cost)	No	Prescription	\$ 8	100%



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Benefits Description

ABP5

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

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Arkansas's EHB base benchmark plan is composed of benefits offered through the Arkansas Blue Cross Blue Shield Health Advantage Point of Service (POS) Plan and is supplemented with the mental health and substance abuse benefits from the QualChoice Federal Plan. The State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment services. For beneficiaries up to age 21 receiving the ABP through Qualified Health Plans (QHPs) under Arkansas's 1115 demonstration waiver, Arkansas Medicaid will provide wrap around 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 wrapped benefits. Since the QHPs must cover all EHBs, we anticipate that Arkansas will provide wrap around coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.

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

Secretary-Approved



Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services

Collapse All

Benefit Provided:

Primary Care Visit to Treat an Injury or Illness

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Coinsurance applies for services and procedures provided in Specialist office other than consultation and evaluation.

Benefit Provided:

Other Practitioner Office Visit (Nurse, PA)

Source:

Base Benchmark Small Group

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:



Alternative Benefit Plan

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

Remove

Benefit Provided:

Outpatient Facility Fee (Ambulatory Surgery Ctr).

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Benefit Provided:

Outpatient Surgery Physician/Surgical Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Benefit Provided:

Hospice Services

Source:

Base Benchmark Small Group

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:



Alternative Benefit Plan

Scope Limit:

Remove

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

Benefit Provided:

Routine Eye Exam (Adult)

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Actual limit is every 2 years.

Scope Limit:

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

Benefit Provided:

Radiation Therapy

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Benefit Provided:

Infusion Therapy

Source:

Base Benchmark Small Group

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan



Alternative Benefit Plan

Amount Limit:

Duration Limit:

Remove

Scope Limit:

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

Benefit Provided:

Renal Dialysis/Hemodialysis

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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



Alternative Benefit Plan

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Remove

Amount Limit:

Duration Limit:

Scope Limit:

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

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

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:

Other Practitioner Office Visits (APN)

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

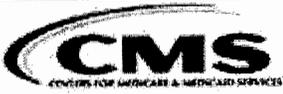
State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Outpatient Surgery

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Depends on what type of surgery is performed.

Benefit Provided:

Vision Exam

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

Eyeglasses not covered.

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

Benefit Provided:

Chiropractic Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

30 aggregate visits per member per contract year

Scope Limit:

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:

Chemotherapy

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Benefit Provided:

Cochlear Implants

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

\$35,000 per covered member, per lifetime

Duration Limit:

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Non Emergency Medical Transportation

Source:

State Plan Other

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

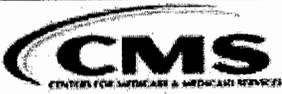
Amount Limit:

Duration Limit:

Scope Limit:

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

Essential Health Benefit 2: Emergency services

Collapse All

Benefit Provided:

Urgent Care Centers or Facilities

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Coverage is the same for In Network and Out of Network.

Benefit Provided:

Emergency Transportation/Ambulance

Source:

Base Benchmark Small Group

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Ground \$1000 per trip.

Duration Limit:

Air limited to 1 air trip per contract year.

Scope Limit:



Alternative Benefit Plan

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

Remove

Add



Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services (e.g., Hospital Stay)

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Benefit Provided:

Transplants

Source:

Base Benchmark Small Group

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:



Alternative Benefit Plan

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

Remove

Add



Alternative Benefit Plan

Essential Health Benefit 4: Maternity and newborn care

Collapse All

Benefit Provided:

Fetal and Postnatal Care

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

Certain services are not covered.

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

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

Benefit Provided:

Mental/Behavioral Health Outpatient Services

Source:

Base Benchmark Federal Employees

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Mental/Behavioral Health Inpatient Services

Source:

Base Benchmark Federal Employees

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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 Outpatient Services

Source:

Base Benchmark Federal Employees

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:



Alternative Benefit Plan

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

Must have treatment plan pre-approved.

Remove

Benefit Provided:

Substance Abuse Disorder Inpatient Services

Source:

Base Benchmark Federal Employees

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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.

Add



Alternative Benefit Plan

Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:



Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:

Home Health Care Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

50 visits per year

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Limited to 60 days per member per contract year

Scope Limit:

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

Benefit Provided:

Outpatient Rehabilitation Services

Source:

Base Benchmark Small Group

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

30 aggregate visits per member per contract year.

Scope Limit:

All therapies combined in the limits.



Alternative Benefit Plan

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

Remove

Benefit Provided:

Durable Medical Equipment

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Some restrictions apply.

Benefit Provided:

Massage Services

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

Under chiropractic or physical therapy only.

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

Benefit Provided:

Developmental Rehabilitation Testing

Source:

Base Benchmark Small Group

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:



Alternative Benefit Plan

Scope Limit:

Remove

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

Benefit Provided:

Physical, Occupational, Speech and Chiropractic

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

30 aggregate visits per member per contract year.

Scope Limit:

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

Benefit Provided:

Hospice

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Case management is involved.

Add



Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services

Collapse All

Benefit Provided:

Diagnostic Test (X-Ray and Lab Work)

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

Scope Limit:

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

Essential Health Benefit 9: Preventive and wellness services and chronic disease management

Collapse All

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

Benefit Provided:

Preventative Care/Screening/Immunization

Source:

Base Benchmark Small Group

Remove

Authorization:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

Duration Limit:

1 visit per year.

Scope Limit:

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:

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

\$250 per program

Duration Limit:

One program per lifetime

Scope Limit:

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

Essential Health Benefit 10: Pediatric services including oral and vision care

Collapse All

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan Other

Remove

Authorization:

None

Provider Qualifications:

State Plan & Public Employee/Commercial Plan

Amount Limit:

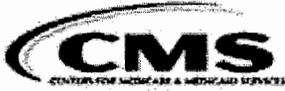
Duration Limit:

Scope Limit:

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

Supplemented using AR CHIP. Contact Lens covered only if medically necessary.

Add



Alternative Benefit Plan

Other Covered Benefits from Base Benchmark

Collapse All



Alternative Benefit Plan

Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All



Alternative Benefit Plan

Other Base Benchmark Benefits Not Covered

Collapse All



Alternative Benefit Plan

Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All



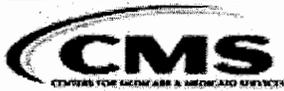
Alternative Benefit Plan

<input type="checkbox"/> 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 <input type="checkbox"/>
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V.20130814



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Benefits Assurances

ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

- The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).
- The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

- Through an Alternative Benefit Plan.
- Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

For beneficiaries up to age 21 receiving the ABP through Qualified Health Plans (QHPs) under Arkansas's 1115 waiver, Arkansas Medicaid will provide wrap around coverage for any EPSDT services that are not covered by the QHP. Beneficiaries will access these additional services through fee-for-service Medicaid, and beneficiaries will receive notices informing them of how to access the wrapped benefits. Since the QHPs must cover all EHBs, we anticipate that Arkansas will provide wrap around coverage for a small number of EPSDT benefits, such as pediatric vision and dental services.

Prescription Drug Coverage Assurances

- The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.
- The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.
- The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.
- The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

- The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.



Alternative Benefit Plan

- The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

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V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Service Delivery Systems

ABP8

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

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

Select one or more service delivery systems:

- Managed care.
- Fee-for-service.
- Other service delivery system.

Other Service Delivery Model

Name of service delivery system:

Private Option - Premium Assistance

Provide a narrative description of the model:

The Demonstration will use premium assistance to purchase QHP coverage for Private Option beneficiaries. Each Private Option beneficiary will have the option to choose between at least two high-value silver plans offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums; all cost-sharing in the high-value silver plans will comply with Medicaid requirements. Additionally, the State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment services for individuals participating in the Demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT services to the extent such services are not covered under the QHP). EPSDT services are relevant to the Private Option only because the Affordable Care Act defines 19 and 20 year olds as children for purposes of service benefit requirements, but adults for purposes of eligibility. If family planning services are accessed at out-of-network providers, the State's fee-for-service Medicaid program will cover those services, as required under federal Medicaid law. Because of Arkansas's Any Willing Provider Law, few, if any, such providers are expected to be outside of private insurance carrier networks.

PRA Disclosure Statement

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

V.20130718



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Employer Sponsored Insurance and Payment of Premiums

ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.

No

The state/territory otherwise provides for payment of premiums.

Yes

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

The State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or incarcerated or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare or incarcerated (collectively "Private Option beneficiaries"). Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace. The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals (and in the longer run, families), improving access to providers, smoothing the "seams" across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives. Ultimately, the Demonstration will provide truly integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Private Option beneficiaries. Additionally, by nearly doubling the size of the population enrolling in QHPs offered through the Marketplace, the Demonstration is expected to drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

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Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

General Assurances

ABP10

Economy and Efficiency of Plans

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

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

Yes

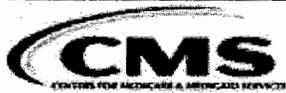
Compliance with the Law

- The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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V.20130807



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

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

An attachment is submitted.

PRA Disclosure Statement

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