

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00287/6

TITLE: Arkansas Works Section 1115 Demonstration

AWARDEE: Arkansas Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditure under section 1903 shall, for the period of this demonstration be regarded as expenditures under the state's Title XIX plan but are further limited by the special terms and conditions (STCs) for the Arkansas Works Section 1115 demonstration.

The expenditure authorities listed below promote the objectives of title XIX by: increasing overall coverage of low-income individuals in the state, improving health outcomes for Medicaid and other low-income populations in the state, and increasing access to, stabilizing, and strengthening the availability of provider and provider networks to serve Medicaid and low-income individuals in the state.

The following expenditure authorities shall enable Arkansas to implement the Arkansas Works section 1115 demonstration:

1. **Premium Assistance and Cost Sharing Reduction Payments** Expenditures for part or all of the cost of private insurance premiums in the individual market, and for payments to reduce cost sharing under such coverage for certain individuals eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Act.
2. **Premium Assistance Payments for Employer-Sponsored Insurance** Expenditures for the employee share of cost-effective small group employer-sponsored insurance when the employer contributes at least 25 percent of the overall cost of the coverage for individuals enrolled in the new adult group described in section 1905(a)(10)(A)(i)(VIII) of the Act, that would not meet the requirements for premium assistance under the state plan.
3. **Employer Incentives for New Or Expanded Employer-Sponsored Insurance.** Expenditures for the employer share of cost-effective small group employer-sponsored insurance attributable to individuals receiving premium assistance under demonstration expenditure authority #2, to the extent that the remaining employer contribution is no less than 25 percent of the overall cost of the coverage, limited to a three year period per employer and only for employers who either (1) offer coverage effective on or after January 1, 2017 and had not offered coverage in calendar year 2016 or (2) offer non-grandfathered small group coverage effective on or after January 1, 2017 and had previously offered only grandfathered coverage.

Requirements Not Applicable to the Expenditure Authority:

1. Cost Effectiveness

**Section 1902(a)(4) and
42 CFR 435.1015(a)(4)**

To the extent necessary to permit the state to offer, with respect to individuals covered under this demonstration through qualified health plans, premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00287/6
TITLE: Arkansas Works Section 1115 Demonstration
AWARDEE: Arkansas Department of Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from January 1, 2017 through December 31, 2021. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs.

1. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Arkansas Works beneficiary's Qualified Health Plan or Employer Sponsored Insurance. No waiver of freedom of choice is authorized for family planning providers.

2. Payment to Providers **Section 1902(a)(13) and Section
1902(a)(30)**

To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan or Employer Sponsored Insurance participating under Arkansas Works.

3. Prior Authorization **Section 1902(a)(54) insofar as it
incorporates Section 1927(d)(5)**

To permit Arkansas to require that requests for prior authorization for drugs be addressed within 72 hours, and for expedited review in exigent circumstances within 24 hours, rather than 24 hours for all circumstances as is currently required in their state policy. A 72- hour supply of the requested medication will be provided in the event of an emergency.

4. Premiums **Section 1902(a)(14) insofar as it
incorporates Sections 1916 and 1916A**

To the extent necessary to enable the state to collect monthly premiums for individuals with incomes above 100 up to and including 133 percent of the federal poverty level (FPL).

5. Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act.

6. Non-Emergency Medical Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to relieve the state of its obligation to provide non-emergency medical transportation to and from providers for individuals who are enrolled in employer-sponsored insurance and have not demonstrated a need for such transportation.

7. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to not provide retroactive eligibility for the affected populations. This provision will become effective 30 days after the later of CMS receiving written assurance from the state that it complies with the reasonable opportunity provisions in Section 1137(d) of the Social Security Act and CMS receiving written assurance from the state that the state has successfully completed the Arkansas MAGI Backlog Mitigation Plan as provided for in STC 20. The state shall also implement the Affordable Care Act provision on presumptive eligibility determinations by qualified hospitals as provided for in STC 20.

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00287/6
TITLE: Arkansas Works
AWARDEE: Arkansas Department of Human Services

I. PREFACE

The following are the amended Special Terms and Conditions (STCs) for the Arkansas Works section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Arkansas Department of Human Services (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. Enrollment into the demonstration will be statewide and is approved through December 31, 2021.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Populations Affected
- V. Arkansas Works Premium Assistance Enrollment
- VI. Premium Assistance Delivery System
- VII. Benefits
- VIII. Premiums & Cost Sharing
- IX. Appeals
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. Evaluation
- XIV. Monitoring

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Arkansas Works demonstration, the state has been providing premium assistance to support the purchase by beneficiaries eligible under the new adult group under the state plan of coverage from QHPs offered in the individual market through the Marketplace Enrollment activities for the new adult population began on October 1, 2013 for the qualified health plan (QHP) with eligibility effective January 1, 2014. In Arkansas, individuals eligible for coverage under the new adult group are as described at Section 1902(a)(10)(A)(i)(VIII) of the Social

Security Act (collectively Arkansas Works beneficiaries). Arkansas expected approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.

With this amendment and extension, the state will test innovative approaches to promoting individual financial responsibility for care and to minimizing churn through strengthening employer sponsored insurance (ESI). All Arkansas Works beneficiaries with incomes above 100 percent of the FPL will be charged monthly premium payments. Additionally, all Arkansas Works beneficiaries age 21 and over who receive the alternative benefit plan (ABP) and who have access to cost-effective ESI through participating Arkansas Works employers will be required to participate in ESI.

Arkansas Works beneficiaries will receive a state plan ABP. Services will be delivered primarily through the service delivery network of the QHP that they select (or of the ESI plan, if applicable) and the QHP (or ESI, if applicable) will be the primary payer for such services. Beneficiaries will have cost sharing obligations consistent with the state plan.

With this demonstration Arkansas proposes to further the objectives of Title XIX by:

- Promoting continuity of coverage for individuals,
- Improving access to providers,
- Improving continuity of care across the continuum of coverage,
- Furthering quality improvement and delivery system reform initiatives, and
- Leveraging employer contributions for insurance coverage to enhance Medicaid coverage.

Arkansas proposes that the demonstration will provide integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Arkansas Works beneficiaries. The state proposes that the demonstration will also drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace by doubling the size of the population enrolling in QHPs offered through the Marketplace, as well as expanding use of ESI.

The state proposes to demonstrate the following key features:

Continuity of coverage and care – For households with members eligible for coverage under Title XIX and Marketplace coverage as well as those who have income fluctuations that cause their eligibility to change year-to-year, or multiple times throughout the year, the demonstration will create continuity of health plans available for selection as well as provider networks. Households may stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, or Advanced Payment Tax Credits/Cost Sharing Reductions (APTC/CSRs). Similarly, individuals with access to ESI will be able to maintain coverage through their ESI, regardless of whether their income fluctuates above or below Medicaid levels.

Support equalization of provider reimbursement and improve provider access – The demonstration will support equalization of provider reimbursement across payers, toward the end of expanding provider access and eliminating the need for providers to cross-subsidize. Arkansas Medicaid provides rates of reimbursement lower than Medicare or commercial payers,

causing some providers to forego participation in the program and others to “cross subsidize” their Medicaid patients by charging more to private insurers.

Integration and efficiency – Arkansas is proposing taking an integrated and market-based approach to covering uninsured Arkansans.

Strengthening the state’s employer sponsored insurance market – The state will strengthen its employer-sponsored insurance market by expanding the number of potential individuals covered through employer-sponsored insurance and by reducing changes in coverage due to fluctuations in income for individuals covered through employer-sponsored insurance.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Children’s Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to provide the state with additional notice of the changes.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** If the eligibility of a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.
 - a. Should the state amend the state plan to make any changes to eligibility for this population, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request a corresponding technical correction to the demonstration.

6. **Changes Subject to the Amendment Process.** Changes related to demonstration features including eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan and/or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
 - a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;
 - b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

- 8. Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.
- a. Compliance with Transparency Requirements at 42 CFR Section 431.412.
 - b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 15.
- 9. Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into the revised plan.
 - b. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.
 - c. **Transition and Phase-out Plan Requirements:** The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.
 - d. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they

qualify for Medicaid eligibility under a different eligibility category. 42 CFR Section 435.916.

- e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).
 - f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- 10. Pre-Approved Transition and Phase Out Plan.** The state may elect to submit a draft transition and phase-out plan for review and approval at any time, including prior to when a date of termination has been identified. Once the transition and phase-out plan has been approved, implementation of the plan may be delayed indefinitely at the option of the state.
- 11. Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.
- 12. Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the State must submit a transition plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:
- a. Expiration Requirements. The State must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
 - b. Expiration Procedures. The State must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration enrollees as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration enrollee requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Section 431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
 - c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the State's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and

approval of the State's demonstration expiration plan. The State must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

- d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling enrollees.

13. Withdrawal of Demonstration Authority. CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.

14. Adequacy of Infrastructure. The State must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the State's approved state plan, when any program changes to the demonstration are proposed by the State.

- a. In States with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
- b. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).
- c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

- 16. Federal Financial Participation (FFP).** No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. POPULATIONS AFFECTED

The State will use this demonstration to ensure coverage for Arkansas Works eligible beneficiaries provided primarily through QHPs offered in the individual market or through ESI instead of the fee-for-service delivery system that serves the traditional Medicaid population. The State will provide premium assistance to aid individuals in enrolling in coverage through QHPs in the Marketplace or ESI for Arkansas Works beneficiaries.

- 17. Populations Affected by the Arkansas Works Demonstration.** Except as described in STCs 18 and 19, the Arkansas Works Demonstration affects the delivery of benefits, as set forth in section 1905(y)(2)(B) of the Act and codified at 42 CFR Section 433.204(a)(2), to adults aged 19 through 64 eligible under the state plan under 1902(a)(10)(A)(i)(VIII) of the Act, 42 CFR Section 435.119. Eligibility and coverage for these individuals is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid state plan amendments to this eligibility group, including the conversion to a modified adjusted gross income standard on January 1, 2014, will apply to this demonstration.

Table 1 Eligibility Groups

Medicaid State Plan Mandatory Groups	Federal Poverty Level	Funding Stream	Expenditure and Eligibility Group Reporting
New Adult Group	This group includes adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act	Title XIX	MEG – 1

- 18. Medically Frail Individuals.** Arkansas will institute a process to determine whether an individual is medically frail. The process is described in the Alternative Benefit state plan. Medically frail individuals will be excluded from the demonstration with the following exception for individuals who have access to and chose to enroll in ESI. Specifically, for the purposes of these STCs, the terms “medically frail” or “medically frail individuals” shall exclude any individuals identified as medically frail by the state, consistent with the process described in the Alternative Benefit state plan, if that individual is age 21 or over and has elected to receive the Alternative Benefit Plan, and has access to cost-effective ESI through an employer participating in Arkansas Works. All such individuals will be covered through the demonstration and will be required to enroll in ESI. For the purposes of these STCs, these individuals will be included in the term “Arkansas Works beneficiaries,” unless expressly noted otherwise.
- a. Medically frail individuals will only be subject to cost sharing under the terms of this demonstration if they are age 21 or over, have elected to receive the Alternative Benefit Plan, and are enrolled in cost-effective ESI through an employer participating in Arkansas Works.
 - b. Individuals excluded from enrolling in QHPs through the Arkansas Works as a result of a determination of medical frailty as that term is defined above will have the option of receiving direct coverage through the state of either the same ABP offered to the new adult group or an ABP that includes all benefits otherwise available under the approved Medicaid state plan (the standard Medicaid benefit package). Direct coverage will be provided through a fee- for- service (FFS) system.
- 19. American Indian/Alaska Native Individuals.** Individuals identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in QHPs or ESI in this demonstration, but can choose to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted into the Arkansas Works will receive the ABP available to the new adult group and operated through a fee for service (FFS) system. An AI/AN individual will be able to access covered benefits through Indian Health Service (IHS), Tribal or Urban Indian Organization (collectively, I/T/U) facilities funded through the IHS. Under the Indian Health Care Improvement Act (IHCIA), I/T/U facilities are entitled to payment notwithstanding network restrictions.
- 20. Retroactive Coverage.** Upon completion of the Arkansas MAGI Backlog Mitigation Plan, the state shall submit written assurance with supporting documentation that the backlog has been eliminated and that eligibility determinations and redeterminations are completed on a timely basis. The state shall submit data on a quarterly basis to CMS to demonstrate continued compliance with timely determinations of eligibility.

The state shall submit written assurance with supporting documentation that it provides benefits during a reasonable opportunity period to individuals who are otherwise eligible for Medicaid and who attest to eligible immigration status, consistent with Section 1137(d) of the Social Security Act.

The state will also implement the Affordable Care Act requirement that allows qualified hospitals to make presumptive eligibility (PE) determinations for certain Medicaid populations and have an approved State Plan Amendment for hospitals to make presumptive eligibility (PE) determinations by April 1, 2017. Any Medicaid-enrolled hospital that agrees to the PE determination process established by the state will be considered a qualified hospital.

V. ARKANSAS WORKS PREMIUM ASSISTANCE ENROLLMENT

- 21. Arkansas Works.** For Arkansas Works beneficiaries, enrollment in either a QHP or ESI will be a condition of receiving benefits. All Arkansas Works beneficiaries ages 21 and over with access to cost-effective ESI through an employer participating in the Arkansas Works program will be required to enroll in ESI; all other Arkansas Works beneficiaries will be required to enroll in a QHP, unless they have been determined to be medically frail.
- 22. Notices.** Arkansas Works beneficiaries will receive a notice or notices from Arkansas Medicaid or its designee advising them of the following:
 - a. Requirement to Enroll in ESI or QHP. The notice will inform Arkansas Works beneficiaries whether they are required to enroll in ESI or QHPs to receive coverage.
 - b. QHP Plan Selection. If applicable, the notice will include information regarding how Arkansas Works beneficiaries who are required to enroll in QHPs can select a QHP and information on the State's auto-assignment process in the event that the beneficiary does not select a plan.
 - c. ESI Enrollment. If applicable, the notice will include information regarding how Arkansas Works beneficiaries who are required to enroll in ESI should enroll in ESI and how the beneficiary will access services before ESI begins.
 - d. State Premiums and Cost-Sharing. The notice will include information about the individuals premium and cost-sharing obligations, if any, as well as the quarterly cap on premiums and cost-sharing.
 - e. Access to Services until QHP/ESI Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP or ESI enrollment is effective. In addition to a CIN number, Arkansas Works beneficiaries who are required to enroll in ESI will receive an Arkansas Works card to access services prior to ESI enrollment and any wrapped benefits after ESI enrollment.
 - f. Wrapped Benefits. The notice will also include information on how beneficiaries can access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 37.
 - g. Appeals. The notice will also include information regarding the grievance and appeals process.

- h. Identification of Medically Frail. The notice will include information describing how Arkansas Works beneficiaries who believe they may be exempt from the Arkansas Works ABP, and individuals who are medically frail, can request a determination of whether they are exempt from the ABP. The notice will also include alternative benefit plans options.
23. **QHP Selection.** The QHP in which Arkansas Works beneficiaries will enroll will be certified through the Arkansas Insurance Department's QHP certification process. The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.
24. **Enrollment Process.** In accordance with the state established timeframes established in the Enrollment Protocols, individuals will enroll through the process described in operational protocols developed by the state and approved by CMS.
25. **Auto-assignment.** In the event that an individual is determined eligible for coverage through the Arkansas Works QHP premium assistance program, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's rating area. Individuals who are auto-assigned will be notified of their assignment, and the effective date of QHP enrollment, and will be given a thirty-day period from the date of enrollment to request enrollment in another plan.
26. **Distribution of Members Auto-assigned.** Arkansas Works QHP auto-assignments will be distributed among QHP issuers in good standing with the Arkansas Insurance Department offering certified silver-level QHPs certified by the Arkansas Insurance Department with the aim of achieving a target minimum market share of Arkansas Works enrollees for each QHP issuer in a rating region. Specifically, the target minimum market share for a QHP issuer offering silver QHP in a rating region will vary based on the number of competing QHP issuers as follows:
- Two QHP issuers: 33 percent of Arkansas Works enrollees in that region.
Three QHP issuers: 25 percent of Arkansas Works enrollees in that region.
Four QHP issuers: 20 percent of Arkansas Works enrollees in that region.
More than four QHP issuers: 10 percent of Arkansas Works enrollees in that region.
27. **Changes to Auto-assignment Methodology.** The state will advise CMS 60 days prior to implementing a change to the auto-assignment methodology.
28. **Disenrollment.** Enrollees in the Arkansas Works QHP Premium Assistance Program may be disenrolled if they are determined to be medically frail after they were previously determined eligible. Enrollees in the Arkansas Works ESI Premium Assistance Program may be disenrolled if they are determined to be medically frail and select to receive the standard benefit package at any time.
29. **Operational Protocols.** By April 30, 2017, the state will submit for CMS approval operational protocols further describing, among other things the enrollment/disenrollment process for all Arkansas Works beneficiaries. The protocol must include, at a minimum, a description of the following items:

- a. The process for identifying participating employers;
- b. The process for demonstrating cost effectiveness in ESI;
- c. The process for assisting beneficiaries in enrolling in ESI;
- d. The process for ensuring beneficiaries have access to services before ESI coverage become effective;
- e. The methodology for determining employer incentives for new or expanded ESI;
- f. The beneficiary incentive benefit structure and design;
- g. The process for qualifying for the beneficiary incentive benefit; and
- h. Information on how beneficiaries can access wrapped services and cost sharing, including services from a non-Medicaid provider.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

30. Memorandum of Understanding for QHP Premium Assistance. The Arkansas Department of Human Services and the Arkansas Insurance Department have entered into a memorandum of understanding (MOU) with each QHP that will enroll individuals covered under the Demonstration. Areas to be addressed in the MOU include, but are not limited to:

- a. Enrollment of individuals in populations covered by the Demonstration;
- b. Payment of premiums and cost-sharing reductions, including the process for collecting and tracking beneficiary premiums;
- c. Reporting and data requirements necessary to monitor and evaluate the Arkansas Works including those referenced in STC 71, ensuring enrollee access to EPSDT and other covered benefits through the QHP;
- d. Requirement for QHPs to provide, consistent with federal and state laws, claims and other data as requested to support state and federal evaluations, including any corresponding state arrangements needed to disclose and share data, as required by 42 CFR 431.420(f)(2), to CMS or CMS' evaluation contractors.
- e. Noticing requirements; and,
- f. Audit rights.

31. Qualified Health Plans. The State will use premium assistance to support the purchase of coverage for Arkansas Works beneficiaries through Marketplace QHPs.

32. Choice of QHPs. Each Arkansas Works beneficiary required to enroll in a QHP will have the option to choose between at least two silver plans covering only Essential Health Benefits that are offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums.

- a. Arkansas Works beneficiaries will be able to choose from at least two silver plans covering only Essential Health Benefits that are in each rating area of the State
- b. Arkansas Works beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area and that meet the purchasing guidelines established by the State in that year, and thus all Arkansas Works beneficiaries will have a choice of at least two qualified health plans.

- c. The State will comply with Essential Community Provider network requirements, as part of the Qualified Health Plan certification process.
 - d. Arkansas Works beneficiaries will have access to the same networks as other individuals enrolling in silver level QHPs through the individual Marketplace.
- 33. Memorandum of Understanding for ESI Premium Assistance.** The Arkansas Department of Human Services will require that its vendor enter into a memorandum of understanding with all employers participating in the ESI Premium Assistance Program.
- 34. Coverage Prior to Enrollment in a QHP or ESI.** The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for the New Adult Group until the individual's enrollment in the QHP or ESI becomes effective.
- a. For individuals who enroll in a QHP (whether by selecting the QHP or through auto-assignment) or ESI between the first and fifteenth day of a month, QHP/ESI coverage will become effective as of the first day of the month following QHP/ESI enrollment.
 - b. For individuals who enroll in a QHP (whether by selecting the QHP or through auto-assignment) or ESI between the sixteenth and last day of a month, QHP/ESI coverage will become effective as of the first day of the second month following QHP/ESI selection (or auto-assignment).
- 35. Family Planning.** If family planning services are accessed at a facility that the QHP/ESI considers to be an out-of-network provider, the State's fee-for-service Medicaid program will cover those services.
- 36. NEMT.** Non-emergency medical transport services will be provided through the State's fee-for-service Medicaid program. See STC 43 for further discussion of non-emergency medical transport services.

VII. BENEFITS

- 37. Arkansas Works Benefits.** Individuals affected by this demonstration will receive benefits as set forth in section 1905(y)(2)(B) of the Act and codified at 42 CFR Section 433.204(a)(2). These benefits are described in the Medicaid state plan.
- 38. Alternative Benefit Plan.** The benefits provided under an alternative benefit plan for the new adult group are reflected in the State ABP state plan.
- 39. Medicaid Wrap Benefits.** The State will provide through its fee-for-service system wrap-around benefits that are required for the ABP but not covered by qualified health plans or ESI. These benefits include non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21.
- 40. Access to Wrap Around Benefits.** In addition to receiving an insurance card from the applicable QHP or ESI issuer, Arkansas Works beneficiaries will have a Medicaid CIN or

Arkansas Works card (for ESI enrolled beneficiaries) through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN or card will include information about which services Arkansas Works beneficiaries may receive through fee-for-service Medicaid and how to access those services. This information will also be posted on Arkansas Department of Human Service's Medicaid website and be provided through information at the Department of Human Service's call centers and through QHP issuers or through the call center for ESI enrollees established by the state or its vendor.

41. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The State must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).
42. **Access to Federally Qualified Health Centers and Rural Health Centers.** Arkansas Works enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC and RHC. Arkansas Works beneficiaries receiving coverage through ESI will have access to at least one FQHC and RHC through their ESI. If their ESI does not contract with an FQHC and RHC, they may access an FQHC and RHC through fee-for-service Medicaid.
43. **Access to Non-Emergency Medical Transportation.** For individuals in the eligibility group established under Section 1902(a)(10)(A)(i)(VIII), the state will establish prior authorization for NEMT in the ABP. Individuals served by IHS or Tribal facilities, and medically frail individuals will be exempt from such requirements. The state will have no obligation to provide NEMT to individuals covered through ESI premium assistance to individuals who have not demonstrated a need for such services.
44. **Incentive Benefits.** To the extent an amendment is approved by CMS and also described in operational protocols developed by the state, Arkansas will offer an additional benefit not otherwise provided under the Alternative Benefit Plan for Arkansas Works enrollees who make timely premium payments (if above 100 percent FPL) and engage with a primary care provider (PCP). Arkansas Works enrollees with incomes at or below 100 percent FPL and others who are exempt from premiums, will be eligible for an incentive benefit at the time the amendment is approved.

VIII. PREMIUMS & COST SHARING

45. **Premiums & Cost sharing.** Cost sharing for Arkansas Works enrollees must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR Section 447.56(a).
46. **Premiums & Cost Sharing Parameters for the Arkansas Works program.** With the approval of this Demonstration:
 - a. Enrollees up to and including 100 percent of the FPL will have no cost sharing.
 - b. Enrollees above 100 percent of the FPL will have cost sharing consistent with Medicaid requirements.

- c. Enrollees above 100 percent of the FPL will be required to pay monthly premiums of up to 2 percent of household income.
 - d. Premiums and cost-sharing will be subject to an aggregate cap of no more than 5 percent of family monthly or quarterly income.
 - e. Cost sharing limitations described in 42 CFR 447.56(a) will be applied to all program enrollees.
 - f. Copayment and coinsurance amounts will be consistent with federal requirements regarding Medicaid cost sharing and with the state's approved state plan; premium, copayment, and coinsurance amounts are listed in Attachment B.
- 47. Payment Process for Payment of Cost Sharing Reduction to QHPs.** Agreements with QHP issuers may provide for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost sharing for Arkansas Works beneficiaries. Such payments will be subject to reconciliation at the conclusion of the benefit year based on actual expenditures by the QHP for cost sharing reduction. If a QHP issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the QHP issuer will be entitled to during reconciliation, the QHP issuer may ask Arkansas' Department of Human Services to adjust the advance payments. Arkansas' reconciliation process will follow 45 CFR Section 156.430 to the extent applicable.
- 48. Grace Period/Debt Collection.** Arkansas Works members will have two months from the date of the payment invoice to make the required monthly premium contribution. Arkansas and/or its vendor may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The state and/or its vendor may not "sell" the debt for collection by a third party.
- 49. Process for Cost-Sharing for ESI.** The state will pay cost sharing in excess of levels specified in Attachment B for all Arkansas Works beneficiaries enrolled in ESI whose ESI imposes cost-sharing. The state will pay such excess cost-sharing directly to providers, provided that such providers are enrolled in the Medicaid program.
- a. **Tracking.** The state will create a process for individuals enrolled in the ESI premium assistance program to submit receipts of their cost sharing, if it reaches an aggregate cap of no more than 5 percent of family monthly or quarterly income. Once the state verified that the limit had been reached, the state will shut off the individual's cost sharing for the remainder of that quarter. This interim tracking of beneficiary cost sharing will only be allowed until March 31, 2018. At such time, the state will track beneficiary's cost sharing through its MMIS system. The state will provide quarterly updates to CMS on its progress in implementing the new MMIS system for purposes of tracking.
 - b. **Appeals.** The state will create a process for individuals enrolled in ESI premium assistance to have access to the state fair hearing system for denial or reduction of benefits or services similar to the one already used for the QHP premium

assistance programs. If the procedure for accessing state fair hearings for individuals enrolled in ESI premium assistance differs from the one used in QHP premium assistance programs, the state will submit a new single state agency SPA to document such changes.

IX. APPEALS

Beneficiary safeguards of appeal rights will be provided by the State, including fair hearing rights. No waiver will be granted related to appeals. The State must ensure compliance with all federal and State requirements related to beneficiary appeal rights. Pursuant to the Intergovernmental Cooperation Act of 1968, the State has submitted a state plan amendment delegating certain responsibilities to the Arkansas Insurance Department.

X. GENERAL REPORTING REQUIREMENTS

50. Deferral for Failure to Submit Timely Demonstration Deliverables. The state agrees that CMS may issue deferrals in the amount of \$5,000,000 when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

- a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit a written request for an extension in which to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.
- c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
- d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
- e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
- f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

51. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. Pursuant to 42 CFR 431.420(c), the state must include a summary of the

comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

52. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.
53. **Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

54. **Quarterly Expenditure Reports.** The State must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XII of the STCs.
55. **Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
 - a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 62.
 - b. **Cost Settlements.** For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9P Waiver)

for the summary sheet sine 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.

- c. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.
- e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. MEG 1 – “New Adult Group”
- f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

Table 3 Demonstration Populations

Demonstration Year 1 (DY1)	January 1, 2014	12 months
Demonstration Year 2 (DY2)	January 1, 2015	12 months
Demonstration Year 3 (DY3)	January 1, 2016	12 months
Demonstration Year 4 (DY4)	January 1, 2017	12 months
Demonstration Year 5 (DY5)	January 1, 2018	12 months
Demonstration Year 6 (DY6)	January 1, 2019	12 months
Demonstration Year 7 (DY7)	January 1, 2020	12 months
Demonstration Year 8 (DY8)	January 1, 2021	12 months

- 56. Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs (“ADM”).
- 57. Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements resulting from annual reconciliation) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.
- 58. Reporting Member Months.** The following describes the reporting of member months for demonstration populations:
- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 83, the actual number of eligible member months for the demonstration populations defined in STC 17. The State must submit a statement accompanying the quarterly report, which certifies the accuracy of this information. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.
 - b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.
- 59. Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The State must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
- 60. Extent of FFP for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching

rate for the demonstration as a whole as outlined below, subject to the limits described in STC 63:

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

61. Sources of Non-Federal Share. The State must certify that the matching non-federal share of funds for the demonstration is state/local monies. The State further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

62. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for federal match.

- d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes - including health care provider-related taxes - fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 63. Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 66, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
- 64. Risk.** The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 63, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
- 65. Calculation of the Budget Neutrality Limit.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 66 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 67 below.

66. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in STC 66. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

Table 4 Per Capita Cost Estimate

MEG	TREND	DY 4 - PMPM	DY 5 – PMPM	DY 6 – PMPM	DY 7 – PMPM	DY 8 – PMPM
New Adult Group	4.7%	\$570.50	\$597.32	\$625.39	\$654.79	\$685.56

- a. If the State’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
- b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- c. The State will not be allowed to obtain budget neutrality “savings” from this population.

67. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

- 68. Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.
- 69. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the State’s expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the State must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Table 5 Cap Thresholds

Year	Cumulative target definition	Percentage
DY 4	Cumulative budget neutrality limit plus:	0%
DY 5	Cumulative budget neutrality limit plus:	0%
DY 6	Cumulative budget neutrality limit plus:	0%
DY 7	Cumulative budget neutrality limit plus:	0%
DY 8	Cumulative budget neutrality limit plus:	0%

- 70. Exceeding Budget Neutrality.** If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

- 71. Evaluation Design and Implementation.** The State shall submit a draft evaluation design for Arkansas Works to CMS no later than 60 days after the award of the Demonstration extension. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the Health Care Independence Program. The state must submit a final evaluation design within 60 days after receipt of CMS’ comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval.

- 72. Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
- 73. Cost-effectiveness.** While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the Arkansas Works Demonstration using premium assistance when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.
- a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.
 - b. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the Arkansas Works demonstration compared to what would have happened for a comparable population in Medicaid fee-for-service.
 - c. The State will compare total costs under the Arkansas Works demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.
 - d. The State will compare changes in access and quality to associated changes in costs within the Arkansas Works. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Arkansas will be determined and compared to improvement efforts undertaken in other delivery systems.
- 74. Evaluation Requirements.** The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.
- The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.
- 75. Evaluation Design.** The Evaluation Design shall include the following core components to be approved by CMS:

- a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
- ii. Premium Assistance beneficiaries will have equal or better access to preventive care services.
- iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.
- iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.
- v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
- vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.
- vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
- viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
- ix. QHP Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
- x. QHP Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
- xi. QHP Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
- xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 69 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
- xiii. The use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance.
- xiv. ESI premium assistance will increase the number of employers offering ESI coverage.

- xv. Continuity of coverage under ESI premium assistance will be improved compared to QHP premium assistance for individuals with access to ESI.
- xvi. Incentive benefits offered to Arkansas Works beneficiaries will increase participation rates for premium contributions compared to historical experience with Independence Accounts and increase primary care utilization.

These hypotheses should be addressed in the demonstration reporting described in STC 83 and 84 with regard to progress towards the expected outcomes.

- b. Data: This discussion shall include:
 - i. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;
 - ii. Method of data collection
 - iii. Frequency and timing of data collection..

The following shall be considered and included as appropriate:

- i. Medicaid encounters and claims data,
 - ii. Enrollment data, and
 - iii. Consumer and provider surveys
- c. Study Design: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. To the extent possible, the former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered
- d. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.
- e. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the

effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and denominator clearly defined. To the extent possible, the State may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.

- f. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.
- g. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.
- h. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, and the deliverables outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.
- i. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.
- j. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

76. Interim Evaluation Report. The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending December 31, 2021. The Interim Evaluation Report shall include the same core components as identified in STC 77 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

77. Summative Evaluation Reports.

- a. The state shall provide the summative evaluation reports described below to capture the different demonstration periods.

- i. The state shall provide a Summative Evaluation Report for the Arkansas Private Option demonstration period September 27, 2013 through December 31, 2016. This Summative Evaluation Report is due July 1, 2018, i.e., eighteen months following the date by which the demonstration would have ended except for this extension.
- ii. The state shall provide two Summative Evaluation Reports for the Arkansas Works demonstration period starting January 1, 2017 through December 31, 2021.
 - a. The first of these is due within 210 days of the end of this demonstration period, i.e., July 28, 2022. This report shall include documentation of outstanding assessments due to data lags to complete the summative evaluation.
 - b. The second of these is due within 500 days of the end of this demonstration period, i.e., May 15, 2023. The State should respond to comments and submit the final Summative Evaluation Report within 30 days after receipt of CMS' comments.
- b. The Summative Evaluation Report shall include the following core components:
 - i. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
 - ii. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
 - iii. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.
 - iv. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
 - v. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.
 - vi. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

- 78. State Presentations for CMS.** The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 71. The State will present on its interim evaluation in conjunction with STC 76. The State will present on its summative evaluation in conjunction with STC 77.
- 79. Public Access.** The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.
- a. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.
- 80. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate timely and fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner. Failure to cooperate with federal evaluators in a timely manner, including but not limited to entering into data use agreements covering data that the state is legally permitted to share, providing a technical point of contact, providing data dictionaries and record layouts of any data under control of the state that the state is legally permitted to share, and/or disclosing data may result in CMS requiring the state to cease drawing down federal funds until satisfactory cooperation, until the amount of federal funds not drawn down would exceed \$5,000,000.
- 81. Cooperation with Federal Learning Collaboration Efforts.** The State will cooperate with improvement and learning collaboration efforts by CMS.

XIV. MONITORING

- 82. Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

Areas to be addressed include, but are not limited to:

- a. Transition and implementation activities;
- b. Stakeholder concerns;
- c. QHP operations and performance;
- d. Enrollment;
- e. Cost sharing;
- f. Quality of care;
- g. Beneficiary access,

- h. Benefit package and wrap around benefits;
- i. Audits;
- j. Lawsuits;
- k. Financial reporting and budget neutrality issues;
- l. Progress on evaluation activities and contracts;
- m. Related legislative developments in the state; and
- n. Any demonstration changes or amendments the state is considering.

83. Quarterly Reports. The state must submit three Quarterly Reports and one compiled Annual Report each DY.

- a. The state will submit the reports following the format established by CMS. All Quarterly Reports and associated data must be submitted through the designated electronic system(s). The Quarterly Reports are due no later than 60 days following the end of each demonstration quarter, and the compiled Annual Report is due no later than 90 days following the end of the DY.
- b. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
- c. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.
- d. The Quarterly Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section. The reports shall provide sufficient information for CMS to understand implementation progress and operational issues associated with the demonstration and whether there has been progress toward the goals of the demonstration.
 - i. Operational Updates - The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
 - ii. Performance Metrics – Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.
 - iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly

expenditures associated with the populations affected by this demonstration on the Form CMS-64.

- iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends for monitoring and evaluation of the demonstration.

- e. The Annual Report must include all items included in the preceding three quarterly reports, which must be summarized to reflect the operation/activities throughout the whole DY. All items included in the quarterly report pursuant to STC 83 must be summarized to reflect the operation/activities throughout the DY. In addition, the annual report must, at should include the requirements outlined below.
 - i. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
 - ii. Total contributions, withdrawals, balances, and credits; and,
 - iii. Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

84. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

ATTACHMENT B

Copayment Amounts¹

General Service Description	Cost Sharing for Enrollees with Incomes >100% FPL
Behavioral Health – Inpatient	\$140/day
Behavioral Health – Outpatient	\$4
Behavioral Health – Professional	\$4
Durable Medical Equipment	\$4
Emergency Room Services	-
FQHC	\$8
Inpatient	\$140/day
Lab and Radiology	-
Skilled Nursing Facility	\$20/day
Other	\$4
Other Medical Professionals	\$4
Outpatient Facility	-
Primary Care Physician	\$8
Specialty Physician	\$10
Pharmacy – Generics	\$4
Pharmacy – Preferred Brand Drugs	\$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	\$8

No copayments for individual at or below 100% FPL.

¹ Enrollees with incomes above 100% FPL will also be required to pay monthly premiums of up to 2 percent of household income.