

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



MAY 12 2015

Dawn Stehle
Director, Division of Medical Services
State of Arkansas, Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

Dear Ms. Stehle:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend Arkansas' TEFRA-like section 1115 demonstration (Project No. 11-W-00163). This extension is effective through December 31, 2017. This extension is granted under the authority of section 1115(a) of the Social Security Act.

Noteworthy changes to the Special Terms and Conditions (STCs) included in this approval are as follows:

- Updated quarterly reporting requirements to provide detailed data related to premium collection and terminations resulting in new applications.
- Clarified the length of the state's grace period to pay overdue premiums before termination from the TEFRA program.
- Identified consequences for the state in the event deliverables are not provided timely.
- Clarified that the state's budget neutrality model does not allow savings to be acquired.
- Refined the evaluation design requirements pertaining to premium payments and lockouts and required a new evaluation design.
- Removed the 90-day waiting period for parents who voluntarily disenroll from private insurance in order to enroll into Medicaid coverage.

The authority to deviate from Medicaid requirements is limited to the specific waivers and expenditure authorities described in the enclosed lists, and to the purposes indicated for each of those waivers and expenditure authorities. The enclosed STCs further define the nature, character, and extent of anticipated federal involvement in the project, and the state's responsibilities to CMS during the demonstration period. Our approval of the demonstration is conditioned upon CMS' receipt of the state's written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your technical director for this demonstration is Ms. Julie Sharp. She is available to answer any questions concerning your section 1115 demonstration. Ms. Sharp'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) 786-2292
E-mail: Juliana.Sharp@cms.hhs.gov

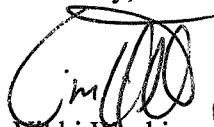

Official communications regarding program matters should be sent simultaneously to Ms. Sharp and to Mr. Bill Brooks, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Centers for Medicare & Medicaid Services
1301 Young Street
Room 714
Dallas, TX 75202
Telephone: (214) 767-6495
E-mail: Bill.Brooks@cms.hhs.gov

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.

Thank you for all your work with us over the past several months on finalizing this important demonstration extension.

Sincerely,


Vikki Wachino 
Director

Enclosure

cc: Bill Brooks, Associate Regional Administrator, CMS Dallas

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST**

NUMBER: 11-W-00163/6

TITLE: TEFRA-like

AWARDEE: Arkansas Department of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Arkansas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration, be regarded as expenditures under the state's title XIX state plan.

The following expenditure authority shall enable Arkansas to operate the TEFRA-like Medicaid section 1115 demonstration.

1. **Demonstration Population 1.** Expenditures for services provided to children under 19 years of age, who require an institutional level of care, and would otherwise be Medicaid-eligible under a TEFRA state plan option.

Title XIX Requirements Not Applicable

All requirements of the Medicaid program expressed in law, regulation, or policy statement, not expressly identified as not applicable in the list below, shall apply to the demonstration project beginning May 12, 2015, through December 31, 2017.

1. **Cost Sharing**

**Section 1902(a)(14)
insofar as it incorporates
Section 1916**

To enable Arkansas to charge a sliding scale monthly premium to custodial parent(s) of eligible children with annual family income above \$25,000, except that no premium may be charged to families with incomes less than 150 percent of the federal poverty level.

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

NUMBER: 11-W-00163/6

TITLE: TEFRA-like Demonstration

AWARDEE: Arkansas Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Arkansas TEFRA-like section 1115(a) Medicaid demonstration extension (hereinafter “demonstration”). The parties to this agreement are the Arkansas Department of Health and Human Services (state) and the Centers for Medicare & Medicaid Services (CMS). The 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 demonstration extension is approved through December 31, 2017. All previously approved STCs are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

- Program Description and Objectives;
- General Program Requirements;
- Eligibility, Benefits, and Enrollment;
- Cost Sharing;
- Delivery Systems;
- General Reporting Requirements;
- General Financial Requirements;
- Monitoring Budget Neutrality for the Demonstration;
- Evaluation of the Demonstration;
- Health Information Technology;
- T-MSIS Requirements; and,
- Schedule of State Deliverables.

Additionally, one attachment has been included to provide supplementary guidance.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Arkansas TEFRA-like demonstration was initially approved October 17, 2002, and implemented January 1, 2003. The demonstration provides services to disabled children eligible for Medicaid under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA (also known as the Katie Beckett Option after the child whose plight inspired Congress to enact this option into Medicaid law) was developed to allow a child with disabilities living in a family with income that is too high to qualify for Medicaid to gain Medicaid eligibility based on the income and resources of the child. Prior to 2002, Arkansas covered these children under the Medicaid state plan. Rather than eliminating this coverage option altogether, the state

Demonstration Approval Period: May 12, 2015 – December 31, 2017

proposed to use a section 1115 demonstration to keep coverage in place but charge premiums for the coverage based on family income. Such premiums would not have been permitted under the state plan. The program currently serves 3,937 children.

The expenditure authority granted in this demonstration enables Arkansas to provide coverage to a population of sick children with special health care needs while testing the hypotheses:

- The Arkansas TEFRA-like demonstration will increase access to quality health care services for all children eligible for the program;
- Premium contributions for individuals in the Arkansas TEFRA-like demonstration are affordable and do not create a barrier to health care access; and
- Few individuals will experience the lock-out period because the policy will deter nonpayment of premiums for Arkansas TEFRA-like demonstration beneficiaries.

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), must 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 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; and
- 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 6 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 §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 §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 §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 27 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 28.

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 Section 431.408(b)(3)).
- c) The state must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

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

17. Deferral for Failure to Provide Deliverables on Time. The state agrees that CMS may require the state to cease drawing down federal funds until such deliverables are timely submitted in a satisfactory form, until the amount of federal funds not drawn down would exceed \$5,000,000.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

18. Eligibility. The TEFRA-like demonstration provides coverage for services furnished to children who were previously included in the state's optional TEFRA Program. Eligibility is without regard to whether the children have other insurance. All Medicaid state plan services are available under the demonstration. The population known as "TEFRA Children" is defined as children:

- a) Disabled according to the Social Security Administration definition;
- b) Under 19 years of age;
- c) Who are U.S. citizens or qualified aliens;

- d) With established residency in the state of Arkansas;
- e) Who have a Social Security Number or have applied for one;
- f) Whose annual gross income is up to 3 times the current Supplemental Security Standard Payment Amount (SSI/SPA) (the parent(s)' income is not considered);
- g) Whose countable assets do not exceed \$2,000 (the parent(s)' assets are not considered); and
- h) Who meet the medical necessity requirement for institutional placement in a hospital, a skilled nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or who are at risk for future institutional placement.

19. Benefits. Individuals enrolled in the demonstration receive coverage for all Medicaid state plan benefits. Medicaid payment is secondary to liable third parties.

20. Enrollment and Choice. The state will facilitate outreach and enrollment into all appropriate title XIX programs. Families applying to participate in the TEFRA-like demonstration will be evaluated for likely eligibility in Arkansas title XIX programs. If found to be eligible for more than one program, the family will be counseled and given the opportunity to enroll in the program of their choice.

V. COST SHARING

21. Program Premiums. Families will be charged a sliding scale monthly premium based upon the income of the custodial parents. Those custodial parents with incomes above 150 percent of the federal poverty level and in excess of \$25,000 annually will be subject to a sliding scale monthly premium. The monthly premium, described in following chart, can only be assessed if the family income is in excess of 150 percent of the FPL.

Family Income		Monthly Premiums (applicable <u>only</u> to families with incomes in excess of 150 percent of the FPL)		
From	To	Percent	From	To
\$0	\$25,000	0%	\$0	\$0
\$25,001	\$50,000	1.00%	\$20	\$41
\$50,001	\$75,000	1.25%	\$52	\$78
\$75,001	\$100,000	1.50%	\$93	\$125
\$100,001	\$125,000	1.75%	\$145	\$182
\$125,001	\$150,000	2.00%	\$208	\$250
\$150,001	\$175,000	2.25%	\$281	\$328
\$175,001	\$200,000	2.50%	\$364	\$416
\$200,001	No Limit	2.75%	\$458	\$458

There are no co-payments charged for services to TEFRA Children, and a family's total annual out-of-pocket cost sharing cannot exceed five percent of the family's gross income.

22. Payment of Premiums.

- a) Custodial parent(s) are allowed a 3-month grace period to pay past due premiums. If there is a lapse of payment for 3 months, a 10-day advance notice of closure will be provided to the parent(s) during the last month of the grace period. If payment is not made within the 10-day window, the case will be closed. If the arrearages are paid after the case is closed, a new application must be submitted before the child will be reinstated. If medical necessity and appropriateness of care have been determined within the past 10 months, a new determination will not be necessary. If the case is closed, the parent(s) must pay the arrearage prior to eligibility approval if another application is filed for the child within 12 months following the case closure. If an application is filed more than 12 months after case closure, the parent(s) have absolution from overdue premiums

- b) Once a child is determined eligible, the effective date of coverage will be the application date (unless retroactive coverage is needed and all eligibility requirements are met). Premium payments, if applicable, are assessed beginning the first day of the month following the month in which eligibility is determined. If payment is not received within 20 days, a 10-day advance notice of closure will be provided to the parent(s). If payment is not made within the 10-day window, the case will be closed. If the case is closed, the parent(s) must pay the arrearage prior to eligibility approval if another application is filed for the child within 12 months following the case closure. If an application is filed more than 12 months after case closure, the parent(s) have absolution from overdue premiums.

If medical necessity and appropriateness of care have been determined within 10 months of a termination, a new medical assessment will not be required with a new application.

- c) The state may attempt to collect unpaid premium and debts from the beneficiary, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, seek a court order to seize a portion of the individual's earnings. The state also may not "sell" the debt for collection by a third-party. Further, while the debt is collectible by the state, re-enrollment is not conditional on repayment after the case has been closed for 12 months."

VI. DELIVERY SYSTEMS

23. Service Delivery. Services provided under the demonstration are delivered through the state's existing network of Medicaid providers. Demonstration beneficiaries select a primary care physician and all services are reimbursed on a fee-for-service basis.

VII. GENERAL REPORTING REQUIREMENTS

- 24. General Financial Requirements.** The state must comply with all general financial requirements set forth in Section VIII.
- 25. Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements set forth in Section IX.
- 26. Bi-Monthly Calls.** CMS will schedule bi-monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, benefits, audits, lawsuits, financial reporting related to budget neutrality issues, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state 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 shall jointly develop the agenda for the calls.
- 27. Quarterly Reports:** The state must submit progress reports in the format outlined below (see also Attachment A), no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:
- a) An updated budget neutrality monitoring spreadsheet;
 - b) Events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, including, but not limited to: benefits; enrollment; grievances; quality of care; access; pertinent legislative or litigation activity, and other operational issues;
 - c) Action plans for addressing any policy, administrative, or budget issues identified;
 - d) Quarterly enrollment reports for demonstration eligibles for each demonstration population as defined in STC 18;
 - e) Number of demonstration beneficiaries whose cases have been closed due to non-payment of premiums;
 - f) Number of beneficiaries who have been reinstated into the demonstration via a new application after their cases have been closed due to non-payment of premiums;
 - g) Number of beneficiaries found continued eligible for the demonstration after new medical necessity/appropriateness of care assessment is completed at the time of re-evaluation;

- h) Number of demonstration beneficiaries absolved of overdue premiums after 12 month reinstatement;
- i) Number of demonstration beneficiaries who have Third Party Liability (TPL);
- j) Evaluation activities and interim findings; and,
- k) Other items as requested.

Notwithstanding this requirement, the fourth-quarter Quarterly Report may be included as an addendum to the annual report required in paragraph 28.

28. Annual Report. The state must submit an annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly reports required under paragraph 27. The state must submit this report no later than 90 days after the close of each demonstration year.

29. 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 will 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.

VIII. GENERAL FINANCIAL REQUIREMENTS

30. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide 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 IX.

31. Expenditures Subject to the Budget Neutrality Expenditure Limit. All expenditures for health care services for demonstration participants, as defined in STC 32(e), are subject to the budget neutrality agreement.

32. Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit. The following describes the reporting of expenditures subject to the budget neutrality agreement:

- a) **Tracking Expenditures.** In order to track expenditures, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All

demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00185/4) assigned by CMS, including the project number extension which indicates the demonstration year (DY) in which services were rendered.

- b) **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 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 state Medicaid Manual.
- c) **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions 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 9D, 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 demonstration year on 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.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
- e) **Use of Waiver Forms.** For each DY, a Waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter to report title XIX expenditures associated with the Demonstration. The expression in quotations marks, for the Population/Eligibility Group (EG) below, is the waiver name to be used to designate these waiver forms in the MBES/CBES system.
 - i. **Demonstration Population/EG 1 "TEFRA Children":** TEFRA children as described in STC 18.

- f) **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
- g) **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) 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 demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.

33. 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 paragraph 27, the actual number of eligible member months for EGs defined in paragraph 32(e). 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 for an additional 180 days after the end of each quarter.
- 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 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

34. 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 limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administrative Costs (ADM). CMS shall 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. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

35. Extent of FFP. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in section IX.

- a) Administrative costs, including those associated with the administration of the demonstration; and,
- b) Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

36. Sources of Non-Federal Share. The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures 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 at any time the sources of the non-federal share of funding for the demonstration. 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.

37. 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; and,
- e) 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 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.

38. Monitoring the Demonstration. The state must provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

39. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

40. 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 using a per capita cost method. The budget neutrality targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. All data supplied by the state to CMS 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 CMS-64 Report from the MBES/CBES System. No savings can be accrued or used with this budget neutrality model.

41. Risk. The state shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in the TEFRA eligibility group. By providing FFP for all demonstration enrollees, the state will not be at risk for changing economic conditions which impact enrollment

levels. However, by placing the state at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

42. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for the EG in STC 32(e) as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under paragraph 33, times the appropriate estimated PMPM costs from the table in subparagraph (iii) below.
 - ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by demonstration eligibles.
 - iii. The PMPM costs for the EG used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Category	Trend Rate	DY 12 CY 2014 PMPM	Trend Rate	DY 13 CY 2015 PMPM	Trend Rate	DY 14 CY 2016 PMPM	Trend Rate	DY 15 CY 2017 PMPM
TEFRA Children	6.1%	\$1,691.00	4.6%	\$1,768.79	4.6%	\$1,850.15	4.6%	\$1,935.26

- b) The overall budget neutrality expenditure limit for the 3-year demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iii) above for each of the 3 years. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in paragraph 29(e) during the demonstration period.

43. 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 exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
Years 1 through 9	Cumulative budget neutrality cap plus:	1.0 percent
Years 1 through 10	Cumulative budget neutrality cap plus:	0.5 percent
Years 1 through 15	Cumulative budget neutrality cap plus:	0 percent

44. Exceeding Budget Neutrality. If, at the end of this demonstration period, the budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS.

X. EVALUATION OF THE DEMONSTRATION

45. Submission of Draft Evaluation Design. The state must submit to CMS for approval, within 120 days of the approval date of the demonstration a draft evaluation design. A delay in submitting the draft evaluation design could subject the state to penalties described in STC 17. At a minimum, the draft design must include a discussion of the goals, objectives, and specific testable hypotheses. The analysis plan must cover all elements in STC 47. The design should be described in sufficient detail to determine that it is a sound evaluation design strategy to address the hypotheses. The data strategy must be thoroughly documented. The design must describe the state's process to contract with an independent evaluator (if applicable), ensuring no conflict of interest. The design is subject to CMS approval to assure the evaluation meets the requirements of STC 47.

46. Cooperation with Federal Evaluators. Should HHS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate fully with CMS or the evaluator selected by HHS. In addition, the state shall submit the required data to HHS or its contractor in a timely manner and at no cost to CMS or the contractor, unless the state incurs a cost in which case CMS will participate in accordance with regular administrative matching rules.

47. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

- a. Focus. The research questions should focus on processes and outcomes that relate to the better care, better health, and reduced costs. The following are among the hypotheses to be considered in the development of the evaluation and design and will be included in the design as appropriate.
 - i. The Arkansas TEFRA-like demonstration will increase access to quality health care services for all children eligible for the program.
 - ii. Premium contributions for individuals in the Arkansas TEFRA-like demonstration are affordable and do not create a barrier to health care access.
 - iii. Few individuals will experience the lock-out period because the policy will deter nonpayment of premiums for Arkansas TEFRA-like demonstration beneficiaries.
- b. Arkansas must use the results of the premium payment monitoring data as well as other available data to conduct an evaluation that examines premium payment for Arkansas TEFRA-like beneficiaries. Include hypotheses that address the effect of the lockout policy on enrollment and reenrollment for Arkansas TEFRA-like beneficiaries broken down by income level and questions including:

- i. How many individuals were disenrolled by income level?
 - ii. What are the reasons beneficiaries did not make contributions?
 - iii. What health care needs did individuals have while they were in the lockout period and how did they address those needs?
- c. Measures. The draft evaluation design must discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, including:
 - i. A description of each outcome measure selected, including clearly defined numerators and denominators, and National Quality Forum (NQF) numbers (as applicable);
 - ii. The measure steward;
 - iii. The baseline value for each measure; and
 - iv. The sampling methodology for assessing these outcomes.
- d. Sources of Measures. CMS recommends that the state use measures from nationally-recognized sources and those from national measures sets (including CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, and the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults).
- e. The evaluation design must also discuss the data sources used, including, but not limited to, the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state. The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

A delay in submitting this report could subject the state to penalties described in STC 17.

48. Final Evaluation Design and Implementation. CMS shall provide comments on the draft design and the draft evaluation strategy, and the state shall submit a final design within 60 days of receipt of CMS's comments. A delay in submitting the final evaluation design could subject the state to penalties described STC 17. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

49. Interim Evaluation Report. The state must submit an interim evaluation report to CMS as part of any future request to extend the demonstration, or by June 30, 2016, if no extension request has been submitted by that date. The interim evaluation report will discuss evaluation progress and present findings to date.

50. Final Evaluation Report. The state must submit to CMS a draft of the evaluation final report within 60 days after to the expiration of the demonstration. The report shall including items as required in the Evaluation Design. The state must take into consideration CMS'

comments for incorporation into the final report. The final evaluation report is due to CMS no later than 120 days after receipt of CMS' comments. A delay in submitting the draft of the final evaluation report or final evaluation report could subject the state to penalties described in STC 17.

51. Public Access. The state shall post the final approved Evaluation Design on the state Medicaid website within 30 days of approval by CMS.

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

XI. HEALTH INFORMATION TECHNOLOGY

53. Health Information Technology (HIT). The state shall 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. Arkansas must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified electronic health record (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 health information exchange (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's state Medicaid HIT Plan and other planning efforts such as the Office of National Coordinator HIE Operational Plan.

XII. 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 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 SMM 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.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Per award letter- Within 30 days of the date of award	Confirmation Letter to CMS accepting demonstration STCs
Per Section X, STC 45	Submit Draft Evaluation Design
Per Section X, STC 48	Submit Final Evaluation Design
Per Section III, STC 8	Submit Demonstration Extension Application
Per Section III, STC 10	Post-award Forum
Quarterly	Deliverable
Per Section VII, STC 27	Quarterly Progress Report
Per Section VIII, STC 30	Quarterly Expenditure Report
Annual	Deliverable
Per Section III, STC 10	Post Award Forum Transparency Deliverable
Per Section VII, STC 28	Annual Report
Renewal/Closeout	Deliverable
Per Section X, STC 50	Draft Final Evaluation Report
Per Section X, STC 50	Final Evaluation Report
Per Section VII, STC 29	Final Report

ATTACHMENT A

Under STC 27, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – AR TEFRA-like

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 11 (1/1/2011 – 12/31/2011)

Federal Fiscal Quarter: 2/2011 (1/1/2011 – 3/31/2011)

Introduction

Please provide information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by “0”. Enrollment counts should be person counts.

Demonstration Populations (as hard coded in the Form CMS-64)	Total as of end of Current Quarter	Voluntary Disenrolled in Current Quarter	Involuntary Disenrolled in Current Quarter
Population 1 – TEFRA Children			

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Consumer Issues

Provide a summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance /Monitoring Activities

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the state's actions to address these issues.

Enclosures/Attachments

Identify by title any attachments, along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS