Centers for Medicare & Medicaid Services (CMS)

Special Terms and Conditions

Project Numbers: 11-W-00214/6 (Title XIX)
21-W-0051/6 (Title XXI)
Project Title: Arkansas Safety Net Benefit Program
State: State of Arkansas, Department of Health and Human Services

I. PREFACE

The following are Special Terms and Conditions (STCs) for the Arkansas Safety Net Benefit Program, a title XIX and title XXI section 1115(a) demonstration. The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility; Benefits; Enrollment, Implementation, and Benchmarks; Maintenance of Effort, Health and Wellness Benefits Program (HWBP) and Milestones; Maintenance of Coverage; Cost Sharing; General Reporting Requirements; Monitoring and Evaluation; Reimbursement and Funding; Monitoring; General Financial Requirements; Monitoring Budget Neutrality; Schedule of State Deliverables.

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. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Associate Regional Administrator at the addresses shown on the award letter.

II. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration project is part of the Health Insurance Flexibility and Accountability (HIFA) initiative. Under HIFA, the Administration puts a particular emphasis on broad Statewide coverage approaches like Arkansas' that target populations with incomes at or below 200 percent of the Federal poverty level (FPL) which coordinate public title XIX and title XXI and private coverage.

Employer Participation

Arkansas will undertake a competitive bidding process to select one or more private insurance companies to offer the Arkansas Safety Net Benefit Program to a limited number of small and mid-size employers (500 or less employees) who elect to participate in the program. The program will be employer driven. Employers will be eligible to participate in the program if they have not offered group health insurance in the past 12

months. Eligible employers will voluntarily participate in the program. Participating employers will also be required to achieve 100 percent employee health insurance coverage, regardless of income. This program thereby reduces the percent of working uninsured by promoting the coordination of health care between the public and private sectors.

Program Overview

The Arkansas HIFA will expand health insurance coverage through a public/private partnership that will provide a "safety net" benefit package to approximately 50,000 uninsured individuals over 5 years. This demonstration is unique because it is designed to allow small and mid-size employers who have not previously provided health care coverage to their employers with this opportunity.

The demonstration will occur in two phases. Enrollment for Phase I (year 1 and year 2) will be capped at 15,000 parents and childless adults. Phase II enrollment will begin in year 3, and will target the remaining 35,000 individuals. The targeted implementation date for Phase I of this demonstration is October 1, 2006. The State will use title XXI funds to cover approximately 30,000 parents and spouses of Medicaid and the State Children's Health Insurance Program's (SCHIP) children, as well as title XIX funds to cover 20,000 childless adults and spouses, who are ages 19-64 with incomes up to 200 percent of the FPL. The Arkansas Safety Net Benefit Program will provide coverage to adults who are employed by participating employers. Employees over 200 percent of the FPL will be covered through the program, but no Federal or State dollars will be supplementing the benefit.

Eligible Populations

The Arkansas HIFA demonstration will provide "safety net" benefits to parents and spouses of Medicaid and SCHIP children aged 19 to 64 with family income up to and including 200 percent of the FPL (referred to as Population I in the STCs); childless adults and spouses aged 19 to 64 with family income up to 200 percent of the FPL (referred to as Population II in the STCs); and include the State's Medicaid Primary Care Case Management (PCCM) program, ConnectCare, operated under Section 1915(b) of the Social Security Act (the Act) (referred to as Population III in the STCs). Lastly, the demonstration incorporates Federal funding for a calculated percentage of five previously State-funded tobacco cessation programs, one indigent care program and two minority health initiatives (collectively called HWBP) to extend services to demonstration enrollees. This will allow demonstration participants access to smoking cessation and other preventive services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall 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 SCHIP, Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy Statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the demonstration.

3. **Changes in Law.** The State must, within the timeframe specified in law, come into compliance with any changes in Federal law affecting the Medicaid and SCHIP programs that occur after the approval date of this demonstration, unless the provision being changed is explicitly waived.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid or SCHIP spending on program components included in the demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. 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.** The State shall not be required to submit title XIX or title XXI State plan amendments for changes to any populations covered solely through the demonstration. If a population covered through the State plan is affected by a change to the demonstration, a conforming amendment to the State plan may be required except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget and allotment neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. The State must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive, and Federal financial participation (FFP) may not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process:** Amendment requests must be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:

    a. An explanation of the public process used by the State to reach a decision regarding the requested amendment (pursuant to paragraph 15);

b. Current assessment, including the necessary expenditure data, of the impact the requested amendment shall have on budget and allotment neutrality;

c. A detailed description of the amendment, including impact on enrollees, with sufficient supporting documentation; and,

d. A description of how the evaluation design shall be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration**. If the State intends to extend the demonstration beyond the period of approval granted under section 1115(a) of the Act, then the State is responsible for reviewing, complying, and adhering to the timeframes and reporting requirements, as stated in sections 1115(a), 1115(e) and 1115(f) of the Act. Complete budget neutrality data must be submitted six (6) months prior to the expiration of the demonstration period. Should complete budget neutrality data not be submitted within this timeframe, the demonstration will not be considered for renewal under the authority of section 1115(e).

9. **Demonstration Phase-Out.** The State may suspend or terminate this demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan and extension-plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal close-out costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation during the Last 6 Months:** If the demonstration has not been extended, no new enrollment of individuals eligible solely on the basis of the demonstration is permitted during the last 6 months of the demonstration.

11. **CMS Right to Terminate or Suspend.** The CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. In the event CMS elects to terminate or suspend the demonstration in whole or in part, CMS shall promptly notify the State in writing of the determination. CMS will provide the State with the reasons for the suspension or termination, the parameters of a phase-out-plan, which shall include

the process by which the State will undertake to provide public notice, and the effective date of the termination or suspension. The effective date will be no later than 6 months from the date CMS notified the State of its election to terminate. If the demonstration is terminated, FFP is limited to normal close-out costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

13. **Withdrawal of Waiver Expenditure Authority.** The CMS reserves the right to 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; promote the objectives of titles XIX or XXI; or in the event it determines that the State has materially failed to comply with the terms of the project. In the event CMS elects to withdraw waiver or expenditure authority of the demonstration in whole or in part, CMS shall promptly notify the State in writing of the determination. CMS will provide the State with the reasons for the withdrawal of waiver and expenditure authority, the parameters of a phase-out plan, which shall include the process by which the State will undertake to provide public notice, and the effective date. The effective date will be no later than 6 months from the date CMS notified the State of its election to terminate. If a waiver or expenditure authority is withdrawn, FFP is limited to normal close-out costs associated with phasing out the waiver and expenditure authority including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The State will 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 and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) and the tribal consultation requirements issued via letter by CMS on July 17, 2001, when any program changes to the demonstration including, but not limited to, those referenced in Section III, paragraph 6, are proposed by the State.

16. **Federal Funds Participation.** No Federal matching funds for service expenditures for this demonstration will take effect until the date of the demonstration implementation. Federal match for administrative expenditures is available during planning and implementation.

IV. ELIGIBILITY FOR THE DEMONSTRATION

17. **Eligibility:** Mandatory and optional State plan groups described below are subject to all applicable Medicaid and SCHIP laws and regulations except as expressly waived. Those groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration are not subject to Medicaid or SCHIP laws or regulations except as specified in the STCs and waiver and expenditure authorities for this demonstration. The criteria for the Arkansas Safety Net Benefit program eligibility groups are as follows:

ARKANSAS SAFETY NET BENEFIT PROGRAM

POPULATIONS I AND II	**INCOME LEVEL**
Demonstration Eligible Groups	
Population I: Parents and spouses	Up to and including 200 percent FPL
Population II: Childless adults and spouses	Up to and including 200 percent FPL
POPULATION III- ConnectCare	
Mandatory State Plan Groups	**FPL Level and/or other qualifying Criteria**
AFDC/TANF children and related populations covered by section 1931	FPL based on TANF methodology
AFDC/TANF adults and related populations covered by Section 1931	FPL based on TANF methodology
Pregnant women and infants	Up to 133 percent
Blind/disabled Adults 18 and older	Countable income below $623 (SSI level)
Blind/disabled children 0-18	Countable income below $623 (SSI level)
Aged adults 65 and older	Countable income below $623 (SSI level)
Foster Care Children	Title IV-E
Optional State Plan Groups	
Pregnant women and infants	133 - 185 percent of the FPL
Blind/disabled Adults 18 and older	Countable income above SSI level but below 100 percent FPL
Blind/disabled children 0-18	Countable income above SSI level but below 100 percent FPL
Aged adults 65 and older	Countable income above SSI level but below 100 percent FPL
Children 1 – 6 through the SCHIP Medicaid expansion	133 up to 200 percent FPL and for whom the State is claiming title XXI funding
Children 6 -19 through the SCHIP Medicaid expansion	100 up to 200 percent FPL and for whom the State is claiming title XXI funding

18. **Eligibility Standards for ConnectCare Population III.** For the populations enrolled in ConnectCare, the current Primary Care Case Management Program, the same eligibility criteria will be applied under the 1115 demonstration. Any

changes to eligibility standards are subject to the amendment process set forth in paragraph 7.

19. **Excluded Populations For Population III.** Those populations currently excluded from participation in the State's section 1915(b) waiver will continue to be excluded from this demonstration.

V. BENEFITS AND DELIVERY SYSTEMS AND ACCESS FOR THE DEMONSTRATION

20. **Benefits for Populations I and II.** The benefit package consists of a total of 15 days of service: 6 outpatient visits per year; 2 outpatient hospital visits per year; 2 prescriptions per month; and, 7 days inpatient coverage per year. Lab and x-ray are inclusive on the date of service and do not count as a day of service provided that the service is received on the same day as further described in the employer sponsored insurance package.

21. **Benefits for Populations III.** In addition to the demonstration expansion adult groups, Populations I and II, the demonstration will include the State's ConnectCare program, a Medicaid PCCM, currently operated under section 1915(b) of the Act, as Population III. The transition of the waiver authority in section 1115 of the Act will be effective on the date of implementation. Any benefit changes from the Medicaid State plan or ConnectCare program are subject to the amendment process in Paragraph 7.

    a. **Delivery System for Population III.** For the populations enrolled in the current PCCM, ConnectCare, all services covered under the Medicaid State Plan, will continue to be available and accessible. Under ConnectCare a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Transition of the ConnectCare program to this demonstration will be seamless to the enrollees.

    b. **Choice of at Least Two Providers for Population III.** The State will continue to offer ConnectCare enrollees a choice of two or more primary care providers within one PCCM system.

    c. **Disenrollment for Population III.** The State will allow enrollees to disenroll from/transfer between PCCMs. Enrollees are allowed to terminate or change their enrollment for any stated reason at any time. The disenrollment/transfer is effective immediately. Enrollees may disenroll/transfer once during any 6-month period.

    d. **Self Referrals for Population III.** The State will continue to require PCCMs to allow enrollees to self-refer (i.e., access without prior authorization) under the circumstances or for the services defined in Appendix D2.S of the 1915(b) conversion application. Any changes to Appendix D2.S are subject to the amendment process in paragraph 7.

22. **Access to HWBP.** The State must assure that all demonstration populations have access to the services provided under the Health and Wellness Benefits Program.

VI. ENROLLMENT, IMPLEMENTATION, AND BENCHMARKS FOR THE ADULT COVERAGE EXPANSION (Populations I and II)

23. **Enrollment Limits**. Total enrollment for phase I (year 1) will be capped at 15,000 individuals. In year 1, the State will enroll up to 15,000 parents and their spouses and childless adults and their spouses.

24. **Employer Size Limits.** The State shall limit employer participation to employers with no more than 500 employees. For the purpose of this waiver, employer is defined as a business entity with a unique State and/or Federal tax identification number and employees.

25. **Expected Target Dates for Implementation**
    - Recruitment of employers by October 1, 2006
    - Enrollment by November 1, 2006
    - Coverage by January 1, 2007

VII. HWBP MAINTENANCE OF EFFORT, MATCHING OF STATE-FUNDED PROGRAM AND COST-CONTAINMENT

26. **HWBP Maintenance of Effort and Matching of State-Funded Program:** FFP is available as matching funds for a percentage of five State-funded tobacco cessation programs (community programs, chronic disease programs, Statewide programs, cessation programs and prevention/education programs), two minority health initiatives (special minority initiatives and Minority Health Commission) and one indigent care program (Arkansas Rural Health Education Centers). These are collectively called HWBP. The demonstration increases the amount and scope of publicly funded health care services in the State.

    a. **HWBP Maintenance of Effort.** The amount of State fiscal year (SFY) 2006 State funds expended for the HWBP for the programs described above will be maintained or increased above the SFY 2006 level during the operation of the demonstration. State expenditures for the parent and childless adult expansion and the HWBP will count toward meeting the maintenance of effort requirement.

    b. **Monitoring HWBP Maintenance of Effort.** Within 45 days prior to implementation, the State must submit a plan detailing how they will monitor and ensure that the maintenance of effort requirement for the HWBP contained in the aforementioned STC is met for CMS approval.

    c. **Match for HWBP State-Funded Program.** HWBP expenditures related to appropriate services for demonstration target populations are eligible for Federal matching funds through this demonstration. No other current

or previous State-funded program is eligible for Federal matching funds. Under the authority granted in this demonstration, the availability of demonstration funding the State may use to pay for HWBP costs will begin with the implementation date of the demonstration for costs incurred on and after that date through the end of the 5-year demonstration period (pursuant to section XII).

d. **HWBP Documentation.** Within 30 days of approval, the State will provide information demonstrating that the State programs (tobacco cessation, indigent care, minority health) are paying for appropriate services to target populations. Upon receipt of this information, CMS reserves the right to renegotiate the amount available for Federal match. Within 30 days CMS will issue a decision on the appropriateness of the HWBP programs.

e. **Available FFP for HWBP.** Annually, FFP is authorized to pay for HWBP costs during the 5-year demonstration period. The State shall be limited to the following cumulative amounts as based on actual HWBP costs (i.e., costs authorized for FFP for HWBP should not exceed $11,683,764 through demonstration year 2 and total costs should not exceed $27,927,552 through the 5-year demonstration period):

Demonstration Year	**1**	**2**	**3**	**4**	**5**
Maximum Cumulative Amount of Funds Available for FFP	$5,930,845	$11,683,764	$17,264,096	$22,677,018	$27,927,552

f. **Demonstration Enrollment Requirements.** In the event the State has not enrolled at least 75 percent of its projected amount of enrollees at or below 200 percent FPL into the new program at the end of Demonstration Year 1, then CMS reserves the right to reduce the percentage of federally matched HWBP costs by an amount equivalent to the costs of unmet projected enrollment until the projected enrollment for this population is met. In addition, the State will submit a plan to CMS detailing the actions it will undertake to increase enrollment.

g. **Reporting HWBP Payments.** The State will report all expenditures for HWBP payments to the above listed programs under this demonstration on the Forms CMS-64.9 Waiver and/or 64.9P Waiver under the appropriate waiver name, as well as on the appropriate forms CMS-64.9I and CMS-64.9PI.

h. **Monitoring HWBP.** The State must provide to CMS the annual Tobacco Settlement Commission report made to the Arkansas General Assembly

including external evaluation results, programmatic performance assessments, and fiscal accountability reports for component programs of the state's Tobacco Settlement Act (TSA) related to the demonstration. In addition, CMS may conduct a review of the HWBP to assess continued expenditure of funds for appropriate services to target populations. The State will cooperate fully with CMS to assess the financial impact and program integrity of the HWBP related to this demonstration (pursuant to STC numbers 45 and 46).

27. **Cost-containment Strategy Plan.** Prior to implementation, the State must provide to CMS a cost-containment strategy plan that includes mechanisms designed to achieve increased Medicaid expenditure savings through the HIFA demonstration. The strategy may include provisions from the Deficit Reduction Act (DRA) (i.e., changes in cost sharing or benefits), other cost containment mechanisms or prevention interventions. If the State is unable to submit the strategy, which demonstrates the State's commitment to generating Medicaid savings, then FFP will not be available for the childless adult expansion (Population II).

28. **Cost-containment Strategy Implementation.** The State must implement the cost-containment strategy plan by the end of the second year of the demonstration. Should the State not implement the cost-containment strategy plan by the end of the second year of the demonstration, title XIX expenditure authorities under section 1115(a)(2) of the Act will be terminated pursuant to the term and condition entitled "Withdrawal of Waiver Authority."

VIII. MAINTENANCE OF COVERAGE

29. **Concurrent Operation**. The State's title XXI State plan, as approved and the ARKids B demonstration will continue to operate concurrently with this section 1115 demonstration.

30. **Maintenance of Coverage and Enrollment Standards for Children.**

    a. The State shall not close enrollment, institute waiting lists, decrease benefits, increase cost sharing above 5 percent of the family income, or decrease eligibility standards with respect to the children covered under its title XXI State plan or the ARKids B demonstration while this demonstration is in effect.

    b. The State shall, throughout the course of the demonstration, include a review of enrollment data to provide evidence that children are not denied enrollment and continue to show that it has implemented procedures to enroll and retain eligible children for title XXI.

c. The State will establish a monitoring process to ensure that expenditures for the HIFA demonstration do not exceed available title XXI funding (i.e., the title XXI allotment) and the appropriate State match. The State will use title XXI funds to cover services for the SCHIP and HIFA populations in the following priority order:

1) Children eligible under the title XXI State plan and title XXI funded section 1115 ARKids B demonstration:

a. Unborn children with family incomes up to and including 200 percent of the FPL, who are not otherwise eligible for Medicaid under its SCHIP State plan, and

b. Children up to age 19 who are eligible for the title XXI funded Section 1115 ARKids B demonstration.

2) **Demonstration Population I.** If the State determines that available State or title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population and the title XXI funded section 1115 ARKids B demonstration population, then Demonstration Population I individuals.

d. For Demonstration Population I, the State may:
- Lower the FPL used to determine eligibility; and/or
- Suspend eligibility determination and/or intake into the program; or
- Discontinue coverage.

e. Before taking any of the above actions related to the priority system, Arkansas will provide a 60-day notice to CMS.

IX. COST SHARING

31. **Cost Sharing**. Cost sharing may be imposed on populations covered under this demonstration to the extent consistent with rules submitted by the State to, and approved by, CMS. Claimed expenditures for group health insurance premiums will be reduced by any enrollment fee paid by enrollees. Enrollee cost sharing will be assessed without regard to family income and the State will require enrollee cost sharing as follows, unless other cost-sharing provisions are approved by CMS: $100 deductible; 15 percent coinsurance for all services except pharmacy; $1,000 annual out-of-pocket maximum for coinsurance and deductible. Payments toward tiered drug co-payments do not count toward the out-of-pocket maximum. Population III will continue to be subject to the cost-sharing charges under the current ConnectCare program. Any cost-sharing changes from the Medicaid State plan or ConnectCare program are subject to the amendment process in Paragraph 7.

X. GENERAL REPORTING REQUIREMENTS

32. **Quarterly Progress Reports.** Arkansas will submit quarterly progress reports, which are due 60 days after the end of each quarter, beginning after the date of the approval letter. The format for the report will be agreed upon by CMS and the State. These reports must include information on operational and policy issues appropriate to the State's program design. It must also include information on any issues that arise in conjunction with the Arkansas Safety Net Benefit Program for title XXI or title XIX-eligible individuals. The report must also include proposals for addressing any problems identified in each report.

    a. **Progress on Reducing the Rate of Uninsurance.** The State will include a separate section in the quarterly report that describes the State's progress toward agreed-upon goals for reducing the rate of uninsurance. From data that are readily available, the State will monitor the private insurance market (i.e., changes in employer contribution levels, if possible, among employers with low-income populations, trends in sources of insurance, etc.) and other related information in order to provide a context for interpreting progress toward reducing uninsurance. The State will also continue to monitor substitution of coverage (i.e., participants dropping private coverage).

    b. **Covering Employees with Incomes Above 200 Percent of the FPL.** The State will report stratified salary levels by percentage of the FPL of all employees that are earning greater than 200 percent of the FPL that are being covered through the Safety Net Benefit Program for whom the State is not claiming FFP.

    c. **HWBP Description.** The State will also include a separate section in the quarterly report that describes aspects of the HWBP including, but not limited to, progress on finalizing the reimbursement system, a description of HWBP programs and other programmatic processes.

33. **Quarterly Enrollment Reports.** Each quarter the State will provide CMS with an enrollment report by demonstration population, showing end of quarter actual and unduplicated ever-enrolled figures. Enrollment data for Demonstration Population I will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. The State will provide enrollment information for Demonstration Populations II and III as described in paragraphs 50 and 61 (both the enrollment and expenditure data shall be reported by population).

34. **Monthly Enrollment Reports.** In addition, the State will provide monthly enrollment data, as specified by CMS, for each demonstration population.

35. **Monthly Calls.** The CMS shall schedule 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, program operations, health care delivery, enrollment (including the State's progress on enrolling individuals into the Safety Net Benefit program), cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, financial performance that is relevant to the demonstration, progress on evaluations, State legislative developments, and any demonstration amendments, concept paper,s or State plan amendments the State is considering submitting. 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 (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

36. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy, administrative difficulties in the operation of the demonstration, and other subject areas, in a format to be agreed upon by the State and CMS. The State must submit the draft annual report no later than 60 days after the end of each operational demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

XI. MONITORING AND EVALUATION

37. **State Demonstration Evaluation.** The State must submit to CMS for approval a draft evaluation design no later than May 1, 2006. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. 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 draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

38. **Final Evaluation Design and Implementation.** The CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final design within 60 days of receipt of CMS comments. The State must implement the evaluation design and submit its progress in the demonstration quarterly reports. The State must submit to CMS a draft of the evaluation report 120 days prior to the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the demonstration.

39. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration. In addition, CMS may conduct a review of the State's to assess continued expenditure of funds for appropriate services to target populations. The State will cooperate fully with CMS to assess the financial impact and program integrity of the HWBP related to this Demonstration. The State will submit any existing data or information to CMS as requested.

40. **Survey Report of Participating Employers and Employees.** The State will conduct a series of surveys and focus groups of participating employers and emploees to determine satisfaction levels within the pilot project, including the adequacy of the benefit package. This information from Phase I will be utilized to assist the State in its design and operation of Phase II of the demonstration. The first report will be due 1 year after the implementation date and on an annual basis thereafter. The State may submit this report as an attachment to its annual report.

41. **Phase II Feasibility Study for Covering Individuals without Access to Employer Health Care Coverage.** The State will explore the feasibility of extending participation in the demonstration to individuals who are not affiliated with participating employers for Phase II of the demonstration. The State may choose to assess the feasibility of covering additional individuals with non-participating employers through use of recent survey and/or focus groups or additional analysis of current information collected through the Health Resources and Services Administration State Planning Grant process. CMS expects the State to address whether it will extend coverage to individuals in Phase II of the demonstration in the quarterly report; this information must be provided 60 days prior to implementation of Phase II.

42. **Quality Monitoring Plan**. Describe the State's overall quality assurance monitoring plan. The plan should include, at a minimum, the following: Quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.

43. **Monitoring of Employer-Sponsored Insurance (ESI**). The State must monitor the extent to which employers may decrease or cease to provide ESI. This monitoring can be accomplished by tracking changes in employer contribution levels towards ESI and/or by measuring the degree of substitution of ESI coverage by employers with the demonstration benefit package. The State shall not only monitor such changes, but shall be prepared to address substantial decreases in employer contribution levels as well as data delineating significant

substitution of coverage. This information will be included in the State's demonstration annual report.

XII. REIMBURSEMENT AND FUNDING

44. **Sources of Non-Federal Share.** All sources of the non-Federal share are subject to CMS approval. Upon review of the sources of the non-Federal share of payments under the Demonstration, all funding sources that are not in compliance with Federal statutes and regulations will not be considered eligible for Federal match. 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.

45. **Permissible Sources for the Non-Federal Share.** The State must have (and must demonstrate to CMS, as requested) permissible sources for the non-Federal share of payments for the HWBP, including CPEs from government-operated entities. Sources of non-Federal funding shall not include provider taxes or donations impermissible under section 1903(w), premiums and enrollment fees, employer contributions, assessments or contributions or Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes).

46. **Certification.** Units of government, including governmentally operated health care providers may certify that State or local tax dollars have been expended to satisfy costs eligible for Federal matching funds under Medicaid, specifically, the following provisions are applicable, but not limited to the HWBP.

    a. To the extent the State utilizes 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.

    b. To the extent the State utilizes the CPE funding mechanism for payments for health care services provided to the uninsured, CMS must approve the cost reporting vehicle for which the State would certify such costs as eligible for FFP, prior to Federal matching of any such costs.

    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 (non-Federal share pursuant to paragraphs 44 and 45). The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

47. 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 claimed expenditure.

48. The State may not use employer contributions as State share in this demonstration.

XIII. GENERAL FINANCIAL REPORTING REQUIREMENTS FOR DEFINED AUTHORIZED EXPENDITURES

49. **State Certification of Funding Conditions.** The State certifies that matching funds for the demonstration are State/local appropriations. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by Federal 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 and distribution of monies involving Federal match are subject to CMS approval.

    a. The CMS may review the sources of the non-Federal share of funding and distribution methods for Demonstration funding at any time. All funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes 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.

General Financial Requirements under Title XXI for Demonstration Population I:

50. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided to Demonstration Population I enrollees (Waiver Name: Parents). This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide enhanced FFP only for allowable expenditures that do not exceed the State's available title XXI funding.

51. **Reporting Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES)**. In order to track title XXI expenditures under this demonstration, the State will report demonstration expenditures through the MBES/CBES, following routine Form CMS-21 reporting instructions as outlined in Section 2115 of the State Medicaid manual. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS

(including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the State will be required to identify the program code and coverage (children or adults).

a. All claims for expenditures related to the demonstration (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 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 Form CMS-21.

b. The standard SCHIP funding process will be used during the demonstration. Arkansas must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the demonstration population. 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-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c. Arkansas will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI separate child health program or for the ARKids B Medicaid Expansion demonstration until the next allotment becomes available.

52. **Limitation on Title XXI Funding.** Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan AR Kids B) are restricted to the State's available allotment and reallocated funds. Title XXI funds must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining allotment funds.

53. **Administrative Costs.** Total expenditures for outreach and other reasonable costs to administer the title XXI State plan, title XXI ARKids B, and this demonstration that are applied against the State's title XXI allotment, may not exceed 10 percent of total title XXI expenditures.

54. **Exhaustion of Title XXI Funds.** If the State exhausts the available title XXI Federal funds in a FFY during the period of the demonstration, the State will continue to provide coverage to the approved title XXI State plan separate child health program population, ARKids B, and Demonstration Population I with State funds (pursuant to paragraph 31).

55. **All Federal Rules Shall Continue To Apply If Title XXI Funds Are Exhausted.** All Federal rules shall continue to apply during the period of the demonstration that State or title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Demonstration Population I. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

General Financial Requirements under Title XIX for Demonstration Populations II and III and HWBP:

56. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. 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 XIV**.**

57. **Reporting MBES/CBES.** The following describes the reporting of expenditures under the demonstration:

    a. In order to track expenditures under this demonstration, Arkansas must report demonstration expenditures through the MBES/CBES, following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid manual. All Demonstration expenditures must be reported 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 demonstration year in which services were rendered or for which capitation or ESI support payments were made).

    b. 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 9.D, columns A and B. In order to assure that the demonstration is properly credited with premium collections, the premium collections (both total computable and Federal share) should also be reported on the Form CMS-64 Narrative.

    c. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not

attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid manual.

d. For each demonstration year at least three separate waiver Form CMS-64.9 Waiver and/or 64.9P Waiver must be completed reporting expenditures for individuals enrolled in the demonstration as follows:

1. PCCM/Medicaid (Waiver Name): ConnectCare expenditures (Demonstration Population III which is also the combination of all without waiver Eligibility Groups);
2. Childless Adults (Waiver Name): Demonstration Population II expenditures; and,
3. HWBP (Waiver Name): Expenditures for the Health and Wellness Benefits Program.

e. The State must assure CMS that no payments duplicative of Federal expenditures will be made for individuals enrolled in the State's Medicaid or SCHIP programs. The State will do a quarterly reconciliation to ensure that duplicative payments are not made.

58. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of Demonstration Population II; controlled and impacted ConnectCare Medicaid expenditures for Demonstration Population III (services defined in Appendix D2.S of the 1915(b) conversion application); and all Medicaid expenditures for HWBP. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

59. **Premium Collection Adjustment.** The State must include section 1115 premium collections by the State as a manual adjustment (decrease) to the demonstration's quarterly budget neutrality monitoring assessment.

60. **Employer Contributions.** The State may not claim FFP for employer contributions, nor may it use employer contributions as State share.

61. **Administrative Costs.** Administrative costs are not included in the budget neutrality limit, 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.

62. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. 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 CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

63. **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 on a quarterly basis the actual number of eligible member months for the Demonstration Eligibility Groups (EGs) (Demonstration Population III) defined in section XIV and included in table of STC number 17. This information must be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report. To permit full recognition of "in-process" eligibility, reported counts of member months must be subject to minor revisions for an additional 180 days after the end of each quarter. For example, the counts for the quarter ending September 30, 2007, due to be reported by November 30, 2007, are permitted to be revised until June 30, 2008.

    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.

64. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Arkansas must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap and separately report these expenditures by quarter for each FFY on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs. 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.

65. **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 following, subject to the limits described in section XIV.

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 Medicaid State plan; and

c. Net expenditures made with dates of service during the operation of the demonstration.

XIV. MONITORING BUDGET NEUTRALITY FOR HWBP AND DEMONSTRATION POPULATIONS II AND III

66. **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 a per capita cost method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire demonstration.

67. **Risk.** Arkansas shall be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles in the EGs described below under this budget neutrality agreement, but not for the number of Medicaid eligibles in the group. Arkansas shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Arkansas at risk for the per capita costs for Medicaid eligibles in the EG under this agreement, CMS assures that Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

68. **EGs in the Budget Neutrality Per Capita Cost Method.** The EGs in this budget neutrality agreement Comprise Demonstration Population III and are the following: Children; Adults; Aged; and Disabled.

69. **Budget Neutrality Ceiling:** The following describes the method for calculating the budget neutrality ceiling:

For each year of the budget neutrality agreement an annual limit is calculated for each EG. The annual limit for the demonstration is the sum of the projected annual limits for all EGs.

a. Each EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 61 for that EG, times the appropriate estimated per member per month (PMPM) cost from the table in (paragraph f) below.

c. The PMPM limits were determined by applying the following growth rates to the base year experience (all groups were aged at 5 percent):

EG	Rate
Aged	5.95 percent
Disabled	6.94 percent
Child	6.89 percent
Adult	6.83 percent

c. The budget neutrality ceiling is the sum of the annual PM/PM limits for the demonstration period. The Federal share of the budget neutrality ceiling represents the maximum amount of FFP that the State may receive for demonstration expenditures described in paragraph 57 on behalf of eligibles during the demonstration period.

d. The following are the ceiling PM/PM costs for the calculation of the budget neutrality expenditure ceiling for the demonstration enrollees under this section 1115 demonstration:

EG	DY01	DY02	DY03	DY04	DY05
Aged	$328.50	$348.05	$368.76	$390.70	$413.95
Disabled	$690.53	$738.45	$789.70	$844.51	$903.12
Child	$223.86	$239.28	$255.77	$273.39	$292.22
Adult	$314.77	$336.27	$359.24	$383.77	$409.98

70. **Budget Neutrality Data.** Within 30 days of approval, the State must submit complete budget neutrality information for the 4 Medicaid Eligibility Groups (MEGs), including adequate historical data to develop the without waiver baseline. At that point, the without waiver baseline and trend rate will be revisited. If the State fails to provide satisfactory information within 30 days, the trend rate will be the President's Budget trend rate minus two points for the 4 MEGs until such time as CMS has determined the appropriate rate. Within 30 days of the State's submission CMS will issue a decision on budget neutrality including baseline and trend rates.

71. **Enforcement of Budget Neutrality.** The 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 target 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
DY 1	Budget neutrality ceiling plus	8 percent
DY 1 & 2	Combined budget neutrality ceiling plus	3 percent
DY 1, 2 & 3	Combined budget neutrality ceiling plus	1 percent
DY 1, 2, 3 & 4	Combined budget neutrality ceiling plus	0.5 percent
DY 1, 2, 3, 4 & 5	Combined budget neutrality ceiling plus	0.0 percent

72. **Exceeding Budget Neutrality.** If, at the end of this demonstration period the budget neutrality limit has been exceeded, the excess Federal funds must be

returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XV. SCHEDULE OF STATE DELIVERABLES DURING THE TERM OF THIS DEMONSTRATION EXTENSION

Date	**Deliverable**
Monthly	Enrollment reports
Within 90 days of demonstration approval	Evaluation Design
60 days prior to implementation of Phase II	Feasibility Study for Covering Individuals Without Access to Employer Health Care Coverage
Due 1 year after implementation date and on an annual basis thereafter	Survey Report of Participating Employers and Employees
60 days after end of each operational demonstration year	Draft Annual Report
45 days prior to implementation	Maintenance of Effort Monitoring Plan for the HWBP
Within 120 days of demonstration expiration	Draft Evaluation Report
Quarterly	**Deliverables**
Quarterly basis	Reporting on member months
Due 60 days after the end of each quarter	Progress Reports
Due 30 days after the end of each quarter	Quarterly Enrollment Reports
Quarterly basis	Quarterly Expenditure Reports

EXPENDITURE AUTHORITY AND WAIVER LIST

FOR ARKANSAS SECTION 1115(a) DEMONSTRATION

NUMBERS: **11-W-00214/6 (Title XIX)**
21-W-0051/6 (Title XXI)

TITLE: **Arkansas Safety Net Benefit Program**

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 the State for the items identified below, which are not otherwise included as expenditures under section 1903 or section 2106(e)(2)(A) shall, for the period of the Arkansas Safety Net Benefit Program, be regarded as expenditures under the State's title XIX and title XXI plan. Title XXI expenditures are to be used for the parent population; "Demonstration Population I" are limited to the extent of the State's available allotment under section 2104 of the Act. The employer contribution for the Safety Net Benefit Program will not be matched with Federal funds. All requirements of the title XXI and title XIX statutes will be applicable to such expenditures, except those specified below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed Special Terms and Conditions (STCs) will apply to these expenditure authorities.

The following costs not otherwise matchable expenditure authorities shall enable the State to implement the approved STCs for the Arkansas Safety Net Benefit Program, a section 1115 title XXI and title XIX HIFA Demonstration. Expenditures to provide coverage to the following populations that are not otherwise covered under the State Children's Health Insurance Plan (SCHIP) or Medicaid State plan:

1. **Demonstration Population I:** Expenditures for health benefits coverage obtained through the Arkansas Safety Net Benefit Program for those employed by participating employers or spouses of such employees who: 1) are aged 19-64; 2) have a dependent child; 3) have no other health insurance coverage or group health insurance coverage; 4) are not eligible for Medicaid or Medicare; 5) are not State employees; 5) are U.S. citizens or have State verification of qualified alien status in accordance with section 432 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; 6) have family incomes up to and including 200 percent of the Federal poverty level (FPL) and for whom the State is claiming title XXI funding in accordance with the standard terms and condition in Section X, number 32 b, and not through the traditional Medicaid and SCHIP eligibility determination process.

2. **Demonstration Population II:** Expenditures for health benefits coverage obtained through the Arkansas Safety Net Benefit Program for those employed by participating employers or spouses of such employees who: 1) are aged 19-64; 2)

are childless; 3) have no other health insurance coverage or group health insurance coverage; 4) are not eligible for Medicaid or Medicare; 5) are not State employees; 6) are U.S. citizens or have State verification of qualified alien status in accordance with section 432 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; 7) have family incomes up to and including 200 percent of the FPL and for whom the State is claiming title XIX funding.

3. **Expenditure Authority:** Expenditures for alternative services provided to ConnectCare enrollees (i.e. Demonstration Population III) as identified in Appendix D.2.S of the 1915(b) conversion waiver application.

4. **Health and Wellness Benefits Program (HWBP)**: Expenditures for health care-related services that support the health and wellness of demonstration enrollees that would not otherwise be covered and are subject to the parameters and restrictions set forth in the STCs.

SCHIP Requirements Not Applicable to the SCHIP Expenditure Authorities:

All requirements of the SCHIP program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this letter shall apply to this demonstration for the parent population. To further this demonstration, we are identifying the following requirements as inapplicable to the extent indicated:

1. **General Requirements, Eligibility and Outreach - Section 2102**

The State child health plan does not have to reflect the demonstration populations, and eligibility standards do not have to be limited by the general principles in section 2102(b).

2. **Restrictions of Coverage and Eligibility to Targeted Low-Income Children – Sections 2102 and 2110**

The State will extend coverage and eligibility for the demonstration populations to individuals who are not targeted low-income children, and who have group health insurance coverage or other health insurance coverage.

3. **Eligibility Conditions – Section 2102(a)**

The State will restrict eligibility for the demonstration populations based on employment with participating employers, which is not a condition otherwise authorized by section 2102(a) of the Act.

4. **Benefit Package Requirements - Section 2103**

The State may offer a benefit package that does not meet the requirements of section 2103 of the Act, as implemented by Federal regulations at 42 CFR 457.410(b)(1) for Demonstration Populations I and II.

5. **Cost Sharing - Section 2103(e)**

Cost sharing for the demonstration population may exceed the limitations on cost sharing under section 2103(e) of the Act.

6. **Federal Matching Payment and Family Coverage Limits – Section 2105**

Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration populations, and limits on family coverage are not applicable with respect to the demonstration populations. Federal matching payments remain limited by the allotment determined under section 2104 of the Act. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2) of the Act.

Title XIX Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 1, 2006 through September 30, 2011. In addition, these waivers may only be implemented consistently with the approved STCs.

1. **Amount Duration and Scope** **Section 1902(a)(10)(B)**

To permit plans providing coverage to Arkansas Safety Net Benefit Program enrollees to provide additional benefits that may not be available to enrollees in other plans or to Medicaid recipients not enrolled in the Arkansas Safety Net Benefit Program.

2. **Freedom of Choice** **Section 1902(a)(23)**

To enable Arkansas to restrict the freedom of choice of providers.

3. **Comparability of Services** **Section 1902(a)(10)(B)**

To permit the State to vary the amount, duration, and scope services to provide additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

Medicaid Requirements Not Applicable to the Expenditure Authorities:

In order to permit the demonstration project to function as amended, in addition to and/or consistent with previously approved waiver and expenditure authorities described above, the following Medicaid requirements are not applicable to the Expenditure Authorities:

1. **Provision of Medical Assistance** **Section 1902(a)(10)(A)**

To enable Arkansas to limit the medical assistance for Demonstration Populations I and II available to the types of assistance described in these expenditure authorities.

2. **Methods of Administration: Transportation** **1902(a)(4) and 42 CFR 431.50**

The State is not required to assure transportation to and from providers for Demonstration Populations I and II.

3. **Eligibility Procedures** **1902(a)(10)(A) and 1902(a)(10)(C)(I)-(III)**

The State may use streamlined and alternative eligibility procedures for Demonstration Populations I and II.

4. **Cost-sharing and Premiums** **1902(a)(14)**

The State may charge premiums and require cost-sharing contributions prior to service delivery for Demonstration Populations I and II.

5. **Retroactive Eligibility** **1902(a)(34)**

The State is not required to provide services to Demonstration Populations I and II for any time prior to when application is made.

6. **Income & Eligibility Verification** **1902(a)(46)**

The State may accept self-attestation as proof of income for eligibility determinations for Demonstration Populations I and 2.

7. **Disenrollment for Non-Payment of Premiums** **1916(c)(3)**

Individuals in Demonstration Populations I and II may be disenrolled from private coverage for failure to pay premiums.