DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 31 2014

Mr. John Selig
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201

Dear Mr. Selig:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas' request to amend its Medicaid demonstration entitled, Arkansas Health Care Independence Program (Private Option), Project Number 11-W-00287/6, originally approved by CMS on September 27, 2013.

This amendment provides a waiver of section 1902(a)(14) of the Social Security Act for Arkansas to establish Independence Accounts (IA) to collect monthly contributions from beneficiaries with incomes from 50 percent up to and including 133 percent of the Federal Poverty Level (FPL). With a few exceptions, beneficiaries with incomes starting from 50 percent up to 133 percent of the FPL will be asked to contribute a monthly amount based on income. Beneficiaries will not lose or be denied eligibility for the Private Option if they do not contribute to the IA. Beneficiaries who do not make monthly IA contributions will be charged cost sharing, in a manner consistent with federal regulations. This amendment will enable the state to test the impact of IA in smoothing beneficiary transitions out of the Private Option and into private market plans or Medicare.

CMS's approval of this amendment is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for this demonstration is Mrs. Vanessa Sammy. She is available to answer any questions concerning your section 1115 demonstration Mrs. Sammy's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2613
Facsimile: (410) 786-5882

E-mail: Vanessa.Sammy@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mrs. Sammy and to Mr. Bill Brooks, Associate Regional Administrator for the Division of Medicaid and Children's Health in our Dallas Office. Mr. Brooks' contact information is as follows:

Mr. Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children Health Operations
1301 Young St., Ste. 833
Dallas, TX 75202

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Sincerely,

[redacted]

Marilyn Tavenner

Enclosures

cc: Bill Brooks, ARA, Region VI

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00287/6**

TITLE: **Arkansas Health Care Independence Program (Private Option) 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 Health Care Independence Program (Private Option) Section1115 demonstration.

1. **Premium Assistance and Cost Sharing Reduction Payments** Expenditures for part or all of the cost of private insurance premiums, and for payments to reduce cost sharing for certain individuals eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(XVIII) of the Act.

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 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 Health Care Independence Program (Private Option) 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 September 27, 2013 through December 31, 2016. 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 Private Option beneficiary's Qualified Health Plan. No waiver of freedom of choice is authorized for family planning providers.

2. **Payment to Providers** **Section1902(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 providing primary coverage for services under the Private Option.

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, rather than 24 hours 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. **Independence Account Contributions** **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable the state to collect monthly contributions for individuals with incomes between 50 and 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.

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 who are not current with their Independence Account payments.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00287/6

TITLE: Arkansas Health Care Independence Program (Private Option)

AWARDEE: Arkansas Department of Human Services

I. PREFACE

The following are the amended Special Terms and Conditions (STCs) for the Arkansas Health Care Independence Program (Private Option) section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable Arkansas (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. The amended STCs are effective on the date of the signed approval. Enrollment activities for the new adult population began on October 1, 2013 for the Private Option qualified health plan (QHP) with eligibility effective January 1, 2014. Contributions to Independence Accounts (IA) for certain demonstration populations will begin in accordance with the timeframes established in the operational protocols approved by CMS. Enrollment into the demonstration will be statewide and is approved through December 31, 2016.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Private Option 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. In Arkansas, individuals eligible for coverage under the new adult group are both (1) childless adults ages 19 through 64 with incomes at or below 133 percent of the federal poverty limit (FPL) or (2) parents and other caretakers ages 19 through 64 with incomes between 17 percent and at or below 133 percent of the FPL (collectively Private Option beneficiaries). Arkansas expected approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.

With this amendment, the State will test innovative approaches to newly eligible adult beneficiary cost sharing and individual financial responsibility for care. All Private Option beneficiaries, unless specifically excluded, with incomes between 50 percent and 133 percent of the FPL will be assigned an Independence Account (IA) administered by a third party administrator (TPA). The beneficiary will then receive a credit or debit card to access amounts credited to the IA account for use to cover copayments and coinsurance.

The IA will be funded by both the participant and the state. The new adult population with incomes above 100 percent FPL will be required to make contributions of $10-$25 per month to their IA, depending on income. Such individuals who make the required contributions will be able to pay QHP copayments or coinsurance with the IA credit/debit card. Such individuals who do not make contributions may not pay QHP copayments or coinsurance with the IA credit/debit card, but must pay the QHP's copayments or coinsurance at the point of service in order to receive services. If the individual restarts making contribution payments, the card will be reactivated to cover QHP-level copayments or coinsurance at the point of service. The state will ensure that the IA is funded sufficient to cover any copayment and coinsurance obligation that is not otherwise the responsibility of the individual. Notices will educate individuals about the value of participating. To provide a financial incentive to participate, individuals making at least six monthly contributions will be eligible to receive credits to offset future QHP premium payments (after enrollment in the private option has terminated), the employee's contribution to employer-sponsored insurance, or Medicare premiums (for individuals over age 64), so long as the individual resides in Arkansas.

The new adult population with incomes between 50 percent and 100 percent FPL will be required to contribute $5 per month to their IA. Individuals at this income level who do not make a monthly contribution may still use the IA credit/debit card to pay QHP copayments or coinsurance at the point of service, but will be billed for Medicaid-level copayments by the TPA. The beneficiary can avoid future Medicaid-level copayments or coinsurance by making the monthly $5 contribution to their IA.

Private Option beneficiaries will receive the state plan Alternative Benefit Plan (ABP). Services will be delivered primarily through the service delivery network of the QHP that they select and, and the QHP 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,
- Smoothing the "seams" across the continuum of coverage, and
- Furthering quality improvement and delivery system reform initiatives.

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 Private Option 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.

The state proposes to demonstrate 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). IAs will also be established for individuals with income from 50–133 percent FPL to help smooth the transition out of the Private Option and into private market plans or Medicare. For those who start at a very low income and progress to higher income levels, IAs can provide a consistent approach to the financing and receipt of health care services.

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.

Promote accountability, personal responsibility and transparency, and encourage and reward responsible choices – The introduction of IAs will provide participants with direct information about the cost of health care services and out-of-pocket costs; It also has the goal of promoting independence and self-sufficiency by providing participants with the possibility of having additional credits to be distributed as cash, which can be used to pay future private market premiums. Credits are intended to provide stability to individuals as they move into the private market, helping to sustain enrollees in the private market for a longer period of time and, in turn, reducing their reliance on state funded public programs.

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

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 allow the state to provide comment.

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 §431.412.
    b. As part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR §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. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the State will 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. The State can either use its Medical Care

Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments in the quarterly report as specified in STC 46 associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in STC 48.

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 Waiver 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 Section431.408(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 Private Option eligible beneficiaries provided primarily through QHPs offered in the individual market 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 for Private Option beneficiaries and establish IAs to address cost sharing requirements and assist in the transition to private insurance or Medicare coverage.

17. **Populations Affected by the Arkansas Health Care Independence (Private Option) Demonstration.** Except as described in STCs 18 and 19, the Arkansas Health Care Independence (Private Option) 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 both the parent and caretakers as well as the childless adults up to 133 percent of the FPL	Title XIX	MEG – 1

18. **Medically Frail Individuals**. Arkansas will institute a process to determine whether an individual is medically frail. The process will be described in the Alternative Benefit state plan. Medically frail individuals will be excluded from the demonstration.
    a. Medically frail individuals will not be subject to cost sharing under the terms of this demonstration, will not have Independence Accounts available and will not be subject to Independence Account requirements or benefits.
    b. The term "medically frail" is inclusive of both individuals who meet the medically frail definition in 42 CFR 440.315(f) and individuals who have exceptional medical needs as determined through the Arkansas health care needs questionnaire.
    c. Individuals excluded from enrolling in QHPs through the Private Option 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 in this demonstration, but can choose to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. AI/AN individuals who elect to participate in the demonstration will not be assigned an IA, instead they will be enrolled in the plan they select and will receive cost sharing protections. Individuals who are AI/AN and who have not opted into the Private Option 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.

V. PRIVATE OPTION PREMIUM ASSISTANCE ENROLLMENT

20. Private Option. For individuals affected by the Private Option, enrollment in a QHP will be a condition of receiving benefits.

21. Notices. Private Option beneficiaries will receive a notice from Arkansas Medicaid advising them of the following:

a. QHP Plan Selection. The notice will include information regarding how Private Option beneficiaries can select a QHP and information on the State's auto-assignment process in the event that the beneficiary does not select a plan.

b. Independence Accounts. For individuals who will be enrolled in IAs, the notices will include specific information on cost sharing obligations, the requirements related to IAs, how the IAs are established, expected participant contributions into the accounts, the State and other public/private contributions into the IAs, how Private Option Enrollees use the IAs, the incentives that apply to the IAs, and the consequences if contributions are not paid. The notices will also explain when the IAs will become effective.

c. Access to Services until QHP 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 enrollment is effective.

d. Wrapped Benefits. The notice will also include information on how beneficiaries can use the CIN number to 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.

e. Appeals. The notice will also include information regarding the grievance and appeals process.

f. Exemption from the Alternative Benefit Plan. The notice will include information describing how Private Option beneficiaries who believe they may be exempt from the Private Option ABP, and individuals who are medically frail, can request a determination of whether they are exempt from this ABP.

22. **QHP Selection.** The QHP in which Private Option 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.

23. **Enrollment Process.** Individuals receiving coverage through the Private Option demonstration began to enroll during the initial QHP enrollment period (October 1, 2013–March 31, 2014). In accordance with the state established timeframes established in the Enrollment Protocols, individuals will enroll through the following process:
    a. Individuals will submit a joint application for insurance affordability programs - Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions - electronically, via phone, by mail, or in-person.
    b. An eligibility determination will be made either through the Marketplace or the Arkansas Eligibility & Enrollment Framework (EEF).
    c. Once individuals have been determined eligible for coverage under Title XIX, they will have an opportunity to complete the health care needs questionnaire, through the State's web-based portal, to be assessed for medical frailty as defined in STC 21(a).
    d. Individuals who are determined eligible to receive coverage through the Private Option will have the opportunity to shop among QHPs available to Private Option eligible individuals, and to select a QHP, through the State's web-based portal.
    e. The State's MMIS will capture their plan selection information and will transmit the 834 enrollment transactions to the QHP issuers and transmit a notice to the TPA for enrollment in an IA, if applicable.
    f. QHP issuers will issue insurance cards to Private Option enrollees.
    g. The State's MMIS will pay QHP premiums on behalf of beneficiaries directly to the QHP issuer.
    h. State MMIS QHP premium payments will continue until the individual is determined to no longer be eligible for the Private Option (including when the individual is determined to be medically frail and will have the option of receiving either the ABP operated through FFS or the ABP that is the Medicaid state plan).
    i. An IA will be established with the TPA and the IA debit/credit card will be sent to the individual for use when paying Medicaid coinsurance or copayments.
    j. Where applicable, the TPA will pay QHP-level copayments and coinsurance on behalf of beneficiaries to the provider for individuals with IAs who use the IA debit/credit card.
    k. For individuals who have an IA and meet their contribution obligations to the IA on a current basis, the TPA will pay copayments and coinsurance when the individual uses the IA debit/credit card, until the individual is notified of ineligibility for the Private Option, including when the individual is determined to be medically frail. When an individual does not make required contributions into the IA, the effect on TPA payment of copayments and coinsurance is the following:
        i. For individuals with incomes between 50 and 100 percent FPL who do not make contributions to the IA, the TPA will continue to pay QHP-level co-

payments and co-insurance when the individual uses the IA debit/credit card, but will bill the individual for Medicaid copayments. If the individual fails to pay the amount billed by the TPA, the TPA will deduct the unpaid amounts from credits in the IA at the point of annual reconciliation, if applicable. When there are not enough credits in the IA to cover the amount billed by the TPA at the time of annual reconciliation, the individual will incur a collectible debt to the State, unless the individual self-attests to a financial hardship.

ii. For individuals with incomes greater than 100 percent FPL who do not make contributions to the IA, the TPA will notify the individual, suspend the operation of the IA debit/credit card, and will not pay copayments or coinsurance for services received. The individual will be required to pay the QHP copayments or coinsurance to the provider at the point of service. The provider can deny services for failure to pay the copayment or coinsurance. Copayments will be consistent with STC 42.

24. Auto-assignment. In the event that an individual is determined eligible for coverage through the Private Option, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's county. 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.

25. Distribution of Members Auto-assigned. In demonstration year one (DY1), Private Option 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 Private Option 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 Private Option enrollees in that region.
Three QHP issuers: 25 percent of Private Option enrollees in that region.
Four QHP issuers: 20 percent of Private Option enrollees in that region.
More than four QHP issuers: 10 percent of Private Option enrollees in that region.

26. Changes to Auto-assignment Methodology. The State will advise CMS 60 days prior to implementing a change to the auto-assignment methodology.

27. Disenrollment. Enrollees in the QHP Private Option may be disenrolled if they are determined to be medically frail after they were previously determined eligible.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

28. Memorandum of Understanding. 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;
c. Reporting and data requirements necessary to monitor and evaluate the Private Option including those referenced in STC 71, ensuring enrollee access to EPSDT and other covered benefits through the QHP;
d. Noticing requirements; and, Audit rights.

29. Qualified Health Plans. The State will use premium assistance to support the purchase of coverage for Private Option beneficiaries through Marketplace QHPs.

30. Choice. Each Private Option beneficiary 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.

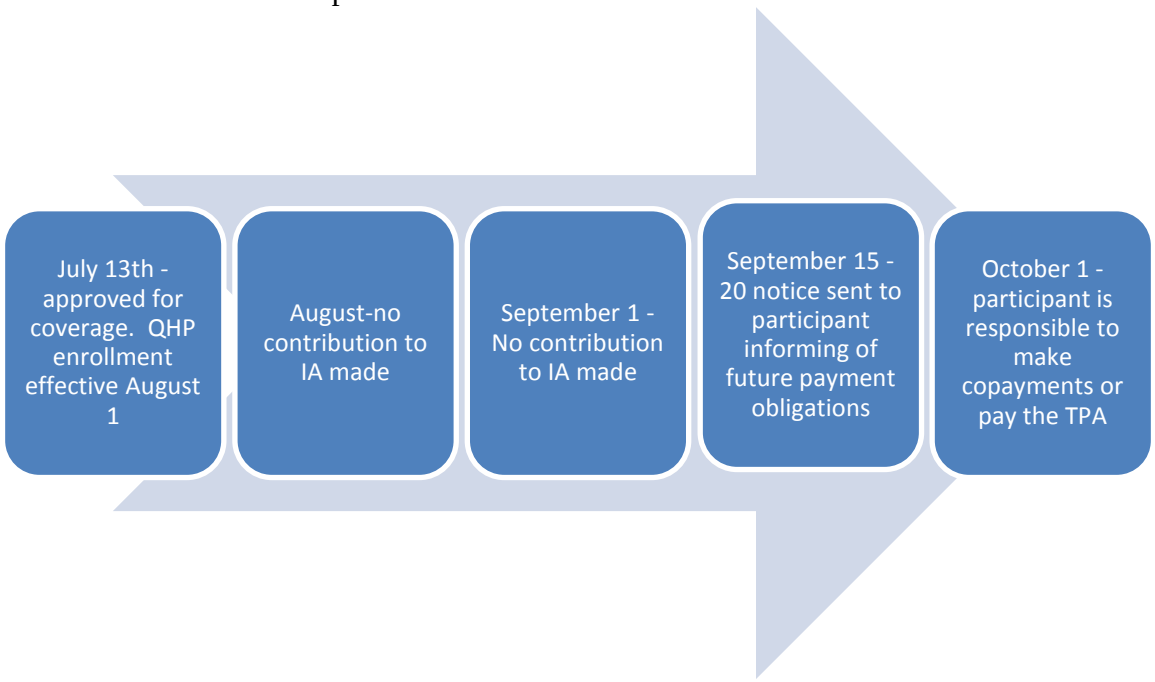
a. Private Option beneficiaries will be able to choose from at least two silver plans covering only Essential Health Benefits that are in each rating area of the State
b. Private Option beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area, and thus all Private Option 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. Private Option beneficiaries will have access to the same networks as other individuals enrolling in silver level QHPs through the individual Marketplace.

31. Coverage Prior to Enrollment in a QHP. 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 becomes effective.

a. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment).
b. For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).
c. For individuals in the Private Option who are eligible for Independence Accounts, participants must make their initial contribution by the monthly due date prior to the end of the second month after their QHP coverage becomes effective.
    i. For individuals with incomes between 50 and 100 percent FPL who do not make contributions to the IA by the monthly due date prior to the first day of the third month of QHP coverage, the TPA will continue to pay the QHP-level co-payments and co-insurance, but will start deducting the copayment amounts from remaining IA balances and/or will start billing the participant for Medicaid copayments.
    ii. For individuals with incomes greater than 100 percent FPL who do not make contributions to the IA by the monthly due date prior to the first day of the third month of QHP coverage, the participant will be required to

make QHP copayments or coinsurance at the point of service in order to receive services. The provider can deny services for failure to pay the copayment or coinsurance.

The timeline for requiring payments for those who do not contribute to their IAs is demonstrated in the example below:



32. **Family Planning.** If family planning services are accessed at a facility that the QHP considers to be an out-of-network provider, the State's fee-for-service Medicaid program will cover those services**.**

33. **NEMT.** Non-emergency medical transport services will be provided through the State's fee-for-service Medicaid program.

VII. BENEFITS

34. **Arkansas Health Care Independence Program (Private Option) 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.

35. **Alternative Benefit Plan.** The benefits provided under the State's alternative benefit plan for the new adult group are reflected in the State ABP state plan.

36. **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. 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**.**

37. **Access to Wrap Around Benefits.** In addition to receiving an insurance card from the applicable QHP issuer, Private Option beneficiaries will have a Medicaid CIN through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN will include information about which services Private Option 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.

38. **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).

39. **Access to Federally Qualified Health Centers and Rural Health Centers**. Private Option enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC.

40. **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, with the exception of the AI/AN and medically frail individuals.

VIII. COST SHARING

41. **Cost sharing.** Cost sharing for Private Option 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(b).

42. **Cost Sharing Parameters for the Arkansas Premium Assistance program**. With the approval of this Demonstration:
    a. Enrollees under 50 percent of the FPL will have no cost sharing.
    b. Enrollees at 50 percent of the FPL and above will have cost sharing consistent with Medicaid requirements and must include an aggregate cap of no more than 5 percent of family monthly or quarterly income.
    c. Cost sharing limitations described in 42 CFR 447.56(a) will be applied to all program enrollees.
    d. Copayment and coinsurance amounts will be consistent with federal requirements regarding Medicaid cost sharing and with the State's approved state plan; copayment and coinsurance amounts are listed in Attachment B

43. **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 Private Option 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.

IX. CONTRIBUTIONS TO ARKANSAS INDEPENDENCE ACCOUNTS

This section provides an overview of the planned framework that will be used to further define the programmatic features of the Arkansas Health Care Independence Program demonstration. Following the development and subsequent approval of the IA Protocols, Private Option beneficiaries enrolled in the demonstration will have responsibility to make contributions to IAs. The State may request changes to the Protocols, which must be approved by CMS, and which will be effective prospectively. Changes may be subject to an amendment to the STCs in accordance with paragraph 7, depending upon the nature of the proposed change. An individual's IA may be used to pay cost sharing that is imposed by the individual's QHP that is consistent with STC 42 and all Medicaid requirements that are set forth in statute, regulation and policies, except as expressly modified by the waivers implemented in accordance with the terms and conditions granted for this demonstration. As noted in STC 43, the state may enter into arrangements to prepay for QHP cost sharing that exceeds such limits and is attributable to Medicaid enrollees in the QHP.

44. Arkansas Health Care Independence Program Independence Account Contributions. Private Option beneficiaries with incomes greater than 50 percent FPL will be required to make monthly contributions into IAs. The TPA will track and record beneficiary contributions and liabilities for cost sharing utilization within each IA. Participants also have the opportunity to receive credits resulting in funds for consistent contribution into these accounts, as specified in the Protocols. A TPA will administer and manage the IAs and associated debit/credit cards used to pay QHP cost sharing. There will be one statewide TPA, which will be selected in accordance with state procurement rules.

Private Option beneficiaries will make contributions up to the amounts described below:

Table 2 Contribution Amounts

INCOME RANGE	>50%-100% FPL	>100% -115% FPL	>115%-129% FPL	>129%-133% FPL
MONTHLY CONTRIBUTION	$5	$10	$17.50	$25

*No household shall pay more than 2 percent of household income.

a. The new adult population with incomes between 50 percent and 100 percent FPL will have an option in which they contribute $5 per month to their IA. The State will also contribute funds to ensure the account covers the individual's QHP

copayment and coinsurance obligations. Individuals at this income level who make their contributions will use the IA debit/credit card to pay providers for copayments and coinsurance obligations, and will not be billed by the TPA for Medicaid copayments for services received during the month following the contribution. No reduction will be made in the IA for the amounts charged to the IA debit/credit card.

i. Individuals who contribute to the IA for at least 6 months (which can be non-consecutive months) in a calendar year will also receive a credit that will be distributed as cash to the individual which may be used for future QHP premium payments, or for contributions to employer-sponsored insurance, or Medicare premiums (for individuals over age 64), when the individual is no longer Medicaid eligible in the new adult group, so long as the individual resides in Arkansas. Individuals will accrue a credit of the lesser of the amount contributed or $15 for each month they make a timely contribution to the IA, regardless of the amounts of coinsurance or cost sharing charged to the individual's IA debit/credit card. Credits will be capped at $200 for the lifetime of the demonstration and have to be used within two years of accrual.

ii. Individuals who do not make a monthly contribution will use the IA debit/credit card to pay providers for QHP copayments and coinsurance obligations and will be billed by the TPA for Medicaid copayment amounts for services received. If the individual fails to pay the TPA the Medicaid coinsurance or copayment amounts due, any previously accrued credit in the IAs will be used to pay the debt. Once those funds have been exhausted, if there are additional coinsurance or copayment amounts due, the individual will incur a debt to the State.

b. The new adult population with incomes above 100 percent FPL through 133 percent FPL will contribute $10-$25 per month to their IA (depending on their income as outlined in Table 2 above). The State will also contribute funds to ensure that the account contain enough funds to cover the individual's copayment and coinsurance obligations, when applicable. Participants will pay their QHP copayments and coinsurance obligations through the debit/credit card associated with their IA.

i. Participants who contribute to the IA for at least 6 (which can be non-consecutive) months in a calendar year, will also be eligible to receive a credit that will be distributed as cash to the individual which may be used to offset future QHP premium payments, contributions to employer-sponsored insurance, or for Medicare premiums (for individuals over age 64), when the individual is no longer Medicaid-eligible in the new adult group, so long as the individual resides in Arkansas. Individuals will accrue a credit of the lesser of the amount contributed or $15 for each month they make a timely contribution to the IA, regardless of the amounts of coinsurance or cost sharing charged to the individual's IA debit/credit card. Credits will be capped at $200 for the lifetime of the demonstration and have to be used within two years of accrual.

ii. Individuals who do not make a monthly contribution will be required to pay QHP copayments or coinsurance at the point of service in order to receive services. But such copayments or coinsurance must be consistent with STC 42.

45. Private Option Beneficiary Protections. The following beneficiary protections will be maintained.

a. No individual may lose eligibility for Medicaid, be denied eligibility for Medicaid, or be denied enrollment in a Private Option health plan for failure to pay cost sharing liabilities.
b. Beneficiaries between 50 percent FPL and 100 percent FPL who do not make monthly contributions to their IAs will be billed only for copayment amounts as specified in the state plan amendment to be submitted by the State. Beneficiaries between 50 percent FPL and 100 percent FPL may not be denied access to services for failure to make contributions into their IA or failure to pay copayment or coinsurance liabilities.
c. Only individuals with incomes greater than 100 percent FPL can be denied medical services for failure to pay copayments or coinsurance. Cost sharing will not exceed the maximum allowed under federal Medicaid regulation.
d. Cost sharing limitations described in 42 CFR 447.56(a) will be applied to all program beneficiaries.
e. Copayment and coinsurance amounts will be consistent with federal requirements regarding Medicaid cost sharing and with the State's approved state plan; copayment and coinsurance amounts are listed in Attachment B.

46. Assurance of Compliance. Within 120 days of implementation of the IAs, the State shall provide CMS a progress report that verifies the IAs are operating in accordance with the approved Protocol. Should the program be deemed out of compliance, CMS will request the State to provide a corrective action plan. Failure to correct deficiencies may result in disallowance or program suspension until all operations are compliant.

47. Additional Incentives and Penalties. Following CMS approval of the IA Protocols, the State may submit additional changes to the Protocols, subject to CMS approval, to enhance the program's incentives and consequences for program enrollees who are not complying with CMS-approved requirements.

48. Independence Account Operational Protocol. The State must submitted a draft IA Operational Protocol to CMS for review. The State will update the IA Operational Protocol annually or whenever there are issues identified requiring modification, prior to implementing additional changes to the IA Operational Protocol. The IA Operational Protocol will be included as Attachment C of the special terms and conditions. The initial IA Operational Protocol will include the following items:

a. The approach to implementation, including the approach for those whose QHP enrollment occurs on or after the effective date of the amendment and the approach to notify and enroll existing QHP enrollees.

b. The strategy and operational description of how IA debits and credits will be accurately tracked.
c. How the state is doing quarterly tracking for all people subject to cost sharing.
d. A description, strategy and implementation plan of the beneficiary education and assistance process including copies of beneficiary notices, a description of beneficiaries' rights and responsibilities, appeal rights and processes and instructions for beneficiaries about how to interact with state officials for discrepancies or other issues that arise regarding the beneficiaries' IAs.
e. A strategy for educating participants on how to use the statements and understand that their health care expenditures will be covered.
f. For participants who are determined no longer eligible for the demonstration, a method for the distribution of credits.

X. 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 may submit a state plan amendment delegating certain responsibilities to the Arkansas Insurance Department or another state agency.

XI. GENERAL REPORTING REQUIREMENTS

49. General Financial Requirements. The State must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XII of these STCs.

50. Reporting Requirements Related to Budget Neutrality. The State must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.

51. 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; including planning for future changes in the program or intent to further implement the Private Option beyond December 31, 2016. 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. Independence Accounts
g. Quality of care;
h. Beneficiary access,
i. Benefit package and wrap around benefits;
j. Audits;
k. Lawsuits;
l. Financial reporting and budget neutrality issues;
m. Progress on evaluation activities and contracts;
n. Related legislative developments in the State; and
o. Any demonstration changes or amendments the State is considering.

52. Quarterly Progress Reports. The State will provide quarterly reports to CMS.

a. 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.
b. 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.

53. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver 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.

54. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The State will submit the draft annual report no later than 90 days after the end of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.

a. All items included in the quarterly report pursuant to STC 46 must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
c. Total contributions, withdrawals, balances, and credits related to IAs; and
d. Yearly 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;

55. 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.

XII. 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.

56. 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.

57. 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 l0C. 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

58. 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").

59. 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.

60. 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 46, 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.

61. 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.

62. 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 64:

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.

63. 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.

64. 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.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

65. 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 63, 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.

66. 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.

67. 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 STC63 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 63 below.

68. 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 1 - PMPM	DY 2 – PMPM	DY 3 – PMPM
New Adult Group	4.7%	$477.63	$500.08	$523.58

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

1of 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.

69. 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 8), 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.

70. 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.

71. 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 1	Cumulative budget neutrality limit plus:	3%
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	0%

72. 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.

XIV. EVALUATION

73. Submission of Evaluation Design. The State shall submit a draft evaluation design to CMS no later than 60 days after the award of the Demonstration. The evaluation design, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 3, is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the State. The State shall provide the Final Evaluation Design within 45 days of receipt of CMS comments. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment A.

74. 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 Private Option 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 Private Option 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 Private Option 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 Private Option. 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.

75. Evaluation Requirements. The State shall engage the public in the development of its evaluation design. The evaluation design shall incorporate an interim and summative evaluation and will discuss the following requirements as they pertain to each:

a. The scientific rigor of the analysis;
b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
d. How the analysis will support a determination of cost effectiveness;
e. Data strategy including sources of data, sampling methodology, and how data

will be obtained;
f. The unique contributions and interactions of other initiatives; and
g. How the evaluation and reporting will develop and be maintained.

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.

76. 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. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
x. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
xi. 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.

b. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:
   i. Comparisons of provider networks;
   ii. Consumer satisfaction and other indicators of consumer experience;
   iii. Provider experience; and
   iv. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

   The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design 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. 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

c. 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.

d. 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 dominator 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.

e. Data Collection: This discussion shall include:
A description of the data sources; the frequency and timing of data collection; and the method 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

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, if applicable, and deliverables.

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.

77. Interim Evaluation Report. The State is required to submit a draft Interim Evaluation Report 90 days following completion of year two of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 73 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. CMS will provide comments within 60 days of receipt of the draft Interim Evaluation Report. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

78. Summative Evaluation Report. The Summative Evaluation Report will include analysis of data from Year Three of the Premium Assistance Demonstration. The State is required to

submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the expiration date of the Premium Assistance Demonstration, the State shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The State should respond to comments and submit the Final Summative Evaluation Report within 30 days.

79. The Final Summative Evaluation Report shall include the following core components:

a. 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.
b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
c. 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.
d. 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.
e. 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.
f. 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.

80. 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 72. The State will present on its summative evaluation in conjunction with STC 73.

81. 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.

82. Electronic Submission of Reports. The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.

83. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate 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 and at no cost to CMS or the contractor.

84. Cooperation with Federal Learning Collaboration Efforts. The State will cooperate with improvement and learning collaboration efforts by CMS.

85. 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.

86. Deferral for Failure to Provide Summative Evaluation Reports on Time. The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue deferrals in the amount of $5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XV. MONITORING

87. Evaluation Monitoring Protocol. The State shall submit for CMS approval a draft monitoring protocol no later than 60 days after the award of the Demonstration. The protocol is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the State. The State shall provide the final protocol within 30 days of receipt of CMS comments. If CMS finds that the final protocol adequately accommodates its comments, then CMS will approve the final protocol within 30 days.

a. The monitoring protocol, including metrics and network characteristics shall align with the CMS approved evaluation design.
b. The State shall make the necessary arrangements to assure that the data needed from the health plans to which premium assistance will apply, and data needed from other sources, are available as required by the CMS approved monitoring protocol.
c. The monitoring protocol and reports shall be posted on the State Medicaid

website within 30 days of CMS approval.

88. Quarterly Evaluation Operations Report. The State will provide quarterly reports to CMS.

a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration, including the reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

89. Annual Discussion with CMS. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

90. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, 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 under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XVI. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

91. Health Information Technology (Health IT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

a. Health IT: Arkansas must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.

b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange. Federal funding for developing HIE infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers. The State must ensure that all new systems pathways efficiently prepare for 2014 eligibility and enrollment changes.

c. All requirements must also align with Arkansas' State Medicaid HIT Plan and other planning efforts such as the ONC HIE Operational Plan.

XVII. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid

Statistical Information System (T-MSIS) Data", was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in Arkansas against which the premium assistance demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.

ATTACHMENT B

Copayment and Coinsurance Amounts

General Service Description	QHP-Level Cost Sharing	Cost Sharing Applicable for Individuals with Incomes from 50-100% FPL Who Do Not Make Monthly Contributions
Behavioral Health – Inpatient	$140/day	$75/stay
Behavioral Health – Outpatient	$4	$4
Behavioral Health – Professional	$4	$4
Durable Medical Equipment	$4	$4
Emergency Room Services	-	-
FQHC	$8	$4
Inpatient	$140/day	$75/stay
Lab and Radiology	-	$4
Skilled Nursing Facility	$20/day	$75/stay
Other	$4	$4
Other Medical Professionals	$4	$4
Outpatient Facility	-	$4
Primary Care Physician	$8	$4
Specialty Physician	$10	$4
Pharmacy – Generics	$4	$4
Pharmacy – Preferred Brand Drugs	$4	$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	$8	$8

ATTACHMENT C

Arkansas Healthcare Independence Accounts
Operational Protocol

Purpose

This document describes the background and requirements for the implementation and operation of the Arkansas Healthcare Independence Accounts (HIA).

Background

The Arkansas HIA is a health care savings instrument through which participant cost-sharing requirements, which include co-pays and coinsurance, will be satisfied, monitored and communicated to the beneficiary. The HIAs provide a unique educational opportunity for low-income participants to learn about commercial health insurance principles through the use of financial incentives and a low-risk cost sharing program. The Arkansas Department of Human Services (the Department) has established uniform standards and expectations for the HIA's operation through this Operational Protocol and by contract as appropriate.

The 2015 Arkansas General Assembly suspended the application of any additional cost sharing requirements that were to be effective on or after January 31, 2015, under the Health Care Independence Program to Medicaid beneficiaries with incomes below 100% FPL. Therefore, while the amended Standard Terms and Conditions address the policies related to copayments and IAs for participants with incomes below 100% FPL, these provisions related to those below 100% FPL will not be implemented until further notice. Consequently, procedures for participants with incomes below 100% FPL are not included in this Protocol. The State will update this Protocol and notify CMS at least 30 days before implementing IAs and copayments for those with incomes below 100% FPL.

Third Party Administrator

Arkansas has contracted with a third party administrator (TPA) to provide the following functions related to the administration of the HIA operations:

- establish and operate the HIAs for all eligible Health Care Independence Program (HCIP) participants
- accept contributions from HCIP participants and deposit and maintain those funds in the HIA account
- deliver HIA cards to HCIP participants
- process all financial transactions associated with HIA operations
- pay providers the amounts they are due resulting from HCIP participants using the HIA card to cover their cost sharing obligations
- establish a rollover process to issue accumulated credits to HCIP participants who leave the HCIP program
- accept fund transfers from the Department, and apply those funds to the appropriate accounts

- track individual contributions to the HIA program
- create and distribute periodic account activity reports to HIA participants

Use of MyIndyCard

Once the participant selects or is assigned to a qualified health plan (QHP), the State will notify the TPA to enroll the participant into an HIA. The TPA will send the HCIP participants their debit card identified as the "MyIndyCard" and a user guide, which will provide information on how to activate and use the card. The participants will activate their MyIndyCard by phone or internet. Once activated, the card will be used by the HCIP participant to cover all in-network cost sharing. The card will not cover out-of network payments and the participant will be responsible to pay any non-covered, out-of-network out-of-pocket costs.

Participant Education and Access to Information

All new applicants will receive an initial welcome letter and a pocket guide that explains the cost sharing obligation, enrollment into an HIA, notice that the MyIndyCard will soon be received, and a brief explanation of the HIA program. The pocket guide, which will be enclosed with the welcome letter, will include information regarding:

- how to activate the MyIndyCard when it arrives
- points of contact should the participant have problems with the MyIndyCard
- where the card should be used
- where payments into the HIAs should be made.

Every HCIP participant will also receive a detailed user guide along with their first MyIndyCard that provides information on the HIA process. The user guide will provide information about the MyIndyCard which will be used to pay participant cost sharing. The user guide will explain:

- the overall program and the HIAs
- how to use the MyIndyCard
- what to do if the MyIndyCard is lost
- the monthly statements related to the use of the card
- how and when to make the monthly contribution to the HIA
- addressing failures to make monthly contributions
- the meaning of important terms
- the toll-free phone number for the MyIndyCard call center for questions concerning the use of the card and payment options
- the MyIndyCard website address to access downloadable resources for card users, such as guides to understanding the monthly statement and general FAQs concerning the program and participation benefits

The guide will also provide a link to access additional information regarding incentive payment opportunities for HIA credits.

Periodically, the pocket guide will be enclosed with the monthly statement. This will help participants maintain easy access to information regarding the use of the MyIndyCard and HIA payments.

The HCIP participant can also obtain information over the internet at www.MyIndyCard.org. The website will include a short educational video that explains how the MyIndyCard works.

The pocket guide and user guide can be viewed and download at the following website: www.MyIndyCard.org/resources

Appeals and Issue Resolution

HCIP participants will have access to the standard Medicaid fair hearing process for complaints regarding (1) the amount of monthly contributions owed; (2) whether a monthly contribution was made; (3) whether a debt is owed to the State; and (4) the rollover balance accrued. No modifications to the existing processes are needed.

If an HIA participant believes there is an error on the monthly statement, the HIA participant may use the TPA's informal issue resolution process prior to filing a formal appeal.

When a participant calls to inquire about a payment for the HIA program that is not reflected on the monthly statement, the customer service representative asks for their name and telephone number and follows the process listed below:

Process for Monthly Contribution Questions or Disputes

Step 1: Collect Information from Participant

When a participant calls to inquire about a monthly payment for the HIA program, the customer service representatives asks the following:

1. What is your name?
2. What is your telephone number?
3. When did you make your payment?
4. How did you make your payment?
    a. Did you include your monthly remit slip?
    b. Did you make the payment or did someone make it on your behalf?
    c. From where did you mail the payment?
    d. Confirm the date (or range) when the payment was mailed

Step 2: Investigate Missing Payment

1. If payment was made by money order or check, check the daily bank file starting on the day the payment was mailed for the following:
    a. Payments with the participant's name and account number (if present)
    b. Receipts that match the payment amount but do not have an account number or a monthly remit slip
        i. If a non-identified payment exists, check the envelope (in the image file) to determine post mark location. Compare post mark location to

on envelop with information provided by Participant to determine if there is a match.

1. If there is a match, apply payment to the account

c. Payments that may have been applied to the wrong account number (search by name).

d. Payments made by one family member but for multiple participants

2. If the payment was made online, check for the following:
    i. If there was a NSF for the account
    ii. If there was a network timeout (which would be noted by a process incomplete status)
    iii. If the transaction was cancelled by the Participant

Step 3: Follow Up with Participant

1. Follow up with participant to obtain any additional information that may be necessary.
2. If we are unable to find their payment, ask them to resend, and we will apply it manually to ensure their card works for the upcoming month.

Monthly Statements

A monthly statement will be issued to each HCIP participant on the 25th of the month. The monthly statement will provide the following information:

- The HIA payment amount that is due
- The payment due date
- When the last payment was made
- The date of a missed payment
- The number and the amount of copayments and coinsurance paid for the prior month
- A reminder to make the next monthly contribution to the HIA

The monthly statement will be mailed, or the participant can choose to receive the statement by email.

An annotated sample of the monthly statement is provided in the user guide.

Payments

HCIP participants who meet the contribution requirements will pay their QHP copayments and coinsurance obligations through the HIA. There will be 3 payment levels depending on the HCIP participant's income. The levels are outlined in Table 1.

Table 1 Contribution Requirements

INCOME RANGE	>100% -115% FPL	>115%-129% FPL	>129%-133% FPL
CONTRIBUTION	$10	$15	$15

The TPA will provide multiple options for HCIP participants to remit monthly contributions. These options will include online payments, check, cashier's check and money orders. There are no restrictions on who can make the monthly payment into the HIA.

Monthly statements mailed to the HCIP participant will inform the participant that payments are due by the 20th of the following month. This information can also be obtained online by checking the HIA or by phone contact with the TPA. See the time line in the Implementation section below for dates when initial payments will be due.

Tracking of HIA Debits and Credits

The TPA will provide processing for all HIA cards and financial transactions. The TPA card transaction processing system will have the capability to recognize if the participant is eligible for the HIA program and is up-to-date on HIA contributions, based on eligibility information received from the MMIS and participant contribution information within the TPA contractor's systems.

The TPA will provide monthly reports to the State with both aggregate financial reports and detailed reporting of financial accounts and transactions at the individual participant level. The TPA will develop an on-line view for state personnel into the TPA records after the basic components of the card issuance, participant interfaces, and financial management systems are operational.

Addressing Failures to Make Monthly Contributions

When a HCIP participant with income greater than 100% FPL does not make a monthly payment by the 20th of the month, their MyIndyCard will be deactivated effective the first of the following month. The individual will pay copayments and coinsurance at the provider site. If the individual restarts contribution payments, the card will be reactivated to cover QHP-level copayments or coinsurance at the point of service for the month following payment. For example, if the participant does not make a payment in March, they will be required to cover copayment and coinsurance at their provider site for any service provided in April. If they make their payment in April, they can use their card to pay any copayments and coinsurance in the month of May.

Tracking of Out of Pocket Expenses

Tracking of out-of-pocket expenditures is not necessary for individuals making contributions to the Independence Accounts because the maximum quarterly contribution is $45, which is below the quarterly cap for individuals with incomes of 100% FPL.

Use of Credits

The TPA will configure the HIA processing system to restrict the use of credits retained after the end of the participant's eligibility for the program. The fund credits will be used only for services identified by the State, including QHP premium payments, contributions to employer-sponsored insurance, or Medicare premiums (for individuals over age 64). No later than June 1, 2015, the TPA contractor will demonstrate the process for issuing accumulated credits to HCIP participants who leave the HCIP program.

The following process has been developed for issuing accumulated credits for HIA participants who become ineligible for the demonstration.

- The daily process for loading files into the TPA's system includes a screen for terminated participants who have accumulated credits.
- The system flags any terminated individuals who have accumulated credits.
- TPA staff will contact those participants to determine if the individual is enrolled in coverage offered in Arkansas or by an Arkansas-based employer.
- After the TPA confirms enrollment in a qualifying plan, the TPA will issue a check in the amount of the accumulated credits to the insurance carrier or employer to offset the participant's premiums or contributions.

Implementation

The implementation schedule applies to both existing HCIP participants and those who enroll on or after the effective date of the Demonstration amendment. Implementation of the HIA program will be phased in based on the following schedule:

Activity	**Date**
Arkansas submits operational protocol to CMS (30 days prior to implementation)	December 2
HP auto-transfer occurs	December 16 or once STCs are approved
The TPA DataPath mails MyIndyCard, user guide, and pocket guide	December 23
MyIndyCard turned on	January 1
DataPath sends first invoice	January 25
First payment due	February 20