DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 — 0 0 1

2. STATE: Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 460

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 30,708.77
b. FFY 2005 $ 1,089,642.22

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Please see attached listing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Please see attached listing

10. SUBJECT OF AMENDMENT:
The Division of Medical Services plans to implement a Program for All-Inclusive Care for the Elderly (PACE).

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Roy Jeffus, MD

13. TYPED NAME: Roy Jeffus

14. TITLE: Director, Division of Medical Services

15. DATE SUBMITTED: December 31, 2003

16. RETURN TO:
Division of Medical Services
P. O. Box 1437
Little Rock, AR 72203-1437

Attention: Joie Wallis
Slot S295

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6 JANUARY 2004

18. DATE APPROVED: 26 MARCH 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 JULY 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: ANDREW A. FREDRICKSON

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:

ATTACHED LISTING FOR
ARKANSAS STATE PLAN
TRANSMITTAL #2004-001

8. Number of the Plan Section or Attachment	9. Number of the Superseded Plan Section or Attachment
Attachment 3.1-A, Page 11	None, New Page
Supplement 3 to Attachment 3.1-A Page 33	None, New Page
Supplement 3 to Attachment 3.1-A Page 34	None, New Page
Supplement 3 to Attachment 3.1-A Page 35	None, New Page
Supplement 3 to Attachment 3.1-A Page 36	None, New Page
Supplement 3 to Attachment 3.1-A Page 37	None, New Page
Supplement 3 to Attachment 3.1-A Page 38	None, New Page
Supplement 3 to Attachment 3.1-A Attachment A Pages 1 and 2	None, New Pages
Attachment 3.1-B Page 10	None, New Page

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27. **Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.**

__X__ **Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.**

_____ **No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.**

1905(a)(26) and 1934

__X__ **Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.**

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits-for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.
A.__X__The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

A special income level equal to 300% of the SSI Federal Benefit (FBR) (42 CFR 435.217)

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B._____The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C.__X__The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1.__X__SSI State. The State is using the post-eligibility rules at 42 CFR 435.726.
Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1.__X__The following standard included under the State plan (check one):
(a) _____SSI
(b)_____Medically Needy
(c)__X__The special income level for the institutionalized
(d)_____Percent of the Federal Poverty Level: _____%
(e)_____Other (specify):_____

SUPERSEDES: NONE - NEW PAGE

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PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

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2. N/A The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3. N/A The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1.____ SSI Standard
2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5 .____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
6.____ The amount is determined using the following formula:
_____
7. X Not applicable (N/A)

(C.) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7. X Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

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PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Regular Post Eligibility

2. _N/A_ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1.___The following standard included under the State plan (check one):

(a) _____SSI

(b) _____Medically Needy

(c) _____The special income level for the institutionalized

(d) _____Percent of the Federal Poverty Level: _____%

(e) _____Other (specify):_____

2.___The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

3.___The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1._____The following standard under 42 CFR 435.121:

_____

2._____The Medically needy income standard

_____

3._____The following dollar amount: $_____

Note: If this amount changes, this item will be revised.

4 .____The following percentage of the following standard that is not greater than the standards above:

_____% of _____ standard.

5._____The amount is determined using the following formula:

_____

_____

6._____Not applicable (N/A)

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PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

(C.) Family (check one):
1.____AFDC need standard
2.____Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3._X_State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:
1. Individual (check one)
(A). _X_The following standard included under the State plan (check one):
1. _____SSI
2. _____Medically Needy
3. _X_The special income level for the institutionalized
4. _____Percent of the Federal Poverty Level: _____%
5. _____Other (specify):_____

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(B). N/A The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C). N/A The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

_____

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See
1. X Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Mr. Robert Damler, FSA, MAAA
Principal and Consulting Actuary
Milliman, USA
111 Monument Circle, Suite 601
Indianapolis, IN 46204-5128

See Pages 37A and 37B for description of the reimbursement methodology for Program of All-Inclusive Care for the Elderly (PACE).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARKANSAS

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Program of All-Inclusive Care for the Elderly (PACE) Reimbursement Methodology

The PACE rates are based on the Upper Payment Limit methodology. The historical fee-for-service population data is extracted for claims and eligibility for a PACE eligible populations for more than one fiscal period. Data for recipient aged, blind and disabled aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to nursing facility level of care eligible or Waiver level of care eligible (waivers included are the ElderChoices Waiver and the Adults with Physical Disabilities Waiver).

The data includes both those that are eligible only for Medicaid and those that are eligible for both Medicaid and Medicare. In addition, this data includes only QMB-Plus and SLMB-Plus populations. The claims data includes all categories of service. The UPL and base rate information is also inclusive of patient liability.

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with historical rate changes rather than the more recent experience.

The following rate category groupings were developed for Arkansas: Pre-65 Medicaid Only, Pre-65 Dual Eligible, Post-65, and QMB Only. The UPL for QMB Only is based on actual expenditures for co-payments and deductibles for the base year period trended forward for inflation, and adjusted for investment income and administration expense. Due to the limited size population in the post-65 age group that was not Medicare eligible, it was determined that a Medicare eligibility rate for those over 65 would not improve predictability. The data did not reflect a necessity for a rate grouping for either geographic region or gender.

Claims completion factors are developed from the fee-for-service paid claims experience with the most recently available paid dates. Claims completion factors were developed for fourteen (14) primary groupings with comparable categories of service grouped for improved predictability. The completion factors were adjusted to exclude low and high outliers for each specific lag month.

The following adjustments are necessary in the development of the rates:

- **Prescription Drug (PD) Rebate – Reduce PD expenditure data to reflect the rebate received by Arkansas.**
- **Investment Income – Reduce expenditure data by 0.2% for all Categories of Services (COS) to reflect an average payment lag of 2.49 months.**
- **Administration Expense – Increase expenditure data for all COS by 0.3% to reflect the cost of administration of the fee-for-service program.**

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- **Co-payments for Medicaid services – Increase the expenditures to reflect co-payment amounts.**
- **PCCM Fees – Decrease the base expenditures to exclude the PCCM fees.**
- **Non-emergency Transportation – Currently under waiver, Arkansas contracts for non-emergency transportation services for all Medicaid recipients eligible for the benefit (nursing facility residents are not eligible). A composite rate is developed with adjustments to reflect the PACE population morbidity.**

The UPL amounts are reduced by a percentage amount to establish the PACE capitation rate. The Percentage (%) amount will be based on the anticipated reductions in health care service costs due to the implementation of the managed care PACE program. Reductions in costs are anticipated to be realized through a reduction in nursing facility and in-patient hospital costs.

The Upper Payment Limits (UPLs) will be rebased/recalculated every two years and the rebasing calculations will be completed for two State Fiscal Years (SFYs). Since the first UPLs and rates were calculated for SFYs 2005 and 2006, the first rebasing process will be completed for SFYs 2007 and 2008, which begin July 1, 2006 and July 1, 2007, respectively. The rebasing/recalculations will be completed in accordance with the methodology described above.

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PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

ARKANSAS MEDICAID STATE PLAN

Program of All-Inclusive Care for the Elderly (PACE) Reimbursement Methodology

The PACE rates are based on the Upper Payment Limit methodology. The historical fee-for-service population data is extracted for claims and eligibility for a PACE eligible populations for more than one fiscal period. Data for recipient aged, blind and disabled aid categories for those 55 or greater is used in the UPL and rate calculations. The level of care codes are limited to nursing facility level of care eligible or Waiver level of care eligible (waivers included are the ElderChoices Waiver and the Adults with Physical Disabilities Waiver).

The data includes both those that are eligible only for Medicaid and those that are eligible for both Medicaid and Medicare. In addition, this data includes only QMB-Plus and SLMB-Plus populations. The claims data includes all categories of service. The UPL and base rate information is also inclusive of patient liability.

The base rates are calculated using calendar year base data. The base year data is trended forward using the historical claims and eligibility information extracted for the fee-for-service population. The recent trend rates are compared to linear regression model trend rates to determine comparability, and to determine if any adjustments are necessary. The trend rates for future periods are expected to be consistent with historical rate changes rather the more recent experience.

The following rate category groupings were developed for Arkansas, Pre-65 Medicaid Only, Pre-65 Dual Eligible, and Post-65. Due to the limited size population in the post-65 age group that was not Medicare eligible, it was determined that a Medicare eligibility rate for those over 65 would not improve predictability. The data did not reflect a necessity for a rate grouping for either geographic region or gender.

Claims completion factors are developed from the fee-for-service paid claims experience with the most recently available paid dates. Claims completion factors were developed for fourteen (14) primary groupings with comparable categories of service grouped for improved predictability. The completion factors were adjusted to exclude low and high outliers for each specific lag month.

The following adjustments are necessary in the development of the rates:

- **Prescription Drug (PD) Rebate – Reduce PD expenditure data to reflect the rebate received by Arkansas.**
- **Investment Income – Reduce expenditure data by 0.2% for all Categories of Services (COS) to reflect an average payment lag of 2.49 months.**
- **Administration Expense – Increase expenditure data for all COS by 0.3% to reflect the cost of administration of the fee-for-service program.**
- **Co-payments for Medicaid services – Increase the expenditures to reflect co-payment amounts.**
- **PCCM Fees – Decrease the base expenditures to exclude the PCCM fees.**
- **Non-emergency Transportation – Currently under waiver, Arkansas contracts for non-emergency transportation services for all Medicaid recipients eligible for the benefit (nursing facility residents are not eligible). A composite rate is developed with adjustments to reflect the PACE population morbidity.**

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SUPERSEDES: NONE - NEW PAGE

In addition to the 3 rate cells described above, a separate Per Member Per Month UPL is calculated for QMB Only eligible recipients. This UPL is based on actual expenditures for co-payments and deductibles for the base year period trended forward for inflation, and adjusted for investment income and administration expense.

The UPL amounts are reduced by a percentage amount to establish the PACE capitation rate. The Percentage (%) amount will be based on the anticipated reductions in health care service costs due to the implementation of the managed care PACE program. Reductions in costs are anticipated to be realized through a reduction in nursing facility and in-patient hospital costs.

The Upper Payment Limits (UPLs) will be rebased/recalculated every two years and the rebasing calculations will be completed for two State Fiscal Years (SFYs). Since the first UPLs and rates were calculated for SFYs 2005 and 2006, the first rebasing process will be completed for SFYs 2007 and 2008, which begin July 1, 2006 and July 1, 2007, respectively. The rebasing/recalculations will be completed in accordance with the methodology described above or other accepted methods.

27. **Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.**

_____ **Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.**

__X__ **No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.**

1905(a)(26) and 1934

_____ **Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.**

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)