Attachment H

Arkansas Works Program
Proposed Evaluation for Section 1115 Demonstration Waiver

February 6, 2017

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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Evaluation for Section 1115 Demonstration Waiver Extension under Arkansas Works

The State of Arkansas continues to implement a novel approach to expanding coverage for individuals newly eligible for Medicaid under the Patient Protection and Affordable Care Act (PPACA). The original **Health Care Independence Program** (HCIP) of 2013 (commonly referred to as the "Private Option") for which state authorization terminated December 31, 2016 has been extended under new state authorization entitled **Arkansas Works**. The state received an extension of its Section 1115 Demonstration Waiver on December 8, 2016 to enable continued use of PPACA funding for premium assistance on the individual marketplace with new requirements supporting employer sponsored insurance and reinforcing private sector practices in the Medicaid program. Arkansas Works is enacted to begin in January, 2017 and run through December, 2021.

The waiver extension continues the use of premium assistance for non-frail expansion beneficiaries in the individual marketplace as under the HCIP. In addition, Arkansas Works incorporates employer premium assistance as described below in addition to programmatic modifications to enhance and incentivize personal responsibility for recipients' health and subsequent engagement with the healthcare system. Additional components incorporated into Arkansas Works included:

- Employer sponsored premium assistance with mandatory participation of employees upon election of the employer to participate and determination of cost-effectiveness by the Arkansas Department of Human Services;
- Elimination of Health Savings Accounts / Independence Accounts with addition of required premiums for individuals between 100-138% federal poverty level (FPL);
- Restrictions on non-emergency transportation for premium assistance participants (individual or employer);
- Incorporation of incentive benefits with eligibility requirements of an annual wellness visit for risk mitigation and chronic disease management for all (0-138% FPL) combined with being up-to-date on premiums for individuals 100-138% FPL; and
- Elimination of retroactive eligibility prior to the month of application.

As publicly stated by Governor Hutchison, additional requests of the new Administration may result in additional waiver modifications through modifications of the terms and conditions impacting this evaluation design.

This required evaluation under Section 1115 terms and conditions for the state is an extension of the evaluation initiated in 2014 under the HCIP programmatic authority. It extends assessments of the original and maintained hypotheses with additional hypotheses incorporated to assess impact of above modifications. Reporting requirements from the evaluation were modified in the waiver extension. The first year (2014) of programmatic experience was detailed in the Interim Report submitted by the State in early 2016. A complete assessment of the HCIP three year program is now required with a summative final report due July 1, 2018.

The evaluation of Arkansas Works will be aided by the ability to study established cohorts of beneficiaries and a more stable program that avoids start-up variation. This will also lend support to being able to study the new tenets of the program, listed above.

1. Background

Arkansas is a largely rural state with significant health care challenges including high health-risk burdens; low median family income; high rates of uninsured individuals; and limited provider capacity, particularly in non-urban areas of the state. Prior to initiating the Health Care Independence Program ("Private Option") in January, 2014, Arkansas's Medicaid program had one of the most stringent eligibility thresholds in the nation, largely limiting coverage to the aged, disabled, and parents with extremely low incomes and limited assets.

Arkansas implemented the Marketplace through a state–federal partnership model with the state conducting plan management and consumer outreach and education. There are seven distinct Marketplace service areas across the state; within each area three to five carriers have committed to offer qualified health plans (QHPs) for 2017. Arkansas Works authorizing legislation provides for the continued use of PPACA funds for premium assistance and requires all Marketplace participating carriers to enroll eligible Arkansas Works adults in their QHP offerings.

Working closely with the Division of Medicaid Services within the Arkansas Department of Human Services, the Arkansas Insurance Department has issued guidance and directives to achieve plan offerings that conform to Centers for Medicaid and Medicare Services (CMS) and Center for Consumer Information and Insurance Oversight (CCIIO) requirements for plan actuarial value, cost-sharing reductions, benefit components, and reporting requirements.

The intent of the Arkansas Works Act of 2016 is to continue the provision of care to HCIP enrolled beneficiaries, enroll newly eligible beneficiaries, enhance offerings of coverage through employer-sponsored insurance, and promote personal responsibility by offering an incentive package when preventive care is obtained and contributions to a health savings account are made.

2. Section 1115 Waiver: Arkansas Works Act

The U.S. Supreme Court's June 2012 ruling[1] allowed states to decide whether or not to extend Medicaid benefits to their citizens who qualify under PPACA expansion. Members of the Arkansas 89th General Assembly took a bipartisan approach to this prospect and crafted a unique proposal that used federal Medicaid funding to provide health care benefits to individuals eligible under the PPACA expansion. These individuals received coverage via private insurance plans offered through the Marketplace. The Private Option[2] and its accompanying appropriation was passed by the required three-fourths majority vote in both the Arkansas House and Senate and signed into law by Governor Mike Beebe on April 23, 2013. Arkansas Works (henceforth referred to as "the act") was signed into law by Governor Asa Hutchinson on April 8, 2016. Funding for the program was authorized thereafter, following procedural maneuvers including a line-item veto in order to gain legislative approval.

The act calls on the Arkansas Department of Human Services (DHS) to explore program design options that reform Arkansas Medicaid so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program using competitive and value-based purchasing to:

- maximize the available service options;
- promote accountability, personal responsibility, and transparency;
- encourage and reward healthy outcomes and responsible choices; and

[1] 567 U.S. ___ (2012).
[2] The Arkansas Health Care Independence Act of 2013, Act 1497, Act 1498.

- promote efficiencies that will deliver value to the taxpayers.

Arkansas DHS has secured approval of a waiver demonstration application submitted to the U.S. Department of Health and Human Services specifically designed to implement the act's requirements.[3]

By virtue of findings from the study of the first year experience of approximately 250,000 individuals enrolled in the Private Option, we conclude it unlikely that Medicaid expansion, through the traditional Medicaid program, would have produced the same level of access or level of quality of care. In short, absent the federal waiver to implement the act, a traditional Medicaid expansion would rely on the existing Medicaid delivery system and perpetuate an inadequately coordinated approach to patient care for those eligible under the PPACA.

A. Arkansas Works Eligibility

The act extends coverage to eligible individuals who meet the following requirements:

- Adults between the ages of 19 and 64 years.
- A U.S. citizen or qualified, documented alien.
- Those not otherwise eligible for Medicaid under current eligibility requirements, such as those who are disabled, children, dual eligible, or are parents earning less than 17 percent FPL.
- Those not enrolled in Medicare.
- Those not incarcerated.

Essentially, the coverage is for childless adults earning between 1 percent and 138 percent of the FPL or parents who earn between 17 percent and 138 percent of the FPL.

B. Arkansas Works Funding and Costs[3]

The act allows the program to continue in perpetuity during the period of the waiver that has been submitted by the Arkansas DHS but is contingent upon annual appropriations by the Arkansas General Assembly. The waiver has been approved by U.S. DHHS for 2017–2021. The costs of the program are shared by the federal government through provisions of the PPACA. In year 2017 the federal share will be 95%, and it will be 94%, 93%, and 90% in years 2018, 2019, and 2020 and beyond, respectively.

In ACHI's comparison of options for extending health insurance coverage to low-income Arkansans, the budget impact of the Health Care Independence Act and subsequent Arkansas Works Act on the state were estimated as follows[4]:

- State spending will increase by $173 million in FY20 at 10% state/90% federal match requirement for expansion population.
- Additional premium tax revenue over the first 5 years of the Private Option will generate $123 million.
- The net impact on the state budget is a favorable $637 million over 5 years.

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[3] Arkansas Department of Health and Human Services. *Arkansas 1115 Waiver-FINAL.* Accessed at https://www.medicaid.state.ar.us/Download/general/comment/ARWorksAppFinal.pdf on January 30, 2017.

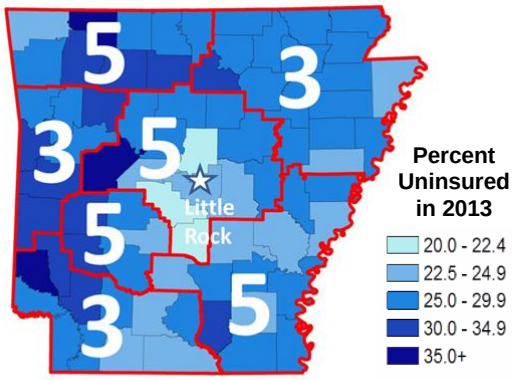
[4] Arkansas Health Reform Legislative Task Force Final Report. December 15, 2016. Accessed at http://www.arkleg.state.ar.us/assembly/2017/Meeting%20Attachments/836/I14805/Final%20Approved%20Report%20from%20TSG%2012-15-16.pdf on January 30, 2017

C. Private Plans Available to Arkansans

The act requires the state to continue an integrated and market-based approach to covering low-income Arkansans by offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program.[3]

A benefit of this approach can be found in the number of private insurance companies who are offering offer plans across the state (Figure 1) superimposed on a county level map of adult uninsured rates in 2013, prior to HCIP.[5] Arkansas citizens living in each region of the state have a choice of plans from at least two companies.[6]

Figure 1: Number of Issuers Offering Individual Plans by Service Area



Issuers:

- Arkansas Blue Cross Blue Shield of Little Rock
- National Blue Cross Blue Shield Multi-state Plan
- QualChoice Health Insurance
- QC Life and Health
- Arkansas Health & Wellness Solutions (Ambetter)

D. Arkansas Works Proposal[3]

The Private Option was crafted to address the provider capacity and care coordination issues noted above. By using premium assistance to purchase qualified health plans (QHPs) offered in the Health Insurance Marketplace, Arkansas promoted continuity of coverage and expanded provider access, while improving efficiency and accelerating multi-payer cost-containment and quality-improvement efforts. By providing a source of health care payments to an estimated 250,000 uninsured citizens, an economic impetus was created that is credited as a factor on no hospital closings due to insolvency.[7] In contrast there were 56 hospital closures in bordering states in 2015. A study sponsored by ACHI and conducted by the RAND Corporation indicated that full implementation of expanded coverage under the PPACA would result in a $550 million annual increase in Arkansas's gross domestic product and the creation of 6,200 jobs, with the majority of this impact accruing to rural Arkansas where the uninsured rates are relatively higher.[7] Further, the Stephen Group report[8] concluded a net benefit of $637 million to the state over five years of the premium assistance model of Medicaid expansion through Arkansas Works.

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[5] Talk Business. *Only Four Insurance Carriers Could Qualify for Arkansas Exchange.* August 2013. Accessed at http://talkbusiness.net/2013/08/only-four-insurance-carriers-could-qualify-for-arkansas-exchange/ on September 24, 2013.

[6] Arkansas Insurance Department. *Bulletin No. 3B-2013.* June 2013. Accessed at http://www.insurance.arkansas.gov/Legal/Bulletins/3B-2013.pdf on September 24, 2013.

[7] Hospital Case Study: Impact of Expanded Healthcare Coverage. November 2013. Accessed at http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=336 on February 1, 2017.

[8] Arkansas Health Reform Legislative Task Force, December 15, 2016. Accessed at http://www.arkleg.state.ar.us/assembly/2017/Meeting%20Attachments/836/I14805/Final%20Approved%20Report%20from%20TSG%2012-15-16.pdf on February 1, 2017.

Continuity of Coverage

For households with members eligible for coverage under Title XIX or the Health Insurance Marketplace, as well as those who have income fluctuations that cause their eligibility to change year to year, the act will create continuity of health plans and provider networks. Households can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, CHIP (after year one), or Advanced Payment Tax Credits. Preliminary numbers suggest approximately 85% of those who were enrolled in a premium assistance plan remained actively enrolled through December, 2015 (unpublished analysis).

Rational Provider Reimbursements and Improved Provider Access

Arkansas's network of providers serving existing Medicaid beneficiaries has fundamental limitations restricting capacity to serve individuals newly eligible under the ACA. First, Arkansas Medicaid's reimbursement rates are generally lower than Medicare or commercial payers, causing some providers to forgo participation in the program and others to "cross-subsidize" their Medicaid patients by charging more to private insurers. Second, due to restrictive eligibility limitations except for children, pregnant women, the dual eligible population, and select services (e.g., family planning), the Medicaid network for adult services has capacity limitations. The act's intent through the use of QHPs is to expand provider access for the newly eligible adult population and reduce the need for providers to cross-subsidize. Through Arkansas Works, the state expects to avoid inflationary pressure on existing Medicaid rates to establish required access and provide deflationary relief in the Marketplace by reducing cross-subsidization.

Integration and Efficiency

Arkansas will continue to take an integrated and market-based approach to covering Arkansans, rather than relying on a system for insuring lower-income families that is separate and duplicative. The transition to private markets under this program is an efficient way to capitalize on the enhanced market competition and to cover Arkansans who often have income fluctuations.

"All Payer" Healthcare Reform

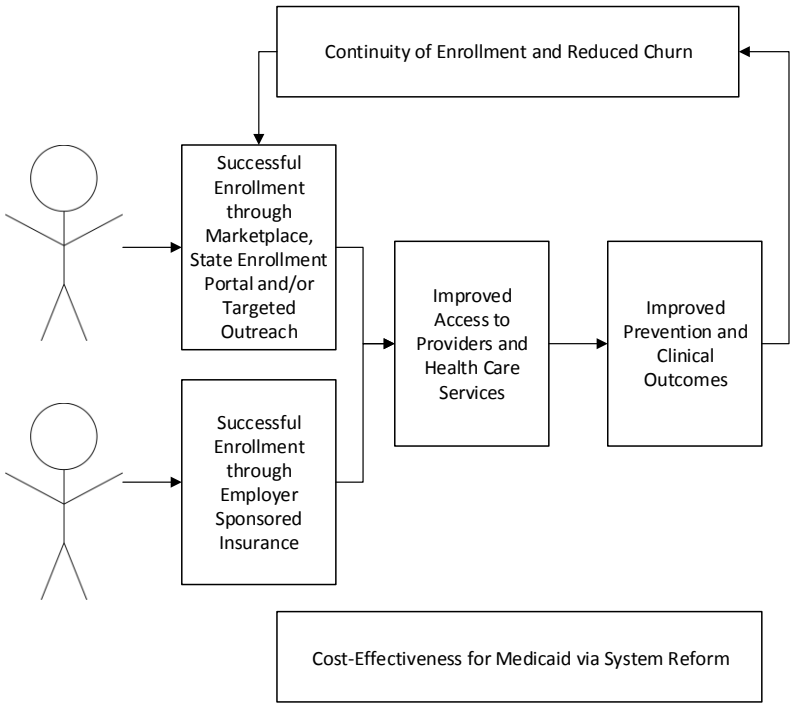
Arkansas is at the forefront of payment innovation and delivery system reform, and Arkansas Works will continue to accelerate and leverage the state's Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort and the number of privately insured Arkansans who benefit from a direct application of these reforms.

3. Evaluation Strategy

A. Goals and Objectives

The Arkansas Works programmatic goals and objectives include successful enrollment, enhanced access, improved quality of care and clinical outcomes, and enhanced continuity of coverage and care at times of reenrollment and income fluctuation. New programmatic enhancements call for the promotion of premium assistance for employer sponsored insurance and incentive benefits to those demonstrating personal responsibility in obtaining preventive care and participating in health savings accounts. These goals and objectives must be achieved within a cost-effective framework for the Medicaid program compared with what would have occurred if the state had provided coverage for the same expansion group in Arkansas Medicaid's traditional fee-for-service delivery system.

Figure 2: Arkansas Demonstration Waiver Evaluation Logic Model



Existing enrollees are currently experiencing improved access to providers and healthcare services, improved prevention and clinical outcomes, and continuity of enrollment. New enrollees will continue to enroll through the Marketplace and state enrollment portal. Eligible employees of employers who participate in the premium assistance employer sponsored insurance program will be required to enroll through the employer's health benefits administrator with additional administrative components facilitated by the Arkansas Health Insurance Marketplace. Compared with what would have occurred in a traditional Medicaid expansion, Arkansas Works and premium assistance employer sponsored insurance enrollees will receive coverage that improves access to providers and health care services by using carrier networks with provider reimbursements under deflationary pressure, thereby reducing payment differentials between Medicaid and privately insured individuals. Through this improved access, Arkansas Works and premium assistance employer sponsored insurance enrollees will receive more appropriate care including prevention, chronic disease management, and therapeutic interventions leading to better clinical outcomes. At times of reenrollment and/or changes in family income, individuals will have a greater ability to continue coverage with the same carrier and clinical relationships with the same providers, which will lead to more seamless transitions and continuity of care. Finally, the enhancements to Arkansas Works clients' experiences described above will be assessed to determine the cost effectiveness of the Arkansas Works demonstration waiver for Medicaid and the broader impact on the health care system. In addition, we will test the hypothesis that individuals offered employer sponsored insurance that is supplemented through premium assistance will have better outcomes than had they been enrolled directly in a premium assistance QHP plan.

B. Hypotheses

Research questions of interest identified in the development and approval process for the Arkansas Works waiver include those examining the goals of improving access, improving care and outcomes, reducing churning, and lowering costs. Appendix 1 provides a table that includes a description of each of the 16 hypotheses outlined in STC #75 that have been re-organized into the following six categories:

1. **HCIP beneficiaries will have equal or better *access to health care* compared with what they would have otherwise had in the Medicaid fee-for-service system over time.** Access will be evaluated using the following measures:

a. Use of primary care and specialty physician services, including analysis of provider networks
b. Use of emergency room services (including emergent and non-emergent use)
c. Potentially preventable emergency department and hospital admissions
d. EPSDT benefit access for young, eligible adults
e. Non-emergency transportation access

2. **HCIP beneficiaries will have equal or better *care and outcomes* compared with what they would have otherwise had in the Medicaid fee-for-service system over time.** Health care and outcomes will be evaluated using the following measures:
    a. Use of preventive and health care services
    b. Experience with the care provided
    c. Use of emergency room services* (including emergent and non-emergent use)
    d. Potentially preventable emergency department and hospital admissions*

3. **HCIP beneficiaries will have better *continuity of care* compared with what they would have otherwise had in the Medicaid fee-for-service system over time.** Continuity will be evaluated using the following measures:
    a. Gaps in insurance coverage
    b. Maintenance of continuous access to the same health plans
    c. Maintenance of continuous access to the same providers

4. **Services provided to HCIP beneficiaries will prove to be *cost effective*.** Cost effectiveness will be evaluated using findings above in combination with the following costs determinations:
    a. Administrative costs for the HCIP beneficiaries, including those who become eligible for Marketplace coverage
    b. Overall premium costs in the Marketplace
    c. Cost for covering HCIP beneficiaries compared with costs expected for covering the same expansion group in Arkansas fee-for-service Medicaid

5. **Arkansas Works employer-sponsored insurance program will produce greater system efficiencies and individual outcomes than QHP premium assistance program.** System and individual metrics that will be assessed include:
    a. Reduce cost of employer-sponsored insurance coverage
    b. More small-group employers will choose to offer employer sponsored coverage or non-grandfathered coverage
    c. Continuity of coverage for individuals with employer-sponsored insurance premium assistance will be improved compared to those with those with QHP premium assistance

6. **Arkansas Works beneficiaries will effectively participate in an incentive benefits program**. The following measure will determine success of the incentive benefit program:
    a. Incentive benefits offered to Arkansas Works beneficiaries will increase participation rates for premium contributions compared to historical experience with Independence Accounts and increase primary care utilization

** The outcomes of interest and evaluation approaches associated with hypotheses 2c and 2d are shared with 1b and 1c. They are listed here, but will not be replicated throughout the rest of this document to avoid redundancy.*

C. Metrics and Data Available

The following sets of metrics will be used throughout the evaluation. Appendix 2 provides a detailed description of each candidate metric including the original definition from the original sources (arranged by source across Appendices 2A, 2B, and 2C). Appendix 3 provides a table with a complete list of each selected metric with the targeted set of hypotheses it will support.

It is anticipated that there will be a core set of measures selected from a larger group that will be used to answer a majority of the questions, while additional measures will be used to supplement these findings. These details will be examined in consultation with the study team, CMS, and the HCIP evaluation National Advisory Committee, to be retained for the Arkansas Works evaluation.

Enrollment

We anticipate data to be made available for all Medicaid enrollees (traditional and assigned for exceptional health care needs) and Arkansas Works QHP enrollees. Indicators considered for monitoring include the following:

- Total and subgroup enrollment within carrier (e.g., market penetration)
- Total and subgroup enrollment within each plan (e.g., plan differentiation)
- Total and subgroup enrollment within each market (e.g., geographic uptake variation)

Continuity of care, including churn and attrition, will be evaluated across markets, plans, and geographic region for all enrollees in Arkansas Works. Transitions across coverage periods will result in maintenance within the same plan or intentional decisions to change plans. These data will primarily be used to address hypotheses related to continuity of care.

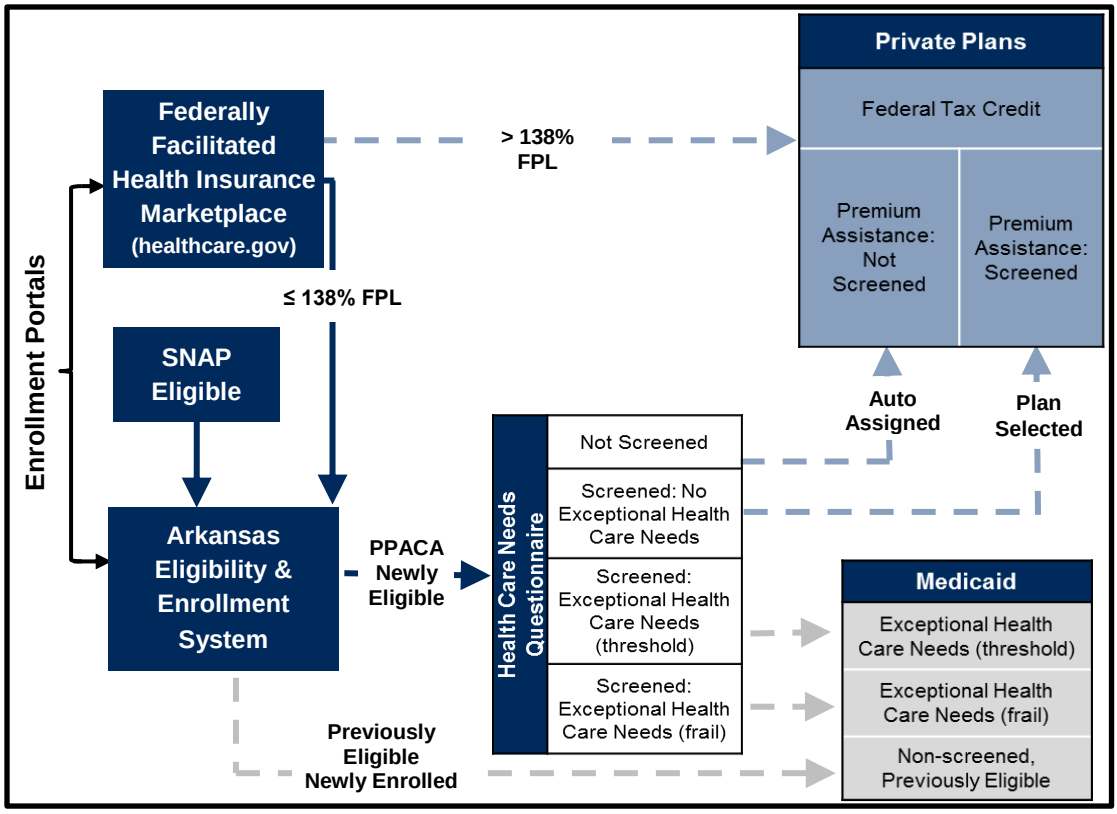
Exceptional Health Care Needs Assessment Screener

The original HCIP authorizing legislation directed DHS to identify those individuals who had exceptional health care needs for whom coverage through the Marketplace was determined to be impractical, overly complex, or would have undermined continuity or effectiveness of care. They were thus to be retained in the fee-for-service Medicaid program.

In consultation with health status and exceptional needs measurement experts at the University of Michigan and the Agency for Healthcare Research and Quality, Arkansas developed a screening process that sought to identify the top 10 percent most medically needy to be included in this population—such as individuals who would benefit from long-term services and supports and targeted outreach and care coordination through the state's emerging health home program and Community First Choice state plan option. There were two stages to the screening process. At the first stage, individuals with significant limitations for daily living and other "automatic" triggers were identified. The second stage involved a weighted set of indicators from the remaining set of

questions that were used to identify a cut point (0.18 on an ordinal scale ranging from 0.02 to 0.64) around which assignments were made about eligibility. This cut point provided a unique opportunity to employ regression discontinuity (described in D1 below) techniques with the individuals who are screened during the second stage. The final screener consisted of 12 questions that provided self-reported information; responses were scored and calibrated to identify the population who were retained in the fee-for-service Medicaid program. Figure 3 describes the enrollment process and insurance plan assignment for those who completed the health care needs assessment screener ("Questionnaire"). Slightly more than 100,000 individuals completed the screener.

Figure 3. Enrollment Pathways and Plan Assignment Process



With the exception of identifying new enrollees with activities of daily living limitations, composite scores based on screener responses is no longer compiled and hence program assignment based on a cutoff threshold score is no longer being conducted. As such, only those in the original 2014 HCIP cohort were subjected to this non-random assignment into a QHP premium assistance plan or Medicaid. We will however use this population to track the long-term benefits of those continuously enrolled who were assigned to each of the health insurance options.

Medicaid Adult Core Set

The Medicaid Adult Core Set is a set of health quality measures identified by CMS in partnership with the Agency for HealthCare Research and Quality (AHRQ). (See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf.) We will use this as our base set of health indicator measures for the evaluation and supplement with additional indicators to address additional hypotheses. See Appendix 2A for a detailed description of each metric.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is one of the most widely used sets of health care performance measures by health plans in the United States to compare how well plans perform in quality of care, access to care, and patient experience with the health plan and plan physicians. National benchmarks and both national and regional thresholds for HEDIS measures and HEDIS/CAHPS survey results are used to score health plans annually. The National Committee for Quality Assurance (NCQA) develops and maintains the measurement set annually.

For the purposes of this evaluation, we propose a subset of candidate measures from HEDIS that include quality of care, access to care, and patient experience measures. See Appendix 2B for definitions of selected metrics and Appendix 3 for a complete list of candidate metrics and their corresponding hypotheses.

CAHPS

Nationwide experience with the Consumer Assessment of Health Plan Survey (CAHPS) has led to important new insights into patient experiences with care both for the Medicaid and the commercially insured populations. Various CAHPS surveys are available that ask consumers and patients to report on their experiences with health care and cover important topics including quality of care, access to care, and experience with care. Surveys are available in the public domain.

The Arkansas Foundation for Medical Care is the current contractor that collects CAHPS for the Arkansas Medicaid program every two years. They have twice fielded a modified Medicaid Adult survey version of CAHPS as part of the HCIP evaluation (see Appendix 2C) that includes questions to address:

- Access to and availability of services
- Consistency of care providers and networks
- Use of primary and specialty care services
- Experience with care

For the purpose of this evaluation, CAHPS will be implemented in Years 2 and 5 of the Arkansas Works program. A stratified sampling procedure will be used to ensure representative participants from each of the geographic regions of the state, as well as age and insurance groups (i.e., traditional Medicaid vs. Arkansas Works).

Focus Groups and Key Stakeholder Structured Interviews

To complement the empirical hypotheses testing on enrollment, claims, and survey data a series of focus groups and key stakeholder structured interviews will be pursued with enrollees (traditional Medicaid, Arkansas Works, and employer sponsored insurance), providers, and employers to understand aspects of the evaluation where there gaps in nuance and context. Using this framework we seek answers to questions on themes such as:

- Reasons for differences in observed and perceived beneficiary access to providers
- Reasons for participating/not participating in the Arkansas Works premium assistance employer sponsored insurance program

Provider Practice Survey

In the HCIP evaluation waiver interim report we observed no differences in geographic access between Medicaid and QHP enrollees and in-network providers. There were however, significant

differences in perceived (responses to CAHPS questions) and realized (time to first contact with health care system) access to care. To better understand these observed differences and assess differentials in appointment access, we will conduct a simulated patient study, also known as a **Secret Shopper Survey**.[9] Actors presenting as Medicaid or QHP beneficiaries will call randomly selected providers within designated regions of the state and attempt to schedule a new patient appointment. For those accepting new patients we will also document the time to appointment availability. From this study we will better be able to understand differences in perceived and observed access differentials to primary care between Medicaid and QHP beneficiaries. To identify the "within clinic" variation in access between Medicaid and QHP beneficiaries, we will conduct an **Arkansas Health Care Provider Survey.** This goal of this survey will be to elicit responses from providers and their clinic managers on internal practices that may contribute to differential access, assess the impact of differential payment rates between Medicaid and the QHPs on provider behavior, and assess changes Medicaid could consider other than payment to access differentials access for beneficiaries in the PCCM program.

D. Design Approaches

We propose a continuation of the main design approach that was utilized in the HCIP Interim Report analysis of data for the 2014 HCIP analytical population. The first compares a population who were assigned to a QHP based on having an exceptional health care needs assessment screener composite score of less than 0.18 (treatment group). The comparison group comprises those who completed the screener and exceeded the composite score threshold of 0.18 and were assigned to fee-for-service Medicaid. For this evaluation we propose to use a regression discontinuity analytical design, described below. This cohort will also allow us to test for long-term divergence or convergence of differential health insurance benefits between assigned treatment and comparison groups.

For QHP beneficiaries who did not complete an exceptional health care needs assessment screener where program assignment was determined by a composite score cutoff, we will use a population of adults who were eligible and assigned to traditional Medicaid as the comparison group. For these analyses we also continue with an HCIP enrolled population for study but can also include newly enrolled Arkansas Works or 2017 onward traditional Medicaid beneficiaries. One (among others) inclusion criteria will stipulate at least 6 months of continuous coverage before being included in an analytical cohort. For this comparison we will use an analytical design that includes stabilized inverse probability of treatment weighting, also described below. Table 1 contains the HCIP cohorts currently under study and it is expected that after attrition Arkansas Works will inherit the majority of those enrolled in the Interim Report analytic cohorts.

New for this Arkansas Works evaluation will be a qualitative research design that includes key stakeholder interviews and focus groups.

The following sections provide information about each of the six major approaches, including the proposed comparison group(s), metrics, and statistical methods. See Appendix 4 for a table of all hypotheses with corresponding candidate metrics and design approaches.

[9] Rhodes KV, Kenney GM, Friedman, AB, et al. Primary Care Access for New Patients on the Eve of Health Care Reform. *JAMA* Intern Med. 2014; 174(6):861-869. Doi:10.1001/jamainternmed.2014.20

Table 1. HCIP Analytic Cohorts

	Stabilized Inverse Probability of Treatment Weighting Comparison Group 1		Regression Discontinuity Comparison Group 2	
DATA SOURCE	Traditional **Medicaid** (did not complete the Questionnaire)	**QHP** (did not complete the Questionnaire)	**Medicaid** (completed the Questionnaire and met the threshold)	**QHP** (completed the Questionnaire but did not meet the threshold)
CLAIMS	N = 11,006	N = 69,499	N = 10,893	N = 60,031
CAHPS	N = 648	N = 895	N = 1,569	N = 1,914

Note: Enrollees in Comparison Group 2 were oversampled for CAHPS attributing to the higher number of responses.

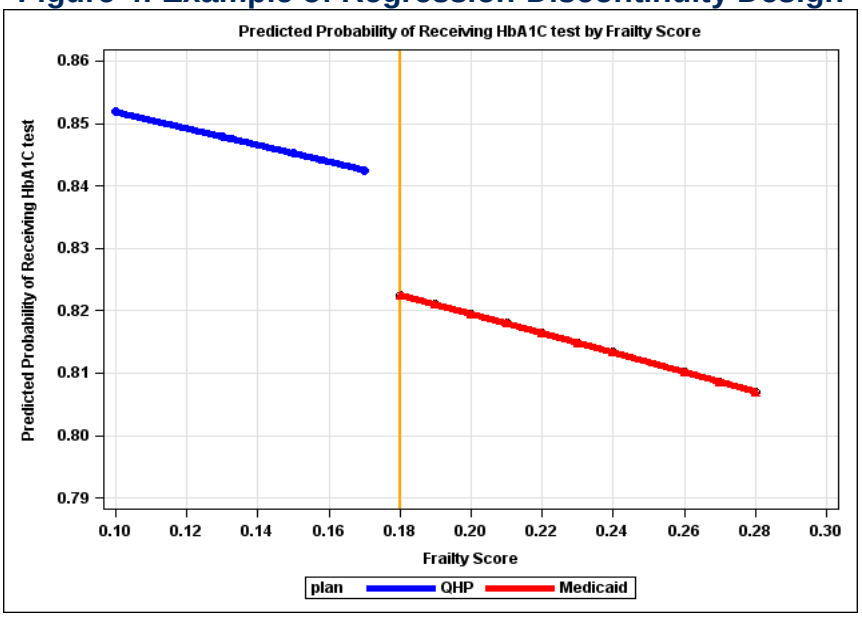
D1. Regression Discontinuity Analysis

In cases where random assignment to treatment and comparison groups is not feasible, comparisons can be made by examining subgroups of individuals based on scores just above or below a cutoff value of a predetermined variable. The assumption is that such individuals with similar scores may not differ significantly on the characteristics of interest, even though the cutoff places the individuals into different treatment groups.

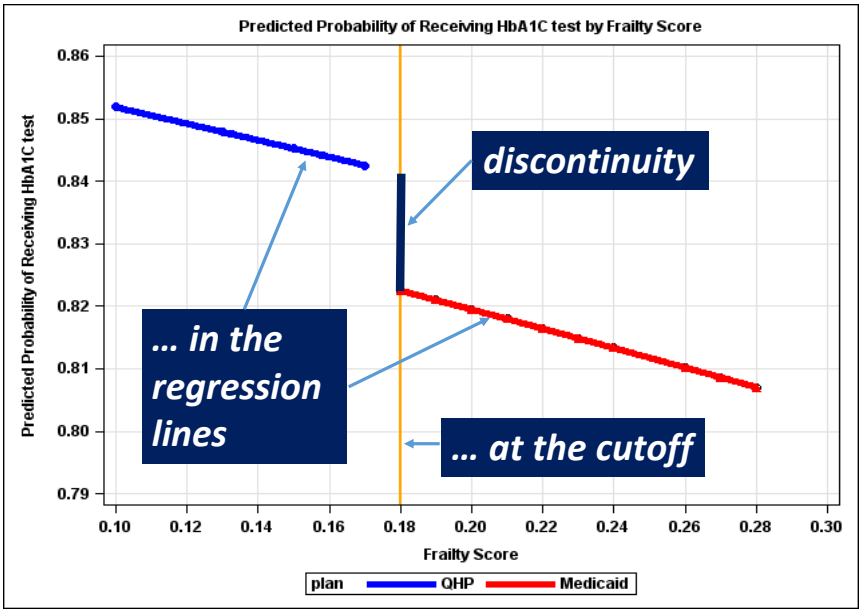
For the case of Arkansas' HCIP and follow-up Arkansas Works we have one cohort where a regression discontinuity (RD) design has been and can continue to be used to compare metrics. This cohort consisted of individuals newly eligible in 2014 for coverage who participated in a screening process to determine if they had sufficient medical needs to warrant retention in the traditional Medicaid program. Since no previous claims history or diagnostic roster was available, identification of these individuals was accomplished through the completion of an exceptional health care needs assessment ("frailty") screener.

An example of an HCIP Interim Report RD finding for the HEDIS metric of diabetics receiving an HbA1C test is presented in Figure 4 along with a descriptive interpretation of the RD results. A program effect is concluded when we observe a "**jump**" or **discontinuity** in the regression lines at the cutoff point for those assigned to Medicaid or a QHP.

Figure 4: Example of Regression-Discontinuity Design



Interpretation: ***There was a …***



Statistical Analysis

For each outcome measure that we have selected for evaluation, we regress the outcome score, Y, on the modified frailty X (X=frailty scores minus the cutoff point), the treatment variable Z (QHP=treatment, Medicaid=comparison), and all higher-order transformations and interactions. The regression coefficient associated with the Z term (i.e., the group membership variable) is the estimate of the main effect of the program. If there is a vertical discontinuity at the cutoff it will be estimated by this coefficient.

D2. Stabilized Inverse Probability of Treatment (Propensity Score) Weighting Analysis

This approach will compare all individuals in Arkansas Works who did not complete the exceptional health care needs assessment screener prior to or during 2014 to individuals enrolled in traditional Medicaid. Arkansas Medicaid identifies individuals as eligible for services in conjunction with the state's DHS county offices or District Social Security Offices.[10] The Social Security Administration automatically sends Supplemental Security Income (SSI) recipient information to DHS. The restricted eligibility for this program depends on age, income, and assets. Prior to HCIP, the only adults who could qualify for Medicaid were the elderly, disabled, pregnant women, and parent/caretakers with incomes up to 17 percent FPL. Most people who qualify for Medicaid are typically in one or more of the following categories:

- Age 65 and older
- Under the age of 19
- Blind
- Pregnant
- The parent or the relative who is the caretaker of a child with an absent, disabled, or unemployed parent
- Living in a nursing home
- Under age 21 and in foster care
- In medical need of certain home- and community-based services
- Persons with breast or cervical cancer
- Disabled, including the working disabled

In comparison with the Arkansas Works enrollees, individuals enrolled in the traditional Medicaid program had much stricter income requirements and, in many cases, more complex health care needs. Statistical considerations are needed to account for these differences.

There will be four major metric groups used with this approach (see Appendix 4 for the complete list of candidate metrics by approach). First, enrollment data will be used to assess the continuity of access to providers and plans. CAHPS data will also be used to assess consistency of care and access to primary and specialty services, as well as the use of services and patient experiences of care. Transportation and claims data will be combined to assess the use of non-emergency transportation services. Lastly, claims data will be used following the CMS Adult Core Reporting guidelines and HEDIS indicators definitions to examine utilization and quality/outcome measures.

Statistical Analysis

A series of stabilized inverse probability of treatment weighted (propensity score) models will be fit for each metric (see Appendix 4). Propensity scores can be described as the probability of being assigned to a treatment group (i.e., QHP group) given a set of underlying characteristics (or observed covariates). For newly eligible individuals in either traditional Medicaid or the QHP who did not have a composite score between (0.02 and 0.64) from the exceptional health care needs assessment screener and no previous health care claims data available, we will calculate the probability of being assigned to a QHP treatment group (as opposed to the traditional Medicaid

[10] Allison A. *Arkansas Medicaid Program Overview-SFY 2012.* Little Rock, AR. Dept. of Health and Human Services-Medicaid. 2013.

comparison group). We will calculate the probability of assignment to treatment based on age, gender, race/ethnicity, and parental status for geocoded and claims data. For outcome metrics obtained from a CAHPS survey, we will in addition include obesity status, education, marital, and recent work status as covariates. For those who have been in the analytical cohort for at least one year, we will in addition add a series of clinical classification software (https://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp) indices based on prior diagnoses and identified health conditions. We will include between 150 to 200 indices in the propensity score models to adjust for underlying individual comorbid conditions and acuity of prior health care episodes. Propensity score models that include this number of covariates are called high-dimensional and are more frequently being used for this purpose[11].

The goal was to balance the groups assigned to traditional Medicaid or a QHP by the underlying characteristics included in the propensity score models. Using propensity scores in our empirical assessment of group differences in access, quality, or healthcare outcomes has the potential to reduce biases associated with imbalanced underlying characteristics across groups. We used a technique called stabilized inverse probability of treatment weighting (SIPTW) to incorporate propensity scores into our statistical general linear regression models.

Each model will include dummy variables for "treatment or comparison" groups as well as identification of the regions identified in Figure 1. Unlike when incorporating general propensity scores, using the stabilized inverse probability of treatment weighting technique precludes using the same covariates used in the propensity score model.

To detect differences between treatment and comparison groups for "time-to" metrics including provider visits or receipt of recommended quality of care indicators, we will use statistical survival analysis and the Kaplan-Meier estimator technique. We will attempt to do so within the SIPTW framework.

If feasible we will incorporate an instrumental variable into models to account for unobserved variable bias. With this method it is often difficult to identify an appropriate instrumental variable, so this approach will have to be considered in light of available data. The contracted research team will explore the appropriate use of such instrumental variables to control for bias, if possible. To test the hypothesis of "equal or better than" for each metric, the models will look for either a non-significant parameter estimate on program type (indicating equal outcomes) or a parameter estimate that favors the treatment group based on a one-sided statistical test. All statistical tests will be performed with the probability of a Type I error of alpha=0.05.

D3. Pre–Post Comparisons

One important subgroup will allow for a longitudinal pre-post research design: youth ages 17–18 who qualify for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Prior to the HCIP, individuals in these subgroups were part of the traditional Medicaid program. With the implementation of HCIP, these individuals will now be provided insurance coverage through premium assistance.

For the EPSDT group we propose identifying a group of youth ages 17–18 who were enrolled in the traditional Medicaid program in the two years prior to being eligible for HCIP or Arkansas Works at age 19. Based on previous estimates of 17-18 year old youths enrolled in Medicaid we anticipate

[11] Schneeweiss S, Rassen JA, GlynnRJ, et al. High-dimensional propensity score adjustment in studies of treatment effects using health care claims data. *Epidemiology.* 2009;20(4):512-522

approximately 12,000 youths in the overlapping 2-year cohorts qualify for EPSDT services in this age group.

Statistical Analysis

Multiple regression models will be used with this group. Models will include a dummy variable of "time" to test whether or not differences in outcomes can be attributed to the transition between the traditional Medicaid program and a QHP, where Time 1 will include outcomes associated with enrollment in traditional Medicaid while Time 2 will be associated with HCIP or Arkansas Works QHP enrollment.

D4. Provider Network Adequacy

A major set of hypothesis grounded in Arkansas' use of premium assistance through the Health Insurance Marketplace is that by utilizing the delivery system available to the privately enrolled individuals in the marketplace, the availability and accessibility of both primary care and specialists will exceed that of a more traditional Arkansas Medicaid expansion. By purchasing health insurance offered on the established Health Insurance Marketplace and utilizing private sector provider networks and their established payment rates, traditional barriers to equitable health care including limited specialist participation and provider availability will be minimized. In fact, as deployed, providers will not be able to differentiate privately insured individuals supported by Medicaid premium assistance (e.g., those earning ≤138% FPL), those supported by tax credits (139%–400% FPL), or those earning above 400% FPL purchasing from the carriers offering on the exchange.

45 CFR § 156.230 requires that Qualified Health Plans (QHPs) "…maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." The Arkansas Insurance Department has developed the following network adequacy targets and data submission requirements to ensure adequacy of provider networks in QHPs offered in the Federally-Facilitated Marketplace (FFM, or "Marketplace").

The Arkansas Insurance Department at the recommendation of the Marketplace Plan Management Advisory Committee is developing network adequacy requirements (see Appendix 5) to be reported by participating carriers on an annual basis. Utilizing geomapping techniques the recommendation, which follows qualified health plan accreditation requirements, requires stratification of network participating information as follows:

- **Primary Care**: GeoAccess maps must be submitted demonstrating a 30-mile or 30-minute coverage radius from each general/family practitioner or internal medicine provider, and each family practitioner/pediatrician. Maps should also show providers accepting new patients. Dental carriers are not required to submit separate categories but should include only non-specialists in this requirement.
- **Specialty Care:** GeoAccess maps must be submitted demonstrating a 60-mile or 60-minute coverage radius from each category of specialist (see list of categories below). Maps should also show providers accepting new patients. Specialists should be categorized according to the list below. (Dental carriers do not need to categorize specialists.)
    - Cardiologists
    - Obstetricians/Gynecologists
    - Psychiatrists and State Licensed Clinical Psychologists
    - Orthopedists

- Internists
- Ophthalmologists
- Oncologists
- General Surgeons
- Hospitals*

**Hospitals types should be categorized according to hospital licensure type in Arkansas.*

- **Essential Community Providers (ECP):** GeoAccess maps must be submitted demonstrating a 30-mile or 30-minute coverage radius from ECPs for each of the categories below. The provider types included in each of the categories align with federal guidelines for ECP providers, with the addition of school-based providers included in the "Other ECP" category.
  - Family Planning Provider
  - Federally Qualified Health Center
  - Hospital
  - Indian Provider
  - Other ECP
  - Ryan White Provider

To evaluate and compare the differences in access and availability by each of the provider types above for the networks of Medicaid demonstration participants compared with the traditional Medicaid network, geomapping efforts for adult patients in the traditional Medicaid would be replicated to enable comparisons of networks available through the Marketplace and those through traditional Medicaid provider panels. In addition, serial examinations of primary care, specialists, and select providers within carrier networks will enable examinations of access continuity for primary care and specialists that compare the traditional Medicaid provider networks with the provider networks evidenced through Arkansas Works. Addresses for providers and 2014 traditional Medicaid and HCIP enrollees were geocoded and geospatial analysis was performed for HCIP Interim Report results. We anticipate reproducing geocoding and analysis for an updated panel of 2019 providers and Arkansas Works enrollees to identify five-year market changes.

D5. Qualitative Research

Qualitative data can provide substantial depth and context to quantitative data results. Qualitative data is collected using individual interviews or focus groups and more open-ended discussion to understand an individual or groups' experience. Given the complexity of healthcare experience, quantitative data often does not tell the whole story or provide a sufficient explanation for statistical differences. For example, we will conduct individual qualitative interviews to better understand the following:

- Observed differences in perceived and realized access between beneficiaries in the Medicaid and QHP programs

- Reasons for employers participating/not participating in the Arkansas Works premium assistance employer sponsored insurance program

We will also conduct individual qualitative interviews to better understand selected quantitative results. For example, if outcome differences are found when comparing traditional Medicaid to AR Works

Premium Assistance for a particular subgroup (e.g., based on age, gender, geographic location, or diagnosis) then we can use qualitative data to better understand the reasons for this difference.

The qualitative interviews will be conducted by a PhD-level qualitative expert. The qualitative team will include the qualitative interviewer and other members of the evaluation team with qualitative data analysis experience. An interview guide will be developed for the specific topic being evaluated and will start with more open-ended questions followed by more specific probe questions. The interviews will be conducted over the phone, recorded, and transcribed verbatim. An initial codebook will be developed based on the structure of the interview guide questions. We will follow the recommendations for team-based qualitative analysis developed by the Center for Disease Control[12]. Once there is agreement among the qualitative team members on the scope and level of detail in the initial codes, the codebook will include: the code, code definition, guidelines for when to use the code, guidelines for when to not use the code, and examples. Members of the qualitative team will then independently code the same interview text. The coded texts will be compared to assess agreement and the coders will discuss differences among code application and will reconcile any disagreements. This process will be repeated and the codebook and code definitions will be revised, as needed, to obtain inter-coder agreement (e.g., 90%). With each codebook revisions, all previously coded text is reviewed and, if needed, recoded to be consistent with the revised codebook. Once the coding scheme is complete, the qualitative team will code the remaining interviews texts, assessing coding consistency throughout the analytic process. The qualitative and quantitative results will then be presented to the full evaluation team to assist with interpretation.

D6. Primary Data Analysis

We will conduct a "secret shopper" assessment of the ability to obtain a primary care physician visit. We will engage male and female actors of various adult ages to seek physician appointments by telephone with Medicaid and QHP network of providers. Two outcome metrics will be measured: the ability to secure an appointment and, if yes, the time to earliest available time. Sample sizes will be calculated to be able to detect a 10% difference with 80% power between Medicaid and QHP appointment seekers in the availability and time to first appointment. Results will be used to identify differences in realized access by insurance beneficiary group.

E. Approach for Test of Cost Effectiveness

The Arkansas Demonstration proposes to enhance cost-effective care received by Medicaid beneficiaries through the use of premium assistance to purchase private coverage through Employer Sponsored Insurance (ESI) or from individual insurance through QHPs on the Arkansas Health Insurance Marketplace.

The Interim Evaluation Report published in Spring, 2016 (available at http://achi.net/Docs/357/) demonstrated enhanced access to primary care and specialty networks, improved preventive and chronic care management, enhanced patient experiences in care and improved clinical process metrics for care received. In comparison to surrounding insurance markets, the Demonstration appears carrier entry into the marketplace, expanded service areas, and competitive pricing in the Marketplace.

[12] MacQueen KM, McLellan E, Kay K, Milstein B. Codebook developments for team-based qualitative analysis. *Cultural Anthropology Methods*. 1998:10(2):31-36

The Interim Evaluation Report included a budget impact analysis to undertake preliminary cost-effectiveness tests to evaluate the assessment of cost and impact of the Demonstration Waiver. This evaluation will continue and expand to include an increased number of long-term clinical outcome indicators and assessments of steady-state financial implications.

The approaches represented recognize the expectation for Arkansas to undertake a robust evaluation to adequately test health outcomes and financial implications of Medicaid coverage expansion through premium assistance, as well as the need to accommodate certain limitations (e.g., comparison groups and data availability). We represent below the requirements, the current approach, challenges identified, anticipated uncertainties, and potential future policy implications.

For the purpose of this Evaluation Plan, we have limited approaches to those for which the state can assure available data to the selected external contractor. Given the potential value of comparison with another state, the evaluation team will continue to explore this possibility with CMS guidance. Of specific interest is comparison with expansion states utilizing Medicaid managed care that report PMPM rates greater than the premiums currently purchased through the Demonstration (e.g., IN, KY). Should these data become available, the evaluation team will explore with CMS what analyses could reasonably be undertaken. Findings and key challenges will be shared in the summative evaluation report.

E1. Cost Effectiveness Requirement – STC #73

While not the only purpose, the core purpose of the evaluation is to determine whether the costs and effectiveness of the Arkansas Works program using premium assistance demonstrates cost effectiveness using short term (1 year) and longer term time horizons. .

a. The evaluation will describe the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.
b. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the Arkansas Works program compared to what would have happened for a comparable population in Medicaid fee-for-service.
c. The State will compare total costs under the Arkansas Works program to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs including supplemental payments, and administrative expenses over time.
d. The State will compare changes in access and quality to changes in costs within Arkansas Works. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Arkansas will be determined and compared to improvement efforts undertaken in other delivery systems.

E2. Anticipated Approach

The primary economic assessment will be based on a budget impact analyses (BIA). The BIA will compare claim costs and supplemental payments to premium payments across alternative programmatic options. A counterfactual estimate of the estimated costs under a traditional Medicaid expansion will be contrasted with the premium payments. As was demonstrated in the interim report, a series of alternative programmatic scenarios based upon observed utilization and associated costs and alternative provider reimbursement schedules be employed to develop potential

costs to gain equivalent outcomes. In addition to the individual premium assistance comparison to the counterfactual traditional Medicaid expansion, this evaluation will also include the observed employer premium assistance compared to the observed individual premium assistance. Alternative scenarios for the traditional Medicaid program will include potential changes in provider reimbursement rates to attain necessary access as well as comparison to other state's Medicaid managed care costs associated with comparable expansion populations.

Secondary pure cost-effectiveness analyses may be available as observation periods enable assessment of true outcomes. The purest cost effectiveness comparison would be to contrast costs and mortality differences between plans. This would provide an estimate of the incremental dollars per death averted and costs per life year gained between the plans (Eq. 1). Alternative effectiveness measures such as clinical outcomes (e.g., diabetic complications such as amputation) and process measures (screening rates) can also be considered, however, there are no conventional thresholds to assess value of these. These will enable estimation of key components of the incremental cost-effectiveness ratio (ICER) from the Medicaid payer perspective:

[Eq. 1] $$ICER = \frac{(COST_{PA} - COST_{PCCM})}{(EFFECT_{PA} - EFFECT_{PCCM})}$$

where *COST* reflects the total cost per beneficiary of the program, *EFFECT* reflects the selected health outcome of interest, for individuals managed through Premium Assistance (PA) and those in the Medicaid Primary Care Case Management (PCCM) program, respectively.

E3. Analytic Perspectives Considered

The primary perspective for analyses will be that of Medicaid as payer consistent with STC #73 requirements. This will enable isolated assessment of the effects, costs, and trade-offs associated with the Demonstration's waived authorities. However, additional perspectives will be considered to satisfy STC #75 hypothesis xi, xii, and xiv.

Hypothesis ix addresses whether "QHP Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care." By definition this is broader than the perspective of the Medicaid program has implications for both state insurance marketplace and federal governmental expenditures beyond Medicaid's. Thus a public sector perspective will be employed to capture both the impact private sector premium costs within the marketplace and the implications for tax credit expenditures of the Internal Revenue Service associated with individuals receiving either premium subsidies or cost-sharing reductions through the individual marketplace.

Hypotheses **xiii** (The use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance) and **xiv** (ESI premium assistance will increase the number of employers offering ESI coverage) require a Medicaid perspective restricted to those individuals covered through premium assistance. The assessment of cost-effectiveness for employer sponsored premium assistance must compare the observed effects and associated costs between individual premium assistance and employer premium assistance. Subsequent application of results of employer uptake and modeling of future potential expansion will inform the potential for expansion of employer recruitment strategies for shared responsibility and reduction in exclusive financial support by Medicaid.

Program effects and associated costs are anticipated to be more stable over the course of this extended evaluation period compared to the initial start-up. Longer-term access, clinical, and

outcome indicators are anticipated to be available. In addition, more in-depth efforts to characterize non-claims costs (e.g., administrative and supplemental payments by Medicaid to providers) will be undertaken. Sensitivity analyses through modeling of alternative inflationary scenarios for provider payment rates and employer uptake for employer premium assistance will be performed to enable optimal interpretation of BIA and CEA results.

4. Evaluation Implementation Strategy, Timeline, & Budget

A. Independent Evaluation

The existing independent evaluation will be extended to include original hypotheses and add new hypotheses associated with waiver modifications (STC #75). The current evaluator, the Arkansas Center for Health Improvement and health services researchers from the University of Arkansas Colleges of Medicine, Pharmacy, and Public Health and both the National Advisory Committee (NAC) will be retained to execute required commitments of the evaluation pending CMS review. As demonstrated in the evaluation activities in DY1-DY3, NAC and the evaluation team have provided independent assessments that have met peer-review at national meetings (AcademyHealth Annual Research Meeting 2016). Continuation of the evaluation underway is based their demonstrated capacity to conduct rigorous evaluations on previous proposals, the qualification of proposed staff, programmatic knowledge and an understanding of the Arkansas healthcare environment, and evidence of the ability to meet project objectives within the proposed timeline and budget.

The evaluation will meet all standards of leading academic institutions and academic journal peer review, as appropriate for each aspect of the evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings. Among the characteristics of rigor that will be met for the interim and final evaluations are use of best available data and controls for and reporting of the limitations of data and their effects on results and the generalizability of results. Treatment and control or comparison groups will be used, and appropriate methods will be used to account and control for confounding variables. The evaluation design and interpretation of findings will include triangulation of various analyses, wherein conclusions are informed by all results with a full explanation of the analytic limitations and differences.

B. Data Availability

For years 2015 and 2016 in the HCIP demonstration waiver evaluation, the Arkansas Center for Health Improvement utilized Medicaid and QHP enrollment and claims data that was submitted with personal identifiers in a standard format utilized by the Arkansas All Payer Claims Database (APCD). The APCD data will be updated on a biannual basis. As such, Arkansas has developed the strategy to secure needed data inclusive of enrollment, claims, and consumer experience (CAHPS) related to the demonstration. Claims data will be the basis for development of access, utilization, and clinical quality indicators from established and accepted national metrics.

For the continued demonstration under Arkansas Works, the state will maintain data collection efforts from DY3 of the HCIP moving into Arkansas Works across DY4 thru DY9.

C. Timeline

Table 1 provides a proposed timeline for the work of this evaluation. It is anticipated that the hired contractor will use this general timeline to create a more thorough timeline and work plan once they are hired. The Arkansas Works demonstration follows three years (DY1-DY3) of HCIP demonstration and is enacted for a subsequent duration of five years (DY4-DY8). We include a

timeline for the evaluation of six years in order to encompass the full five year period of data and report processing. Three major pieces of work include the recruitment and hiring of an independent evaluation team, the collection and analysis of data, and the submission of reports.

One Interim, two Summative reports and 10 biannual enrollment reports to be completed. The enrollment reports will include information about enrollment patterns, reenrollment patterns, and retention patterns throughout DY4–8.

An Interim Evaluation Report will be completed as stipulated in STC #76 one year prior to the renewal period end of December 31, 2021. This report will include findings from data collected including two years of enrollment data, one year of CAHPS data (collected during DY5), and two years of claims data. The first Summative Evaluation Report will be submitted after completion of DY8. It will include five years of enrollment, geomapping, and claims data, as well as two years of CAHPS data.

The Interim Evaluation Report, Draft and Final Summative Evaluation Reports will follow the outline and included components in STC #75.

Table 1. Proposed Project Timeline

	DY 4 (2017)				DY 5 (2018)				DY 6 (2019)				DY 7 (2020)				DY8 (2021)				2022				2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Reports:																												
Enrollment				U				U				U				U				U								
Reenrollment				U				U				U				U				U								
Retention				U				U				U				U				U								
Implementation Update			U				U				U				U				U									
Interim Report											**U**								**U**									
Final Draft Report						**U**																**U**				**U**		
Final Summary Report							**R**																**R**				**R**		
Data Collection & Analysis:																												
Enrollment		x		x		x		x		x		x		x		x		x		x								
Carrier Claims		x		x		x		x		x		x		x		x		x		x								
CAHPS						x	x							x	x													
Qualitative				x					x	x			x															
Provider Practice Surveys			x		x																							
Geomapping									x	x																		

U=Non-Required Report
R=Required Report
X=Data Collection

D. Budget

ARKANSAS WORKS EVALUATION Budget							
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	TOTAL PROJECT
Compensation							
Salaries	545,420	556,328	555,051	560,011	565,071	308,876	3,090,757
Fringe	152,718	155,772	155,414	156,803	158,220	86,485	865,412
Indirect Costs	270,797	334,123	284,263	335,410	261,830	118,474	1,604,896
Total	**968,934**	**1,046,223**	**994,728**	**1,052,224**	**985,121**	**513,835**	**5,561,065**
Reimbursables							
Supplies	60,240	60,240	60,240	60,240	60,240	60,240	361,440
Travel	10,000	10,000	10,000	10,000	10,000	10,000	60,000
Equipment	0	0	0	0	0	0	0
National Advisor Stipends	8,000	0	0	0	0	0	8,000
Contractual	50,000	276,000	95,000	276,000	0	0	697,000
HDI fee	49,596	61,195	52,063	61,430	47,954	37,390	309,629
Lease	15,552	15,552	15,552	15,552	15,552	15,552	93,312
Other (data mngmt/processing)	150,000	150,000	150,000	150,000	150,000	150,000	900,000
Total	**343,388**	**572,987**	**382,855**	**573,222**	**283,746**	**273,182**	**2,429,381**
Total for Contract	**1,312,323**	**1,619,210**	**1,377,583**	**1,625,447**	**1,268,867**	**787,017**	**7,990,446**

5. Supplemental Hypotheses and Future Policy Implications

Additional questions of policy relevance are of interest; however, they are outside of the scope of STC #73 that requires examination of the Arkansas Demonstration in comparison with what would have happened under a traditional Medicaid expansion. These questions will be important completely frame the experience and understanding generated by the first major use of premium expansion through the new health insurance exchanges to cover low-income Americans. We anticipate framing these questions, securing supplemental funding, and conducting appropriate research to capture the experience and learning opportunities of the Arkansas Demonstration.

These policy-relevant questions include both questions of global significance to the Medicaid program and health care system that will inform future policies about safety-net providers, workforce needs, specialty availability, population health impact, and marketplace stabilization. As a poor state with poor health status and outcomes combined with high rates of the uninsured, Arkansas may serve as an incubator to evaluate the following questions.

- Does the provision of health insurance to low-income able-bodied individuals result in improved employment status as reflected by either job engagement, retention, or increasing income?

- What was the experience of work-referrals and job training on individuals identified through the Medicaid eligibility process as candidates for employment support?
- Does the availability of incentive benefits result in increased participation in premium payments and/or preventive care utilization?
- How did the QHP requirement to participate in a state-led transition to value-based payment reform from traditional fee-for-service impact overall and payer specific cost trends?
- Where differences exist in access, outcomes, and experiences of Medicaid beneficiaries and their private-sector counterparts, what are plausible causes and potential policy solutions?
- How did Arkansas expansion of health insurance affect a change on population health indicators compared with sister states with similar risk profiles who elected to delay implementation?
- If Arkansas' Demonstration proves to advantage the health insurance exchange and the Medicaid program through system improvements, actuary risk-pool stability, and/or deflationary pressure on premiums, what are the indirect long-term benefits of a more efficient market and stable risk pool to the federal treasury through lower expenditures on advanced premium tax credits?
- How did providers—both primary care and specialists—react to a major reduction in the numbers of the uninsured and receipt of equivalent payment rates for beneficiaries in the exchange marketplace? Did private-sector providers relocate over time or find alternative delivery strategies to highly concentrated areas of uncompensated care caused by the lack of insurance?
- How did safety-net providers—federally qualified health centers, rural health centers, critical access hospitals, educational institutions—fare under Medicaid expansion utilizing premium assistance through commercial carriers?

These and additional policy-relevant questions will be identified through the implementation experience of the Arkansas Demonstration Waiver. We anticipate both potential federal and state modifications to the program during the demonstration period. Appropriate adjustments in the demonstration's evaluation will be incorporated after development, review, and approval of state and federal officials.

As other states consider Medicaid expansion through the use of premium assistance, both replication of Arkansas's approach and minor variations on coverage strategies could enable multi-state collaborative and cross-state comparisons. We anticipate additional opportunities for exploration outside of the scope of the Demonstration Wavier terms and conditions and welcome exploration, development, and pursuit of funding opportunities to support these analyses.

6. Appendices

Appendix 1: Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

Appendix 2: Proposed Measure Descriptions and Definitions

A. Selected Measures from Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

B. Selected Measures from Healthcare Effectiveness Data and Information Set (HEDIS) 2016

C. Consumer Assessment of Healthcare Providers and Systems Survey

Appendix 3: HCIP Waiver Evaluation Planning: State's Medicaid Reporting Measures

Appendix 4: Candidate Metrics by Approach

Appendix 5: Arkansas Insurance Department Network Adequacy Guidelines and Targets

Appendix 6: Arkansas Insurance Department Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Exchange

Appendix 1

Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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Appendix 1
Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

Arkansas Proposed Evaluation Hypotheses	Arkansas Original Terms and Conditions Hypotheses (Section 8, STC 75, #1)
1—Access	
a. Use of PCP/specialist	i. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
b. Non-emergent ER use	iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.
c. Preventable ER	vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
d. EPSDT	ix. QHP Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
e. Non-emergency transportation	x. QHP Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
2—Care/outcomes	
a. Preventive and health care services	ii. Premium Assistance beneficiaries will have equal or better access to preventive care services.
b. Satisfaction	viii. Premium Assistance beneficiaries will report equal or better satisfaction in the care provided.
c. Non-emergent ER use*	iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.
d. Preventable ER*	vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
3—Continuity	
a. Gaps in coverage	iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.
b. Continuous access to same health plans	v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
c. Continuous access to same providers	

Arkansas Proposed Evaluation Hypotheses	Arkansas Original Terms and Conditions Hypotheses (Section 8, STC 75, #1)
4—Cost effectiveness	
a. Admin costs	vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.
b. Reduce premiums	xi. QHP Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
c. Comparable costs	xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 69 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
5—Employer Sponsored Insurance	xiii. The use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance.
a. Reduced costs	
b. Improved job-based insurance offering	xiv. ESI premium assistance will increase the number of employers offering ESI coverage.
c. Fewer gaps in coverage	xv. Continuity of coverage under ESI premium assistance will be improved compared to QHP premium assistance for individuals with access to ESI.
6—Incentive Benefits	xvi. Incentive benefits offered to Arkansas Works beneficiaries will increase participation rates for premium contributions compared to historical experience with Independence Accounts and increase primary care utilization.
a. Effective incentive benefit plan	

* *The outcomes of interest and evaluation approaches associated with hypotheses 2c and 2d are shared with 1b and 1c.*

Appendix 2

Proposed Measure Descriptions and Definitions

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Appendix 2A—Selected Measures from Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

(HEDIS 2016 codebook for ICD10 codes will be used to calculate measures)

Measure 1: Flu Shots for Adults Ages 50 to 64

National Committee for Quality Assurance

A. DESCRIPTION

A rolling average represents the percentage of Medicaid enrollees ages 50 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS adult survey (see Appendix 2C) was completed.

Guidance for Reporting:

- This measure uses a rolling two-year average to achieve a sufficient number of respondents for reporting. First-year data collection will generally not yield enough responses to be reportable.

B. ELIGIBLE POPULATION

Age	50 to 64 years as of September 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of enrollment of up to 45 days during the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

C. QUESTIONS INCLUDED IN THE MEASURE

Question		Response Choices
H16	Have you had a flu shot since September 1, YYYY? [a]	Yes No Don't know

[a]YYYY = the measurement year (e.g., 2017 for the survey fielded in 2018).

D. CALCULATION OF MEASURE

A rolling average is calculated using the following formula.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

If the denominator is less than 100, a measure result of NA is assigned. If the denominator is 100 or more, a rate is calculated. If the state did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more (Year 2), a rate is calculated; if the denominator is less than 100, the rate is not reported.

Denominator: The number of Medicaid enrollees with a Measure Eligibility Flag of "Eligible" who responded "Yes" or "No" to the question "Have you had a flu shot since September 1, YYYY?"

Numerator: The number of Medicaid enrollees in the denominator who responded "Yes" to the question "Have you had a flu shot since September 1, YYYY?"

Measure 2: Breast Cancer Screening

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid-enrolled women ages 42 to 69 that received a mammogram to screen for breast cancer.

Guidance for Reporting:

- This measure applies to Medicaid enrollees ages 42 to 69. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 42 to 64 and ages 65 to 69.
- Include all paid, suspended, reversed, pending, and denied claims.

B. ELIGIBLE POPULATION

Age	Women ages 42 to 69 as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than a 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator: One or more mammograms during the measurement year or the year prior to the measurement year. A woman had a mammogram if a submitted claim/encounter contains any code in Table 3.1.

Table 3.1. Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue
77055-77057	G0202, G0204, G0206	87.36, 87.37	0401, 0403

Table 3.2. Codes for Identifying Exclusions

Description	CPT	ICD-9-CM Procedure
Bilateral mastectomy		85.42, 85.44, 85.46, 85.48
Unilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307	85.41, 85.43, 85.45, 85.47
Bilateral modifier (a bilateral procedure performed during the same operative session)	50, 09950	
Right side modifier	RT	
Left side modifier	LT	

D. ADDITIONAL NOTES

This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

Measure 3: Cervical Cancer Screening

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid-enrolled women ages 24 to 64 that received one or more Pap tests to screen for cervical cancer.

Guidance for Reporting:

- Include all paid, suspended, reversed, pending, and denied claims.

B. ELIGIBLE POPULATION

Age	Women ages 24 to 64 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than a 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator: One or more Pap tests during the measurement year or the two years prior to the measurement year. A woman had a Pap test if a submitted claim/encounter contains any code in Table 4.1.

Table 4.1. Codes to Identify Cervical Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue	LOINC
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Table 4.2. Codes to Identify Exclusions

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Hysterectomy	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, 752.43, V67.01, V76.47, V88.01, V88.03	68.4-68.8

D. ADDITIONAL NOTES

Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Exclusions (optional)

Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix. The hysterectomy must have occurred by December 31 of the measurement year. Documentation of "complete," "total," or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.

Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

Measure 4: Plan All-Cause Readmission Rate

National Committee for Quality Assurance

A. DESCRIPTION

For Medicaid enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following three categories:

- Count of Index Hospital Stays (IHS) (denominator)
- Count of 30-Day Readmissions (numerator)
- Average Adjusted Probability of Readmission (rate)

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, and denied claims.
- This measure requires risk adjustment. Risk adjustment tables for Medicare and commercial populations are posted at http://www.ncqa.org. There are no standardized risk adjustment tables for Medicaid. States reporting this measure should describe the method they used for risk adjustment weighting and calculation of the adjusted probability of readmission. Appendix A provides additional information on risk adjustment methods in the non-Medicaid population.

B. DEFINITIONS

IHS	Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Classification Period	365 days prior to and including an Index Discharge Date.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the Index Discharge Date.
Continuous Enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor Date	Index Discharge Date.
Benefit	Medical.
Event/ Diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not Medicaid enrollees. Include all acute inpatient discharges for Medicaid enrollees who had one or more discharges on or between January 1 and December 1 of the measurement year. The state should follow the steps below to identify acute inpatient stays.

D. Denominator: The eligible population.

Numerator: At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

E. ADDITIONAL NOTES

States may not use Risk Assessment Protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The PCR measurement model was developed and tested using only claims-based diagnoses and diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.

Measure 5: Diabetes Short-Term Complications Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

The number of discharges for diabetes short-term complications per 100,000 Medicaid enrollees age 18 and older.

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.

B. ELIGIBLE POPULATION

Member months	All member months for Medicaid enrollees age 18 and older as of the 30th day of the month.
Continuous enrollment	There is no continuous enrollment requirement.
Allowable gap	There is no gap in coverage requirement.
Anchor date	There is no anchor date.

C. ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

Numerator: All discharges with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma).

Include ICD-9-CM diagnosis codes:

25010 DM KETO T2, NT ST UNCNTRLD

25011 DM KETO T1, NT ST UNCNTRLD

25012 DM KETOACD UNCONTROLD

25013 DM KETOACD UNCONTROLD

25020 DMII HPRSM NT ST UNCNTRL

25021 DMI HPRSM NT ST UNCNTRLD

25022 DMII HPROSMLR UNCONTROLD

25023 DMI HPROSMLR UNCONTROLD

25030 DMII O CM NT ST UNCNTRLD

25031 DMI O CM NT UNCNTRLD

25032 DMII OTH COMA UNCONTROLD

25033 DMI OTH COMA UNCONTROLD

Exclusions

- Transfer from a hospital (different facility)
- Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- With missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), principal diagnosis (DX1 = missing), or county (PSTCO = missing)
- MDC 14 (pregnancy, childbirth, and puerperium)

Measure 6: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

The number of discharges for chronic obstructive pulmonary disease (COPD) per 100,000 Medicaid enrollees age 18 and older.

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.

B. ELIGIBLE POPULATION

Member months	All member months for Medicaid enrollees age 18 and older as of the 30th day of the month.
Continuous enrollment	There is no continuous enrollment requirement.
Allowable gap	There is no gap in coverage requirement.
Anchor date	There is no anchor date.

C ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

Numerator: All non-maternal discharges with an ICD-10-CM principal diagnosis code for COPD. Select codes appearing in the primary diagnosis position must be accompanied by a secondary diagnosis of COPD.

Include ICD-9-CM COPD diagnosis codes:

4660 ACUTE BRONCHITIS*

490 BRONCHITIS NOS*

4910 SIMPLE CHR BRONCHITIS

4911 MUCOPURUL CHR BRONCHITIS

49120 OBST CHR BRONC W/O EXAC

49121 OBS CHR BRONC W(AC) EXAC

4918 CHRONIC BRONCHITIS NEC

4919 CHRONIC BRONCHITIS NOS

4920 EMPHYSEMATOUS BLEB

4928 EMPHYSEMA NEC

494 BRONCHIECTASIS

4940 BRONCHIECTAS W/O AC EXAC

4941 BRONCHIECTASIS W AC EXAC

496 CHR AIRWAY OBSTRUCT NEC

*Must be accompanied by a secondary diagnosis code of COPD.

Exclusions

- Transfer from a hospital (different facility)
- Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- With missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), principal diagnosis (DX1 = missing), or county (PSTCO = missing)
- MDC 14 (pregnancy, childbirth, and puerperium)

Measure 7: Congestive Heart Failure (CHF) Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

The number of discharges for congestive heart failure (CHF) per 100,000 Medicaid enrollees age 18 and older.

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.

B. ELIGIBLE POPULATION

Member months	All member months for Medicaid enrollees ages 18 and older as of the 30th day of the month.
Continuous enrollment	There is no continuous enrollment requirement.
Allowable gap	There is no gap in coverage requirement.
Anchor date	There is no anchor date.

C. ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

Numerator: All discharges with ICD-10-CM principal diagnosis code for CHF.

ICD-9-CM Diagnosis Codes (Discharges after September 30, 2002):

39891 RHEUMATIC HEART FAILURE

4280 CONGESTIVE HEART FAILURE

4281 LEFT HEART FAILURE

42820 SYSTOLIC HRT FAILURE NOS OCT02-

42821 AC SYSTOLIC HRT FAILURE OCT02-

42822 CHR SYSTOLIC HRT FAILURE OCT02-

42823 AC ON CHR SYST HRT FAIL OCT02-

42830 DIASTOLC HRT FAILURE NOS OCT02-

42831 AC DIASTOLIC HRT FAILURE OCT02-

42832 CHR DIASTOLIC HRT FAIL OCT02-

42833 AC ON CHR DIAST HRT FAIL OCT02-

42840 SYST/DIAST HRT FAIL NOS OCT02-

42841 AC SYST/DIASTOL HRT FAIL OCT02-

42842 CHR SYST/DIASTL HRT FAIL OCT02-

42843 AC/CHR SYST/DIA HRT FAIL OCT02-

4289 HEART FAILURE NOS

ICD-9-CM Diagnosis Codes (Discharges before September 30, 2002):

40201 MAL HYPERT HRT DIS W CHF

40211 BENIGN HYP HRT DIS W CHF

40291 HYPERTEN HEART DIS W CHF

40401 MAL HYPER HRT/REN W CHF

40403 MAL HYP HRT/REN W CHF/RF

40411 BEN HYPER HRT/REN W CHF

40413 BEN HYP HRT/REN W CHF/RF

40491 HYPER HRT/REN NOS W CHF

40493 HYP HT/REN NOS W CHF/RF

Exclusions

- Transfer from a hospital (different facility)
- Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- With missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), principal diagnosis (DX1 = missing), or county (PSTCO = missing)
- MDC 14 (pregnancy, childbirth, and puerperium) With a cardiac procedure code

With a cardiac procedure code-
ICD-9-CM Cardiac Procedure Codes:

0050 IMPL CRT PACEMAKER SYS OCT02-

0051 IMPL CRT DEFIBRILLAT OCT02-

0052 IMP/REP LEAD LF VEN SYS OCT02-

0053 IMP/REP CRT PACEMKR GEN OCT02-

0054 IMP/REP CRT DEFIB GENAT OCT02-

0056 INS/REP IMPL SENSOR LEAD OCT06-

0057 IMP/REP SUBCUE CARD DEV OCT06-

0066 PTCA OCT06-

1751 IMPLANTATION OF RECHARGEABLE CARDIAC CONTRACTILITY MODULATION [CCM], TOTAL SYSTEM OCT09-

1752 IMPLANTATION OR REPLACEMENT OF CARDIAC CONTRACTILITY MODULATION [CCM] RECHARGEABLE PULSE, GENERATOR ONLY OCT09-

3500 CLOSED VALVOTOMY NOS

3501 CLOSED AORTIC VALVOTOMY

3502 CLOSED MITRAL VALVOTOMY

3503 CLOSED PULMON VALVOTOMY

3504 CLOSED TRICUSP VALVOTOMY

3510 OPEN VALVULOPLASTY NOS

3511 OPN AORTIC VALVULOPLASTY

3512 OPN MITRAL VALVULOPLASTY

3513 OPN PULMON VALVULOPLASTY

3514 OPN TRICUS VALVULOPLASTY

3520 REPLACE HEART VALVE NOS

3521 REPLACE AORT VALV-TISSUE

3522 REPLACE AORTIC VALVE NEC

3523 REPLACE MITR VALV-TISSUE

3524 REPLACE MITRAL VALVE NEC

3525 REPLACE PULM VALV-TISSUE

3526 REPLACE PULMON VALVE NEC

3527 REPLACE TRIC VALV-TISSUE

3528 REPLACE TRICUSP VALV NEC

3531 PAPILLARY MUSCLE OPS

3532 CHORDAE TENDINEAE OPS

3533 ANNULOPLASTY

3534 INFUNDIBULECTOMY

3535 TRABECUL CARNEAE CORD OP

3539 TISS ADJ TO VALV OPS NEC

3541 ENLARGE EXISTING SEP DEF

3542 CREATE SEPTAL DEFECT

3550 PROSTH REP HRT SEPTA NOS

3551 PROS REP ATRIAL DEF-OPN

3552 PROS REPAIR ATRIA DEF-CL

3553 PROST REPAIR VENTRIC DEF

3554 PROS REP ENDOCAR CUSHION

3555 PROS REP VENTRC DEF-CLOS OCT06-

3560 GRFT REPAIR HRT SEPT NOS

3561 GRAFT REPAIR ATRIAL DEF

3562 GRAFT REPAIR VENTRIC DEF

3563 GRFT REP ENDOCAR CUSHION

3570 HEART SEPTA REPAIR NOS

3571 ATRIA SEPTA DEF REP NEC

3572 VENTR SEPTA DEF REP NEC

3573 ENDOCAR CUSHION REP NEC

3581 TOT REPAIR TETRAL FALLOT

3582 TOTAL REPAIR OF TAPVC

3583 TOT REP TRUNCUS ARTERIOS

3584 TOT COR TRANSPOS GRT VES

3591 INTERAT VEN RETRN TRANSP

3592 CONDUIT RT VENT-PUL ART

3593 CONDUIT LEFT VENTR-AORTA

3594 CONDUIT ARTIUM-PULM ART

3595 HEART REPAIR REVISION

3596 PERC HEART VALVULOPLASTY

3598 OTHER HEART SEPTA OPS

3599 OTHER HEART VALVE OPS

3601 PTCA-1 VESSEL W/O AGENT

3602 PTCA-1 VESSEL WITH AGNT

3603 OPEN CORONRY ANGIOPLASTY

3604 INTRCORONRY THROMB INFUS

3605 PTCA-MULTIPLE VESSEL

3606 INSERT OF COR ART STENT OCT95-

3607 INS DRUG-ELUT CORONRY ST OCT02-

3609 REM OF COR ART OBSTR NEC

3610 AORTOCORONARY BYPASS NOS

3611 AORTOCOR BYPAS-1 COR ART

3612 AORTOCOR BYPAS-2 COR ART

3613 AORTOCOR BYPAS-3 COR ART

3614 AORTCOR BYPAS-4+ COR ART

3615 1 INT MAM-COR ART BYPASS

3616 2 INT MAM-COR ART BYPASS

3617 ABD-CORON ART BYPASS OCT96-

3619 HRT REVAS BYPS ANAS NEC

362 ARTERIAL IMPLANT REVASC

363 OTH HEART REVASCULAR

3631 OPEN CHEST TRANS REVASC

3632 OTH TRANSMYO REVASCULAR

3633 ENDO TRANSMYO REVASCULAR OCT06-

3634 PERC TRANSMYO REVASCULAR OCT06-

3639 OTH HEART REVASULAR

3691 CORON VESS ANEURYSM REP

3699 HEART VESSLE OP NEC

3731 PERICARDIECTOMY

3732 HEART ANEURYSM EXCISION

3733 EXC/DEST HRT LESION OPEN

3734 EXC/DEST HRT LES OTHER

3735 PARTIAL VENTRICULECTOMY

3736 EXCISION OR DESTRUCTION OF LEFT ATRIAL APPENDAGE (LAA) OCT08-

3741 IMPLANT PROSTH CARD SUPPORT DEV OCT06

375 HEART TRANSPLANTATION (NOT VALID AFTER OCT 03)

3751 HEART TRANPLANTATION OCT03-

3752 IMPLANT TOT REP HRT SYS OCT03-

3753 REPL/REP THORAC UNIT HRT OCT03-

3754 REPL/REP OTH TOT HRT SYS OCT03-

3755 REMOVAL OF INTERNAL BIVENTRICULAR HEART REPLACEMENT SYSTEM OCT08

3760 IMPLANTATION OR INSERTION OF BIVENTRICULAR EXTERNAL HEART ASSIST

SYSTEM OCT08

3761 IMPLANT OF PULSATION BALLOON

3762 INSERTION OF NON-IMPLANTABLE HEART ASSIST SYSTEM

3763 REPAIR OF HEART ASSIST SYSTEM

3764 REMOVAL OF HEART ASSIST SYSTEM

3765 IMPLANT OF EXTERNAL HEART ASSIST SYSTEM

3766 INSERTION OF IMPLANTABLE HEART ASSIST SYSTEM

3770 INT INSERT PACEMAK LEAD

3771 INT INSERT LEAD IN VENT

3772 INT INSERT LEAD ATRI-VENT

3773 INT INSER LEAD IN ATRIUM

3774 INT OR REPL LEAD EPICAR

3775 REVISION OF LEAD

3776 REPL TV ATRI-VENT LEAD

3777 REMOVAL OF LEAD W/O REPL

3778 INSER TEAM PACEMAKER SYS

3779 REVIS OR RELOCATE POCKET

3780 INT OR REPL PERM PACEMKR

3781 INT INSERT 1-CHAM, NON

3782 INT INSERT 1-CHAM, RATE

3783 INT INSERT DUAL-CHAM DEV

3785 REPL PACEM W 1-CHAM, NON

3786 REPL PACEM 1-CHAM, RATE

3787 REPL PACEM W DUAL-CHAM

3789 REVISE OR REMOVE PACEMAK

3794 IMPLT/REPL CARDDEFIB TOT

3795 IMPLT CARDIODEFIB LEADS

3796 IMPLT CARDIODEFIB GENATR

3797 REPL CARDIODEFIB LEADS

3798 REPL CARDIODEFIB GENRATR

Measure 8: Adult Asthma Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

The number of discharges for asthma in adults per 100,000 Medicaid enrollees age 18 and older.

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.

B. ELIGIBLE POPULATION

Member months	All member months for Medicaid enrollees age 18 and older as of the 30th day of the month.
Continuous enrollment	There is no continuous enrollment requirement.
Allowable gap	There is no gap in coverage requirement.
Anchor date	There is no anchor date.

C. ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

Numerator: All non-maternal discharges for enrollees age 18 and older with an ICD-10-CM principal diagnosis code of asthma.

Include ICD-9-CM diagnosis codes:

49300 EXT ASTHMA W/O STAT ASTH

49301 EXT ASTHMA W STATUS ASTH

49302 EXT ASTHMA W ACUTE EXAC OCT00-

49310 INT ASTHMA W/O STAT ASTH

49311 INT ASTHMA W STAT ASTH

49312 INT ASTHMA W ACUTE EXAC OCT00-

49320 CH OB ASTH W/O STAT ASTH

49321 CH OB ASTHMA W STAT ASTH

49322 CH OBS ASTH W ACUTE EXAC OCT00-

49381 EXERCSE IND BRONCHOSPASM OCT03-

49382 COUGH VARIANT ASTHMA OCT03-

49390 ASTHMA W/O STATUS ASTHM

49391 ASTHMA W STATUS ASTHMAT

49392 ASTHMA W ACUTE EXACERBTN OCT00-

Exclusions

- Transfer from a hospital (different facility)
- Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- With missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), principal diagnosis (DX1 = missing), or county (PSTCO = missing)
- MDC 14 (pregnancy, childbirth, and puerperium)With any diagnosis code of cystic fibrosis and anomalies of the respiratory system

ICD-9-CM Cystic Fibrosis and Anomalies of the Respiratory System Diagnosis Codes:

27700 CYSTIC FIBROS W/O ILEUS

27701 CYSTIC FIBROSIS W ILEUS

27702 CYSTIC FIBROS W PUL MAN

27703 CYSTIC FIBROSIS W GI MAN

27709 CYSTIC FIBROSIS NEC

51661 NEUROEND CELL HYPRPL INF

51662 PULM INTERSTITL GLYCOGEN

51663 SURFACTANT MUTATION LUNG

51664 ALV CAP DYSP W VN MISALIGN

51669 OTH INTRST LUNG DIS CHLD

7421 ANOMALIES OF AORTIC ARCH

7483 LARYNGOTRACH ANOMALY NEC

7484 CONGENITAL CYSTIC LUNG

7485 AGENESIS OF LUNG

74860 LUNG ANOMALY NOS

74861 CONGEN BRONCHIECTASIS

74869 LUNG ANOMALY NEC

7488 RESPIRATORY ANOMALY NEC

7489 RESPIRATORY ANOMALY NOS

7503 CONG ESOPH FISTULA/ATRES

7593 SITUS INVERSUS

7707 PERINATAL CHR RESP DIS

Measure 9: Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of discharges for Medicaid enrollees age 21 and older that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:

- Percentage of discharges for which the enrollee received follow-up within 30 days of discharge
- Percentage of discharges for which the enrollee received follow-up within 7 days of discharge

Guidance for Reporting:

- In the original HEDIS specification, the eligible population for this measure includes patients age 6 and older as of the date of discharge. The Medicaid Adult Core Set measure has an eligible population of adults age 21 and older. States should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 21 to 64 and age 65 and older.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITION

Mental Health Practitioner — A practitioner who provides mental health services and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.

C. ELIGIBLE POPULATION

Age	Age 21 and older as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).

Event/diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Table 13.1) on or between January 1 and December 1 of the measurement year. Use only facility claims to identify discharges with a principal mental health diagnosis. Do not use diagnoses from professional claims to identify discharges. The denominator for this measure is based on discharges, not enrollees. If enrollees had more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (Tables 13.1 and 13.2) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health disorder, it is probably for a related condition. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for a mental health principal diagnosis (Tables 13.1 and 13.2) within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table 13.3 for codes to identify nonacute care. Non-mental health readmission or direct transfer: Exclude discharges in which the enrollee was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables 13.1 and 13.2. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow- up visit from taking place.

Table 13.1. Codes to Identify Mental Health Diagnosis ICD-9-

CM Diagnosis
295–299, 300.3, 300.4, 301, 308, 309, 311–314

Table 13.2. Codes to Identify Inpatient Services MS—DRG

876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Table 13.3. Codes to Identify Nonacute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

D. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerators:
30-Day Follow-Up

An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table 13.4) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up

An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table 13.4) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Table 13.4. Codes to Identify Visits

CPT		HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner		
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510		G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table 13.1		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

E. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required time frame for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

Measure 10: Annual HIV/AIDS Medical Visit

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older with a diagnosis of HIV/AIDS and with at least two medical visits during the measurement year, with a minimum of 90 and 180 days between each visit.

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITION

Medical Visit	Any visit with a health care professional who provides routine primary care for the patient with HIV/AIDS (may be a primary care physician, OB/GYN, pediatrician or infectious diseases specialist).

C. ADMINISTRATIVE SPECIFICATION

Denominator: All enrollees age 18 and older with a diagnosis of HIV/AIDS (Table 16.1).
Table 16.1. Codes to Identify HIV/AIDS

Description	ICD-9-CM Diagnosis
HIV-AIDS	042, V08

Numerator 1: Enrollees with at least two medical visits (Table 16.2) during the measurement year, with a minimum of 90 days between each visit.

Numerator 2: Enrollees with at least two medical visits (Table 16.2) during the measurement year, with a minimum of 180 days between each visit.

Table 16.2. Codes to Identify Medical Visits

Description	CPT
Medical Visits	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245

Measure 11: Comprehensive Diabetes Care: LDL-C Screening

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a LDL-C screening test.

Guidance for Reporting:

- This measure is based on the original HEDIS specification that includes multiple diabetes care indicators. Only the LDL screening indicator is included in this measure.
- This measure applies to Medicaid enrollees ages 18 to 75. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Ages18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify Medicaid enrollees with diabetes: by pharmacy data and by claim/encounter data. The organization must use both methods to identify the eligible population, but an enrollee only needs to be identified by one method to be included in the measure. Medicaid enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data. Medicaid enrollees who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table 18.1). Claim/encounter data. Medicaid enrollees who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table 18.2), or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. The state may count services that occur over both years. Refer to Table 18.3 for codes to identify visit type.

Table 18.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlinitide
Antidiabetic combinations	Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metforminMetformin-pioglitazone Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Saxagliptin Sitagliptin-simvastatin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin inhalation Insulin isophane beef-pork Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin zinc human
Meglitinides	Nateglinide Repaglinide
Miscellaneous antidiabetic agents	Exenatide Linagliptin Liraglutide Metformin-repaglinide Sitagliptin
Sulfonylureas	Acetohexamide Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis

codes only.

Table 18.2. Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Table 18.3. Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator: An LDL-C test performed during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in Table 18.4.

The state may use a calculated or direct LDL for LDL-C screening and control indicators.

Table 18.4. Codes to Identify LDL-C Screening

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0

Table 18.5. Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic ovaries	256.4
Steroid induced	249, 251.8, 962.0
Gestational diabetes	648.8

Measure 12: Comprehensive Diabetes Care: Hemoglobin A1c Testing

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test.

Guidance for Reporting:

- This measure is based on the original HEDIS specification that includes multiple diabetes care indicators. Only the HbA1c testing indicator is included in this measure.
- This measure applies to Medicaid enrollees ages 18 to 75. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify Medicaid enrollees with diabetes: by pharmacy data and by claim/encounter data. The state must use both methods to identify the eligible population, but an enrollee only needs to be identified by one method to be included in the measure. Medicaid enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data. Medicaid enrollees who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table 19.1). Claim/encounter data. Medicaid enrollees who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table 19.2), or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. The state may count services that occur over both years. Refer to Table 19.3 for codes to identify visit type.

Table 19.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlinitide
Antidiabetic combinations	Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Saxagliptin Sitagliptin-simvastatin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin inhalation Insulin isophane beef-pork Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin zinc human
Meglitinides	Nateglinide Repaglinide
Miscellaneous antidiabetic agents	Exenatide Linagliptin Liraglutide Metformin-repaglinide Sitagliptin
Sulfonylureas	Acetohexamide Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

Table 19.2. Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Table 19.3. Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator: An HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in Table 19.4.

Table 19.4. Codes to Identify HbA1c Tests

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8, 62388-4, 71875-9

Table 19.5. Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic ovaries	256.4
Steroid induced	249, 251.8, 962.0
Gestational diabetes	648.8

Measure 13: Antidepressant Medication Management

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression that were newly treated with antidepressant medication, and remained on an antidepressant medication treatment. Two rates are reported:

- Effective Acute Phase Treatment. The percentage of newly diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 84 days (12 weeks)
- Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 180 days (6 months)

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITIONS

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression and a 90-day (3-month) Negative Medication History. For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge. For a direct transfer, the IESD is the discharge date from the facility to which the enrollee was transferred.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).
Negative Medication History	A period of 90 days (3 months) prior to the IPSD when the enrollee had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment Days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of April 30 of the measurement year.
Continuous enrollment	90 days (3 months) prior to the IESD through 245 days after the IESD.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	IESD.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population which should be used for both rates.

Table 20.1. Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, 311

Table 20.2. Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
	CPT		POS
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

D. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator 1: Effective Acute Phase Treatment

- At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table 20.3) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication

- Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days)

Table 20.3. Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	Bupropion	Vilazodone	
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine	Selegiline Tranylcypromine	
Phenylpiperazine antidepressants	Nefazodone	Trazodone	
Psychotherapeutic combinations	Amitriptyline-chlordiazepoxide Amitriptyline-perphenazine	Fluoxetine-olanzapine	
SSNRI antidepressants	Desvenlafaxine Duloxetine	Venlafaxine	
SSRI antidepressants	Citalopram Escitalopram	Fluoxetine Fluvoxamine	Paroxetine Sertraline
Tetracyclic antidepressants	Maprotiline	Mirtazapine	
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine	Desipramine Doxepin Imipramine	Nortriptyline Protriptyline Trimipramine

Numerator 2: Effective Continuation Phase Treatment

- At least 180 days (6 months) of continuous treatment with antidepressant medication (Table 20.3) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication
- Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days)

E. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required time frame for the rate (e.g., during the Intake Period).

Measure 15: Adherence to Antipsychotics for Individuals with Schizophrenia

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees ages 19 to 64 with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Guidance for Reporting:

- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITIONS

IPSD	Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the measurement year.
Treatment Period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
Oral Medication Dispensing Event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.
Long-Acting Injections Dispensing Event	Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.

Calculating Number of Days Covered for Oral Medications	If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator . If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.
Calculating Number of Days Covered for Long-Acting Injections	Calculate number of days covered (for the numerator) for long-acting injections using the days-supply specified for the medication in Table 21.1. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply. For multiple J Codes or NDCs for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

C. ELIGIBLE POPULATION

Age	Ages 19 to 64 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population.

D. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator: The number of Medicaid enrollees who achieved a PDC of at least 80 percent for their antipsychotic medications (Table 21.1) during the measurement year.

Measure 16: Postpartum Care Rate

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled females that meet the measurement eligibility criteria.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITIONS

Pre-Term	A neonate whose birth occurs through the end of the last day of the 37th week (259th day) following the onset of the last menstrual period.
Post-Term	A neonate whose birth occurs from the beginning of the first day of the 43rd week (295th day) following the onset of the last menstrual period.
Start Date of the Last Enrollment Segment	For women with a gap in enrollment during pregnancy, the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date.

C. ELIGIBLE POPULATION

Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Event/diagnosis	Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in a birthing center. Refer to Tables 26.1 and 26.2 for codes to identify live births. Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.

D. ADMINISTRATIVE SPECIFICATION

Denominator:

Follow the first two steps below to identify the eligible population.

Numerator:

Postpartum Care

A postpartum visit (Table 26.3) for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

The practitioner requirement only applies to the Hybrid Specification. The enrollee is compliant if any code from Table 26.3 is submitted.

Table 26.3. Codes to Identify Postpartum Visits

CPT	CPT Category II	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	LOINC
57170, 58300, 59400*, 59410*, 59430, 59510*, 59515*, 59610*, 59614*, 59618*, 59622*, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175, 99501	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Note: Generally, these codes are used on the date of delivery, not on the date of the postpartum visit, so this code may be used only if the claim form indicates when postpartum care was rendered.

E. ADDITIONAL NOTES

When counting postpartum visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses if a physician cosignatory is present, if required by state law.

Services that occur over multiple visits count toward this measure as long as all services are within the time frame established in the measure. Ultrasound and lab results alone should not be considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.

A Pap test alone is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for the rate.

The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be

Appendix 2B—Selected Measures from Healthcare Effectiveness Data and Information Set (HEDIS) 2016

Measure: Persistence of Beta-Blocker Treatment after a Heart Attack

Origin: HEDIS 2016

Description:

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Numerator

A 180-day course of treatment with beta-blockers.

Identify all members in the denominator population whose dispensed days supply is ≥135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days supply filled.

Denominator

The eligible population.

Measure: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Origin: HEDIS 2016

Description:

The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

The percentage of discharges for which the member received follow-up within 30 days of discharge.

The percentage of discharges for which the member received follow-up within 7 days of discharge.

Numerator

The number of members who achieved a PDC of at least 70% for their antipsychotic medications during the measurement year.

Denominator

The eligible population.

Measure: Annual Monitoring for Patients on Persistent Medications (MPM)

Origin: HEDIS 2016

Description:

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate.

Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).

Annual monitoring for members on digoxin.

Annual monitoring for members on diuretics.

Annual monitoring for members on anticonvulsants.

Total rate (the sum of the four numerators divided by the sum of the four denominators).

Numerators

Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)

- At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Any of the following during the measurement meet criteria:
  - A lab panel test
  - A serum potassium test **and** a serum creatinine test
  - A serum potassium test **and** a blood urea nitrogen test
- Note: The tests do not need to occur on the same service date, only within the measurement year.

Annual monitoring for members on Digoxin

- At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Any of the following during the measurement meet criteria:
  - A lab panel test
  - A serum potassium test **and** a serum creatinine test
  - A serum potassium test **and** a blood urea nitrogen test
- Note: The tests do not need to occur on the same service date, only within the measurement year.

Annual monitoring for members on Diuretics

- At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year. Any of the following during the measurement meet criteria:
  - A lab panel test
  - A serum potassium test **and** a serum creatinine test

- A serum potassium test **and** a blood urea nitrogen test

- Note: The tests do not need to occur on the same service date, only within the measurement year.

Annual monitoring for members on Anticonvulsants

- At least one drug serum concentration level monitoring rest for the prescribed drug during the measurement year as identified by the following value sets:
  - Members prescribed phenobarbital must have at least one drug serum concentration for phenobarbital
  - Members prescribed carbamazepine must have at least one drug serum concentration for carbamazepine
  - Members prescribed phenytoin must have at least one drug serum concentration for phenytoin
  - Members prescribed valproic acid or divalproex sodium must have at least one drug serum concentration for valproic acid

Measure: Adults' Access to Preventive/Ambulatory Health Services (AAP)

Origin: HEDIS 2016

Description:

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.

Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Numerator

Medicaid and Medicare: One or more ambulatory or preventive care visits during the measurement year.

Commercial: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.

Use the following value sets to identify ambulatory or preventive care visits:

- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set

Denominator

The eligible population (report each age stratification separately).

Measure: Frequency of Selected Procedures (FSP)

Origin: HEDIS 2016

Description:

This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

Selected Procedures

Tonsillectomy

- With or without adenoidectomy. Do not report adenoidectomy performed alone.

Bariatric weight loss surgery

- Report the number of bariatric weight loss surgeries.

Hysterectomy

- Report abdominal and vaginal hysterectomy separately.

Cholecystectomy

- Report open and laparoscopic cholecystectomy separately.

Back surgery

- Report all spinal fusion and disc surgery, including codes relating to laminectomy with and without disc removal

Percutaneous Coronary Intervention (PCI)

- Report all PCIs performed separately. Do not report PCI or cardiac catheterization performed in conjunction with a CABG in the PCI rate or the cardiac catheterization rate; report only the CABG.

Cardiac Catheterization

- Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with a PCI in the cardiac catheterization rate; report only the PCI.
- Do not report PCI or cardiac catheterization performed in conjunction with a CABG in the PCI rate or the cardiac catheterization rate; report only the CABG.

Coronary Artery Bypass Graft (CABG)

- Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved.
- Do not report PCI or cardiac catheterization performed in conjunction with a CABG in the PCI rate or the cardiac catheterization rate; report only the CABG.

Prostatectomy

- Report the number of prostatectomies.

Total Hip Replacement

- Report the number of total hip replacements.

Total Knee Replacement

- Report the number of total knee replacements.

Carotid Endarterectomy

- Report the number of carotid endarterectomies.

Mastectomy

- Report the number of mastectomies. Report bilateral mastectomy procedures as two procedures, even if performed on the same date

Lumpectomy

- Report the number of lumpectomies. Report multiple lumpectomies on the same date of service as one lumpectomy procedure per patient.
- Note: Calls abandoned within 30 seconds and calls sent directly to voicemail remain in the measure and are noncompliant for the numerator.

Measure: Ambulatory Care (AMB)

Origin: HEDIS 2016

Description:

This measure summarizes utilization of ambulatory care in the following categories:

Outpatient Visits

ED Visits

Outpatient Visits

Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits). Report services without regard to practitioner type, training, or licensing.

ED Visits

Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit
- A procedure code with an ED place of service code

Exclusions (required)

The measure does not include mental health or chemical dependency services. Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency.

Note

This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of ambulatory resources nor an effort to be all-inclusive.

Measure: Inpatient Utilization – General Hospital/Acute Care (IPU)

Origin: HEDIS 2016

Description:

This measure summarizes utilization of acute inpatient care and services in the following categories:

Total inpatient

Maternity

Surgery

Medicine

Product Lines

Report the following tables for each applicable product line:

- Table IPU-1a Total Medicaid
- Table IPU-1b Medicaid/Medicare Dual-Eligibles
- Table IPU-1c Medicaid—Disabled
- Table IPU-1d Medicaid—Other Low Income
- Table IPU-2 Commercial–by Product or Combined HMO/POS
- Table IPU-3 Medicare

Appendix 2C

Consumer Assessment of Healthcare Providers and System Survey

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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Consumer Assessment of Healthcare Providers and Systems Survey

This following survey has been implemented twice to HCIP enrollee populations. Similar surveys with potential added questions relevant to the Arkansas Works evaluation will be fielded over the course of the evaluation period.

Appendix 2C – CAHPS

DATA COLLECTION BY ARKANSAS FOUNDATION FOR MEDICAL CARE

Survey Instructions

IMPORTANT: Please read before answering questions!

Answer the questions by checking the box to the left of your answer.

You may be asked to skip some questions that don't apply to you. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

1 ✓ **YES ➡ Go to next question**

2 **NO ➡ Go to question 13**

You may notice a number on the cover of this survey along with the name of the health plan that our records show you are currently enrolled in. This number is ONLY used to let us know if you returned your survey so we won't send you reminders.

If you have questions about this survey, please call toll-free 1-844-493-8763.

All information that would let someone identify you or your family will be kept private. The Arkansas Center for Health Improvement will not share your personal information with anyone without your OK.

We appreciate your help in completing the survey.
You may choose to answer this survey or not.
If you choose not to, however, it will not affect the benefits or treatment you get.

If you have questions or want to know more about this study, please call toll-free 1-844-493-8763.

Si gusta recibir la versión en español de esta encuesta, favor llamar al 1-844-493-8763.

The questions in this survey refer to the health plan named on the front cover of this survey booklet as "Plan name." Please think of that plan as you answer the survey.

1) Our records show that you are now enrolled in the health plan **listed on the front cover of this survey**. Is that right?

1 Yes
2 No, my health plan is: (**Please specify.**)

2) How long have you been enrolled in this health plan?

1 Less than 3 months
2 3 to 6 months
3 7 to 11 months
4 12 months or more

3) If you switched health plans within the last 12 months, what is the main reason you switched health plans?

1 My income changed
2 I was not satisfied with the services from my current doctor
3 I found a plan/doctor that was easier to use (i.e. because of location, appointment availability, etc.)
4 Other: (**Please specify.**)

Your Health Care in the Last 6 Months

These questions ask about your own health care experience in the last 6 months. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

4) In the last 6 months, did you have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?

1 Yes
2 **NO ➡ Go to question 6**

5) In the last 6 months, when you **needed care right away,** how often did you get care as soon as you needed?

1 Never
2 Sometimes
3 Usually
4 Always

6) In the last 6 months, did you make any appointments for a **check-up or routine care** at a doctor's office or clinic?

1 Yes
2 **NO ➡ Go to question 8**

Continued to next page

7) In the last 6 months, how often did you get an appointment for a **check-up or routine care** at a doctor's office or clinic as soon as you needed?

1 Never
2 Sometimes
3 Usually
4 Always

8) In the last 6 months, **not** counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

0 **NONE ➡ Go to question 16**
1 1 time
2 2
3 3
4 4
5 5 to 9
6 10 or more times

9) In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

1 Yes
2 No

10) In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?

1 Yes
2 **NO ➡ Go to question 14**

11) Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?

1 Yes
2 No

12) Did you and a doctor or other health provider talk about the reasons you might **not** want to take a medicine?

1 Yes
2 No

13) When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

1 Yes
2 No

14) Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

00 0 Worst health care possible
01 1
02 2
03 3
04 4
05 5
06 6
07 7
08 8

09 9
10 10 Best health care possible

15) In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

1 Never
2 Sometimes
3 Usually
4 Always

Continued to next page

Your Personal Doctor

16) A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

1 Yes
2 **NO ➡ Go to question 33**

17) Is this person a general doctor or a specialist doctor?

1 General doctor (Family practice or Internal medicine)
2 Specialist doctor (Surgeons, heart doctors, allergy doctors, skin doctors etc.)

18) How many months or years have you been going to your personal doctor?

1 Less than 3 months
2 3 to 6 months
3 At least 6 months but less than 1 year
4 At least 1 year but less than 2 years
5 At least 2 years but less than 5 years
6 5 years or more

19) In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

0 **NONE ➡ Go to question 24**
1 1 time
2 2
3 3
4 4
5 5 to 9
6 10 or more times

20) In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

1 Never
2 Sometimes
3 Usually
4 Always

21) In the last 6 months, how often did your personal doctor listen carefully to you?

1 Never
2 Sometimes
3 Usually
4 Always

22) In the last 6 months, how often did your personal doctor show respect for what you had to say?

1 Never
2 Sometimes
3 Usually
4 Always

23) In the last 6 months, how often did your personal doctor spend enough time with you?

1 Never
2 Sometimes
3 Usually
4 Always

Continued to next page

24) Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

00 0 Worst personal doctor possible
01 1
02 2
03 3
04 4
05 5
06 6
07 7
08 8
09 9
10 10 Best personal doctor possible

25) In the last 6 months, how often did you **not** visit your personal doctor because you could not arrange acceptable transportation?

1 Never
2 Sometimes
3 Usually
4 Always

26) In the last 6 months, how often did you **not** visit your personal doctor because you could not get an appointment at a time that was convenient?

1 Never
2 Sometimes
3 Usually
4 Always

27) In the last 6 months, how often did you **not** visit your personal doctor because you had to wait too long for an appointment?

1 Never
2 Sometimes
3 Usually
4 Always

28) In the last 6 months, how often did you **not** visit your personal doctor because it was too expensive to cover your share of the costs?

1 Never
2 Sometimes
3 Usually
4 Always

29) Does your personal doctor offer to communicate electronically (e.g. by email, smartphone apps, online patient portals or remote monitoring devices)?

1 Yes
2 **NO ➡ Go to question 31**

3 Don't know

30) In the last 6 months, how many times did you communicate with your personal doctor electronically using email, smartphone apps, online patient portals or remote monitoring devices?

0 None
1 1 time
2 2
3 3
4 4
5 5 to 9
6 10 or more times

31) What is your personal doctor's race?
Mark one or more.

A White
B Black or African American
C Asian
D American Indian or Alaska Native
E Native Hawaiian or Other Pacific Islander
F Some other
G Refuse to answer
H Don't know

Continued to next page

32) Is your personal doctor male or female?

1 Male
2 Female
3 Refuse to answer
4 Don't know

34) In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

1 Never
2 Sometimes
3 Usually
4 Always

Getting Health Care from Specialists

When you answer the next questions, do <u>not</u> include dental visits or care you got when you stayed overnight in a hospital.

33) Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

1 Yes
2 **NO ➡ Go to question 43**

35) In the last 6 months, how many times did you go to specialists to get care for yourself?

0 None
1 1 time
2 2
3 3
4 4
5 5 to 9
6 10 or more times

36) How many specialists have you seen in the last 6 months?

0 **NONE ➡ Go to question 43**
1 1 specialist
2 2
3 3
4 4
5 5 or more specialists

37) In the last 6 months, was the specialist you saw most often the same doctor as your personal doctor?

1 Yes
2 No

38) In the last 6 months, how often did you **not** visit a specialist because you could not arrange acceptable transportation?

1 Never
2 Sometimes
3 Usually
4 Always

39) In the last 6 months, how often did you **not** visit a specialist because you could not get an appointment at a time that was convenient?

1 Never
2 Sometimes
3 Usually
4 Always

Continued to next page

40) In the last 6 months, how often did you **not** visit a specialist because you had to wait too long for an appointment?

1 Never
2 Sometimes
3 Usually
4 Always

41) In the last 6 months, how often did you **not** visit a specialist because it was too expensive to cover your share of the costs?

1 Never
2 Sometimes
3 Usually
4 Always

42) We want to know your rating of the specialist you saw **most often** in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?

00 0 Worst specialist possible
01 1
02 2
03 3
04 4
05 5
06 6
07 7
08 8
09 9
10 10 Best specialist possible

Your Health Plan

The next questions ask about your experience with your health plan.

43) In the last 6 months, did you get information or help from your health plan's customer service?

1 Yes
2 **NO ➡ Go to question 46**

44) In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

1 Never
2 Sometimes
3 Usually
4 Always

45) In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

1 Never
2 Sometimes
3 Usually
4 Always

46) In the last 6 months, did your health plan give you any forms to fill out?

1 Yes
2 **NO ➡ Go to question 48**

47) In the last 6 months, how often were the forms from your health plan easy to fill out?

1 Never
2 Sometimes
3 Usually
4 Always

Continued to next page

48) Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

00 0 Worst health plan possible
01 1
02 2
03 3
04 4
05 5
06 6
07 7
08 8
09 9
10 10 Best health plan possible

About You

49) In general, how would you rate your **overall health?**

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

50) In general, how would you rate your overall **mental or emotional** health?

1 Excellent
2 Very good
3 Good
4 Fair
5 Poor

51) Do you have a physical or medical condition that seriously interferes with your ability to work, attend school, or manage your day-to- day activities?

1 Yes
2 No

52) Have you had either a flu shot or flu spray in the nose since July 1, 2015?

1 Yes
2 No
3 Don't Know

53) Do you now smoke cigarettes or use tobacco every day, some days or not at all?

1 Every day
2 Some days
3 Not at all ➡ **Go to question 57**
4 Don't know ➡ **Go to question 57**

54) In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

1 Never
2 Sometimes
3 Usually
4 Always

55) In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

1 Never
2 Sometimes
3 Usually
4 Always

Continued to next page

56) In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

1 Never
2 Sometimes
3 Usually
4 Always

57) In the past 6 months, did you get heath care 3 or more times for the same condition or problem?

1 Yes
2 **NO ➡ Go to question 59**

58) Is this a condition or problem that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

1 Yes
2 No

59) Do you now need or take medicine prescribed by a doctor? Do **not** include birth control.

1 Yes
2 **NO ➡ Go to question 61**

60) Is this medicine to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

1 Yes
2 No

SF-12v2™ Health Survey

Questions 61–71 ask for your views about your health. Answer each question by choosing just one answer. If you are unsure how to answer a question, please give the best answer you can.

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

61) Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

1 Yes, limited a lot
2 Yes, limited a little
3 No, not limited at all

62) Climbing **several** flights of stairs.

1 Yes, limited a lot
2 Yes, limited a little
3 No, not limited at all

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

63) Accomplished less than you would like.

1 All of the time
2 Most of the time
3 Some of the time
4 A little of the time
5 None of the time

64) Were limited in the **kind** of work or other activities.

1 All of the time
2 Most of the time
3 Some of the time
4 A little of the time
5 None of the time

The following questions are about how you have been feeling during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

Continued to next page

68) How much of the time during the **past 4 weeks** have you felt calm and peaceful?

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

65) Accomplished less than you would like.

1 All of the time
2 Most of the time

3 Some of the time
4 A little of the time
5 None of the time

66) Did work or activities **less carefully than usual.**

1 All of the time
2 Most of the time
3 Some of the time
4 A little of the time
5 None of the time

67) During the **past 4 weeks,** how much **did pain interfere** with your normal work (including work outside the home and housework)?

1 Not at all
2 A little bit
3 Moderately
4 Quite a bit
5 Extremely

69) How much of the time during the **past 4 weeks** did you have a lot of energy?

1 All of the time
2 Most of the time
3 A good bit of the time
4 Some of the time
5 A little of the time
6 None of the time

70) How much of the time during the **past 4 weeks** have you felt down-hearted and depressed?

1 All of the time
2 Most of the time
3 A good bit of the time
4 Some of the time
5 A little of the time
6 None of the time

Continued to next page

71) During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)?

1 All of the time
2 Most of the time
3 Some of the time
4 A little of the time
5 None of the time

More About You

72) **During the past 4 weeks,** did you do **ANY** work for pay?

1 Yes, full-time work
2 Yes, part-time work
3 No ➡ Go to question 75
4 Retired ➡ Go to question 75
5 Disabled ➡ Go to question 75
6 Unable to work ➡ Go to question 75

73) Do you currently receive or have the option to purchase health care insurance coverage from your employer?

1 Yes
2 No

74) How many employees work for your employer?

1 1–10
2 11–25
3 26–50
4 51–100
5 More than 100 employees

75) Have you ever applied, or considered applying, for Supplemental Security Income (SSI)?

1 Applied and was approved
2 Applied and was declined
3 Considered applying
4 Never considered applying

76) About how tall are you without shoes?

1 __/__ (ft. /in) Height
2 Don't know/Not sure
3 Refuse to answer

77) About how much do you weigh without shoes?

1 _____ Weight (pounds)
2 Don't know/Not sure
3 Refuse to answer

78) What is the highest grade or level of school that you have completed?

1 8th grade or less
2 Some high school, but did not graduate
3 High school graduate or GED
4 Some college or 2-year degree
5 4-year college graduate
6 More than 4-year college degree

79) Are you now married, widowed, divorced, separated or never married?

1 Married – living with spouse
2 Married – not living with spouse
3 Widowed
4 Divorced
5 Separated
6 Never married

80) What is your race? **Mark one or more.**

A White
B Black or African American
C Asian
D Native Hawaiian or Other Pacific Islander
E American Indian or Alaska Native
F Other

81) Are you of Hispanic or Latino origin or descent?

1 Yes, Hispanic or Latino
2 No, not Hispanic or Latino

Continued to next page

82) What is your preferred language?

1 English
2 Spanish
3 Chinese
4 Other (**Please specify.**)

83) What is your age?

1 18 to 24
2 25 to 34
3 35 to 44
4 45 to 54
5 55 to 64
6 65 to 74
7 75 or older

84) Are you male or female?

1 Male

2 Female

85) Did someone help you complete this survey?

1 **YES ➡ Go to question 86**

2 **NO ➡ Thank you.** Please return the completed survey in the postage-paid envelope.

86) How did that person help you?

Mark one or more.

A Read the questions to me

B Wrote down the answers I gave

C Answered the questions for me

D Translated the questions into my language

E Helped in some other way

Continued to next page

Please use this space to comment on any of your answers.

Also, if there are areas that were not covered by the survey that you feel should have been covered, please write them here.

Thank you for completing this survey

Thank you!

Please return the completed survey in the postage-paid envelope.

Appendix 3

Metrics and Hypotheses

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

ACHI
Arkansas Center for Health Improvement

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Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost	5. Employer Sponsored Insurance	6. Incentive Benefits
1	Medicaid Adult Core #1; CAHPS-H16; NCQA 0039	Flu Shots for Adults Ages 50 to 64	Rolling average represents the percentage of Medicaid enrollees ages 50 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 5.0H survey was completed	Survey	X	X				
2	Medicaid Adult Core #3; NQF 0031	Breast Cancer Screening	Percentage of women ages 42 to 69 that received a mammogram in the measurement year or the year prior to the measurement year	Medical claims	X	X				
3	Medicaid Adult Core #4; NQF 0032	Cervical Cancer Screening	Percentage of women ages 24 to 64 that received one or more PAP tests during the measurement year or the two years prior to the measurement year	Medical claims	X	X				
4	Medicaid Adult Core #7; NQF 1768	Plan All-Cause Readmission Rate	For enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission	Medical claims		X				
5	Medicaid Adult Core #9; PQI 01; NQF 0272	Diabetes Short-Term Complications Admission Rate	Number of discharges for diabetes short-term complications per 100,000 enrollees age 18 and older	Medical claims		X				
6	Medicaid Adult Core #10; PQI 05; NQF 0275	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Number of discharges for COPD per 100,000 enrollees age 18 and older	Medical claims		X				
7	Medicaid Adult Core #10; PQI 08; NQF 0277	Congestive Heart Failure (CHF) Admission Rate	Number of discharges for CHF per 100,000 enrollees age 18 and older	Medical claims		X				
8	Medicaid Adult Core #11; PQI 15; NQF 0283	Adult Asthma Admission Rate	Number of discharges for asthma per 100,000 enrollees age 18 and older	Medical claims		X				

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost	5. Employer Sponsored Insurance	6. Incentive Benefits
9	Medicaid Adult Core #13; NQF 0576	Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for enrollees age 21 and older that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Medical claims		X				
10	Medicaid Adult Core #16; NQF 0403	Annual HIV/AIDS Medical Visit	Percentage of enrollees age 18 and older with a diagnosis of HIV/AIDS and with at least two medical visits during the measurement year, with a minimum of 90 and 180 days between each visit	Medical claims	X	X				
11	Medicaid Adult Core #18; NQF 0063	Comprehensive Diabetes Care: LDL-C Screening	Percentage of enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a LDL-C screening test	Medical claims		X				
12	Medicaid Adult Core #19; NQF 0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Percentage of enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a Hemoglobin A1C test	Medical claims		X				
13	Medicaid Adult Core #20; NQFA 0105	Antidepressant Medication Management	Percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression, that were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) and for at least 180 days (6 months)	Medical claims		X				
15	HEDIS NQF 1879	Adherence to Antipsychotics for Individuals with Schizophrenia	The percentage of members 18 or older during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Medical claims	X	X				
16	Medicaid Adult Core #26; NQF 1517	Postpartum Care Rate	Percentage of deliveries the year prior to the measurement year and that had a postpartum visit on or between 21 and 56 days after delivery.	Medical claims	X					

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost	5. Employer Sponsored Insurance	6. Incentive Benefits
17	HEDIS; NQF 0071	Persistence of Beta-Blocker Treatment After a Heart Attack	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	Medical claims		X				
18	NQF 0543	Adherence to Statin Therapy for Individuals with Cornoary Artery Disease	The percentage of individuals with Coronary Artery Disease (CAD) who are prescribed statin therapy that had a Proportion of Days Covered (PDC) for statin medications of at least 0.8 during the measurement period (12 consecutive months).	Medical and pharmacy claims		X				
19	HEDIS NQF 0021	Annual monitoring for patients on persistent medications	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measuremetn year. For each product line, report each of the four rates separately and as a total rate. • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB). • Annual monitoring for members on digoxin. • Annual monitoring for members on diuretics. • Annual monitoring for members on anticonvulsants. • Total rate (the sum of the four numerators divided by the sum of the four denominators).	Medical claims		X				
20	HEDIS	Adults' Access to Preventive/ Ambulatory Health Services	Uilization rates per 1000 enrollees	Medical claims	X					
21	HEDIS	Frequency of Selected Procedures	Utilization for selected procedures per 1000 enrollees	Medical claims	X					
22	HEDIS	Ambulatory Care (Outpatient ER)	Utilization for selected procedures per 1000 enrollees	Medical claims	X					

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost	5. Employer Sponsored Insurance	6. Incentive Benefits
23	HEDIS	Inpatient Utilization—General Hospital/ Acute Care	Inpatient service use by age	Medical claims	X					
24	CAHPS-4; NQF 0006	Got care for illness/injury as soon as needed	Survey based assessment of enrollee experiences	Survey	X					
25	CAHPS-6; NQF 0006	Got non-urgent appointment as soon as needed	Survey based assessment of enrollee experiences	Survey	X					
26	CAHPS-9; NQF 0006	How often it was easy to get necessary care, tests, or treatment	Survey based assessment of enrollee experiences	Survey	X					
27	CAHPS-10; NQF 0006	Have a personal doctor	Survey based assessment of enrollee experiences	Survey	X					
28	CAHPS-18; NQF 0006	Got appointment with specialists as soon as needed	Survey based assessment of enrollee experiences	Survey	X					
29	CAHPS-HP1; NQF 0007	Number of months or years in a row enrolled in health plan	Survey based assessment of enrollee experiences	Survey			X			
30	CAHPS-8; NQF 0007	Rating of all health care	Survey based assessment of enrollee experiences	Survey		X				
31	CAHPS-16; NQF 0007	Rating of personal doctor	Survey based assessment of enrollee experiences	Survey		X				
32	CAHPS-20; NQF 0007	Rating of specialist	Survey based assessment of enrollee experiences	Survey		X				
33	CAHPS-26; NQF 0007	Rating of health plan	Survey based assessment of enrollee experiences	Survey		X				
34	CAHPS-I1; NQF 0007	Needed interpreter to help speak with doctors or other health providers	Survey based assessment of enrollee experiences	Survey	X					
35	CAHPS-I2; NQF 0007	How often got an interpreter when needed one	Survey based assessment of enrollee experiences	Survey	X					

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost	5. Employer Sponsored Insurance	6. Incentive Benefits
36	CAHPS-PD1; NQF 0007	Had same personal doctor before joining plan	Survey based assessment of enrollee experiences	Survey		X	X			
37	CAHPS-PD2; NQF 0007	Easy to get personal doctor you were happy with	Survey based assessment of enrollee experiences	Survey		X				
38	CAHPS-AR1; NQF 0007	Days wait time between making appointment and seeing provider	Survey based assessment of enrollee experiences	Survey	X					
39	CAHPS-AR2; NQF 0007	How often had to wait for appointment because of provider's lack of hours/availability	Survey based assessment of enrollee experiences	Survey	X					
40	CAHPS-R1; NQF 0007	Easy to get a referral to a specialist	Survey based assessment of enrollee experiences	Survey	X	X				
41	CAHPS-UT1; NQF 0007	Times visited emergency room	Survey based assessment of enrollee experiences	Survey	X	X				
42	AR Medicaid Eval 02	Non-emergency transportation access	Use of non-emergency transportation services	Transportation data	X					
43	AR Medicaid Eval 03	Continuity of PCP care	Consistent use of the same primary care provider over time--proportion of primary care visits with same PCP	Medical claims	X		X			
44	AR Medicaid Eval 04	Continuity of Specialist care	Consistent use of the same specialist provider over time--proportion of type specific same specialist visits over time	Medical claims	X		X			
45	AR Medicaid Eval 05	PCP Network Adequacy	Adequacy of primary care provider network for enrolled populations--proportion of service area without primary care coverage within 30 miles	Carrier / Medicaid geomaps	X					

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost	5. Employer Sponsored Insurance	6. Incentive Benefits
46	AR Medicaid Eval 06	PCP Network Accessibility	Accessibility of primary care provider network for enrolled popluations--proportion of enrollees with primary care accessibile within 30 miles	Carrier / Medicaid geomaps	X					
47	AR Medicaid Eval 07	Specialist network adequacy	Adequacy of specialist provider network for enrolled populations--proportion of service area without specialist coverage within 60 miles	Carrier / Medicaid geomaps	X					
48	AR Medicaid Eval 08	Specialist network accessibility	Accessibility of specialist network for enrolled populations--proportion of enrollees with specialist accessible within 60 miles	Carrier / Medicaid geomaps	X					
49	AR Medicaid Eval 09	Total and subgroup enrollment within carrier (e.g., market penetration)	Carrier, and carrier by market specific enrollment data	Enrollment			X			
50	AR Medicaid Eval 10	Total and subgroup enrollment within each plan (e.g., plan differentiation)	Carrier, and carrier by market, and carrier by market by plan specific enrollment data	Enrollment			X			
51	AR Medicaid Eval 11	Total and subgroup enrollment within each method of entry (e.g., enrollment path)	Carrier specific enrollment path	Enrollment			X			
52	AR Medicaid Eval 12	Total and subgroup enrollment within each market (e.g., geographic uptake variation)	Carrier by market specific enrollment path	Enrollment			X			
53	AR Medicaid Eval 13	Total and Subgroup Medicaid Clinical costs	Direct payments by state Medicaid per enrollee	Cost				X		
54	AR Medicaid Eval 14	Total and Subgroup Medicaid Administrative costs	Direct administrative costs attributed per enrollee	Cost				X		
55	AR Medicaid Eval 15	Total and Subgroup Plan Admin Costs per Enrollee	Direct wrap costs attributed per enrollee	Cost				X		
56	AR Medicaid Eval 16	Total startup programmatic costs (e.g., medical needs screener)	Total Program Start Costs	Cost				X		

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost	5. Employer Sponsored Insurance	6. Incentive Benefits
57	AR Medicaid Eval 17	Total startup programmatic costs (e.g., medical needs screener)	Direct Premium Assistance paid per enrollee	Cost				X		
58	AR Medicaid Eval 18	Total and Subgroup Plan Admin Costs per Enrollee	Estimated plan administrative costs for premium assistance	Cost				X		
59	AR Medicaid Eval 19	Arkansas Program Characteristics	Arkansas specific health insurance exchange program characteristics (e.g., number of plans per market area, actuary risk, average 2nd lowest premium cost)	Cost				X		
60	AR Medicaid Eval 20	Contiguous State Program Characteristics	Contiguous state specific health insurance exchange program characteristics	Cost				X		
61	AR Medicaid Eval 21	Regional average program characteristics	Regional average state specific health insurance exchange program characteristics	Cost				X		
62	ESI 1	ESI Cost Saving	Premium assistance for ESI will be lower than had individuals been enrolled in premium assistance QHP	Medicaid Paid Premiums					X	
63	ESI 2	ESI Participation	Enough employers will participate in the ESI program to offset administration costs	Medicaid					X	
64	ESI 3	ESI Continuity of Care	Individuals enrolled in ESI will have less churn compared to similar individuals enrolled in a premium assistance QHP plan	Medical claims					X	
65	Incentive Benefits	Incentive Benefit Participation	Individuals will participate in the Arkansas Works incentive benefit program at a higher rate than those who participated in the HCIP independence account program.	Benefit administrative data						X
66	Incentive Benefits	Increased Well Visits	Due to the incentive benefit requirement, Arkansas Works enrollees will have higher rates of well visits than cohorts previously enrolled in HCIP	Medical claims						X

Appendix 4

Candidate Metrics by Approach

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Design Approach for Hypothesis Testing

Hypotheses	Design Approach					
	Regression Discontinuity	Stabilized Inverse Probability of Treatment Weighting	Pre-Post Comparison	Provider Network Adequacy (Geospatial)	Qualitative Interviews	Secret Shopper Survey
1—Access						
a. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.	X	X		X	X	X
b. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.	X	X				
c. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.	X	X				
d. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.			X			
e. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.	X	X				
2—Care/Outcomes						
a. Premium Assistance beneficiaries will have equal or better access to preventive care services. (P – Primary Prevention; S – Secondary Prevention; T – Tertiary Prevention)	X	X			X	
b. Premium Assistance beneficiaries will report equal or better experience in the care provided.	X	X				

	Design Approach					
Hypotheses	**Regression Discontinuity**	**Stabilized Inverse Probability of Treatment Weighting**	**Pre-Post Comparison**	**Provider Network Adequacy (Geospatial)**	**Qualitative Interviews**	**Secret Shopper Survey**
a. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.	X	X				
b. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.	X	X				
4—Cost Effectiveness						
a. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.	X	X				
b. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.	X	X				
c. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.	X	X				
5—Employer Sponsored Insurance						
a. The ESI program will enroll enough employers and employees to provide sufficient power to compare metrics with premium assistance QHP participants.					X	
b. Costs for ESI enrollees (premium assistance and health care) will be lower than had individuals been enrolled in premium assistance QHP.		X				

	Design Approach					
Hypotheses	**Regression Discontinuity**	**Stabilized Inverse Probability of Treatment Weighting**	**Pre-Post Comparison**	**Provider Network Adequacy (Geospatial)**	**Qualitative Interviews**	**Secret Shopper Survey**
c. ESI program enrollees will have less churn than similar working enrollees in premium assistance QHPs.		X			X	
6—Incentive Benefits Program						
a. Participation rates in an Arkansas Works incentive benefit program will be higher than the HCIP independence account program.		X				
b. Due to incentive benefit requirement, Arkansas Works enrollees will seek well visits more often and sooner compared to HCIP enrollees.		X				

Appendix 5

Arkansas Insurance Department Network Adequacy Guidelines and Targets

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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Appendix 5
AID Network Adequacy Guidelines and Targets

45 CFR § 156.230 requires that Qualified Health Plans (QHPs) "…maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay**."** AID has developed the following network adequacy targets and data submission requirements to ensure adequacy of provider networks in QHPs offered in the Federally-Facilitated Marketplace (FFM, or "Marketplace"). Failure to meet these standards may not preclude participation in the FFM in the first year of evaluation, but may require additional justification. AID will evaluate whether or not the targets should be adopted as QHP standards in future years.

Medical issuers who apply for participation in the Marketplace may already be accredited and so may not need to submit additional network access information as part of the application process. Non-accredited issuers and dental issuers will be required to submit network information. Additional detail on submission requirements is outlined below. All issuers, both accredited and non-accredited, will be required to comply with the provider directory and ECP guidelines.

Note that QHP service areas in Arkansas may change and network adequacy requirements in this standard must apply to updated service areas.

Accreditation

Issuers are required to receive accreditation on network policies and procedures from a qualifying accreditation entity (NCQA or URAQ) prior to second year of Marketplace participation. Proof of accreditation must be submitted with the QHP application (SERFF binder).

Accreditation entities have indicated that they will consider state standards in evaluating network adequacy. AID will communicate the time and distance targets below to URAC and NCQA to be used in the accreditation process. If carriers currently assess networks with more stringent internal network requirements (i.e. PCP available within 15 minutes or 15 miles), then they should proceed with existing internal standards.

Accredited issuers should report time and distance GeoAcess Maps and metrics according to the standards below as part of QHP submission.

Time and Distance Targets

AID recommends that issuers and accreditation entities evaluate networks based on the following targets. If an issuer is not accredited, GeoAccess maps and other information demonstrating network access based on these targets must be submitted.

- PCP target: 1 provider within 30 miles or 30 minutes
- Specialty care target: 1 provider within 60 miles or 60 minutes
- Mental Health, Behavioral Health, or Substance Abuse (MH/BH/SA): 1 provider within 45 minutes or 45 miles

GeoAccess Map Guidelines

GeoAccess Maps and compliance percentages must be submitted for each of the categories below. Accredited carriers will be required to submit GeoAccses maps for reporting purposes. Map data is only required for service areas that are included in the QHP application. Requested maps can be submitted separately or combined and distinguished by color or other method. Please note exceptions for dental carriers.

- **Primary Care**: GeoAccess Maps must be submitted demonstrating a 30 mile or 30 minute coverage radius from each general / family practitioner or internal medicine provider, and each family practitioner/pediatrician. Maps should also show providers accepting new patients. Dental carriers are not required to submit separate categories, but should include only non-specialists in this requirement.
- **Specialty Care:** GeoAccess Maps must be submitted demonstrating a 60 mile or 60 minute coverage radius from each category of specialist (see list of categories below). Maps should also show providers accepting new patients. Specialists should be categorized according to the list below. (Dental carriers do not need to categorize specialists.)
    - Hospitals*
    - Home Health Agencies
    - Cardiologists
    - Oncologists
    - Obstetricians
    - Pulmonologists
    - Endocrinologists
    - Skilled Nursing Facilities
    - Rheumatologists
    - Opthalmologists
    - Urologists
    - Psychiatric and State Licensed Clinical Psychologist

  **Hospitals types should be categorized according to hospital licensure type in Arkansas.*
- **MH/BH/SA:** GeoAccess Maps must be submitted demonstrating a 45 mile or 45 minute coverage radius from MH/BH/SA providers for each of the categories below. Maps should also show providers accepting new patients.
    - Psychiatric and State Licensed Clinical Psychologist
    - Other (submit document outlining provider or facility types included)
- **Essential Community Providers:** GeoAccess Maps must be submitted demonstrating a 30 mile or 30 minute coverage radius from ECPs for each of the categories below. The provider types included in each of the categories align with federal guidelines for ECP providers, with the addition of school-based providers included in the "Other ECP" category
    - FQHC
    - Ryan White Provider
    - Family Planning Provider
    - Indian Provider
    - Hospital
    - Other ECP

Performance Metric Guidelines for Non-Accredited Carriers

Non-accredited issuers will be required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. Accredited issuers will be required to submit these metrics for reporting purposes. These include:

- The *number of members* and *percentage of total members* within access to a PCP within 30 minutes/miles, a specialist within 60 minutes/miles, or a MH/BH/SA provider within 45 minutes/miles.
- The average distance to first, second, and third closest provider for each provider type.

These figures should be provided overall (entire state) for each category as well as stratified by county for each category.

For example, the percent of enrolled members that are within 30 minutes or 30 miles of a general/family practitioner will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county.

Issuers who do not yet have enrollees in the State of Arkansas will be exempt from this requirement and must attest to not currently having enrollees in Arkansas.

Network Access Policies and Procedures for Non-Accredited Carriers

Non-accredited carriers should submit an access plan describing company policies and procedures for ensuring adequate and sufficient network access. The access plan should include narrative description that addresses each of the following:

(1) The Qualified Health Plan Issuer's network is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week;

(2) The Qualified Health Plan Issuer's procedures for making referrals within and outside its network and notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(3) The Qualified Health Plan Issuer's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

(4) The Qualified Health Plan Issuer's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) The Qualified Health Plan Issuer's methods for assessing the health care needs of covered persons;

(6) The Qualified Health Plan Issuer's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, process for choosing and changing providers, and procedures for providing and approving emergency and specialty care;

(7) The Qualified Health Plan Issuer's method for assessing consumer satisfaction;

(8) The Qualified Health Plan Issuer's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(9) The Qualified Health Plan Issuer's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(10) The Qualified Health Plan Issuer's process for enabling covered persons to change primary care professionals;

(11) The Qualified Health Plan Issuer's proposed plan for providing continuity of care in the event of contract termination of the Qualified Health Plan Issuer and any of its participating providers, or in the event of the Qualified Health Plan Issuer's insolvency or other inability to continue operations. This plan shall explain how covered persons will be notified of the contract termination, or the Qualified Health Plan Issuer's insolvency or other cessation of operations, and transferred to other providers in a timely manner;

(12) The Qualified Health Plan Issuer shall provide access or coverage for health care providers as required by federal law;

(13) The Qualified Health Plan Issuer's procedures to ensure reasonable proximity of participating providers to the business or personal residence of covered persons;

(14) The Qualified Health Plan Issuer's plan that shows how it will continually monitor the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons;

(15) The Qualified Health Plan Issuer's procedures that ensure that if the Issuer has an insufficient number or type of participating providers to provide a covered benefit, the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers; and

(16) Qualified Health Plan Issuer should file with the Commissioner sample contract forms proposed for use with its participating providers and intermediaries

In addition, the applicant should describe the process for ensuring that if there is insufficient number or type of participating providers for an enrollee to access covered benefits that there is at least one participating provider in the next closest city or mileage and drive time radius.

Standards for Essential Community Providers (ECPs)

Issuers (accredited and non-accredited) must complete and submit the Essential Community Providers template and must include in the template all qualifying ECPs in the network. Qualifying ECPs include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. AID will review plans according to the ECP standards in the April 5, 2013 Letter to Issuers unless CCIIO releases additional guidelines prior to the plan year 2015 certification period.

Each issuer will be required to meet conditions of the Private Option 1115 Waiver and offer at least one QHP that has at least one FQHC or RHC in each service area of the plan network.

ECPs in the provider network should be submitted in the FFM ECP template and the ECP Category below should be indicated (as in plan year 2014 QHP Certification).

FFM Categorization of ECPs in ECP Data Submission Template
(with addition of school-based providers)

ECP Categories	ECP Providers
FQHC	FQHC and FQHC look-alike clinica, Native Hawaiian Health Centers
Ryan White Provider	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X Look-Alike Family Planning Clinics
Indian Provider	Tribal and Urban Indian Organization Providers
Hospital	Disproportionate Share Hospitals (DSH), Children's Hospitals, Rural Referral Centers, State Community Hospitals, Free-standing Cancer Centers, and Critical Access Hospitals
Other ECP Provider	Sexually Transmitted Disease (STD) Clinics, Tuberculosis (TB) Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and *School-Based Providers*

Inclusion of School-Based Providers

Providers who are school-based providers and meet credentialing and certification standards of issuers will be included in the ECP template submission, categorized as "Other". Issuers should submit a separate list of school-based providers as part of the QHP application. At a minimum, providers should be identified by NPI, physician or clinic name, address, and provider type.

The 2013 Letter to Issuers also requires that issuers offer contracts prior to the coverage year to:

- *All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and*
- *At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.*

The AR Marketplace will additionally require that issuers offer a contract to at least one school-based provider in each county in the service area, where a school-based provider is identifiable and available and meets issuer certification and credentialing standards.

Provider Directories

45 CFR Section 156.230(b) states that "… a QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients."

AID has the following additional requirements in regard to provider directories:

- Online provider directories must be available in Spanish.
- The directory search must include the ability to filter by each category of ECP.
- The directory search must include an indication of part-time or full-time as well as after-hours availability as reported by providers.

Specialty Services

AID is in the process of developing a rule with guidelines for in-state coverage of specialty services (i.e. transplant, burn center), including services provided at Centers of Excellence. More details forthcoming.

Appendix 6

Arkansas Insurance Department Requirements for Qualified Health Plan Certification in the Arkansas Federally-Facilitated Partnership Exchange

June 25, 2013

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

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Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

BULLETIN NO. 3B-2013

TO: ALL LICENSED INSURERS, HEALTH MAINTENANCE ORGANIZATIONS (HMOs), FRATERNAL BENEFIT SOCIETIES, FARMERS' MUTUAL AID ASSOCIATIONS OR COMPANIES, HOSPITAL MEDICAL SERVICE CORPORATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, PRODUCER AND COMPANY TRADE ASSOCIATIONS, AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: REQUIREMENTS FOR QUALIFIED HEALTH PLAN CERTIFICATION IN THE ARKANSAS FEDERALLY-FACILITATED PARTNERSHIP EXCHANGE (MARKETPLACE)

DATE: June 25, 2013

Qualified Health Plans (QHP), which are non-grandfathered individual or small group plans certified and offered through an Individual or SHOP Marketplace for Arkansas consumers, will be offered through the federally facilitated Health Insurance Marketplace beginning on October 1, 2013, with an effective date of coverage of January 1, 2014. The Affordable Care Act (ACA) requires that all issuers and plans participating in the Federally-facilitated Marketplace Plan Management Partnership (Partnership) meet federal and state certification standards for QHPs. The Arkansas Insurance Department (AID) will require QHP Issuers to meet all state licensure requirements and regulations, as well as state specific plan and QHP requirements and regulations. QHP Issuers will also be responsible for all other State and Federal regulations already prescribed to insurance companies in today's market. The purpose of this Bulletin is to illustrate the new federal and state requirements to be a QHP in the Arkansas individual and SHOP Health Insurance Marketplace.

Beginning on March 5, 2013, and lasting through April 2013, NAIC provided training on the use of SERFF for application and plan submission to the Marketplace. Health Insurance Issuers responding to this guidance should submit their applications to become QHP Issuers together with included rate and form filings between March 28, 2013 and June 30, 2013. Stand Alone Dental (SAD) Issuers should submit their applications with their rate and form filings between May 20, 2013 and June 30, 2013. Toward a requirement that consumers in each of Arkansas's 75 counties have a choice among at least two health insurance issuers, each issuer is required to submit to AID their planned service areas for 2014 by June 3, 2013 to allow the Commissioner adequate time for review of proposed service areas. If changes in a proposed issuer's service area are required, the Commissioner will contact that issuer as soon as possible. Please send this submission to insurance.exchange@arkansas.gov.

The Commissioner will maintain flexibility to conduct ongoing negotiations to achieve a competitive Arkansas Marketplace. AID will review issuer applications through July 31, 2013 and will submit all approved and recommended applications to CMS for certification on July 31, 2013. All issuers waiting until the final deadline to submit their application to offer a QHP should be aware that AID will strive to review all filings and work with issuers to make QHP recommendations to CMS by July 31. Plans will be reviewed in the order received. Any plans not having undergone complete review gaining state approval for recommendation prior to July 31 will be ineligible for offering a QHP through the Marketplace during the 2013 Open Enrollment Period. Issuers will be given an opportunity to address any data errors during the plan review period in

late August. CMS will notify all issuers of the QHP Certification decision and complete the certification agreement in early September 2013. The Federal Government has stated that there will not be any federal appeals related to non-certification during the 2014 plan year due to the shortened first year.

Issuers notified the Marketplace of their intent to participate in the certification process by March 8, 2013 by sending an email to insurance.exchange@arkansas.gov. A secondary bulletin notifying issuers of the intent to participate by SAD Issuers was published on March 15, 2013.

On April 23, 2013, Arkansas enacted the Health Care Independence Act of 2013, establishing the Health Care Independence Program (hereinafter referred to as the "Private Option"). The intent of the Private Option is to create a fiscally sustainable, cost-effective, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options; promote accountability, personal responsibility and transparency; encourage and reward healthy outcomes and responsible choices; and promote efficiencies that will deliver value to Arkansans. The Act is expressly written to "improve access to quality health care…attract insurance carriers and enhance competition in the Arkansas Marketplace… [and] promote individually owned health insurance." See Act 1498 of 2013, p.3. Through authority granted by the Health Care Independence Act and using the Medicaid premium assistance model, Arkansas Medicaid will purchase QHPs doing business in the Marketplace for certain Medicaid eligible beneficiaries. In 2014, Private Option eligible individuals will include childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare and parents between the ages of 19 and 65 with incomes between 17% of the FPL and 138 % FPL who are not enrolled in Medicare. Individuals who have been determined disabled or who have been determined to be more effectively covered under the standard Medicaid program (such as an individual who is medically frail or other individuals for whom coverage through the Health Insurance Marketplace is determined to be impractical, overly complex or would undermine continuity or effectiveness of care) will not be eligible for the Private Option.

Plan Year 2014 is considered a "transition to market" year and, as such, AID will allow flexibility with some certification standards in an effort to attract more issuers to the changing Arkansas Marketplace. Year one certification standards are outlined in the table below. In Plan Year 2015, AID expects to update these standards to include:

- Transition of current identified Medicaid populations off of Medicaid and on to the Private Option;
- Development of cost sharing parameters for 50-100% FPL; and
- Development of Health Savings Account and Medical Savings Account models for populations above 50% FPL.

In 2014, Private Option eligible individuals at or below 138% of FPL will be permitted to shop among and enroll in QHPs offered at the Silver metal level in the Marketplace, at the following actuarial value variations:

- ***Eligible Individuals with Incomes from 0-100% of the Federal Poverty Level:*** Zero Cost Sharing Silver Plan Variation (100% actuarial value) for year one. In year two, AID will implement cost sharing for this income group where actuarial value can be attained (e.g. 50-100% FPL).

- ***Eligible Individuals with Incomes from 101-138% FPL:*** High-Value Silver Plan Variation (94% +/- 1% actuarial value). To facilitate implementation of a consistent approach to cost sharing across all High-Value Silver Plan enrollees, AID will require that all QHP Issuers' High-Value Silver Plan variations conform with prescribed cost sharing amounts as defined

by AID. (See Bulletin Section "*Plan Variations for Individuals Eligible for Cost Sharing: State Standards*")

AID reserves the right to seek modified proposals and/or recommend non-certification of plans to the extent necessary to ensure cost effective pricing of QHPs across all seven rating areas. Because of significant reduction of uncompensated care for uninsured patients and related cost shifting, and increased competition in the marketplace, the State expects deflationary pressure on the cost of care which should reduce premium pricing.

Arkansas's outreach and enrollment efforts will be substantial in order to reach and enroll as many individuals eligible for QHP coverage and the Private Option during the Open Enrollment period beginning on October 1, 2013 and ending on March 31, 2014." These efforts will include targeted outreach to individuals enrolled in other low income programs such as SNAP, parents of AR Kids First enrollees, those receiving child care assistance, etc. AID will also establish a rolling Special Enrollment Period for individuals who are determined eligible or re-determined eligible for the Private Option. All Marketplace requirements with respect to Open Enrollment and Special Enrollment Periods will apply to all QHPs doing business on the Marketplace.

General Requirements	
Federal Standard 45 CFR §§ 153.400, 153.410 45 CFR. § 153.610 45 CFR 155 and 156 45 CFR 156.20 42 USC §18021 42 USC §18022 42 USC §18031 CMS Guidance Rules ACA §1311 ACA §1002 ACA § 1341 ACA § 1343	A QHP Issuer must— (1) Comply with all certification requirements on an ongoing basis; (2) Ensure that each QHP complies with benefit design standards; (3) Be licensed and in good standing to offer health insurance coverage in Arkansas; (4) Implement and report on a quality improvement strategy or strategies consistent with the standards described within the ACA, disclose and report information on health care quality and outcomes as will be later defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agree to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through the Marketplace or whether the plan is offered directly from the issuer or through an agent; (6) Pay any applicable user fees assessed; (7) Comply with the standards related to the risk adjustment program administered by CMS; (8) Notify customers of the effective date of coverage; (9) Participate in initial and annual open enrollment periods, as well as special enrollment periods; (10) Collect enrollment information, transmit such to the Marketplace and reconcile enrollment files with the Marketplace enrollment files monthly; (11) Provide and maintain notice of termination of coverage. A standard policy must be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency must be provided; (12) Segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception; (13) Timely notify the Marketplace if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last

	plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice; (14) In the event that the QHP becomes decertified, terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage; (15) Meet all readability and accessibility standards; (16) Pay the same commission to producers and brokers for the sale of plans inside the SHOP as to similar plans sold in the outside market; (17) Provide a matching benefit plan and price off of the Marketplace if the plan offered within the Marketplace offers all ten Essential Health Benefits; (18) Participate in the reinsurance program, including making reinsurance contributions and receiving reinsurance payments; and (19) Participate in risk adjustment.
State Standard	AID will utilize a certification approach to reviewing, recommending, and submitting the rate, form and QHP Issuer application filings for compliance with federal and state rules and regulations. Certification will be good for a period of one (1) plan year. If an issuer wishes to continue offering a certain QHP following that plan year, the issuer must apply to have that QHP recertified. As part of the application, the QHP Issuer must fill out and submit the checklist that is attached in SERFF and is included for reference purposes only in this Bulletin as Appendix A. AID will review the pricing of QHPs, to ensure that all QHPs are adequately and appropriately priced for the Arkansas Marketplace. AID will work with CMS and the QHP Issuers to move enrollees to other available certified QHPs should a certified QHP in which a consumer is enrolled become decertified or allows its certification to expire. Additionally, AID will allow individuals to enroll in or change from one QHP to another as a result of an individual being determined eligible for or re-determined eligible for the Private Option. AID will also require all QHP Issuers offering a plan which has pediatric dental imbedded as part of its benefits to also offer an identical plan which does not include pediatric dental as part of its benefits. This requirement will be null and void and all QHP Issuers will be required to have an imbedded pediatric dental benefit should no SAD plans become certified on the Marketplace. Three (3) SAD Issuers notified AID of their intent to participate as published in AID Bulletin 8-2013. Another SAD Issuer has since given AID notice to participate. This requirement will not have any affect on the QHPs actuarial value (AV) results related to either the embedded or unembedded plan as the AV Calculator does not review pediatric dental as part of the standard population. Furthermore, in future years of the Marketplace, AID may limit the number of plans or benefit designs that may be offered by a carrier per “metal tier” level on the Marketplace.

Licensure and Solvency	
Federal Requirements 45 CFR 156.200	A QHP Issuer must be licensed and in good standing with the State.
State Requirements	A QHP Issuer must have unrestricted authority to write its authorized lines of business in Arkansas in order to be considered "in good standing" and to offer a QHP through the Marketplace. AID is the sole source of a determination of whether an issuer is in good standing. AID determinations of good standing will be based on authority found in Ark. Code Ann. § 23-63-202. Such authority may include restricting a QHP Issuer's ability to issue new or renew existing coverage for an enrollee. An issuer will be allowed to apply for Arkansas licensure and QHP Issuer and plan certification simultaneously during the first QHP certification cycle; however, a QHP Issuer may not be certified for participation in the Marketplace until state licensure has been established.
Network Adequacy	
Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702(c)	A QHP Issuer must ensure that the provider network of each of its QHPs is available to all enrollees and: (1) (a) Includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area. This must be done by demonstrating one of the following during the first year of the Marketplace: • That the issuer achieved at least 20% ECP participation in network in the service area, agreed to offer contracts to at least 1 ECP of each type available by county; • That the issuer achieved at least 10% ECP participation in the network service area and submits a satisfactory narrative justification as part of its Issuer Application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its Issuer Application. **OR** (b) If an issuer provides a majority of covered services through employed physicians or a single contracted medical group complying with the alternate ECP standard identified within federal regulations, the issuer must verify one of the following: • That the issuer has at least the same number of providers located in designated low income areas as the

	equivalent of at least 20% of available ECPs in the service area; • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its Issuer Application. (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and (3) Makes its provider directory for a QHP available to the Marketplace for publication online in accordance with guidance from the Marketplace and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.
State Standard	AID will require an attestation from the QHP Issuer that states it is in compliance with all network adequacy requirements in addition to one of the following: • The QHP Issuer provides evidence that it has accreditation from an HHS approved accrediting organization that reviews network adequacy as a part of accreditation; or • The QHP Issuer provides sufficient information through a PDF submission related to its policies and procedures to determine that the QHP Issuer's network meets the minimum federal requirements and complies with all requirements in AID Bulletin 11A-2013 Any QHP Issuer that fails to achieve at least 10% ECP participation will undergo a stricter review of its Issuer Application. AID will not impose standards that exceed federal ACA standards in the first year. The percentage of ECPs in a network will be measured against the federal lists that can be found at https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu and https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq. To the extent that issuers subject to the alternate standard cannot meet the safe harbor or minimum expectation levels, factors and circumstances identified in the supplemental response along with an explanation of how the issuer will provide access to low-income and underserved populations will be taken into account. AID reserves the right to add additional state standards for future plan years of the Marketplace.

Accreditation	

Federal Standard
45 CFR 156.275
45 CFR 155.1045
	• QHP Issuers, excluding SAD Issuers, must maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: Clinical quality measures, such as the HEDIS; Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1] survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs.
	
	• The Partnership will accept existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities. For the purposes of QHP Issuer certification in 2013, these are the National Committee for Quality Assurance (NCQA) and URAC.
	
	  • To verify the accreditation information, QHP Issuers must upload their current and relevant accreditation certificates.
	
	  • QHP Issuers must complete attestations about the accreditation data that will be displayed on the Marketplace website.
	
	  • QHP Issuers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to AID and the Partnership
	
	• QHP Issuers without existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities must schedule an accreditation review during their first year of certification and receive accreditation on QHP Issuer policies and procedures prior to their second year of QHP Issuer certification.
	
	• Prior to the QHP Issuer's fourth year of QHP Issuer certification and in every subsequent year of certification, a QHP Issuer must be accredited in accordance with 45 CFR 156.275.

State Standard	AID will follow the Federal requirements related to accreditation and will require the authorized release of all accreditation data. Additionally, AID will require an attestation by QHP Issuers not already accredited that those QHP Issuers will schedule, become accredited on policies and procedures in the plan types used, and provide proof of such accreditation on policies and procedures prior to submission of any application for recertification. The QHP Issuer must also indicate

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) of HHS.

	that it will receive and provide proof of receipt of full Marketplace accreditation prior to its third recertification application.
Service Area	
Federal Standard 45 CFR 155.30 & 155.70	Service area for the Individual Marketplace is the geographic area in which an individual must reside. Service area may additionally be the geographic area where an individual is employed for the purposes of SHOP. A QHP Issuer must specify what service areas it will be utilizing. The service area must be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations.
State Standard	All QHP Issuers must file a statement of intent by June 3, 2013 indicating what service area(s) they intend to serve in 2014. Service areas will have the same geographic boundaries as rating areas as defined in Appendix C. The state will allow QHP Issuers to choose their service area(s) for year one with a goal of having at least three or more issuers per service area. The Commissioner reserves the right to require broader service areas as needed to achieve the state's coverage requirements of at least two issuers per service area. Any application not meeting this standard requires a justification as to why the QHP should be considered for certification and will be subject to stricter review.
Rating Area	
Federal Standard 45 CFR §156.255	As it applies to QHPs, the ACA defines a "Rating Area" as a geographic area established by a state that provides boundaries by which issuers can adjust premiums. The ACA requires that each state establish one (1) or more rating areas, but no more than nine (9) rating areas, within the State of Arkansas based upon its metropolitan areas for purposes of applying the requirement of this title.
State Standard	AID has approved a configuration of seven (7) rating areas to be utilized in Arkansas. These areas are specifically described in Appendix C.
Quality Improvement Standards	
Federal Standard 45 CFR 156.20 ACA §1311 ACA §2717	A QHP Issuer must implement and report on a quality improvement strategy or strategies consistent with standards of the ACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of: • A payment structure for health care providers that provides incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; • Activities to prevent hospital readmissions through a

	comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional; • Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • Wellness and health promotion activities; and • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
State Standard	AID will require all QHP Issuers to participate and report on the implementation of their quality improvement standards and results no less than quarterly. Any changes to the issuer's quality improvement initiatives must be reported to AID within thirty (30) days. Federal quality criterion is not established and therefore cannot be implemented until a future date. AID will notify issuers during the 2014 plan year as the measures are developed. Until the measures are adopted and implemented, AID intends to use Consumer Assessment of Healthcare Providers and Systems (CAHPS) data results from accredited commercial product lines when the data are available for the same QHP product types and adult/child populations. ***In order to advance quality and affordability, Arkansas will require participation in Arkansas's Payment Improvement Initiative no later than year two of the Marketplace. As part of the participation requirements for Plan Year 2015, Arkansas intends to transition participation in the Arkansas Payment Improvement Initiative by requiring, at a minimum, that QHP Issuers will assign a primary care clinician; provide support for patient-centered medical home; and provide access of clinical performance data for providers. Participation in the Arkansas Payment Improvement Initiative will also include a requirement to contribute claims and encounter data for the purposes of measuring cost, quality and access. Timing and processes related to these requirements are still under development and will be released in a future Bulletin.*** AID intends to establish during plan year 2014 a QHP submission process for 2014 claims and encounter data utilizing the X12 standards (www.X12.org) in eligibility files and medical claims, and the National Council for Prescription Drug Programs Standards in Pharmacy Claims Files. Submission will be implemented no sooner than three months from the end of the plan year (e.g., no sooner than April 2015) to support rate requests, assess network adequacy and support quality and payment improvement.
General Offering Requirements	

Federal Standard 45 CFR 155 and 156 45 USC §18022 45 C.F.R. § 156.130(a) 45 CFR §147.126 45 CFR §147.120 45 CFR §147.138 CMS Guidance Rules IRS Revenue Procedure 2013-25 Letter to Issuers	A QHP Issuer must offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level and a child-only plan at the same level of coverage as any QHP offered through either the individual Marketplace or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. This requirement may also be met by submitting an attestation that there is no substantive difference between having a child-only plan and issuing child only policies, and that the QHP Issuer will accept child only enrollees. QHP Issuers may also choose to offer a bronze or platinum metal level plan. All of the plans must meet the AV requirements as specified in 45 CFR 155 and will be verified by use of the AV Calculator. However, SAD plans may not use the AV Calculator and must demonstrate that the SAD plan offers the pediatric dental EHB at either a low level of coverage with an AV of 70% or a high level of coverage with an AV of 85%, and with a de minis variation of +/-2%. This must be certified by an actuary accredited with the American Academy of Actuaries. Additionally, a catastrophic plan may be filed to be sold on the Marketplace in addition to the tiered metal levels. It should be noted that child-only policies are only available in the individual Marketplace. All offerings by a QHP Issuer, excluding stand alone dental issuers, on a single metal tier must show a meaningful difference between the plans and comply with standards in the best interest of the consumer. Moreover, the QHP, excluding pediatric dental, must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. Pediatric dental and vision is required to cover dependents to age 19. The QHP must cover emergency services with no prior authorization, no limitation to participating or in-network providers. Emergency services must be covered at in-network cost-sharing level. Additionally, QHP Issuers will be required to meet all annual limitation and cost sharing requirements without affecting the AV of the plans within each of the tiers. The QHP Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations. IRS published the high-deductible health plan limit for 2014 on May 6, 2013 stating that the annual limitation on cost sharing for embedded plans in the 2014 plan year will be $6,350 for self-only coverage and $12,700 for family coverage. For small group market plans, Issuers may establish separate out-of-pocket limits for medical and dental coverage as long as the total out-of-pocket limit does not exceed the total QHP limit for high deductible health plans. Moreover, the QHP must contain no lifetime limits on the dollar value of any EHB, including the specific benefits and services covered under the EHB-Benchmark Plan. For plans issued in the small group market, the deductible under the plan shall not exceed either: • $2,000 in the case of a plan covering a single individual; and • $4,000 in the case of any other plan. However, an issuer may propose a higher deductible in order to meet

	the actuarial value of the plan that is proposed.
	
	SAD plans must demonstrate that they have a reasonable annual limitation on cost sharing. For 2014, "reasonable" means any annual limitation on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees. Catastrophic plans can be sold to individuals that have not attained the age of 30 before the beginning of the plan year; or an individual who has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. If offered, Catastrophic Plans are offered only in the individual Marketplace and **not** in the SHOP. Additionally, child-only plans are not required to be offered at the catastrophic level of coverage.
	
	A QHP Issuer must comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates must be based upon the analysis of the plan rating assumptions and rate increase justifications in coordination with AID and timely submitted to the FFE-SHOP if appropriate. It should be noted that no additional age rating may be included in SAD plans for pediatric dental for purposes of completing the QHP application, but SAD Issuers may indicate whether the rate is estimated or guaranteed. If the rate is estimated, the SAD Issuer may later add more age rating factors.
	
	If a QHP Issuer would like to participate in the individual market, the QHP Issuer must also participate in the SHOP if the following requirements are met:
	• The QHP Issuer offers products in the small group market and has at least a 20% market share in the small group market; or
	• The QHP Issuer is part of a holding company that also owns other issuers that participate in the small group market and that have at least a 20% market share of the small group market.
	  • If the QHP Issuer under this example does not currently participate in the small group market, the affiliated QHP Issuer holding at least 20% of the small business market must participate in the SHOP.
	  • If the QHP Issuer under this example does participate in the small group market, the QHP Issuer must participate in SHOP.
	
	If a QHP Issuer offers a QHP in the SHOP, the QHP issuer will not be required to offer a QHP in the individual market.

State Standard	Specific state rate and form filing requirements may be found in Appendix A, attached. To the extent that Arkansas has benefits subject to "mandatory offering" statutes, these benefits, if not already imbedded into the QHP, must be offered by: • Providing a link to a plan brochure that describes the

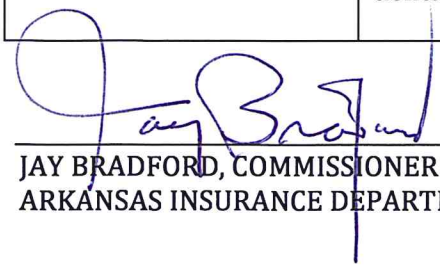
	mandatory offering benefits and how to purchase; and • Including an application and description of mandatory offering benefits in the mailing with the consumer's plan identification card. Information regarding Arkansas mandatory offerings can be found at: http://www.insurance.arkansas.gov/LH/Mandates.html.
Essential Health Benefit Standards	
Federal Standards 45 CFR 156.115 42 U.S.C. § 18022 45 CFR §147.130 45 CFR §148.170 45 CFR §155.170 45 CFR §156.110 45 CFR §156.125	The QHP Issuer must offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan. A QHP Issuer is not required to offer abortion coverage within their benefit plans. The QHP Issuer will determine whether the benefits offered include abortion. If the QHP Issuer chooses to offer abortion benefits, public funds may not be used to pay for these services unless the services are covered as part of the Hyde Amendment exceptions. The QHP Issuer must provide notice through its summary of benefits if such benefit is being made available. The QHP must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention). Additionally, coverage for the medical treatment of mental illness and substance use disorder must be provided under the same terms and conditions as that coverage provided for other illnesses and diseases. Finally, any state mandates in effect as of December 2011 must apply as an EHB in the same way they apply in the current market. These benefits, as with all EHBs, must be offered without annual or lifetime dollar limitations.
State Standards	AID has adopted the Health Advantage Point of Service Plan as the Base Benchmark Plan to set the essential health benefits for Arkansas. AID substituted the mental health benefit with the Federal QualChoice Mental Health Benefit. AID also supplemented the Health Advantage Plan with the AR Kids B (CHIP) pediatric dental and vision plans. Finally, AID has adopted a definition of habilitative services, which may be found in Appendix B to this Bulletin. Additionally, Act 72 of 2013 was adopted which prohibits offering coverage of elective abortions as a part of EHBs on an Exchange established by Arkansas. AID will require an attestation from the QHP Issuer that states the issuer is in compliance with all EHB standards.

Essential Health Benefit Formulary Review	
Federal Standards 45 CFR 156.120 45 CFR §156.295	The QHP must cover at least the greater of one drug in every U.S. Pharmacopeial Convention (USP) category and class or the same number of drugs in each category and class as the base benchmark plan. Issuers must report data such as the following to U.S. DHHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or issuer); percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the issuer; total number of prescriptions that were dispensed; aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.
State Standards	AID will require an attestation of compliance with EHB Formulary Standards. AID will require an attestation that the issuer: (1) provides response by telephone or other telecommunication device within 72 hours of a request for prior authorization, and (2) provides for the dispensing of at least a 72-hour supply of covered drugs in an emergency situation.
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225 45 CFR 155.1045 42 U.S.C. § 300gg-3 45 CFR §148.180	(1) A QHP Issuer must: • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: o Adjusting premiums based on genetic information; o Discriminating with respect to its QHP on the basis of race, color, national origin, disability, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; o Utilizing any preexisting condition exclusions; o Requesting/requiring genetic testing; or o Collecting genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

	(2) A QHP Issuer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs. Outliers in benefit design with regards to QHP cost sharing as part of its QHP certification reviews to target QHPs for more in-depth reviews will be identified.
State Standard	QHP Issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers, including Ark. Code Ann. §23-66-201 et seq., Unfair Trade Practices Act and the requirements defined in Rules 11 and 19. QHP Issuers may inform consumers in QHP marketing materials that the QHP is certified by the Partnership as a QHP. The QHP Issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP. AID will require prior submission of QHP marketing material and an attestation that the QHP Issuer meets all Marketing Standards. Marketing materials must be submitted in PDF format. Any multi-media marketing materials should be provided through a link within a pdf document. AID reserves a right to request a timely upload of the multi-media files for review. If AID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, AID will enforce through use of state remedies up to and including the recommendation of the QHP for decertification.
Actuarial Value Standards	
Federal Standards 45 CFR 156.135	Plans being offered at the various metal tiers within the Marketplace must meet the specified levels of AV (or fall within the allowable variation): Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%) SAD plans must offer plans at either a 70% or 85% AV level.
State Standards	AID will require an attestation of compliance with AV standards.
Quality Rating Standards	
Federal Standard 45 CFR §156.265 (b)(2) 45 CFR §156.265 (f); 45 CFR §156.400 (d) 45 CFR §156.285 (c) PHSA 2794	HHS intends to propose a phased approach to new quality reporting and display requirements for all Marketplaces with reporting requirements related to all QHP Issuers expected to start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP Issuers in all Marketplaces. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements. QHP Issuers must also provide plain language information/data on claims payment policies and practices, periodic financial disclosures,

	data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights must be submitted to the Marketplace, HHS, and the Commissioner.
State Standard	The state will adopt the Quality Rating Standards as provided in federal guidance. Any AID requests for quality information must be made available upon request.
Rate Filing	
Federal Standard	Premiums may be varied by the geographic rating area, but premium rates for the same plan must be the same inside and outside the Marketplace. • Rating will be allowed on a per member basis. For SHOP plans, the geographic premium rating factor will be based on the geographic area of the employer. • ACA: premium rate may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1) All rates filed for individual QHPs will be set for an entire benefit/plan year. For Marketplace plans with an embedded dental benefit, the dental issuer is not allowed to use different geographic area factors and/or network factors than the medical plan geographic and network factors. However, SAD Issuers will be able to make premium adjustments for their SAD plans that are considered excepted benefits upon consumer enrollment, but must indicate that rates are not guaranteed for QHPs offered on the Marketplace. Outlier identification on QHP rates will be conducted to identify rates that are relatively high or low compared to other QHP rates in the same rating area. Identification of a QHP rate as an outlier does not necessarily indicate inappropriate rate development. CMS will notify AID of the results of its outlier identification process. If AID confirms that the rate is justified, CMS expects to certify the QHP if the QHP meets all other standards. QHP Issuers, but not SAD Issuers, are required to submit the Unified Rate Review Template for rate increase.
State Standard	AID will continue to effectuate its rate review program and will review all rate filings and rate increases for prior approval. Rate filing information must be submitted to AID with any rate increase justification prior to the implementation of an increase. A QHP Issuer must prominently post the justification for *any* rate increase on its Web site. AID will limit the use of tobacco use as a rating factor to 1.2:1, applicable only to the individuals in the family that smoke. AID may later issue additional standards related to tobacco cessation.

Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR §155.1030 45 CFR §156.420	The QHP Issuer must offer three silver plan variations for each silver QHP, one zero cost sharing plan variation, and one limited cost sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing must be eliminated for the zero cost sharing plan variation. Cost sharing for certain services must be eliminated for the limited cost sharing plan variation. SAD plans are excluded from cost-sharing reduction (CSR) requirements. However, SAD plans must have a "reasonable" annual limit on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees. This will be completed via rate and benefit templates.
State Standard	AID will require an attestation of compliance with Plan Variation Standards. In support of the Private Option, AID will require that all QHP Issuers' High-Value Silver Plan variations (94% +/- 1% AV) conform to prescribed cost sharing amounts as defined by AID in Appendix D.
Stand Alone Dental Plans	
Federal Standard 45 CFR 155 and 156 45 C.F.R. § 155.1065 PHS Act section 2791 45 C.F.R. § 146.145(c) 45 C.F.R. § 156.440(b)	SAD Issuers and SAD plans must meet the same QHP certification standards as medical plans unless exceptions were noted in the above sections. Additionally, SAD plans are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. Moreover, SAD plans may impose up to a 24 month waiting period for orthodontia services. SAD plans intended to be utilized outside the Marketplace only for use to supplement medical plans such that the medical plans will comply with federal requirement of offering all 10 EHBs outside the Marketplace as required under the Public Health Services Act must follow the Marketplace certification filing process as described within this Bulletin.
State Standard	There are no additional state standards for SAD plans. SAD plans must comply with the AR EHB benchmark plan: AR Kids B (CHIP) pediatric dental.



JAY BRADFORD, COMMISSIONER
ARKANSAS INSURANCE DEPARTMENT

June, 25 2013
DATE

APPENDIX A

✓	Category	Statute Section
	QHP Issuer Application Receipt	
☐	Marketplace application data is complete	
☐	Received Final QHP Issuer Application Submission Attestations, including: • Service Area Attestation • Rating Areas Attestation • Network Adequacy • Actuarial Value • Plan Variation Standards • Marketing Regulations and Transparency • Market Reform Rules • Licensure and solvency • Compliance with Essential Health Benefits • Accreditation • Child Only policy equivalence (if applicable) • AHIP EHB Formulary Compliance • AHIP Pharmacy Prior Authorization	
	Evaluation of QHP Issuer Application	
	Accreditation and Quality Standards	*45 CFR 156.275*
☐	Applicant has *Marketplace* accreditation through NCQA and/or URAC, or: **Year 1-** Applicant has applied for *Marketplace* accreditation through NCQA and/or URAC **Year 2-** Issuer procedures and policies are accredited	
☐	Attestations and supporting documentation are accurate and complete or accreditation is verified in SERFF	
☐	Issuer has authorized release of accreditation data	*State Partnership Guidance 1/2013*
	Complaint and Compliance	
☐	Requested complaint and compliance information (from consumer services division) received and reviewed	
	Cost-Sharing Reductions	*42 CFR 18022(c); 45 CFR 156.130(a); PPACA Section 1302(c) 45 CFR §155.1030 45 CFR §156.420*
☐	Three silver plan cost-sharing variations are submitted for each silver-level QHP.	*PPACA 1402(a)-(c)*
☐	High-Value Silver Plan Variation (94% +/- 1% actuarial value) meets AHIP requirements.	
☐	SAD plans must have a "reasonable" annual limit on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees.	

☐	For each QHP at each level of coverage issuer must submit to the Exchange for certification the health plan and two variations of the health plan: • No Cost Sharing Plan for individuals eligible for cost- sharing reductions under § 155.350(a) • Limited Cost Sharing Plan for individuals eligible for cost- sharing reductions under § 155.350(b)	*PPACA 1402(d)*
☐	Cost-sharing incurred under plan do not exceed the dollar amount limits established by federal and state laws and regulations ($6,350 for self-only coverage and $12,700 for family coverage in plan year 2014).	
	Benefit Design	*45 CFR 156.225; 42 USC 18022*
☐	**Actuarial Value** *Issuer has separately offered at least one QHP at each of the following Actuarial Values:* *Gold: 80% (78 to 82%)* *Silver: 70% (68 to 72%)*	45 CFR 156.200
☐	*Child-Only* Plans are offered at each level of coverage (submitted as separate plans or confirmed by issuer attestation that there is no substantive difference between having a child-only plan and issuing child only policies, and that the QHP Issuer will accept child only enrollees. Catastrophic plans are excluded from this requirement.	PPACA 1302(f)
☐	Actuarial Memorandum and Certification Received	
☐	*Verify that plan is substantially equal to benchmark plan*	
☐	*If the issuer is substituting benefits, confirm that the issuer has demonstrated actuarial equivalence of substituted benefits*	*45 CFR 156.115*
☐	*Compliance with premium rating factors including:* *Self-only or family enrollment,* *geographic rating areas (7 areas)* *Age (3:1 for adults)* *Tobacco use (1.2:1)*	*PPACA 1201 SEC. 2701(a)* *PHSA 2701*
☐	*Justification information received for rate increase, if applicable*	
☐	Confirm Benefit Substitution A/V	
☐	**Confirm Actuarial Metal Level Submitted** *Bronze (60%)* *Silver (70%)* *Gold (80%)* *Platinum (90%)* *Catastrophic (<58%)* *(Allowable variance: +/- 2%)* *For Stand Alone Dental:* *Low (70%)* *High (85)* *(Allowable variance +/- 2%)*	
☐	**Meaningful Difference** Compare all plans an issuer offers to identify multiple, identical plans that are offered in the same counties or have limited variation between deductible and out-of-pocket maximum.	
☐	Inclusion of all 10 Essential Health Benefits that meet or exceed benchmark plan, including:	
☐	***Ambulatory patient services***	

	Primary care physician visits *Specialist office visit* *Services and procedures provided in the Specialist office other than consultation and evaluation* *Outpatient Services* *Surgical Services - Outpatient* *Ambulatory Surgical Center Services* *Outpatient Diagnostics* *Advanced Diagnostic Imaging, subject to prior auth* *Outpatient Physical Therapy* *Outpatient Occupational Therapy* *Home Health* *Hospice Care for individuals with life expectancy of less than 6 months* *Qualified Assistant Surgeon Services*	
☐	***Emergency services*** *Emergency Care Services* *After-hours clinic or urgent care center* *Observation services* *Transfer to in-network hospital* *Ambulance Services*	
☐	***Hospitalization*** *Hospital Services* *Physician Hospital Visits* *Inpatient Services* *Hospital services in connection with Dental Treatment* *Surgical Services - Inpatient* *Inpatient Physical Therapy* *Inpatient Occupational Therapy* *Skilled Nursing Facility Services* *Organ Transplant Services*	
☐	***Maternity and newborn care*** *Certified nurse midwives* *Newborn care in the hospital* *In vitro fertilization for PPO plans* *Genetic testing to determine presence of existing anomaly or disease* *Prenatal and Newborn Testing* *Maternity and Obstetrics, including pre and post natal care*	*§23-79-129 & Bulletin 1-84*
☐	***Mental health and substance use disorders, including behavioral health treatment*** *Professional Services(by licensed practitioners acting within the scope of their license)* *Diagnostics* *Inpatient hospital or other covered facility* *Outpatient hospital or other covered facility*	
☐	***Prescription drugs*** *Prescription Drugs:* *Plan covers at least the greater of: (1) One drug in every category and class; or (2) the same number of drugs in each category and class as the EHB-benchmark plan* *Includes barbiturates, benzodiazepines, and agents used to promote smoking cessation,*	

	including agents approved by the Food and Drug Administration as over-the-counter drugs for the purposes of promoting tobacco cessation.	
☐	***Rehabilitative and habilitative services and devices*** *Physical, Occupational, and Speech Therapies* *Developmental services* *Durable Medical Equipment* *Prosthetic and Orthotic Devices* *Cochlear and other implantable devices for hearing, but not hearing aids* *Medical supplies*	
☐	***Laboratory services*** *Testing and Evaluation*	
☐	***Preventive and wellness services and chronic disease management*** *Case Management Communications made by PCP* *Preventive Health Services* *Routine immunizations* *US Preventive Services Task Force A or B rated benefits*	
☐	***Pediatric Dental (if applicable)*** *Consultations* *Radiographs* *Children's Preventive Services* *Space maintainers* *Restorations* *Crowns* *Endodontia* *Peridontal Procedures* *Removable prosthetic services* *Oral Surgery* *Professional visits* *Hospital Services* *Oral Surgery* *Childhood development testing* *Dental Anesthesia* *Medically-Necessary Orthodontia*	
☐	***Pediatric Vision*** *Eye Exam* *Surgical evaluation* *Eyeglasses – one pair per year* *Lenses* *Medically-Necessary Contact lenses* *Eye prosthesis*	

	Polishing services Vision Therapy Developmental Testing	
☐	**Miscellaneous** *Complications from Smallpox vaccine*	
☐	***State Mandated Benefits***	
	Autism Spectrum Disorders	*23-99-418*
	Breast Reconstruction/Mastectomy	*23-99-405*
	Children's Preventive Health Care	*23-79-141 et al. & Rule 45*
	Colorectal Cancer Screening	*23-79-1201 et al*
	Dental Anesthesia	*23-86-121*
	Diabetic Supplies/Education	*23-79-601 et al & Rule 70*
	Diabetes Management Services	
	Equity in Prescription Insurance & Contraceptive Coverage	*23-79-1101 et al*
	Formula PKU/Medical Foods & Low Protein Modified Food	*23-79-701 et al*
	Medical Foods and Low Protein Modified Foods	
	Gastric Pacemakers	*23-99-419*
	In-Vitro Fertilization (insurance companies only)	*23-85-137, 23-86-118 & Rule 1*
	Loss or Impairment of Speech or Hearing	*23-79-130*
	Maternity & Newborn Coverage	*23-99-404; 23-79-129*
	Mental Health parity	*23-99-501 et al*
	Off-Label Drug Use	*23-79-147*
	Prostate Cancer Screening	*23-79-1301*
	Orthotic & Prosthetic Devices or Services	*23-99-417*
☐	**Mandated Persons Covered, including:**	
☐	*Adopted Children*	
☐	*Handicapped Dependents*	
☐	**Mandated Providers** *Ambulatory Surgery Center, Audiologists, Chiropractors, Dentists, Emergency Services, Nurse Anesthetists, Optometrists, Podiatrists, Psychologists, Physician Assistant*	
☐	**Mandated Benefit Offerings** Mandatory benefit offerings not in the benchmark plan (including hearing aids and TMJ) are included in the QHP, OR issuer demonstrates that they will be offered through URL to brochure that describes the mandatory offering benefits and how to purchase or mailed with an application and description of mandatory benefit offerings with the consumer's plan identification card.	
☐	**Elective Abortion** Coverage of Elective Abortion is prohibited	Act 72 of 2013
	Discriminatory benefit design	*PPACA §1311(c)(1)(A); PPACA §1302(b)(4)(B)*
☐	Plan does not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health care needs	*PPACA §1311(c)(1)(A)*

☐	Benefits not designed in a way that discriminates against individuals because of age, disability, or expected length of life	*PPACA §1302(b)(4)(B)*
☐	Completed form filings for certification that submission meets provisions of the Unfair Sex Discrimination rule in Sale of Insurance (New or revised filings must contain this certification)	*AID Rule and Regulation 19, Ark Code Ann. 23-66-201*
	Pre-existing conditions	*42 USC 300gg-3*
☐	Plan must contain no preexisting condition exclusions	
	State licensure, solvency, and good standing	*45 CFR 156.200(b)(4)*
☐	Issuer properly licensed	
☐	Company financially solvent and in good standing	
	Marketing Standards	*45 CFR 156.220*
☐	Meets marketing standards as described in any applicable State Laws	*45 CFR 156.225 Ark. Rule 19 and 11; Ark. Code Ann §23-66-201 et seq.*
☐	Meets requirement for transparency of coverage with attestation to include: Cost-sharing data is published on Internet Web Site Reporting requirements as listed in 45 CFR 156.22	*45 CFR 156.220*
☐	Complies with Arkansas Discriminatory Benefit Design Regulations	*Ark. Code Ann. § 23-66-201 et seq.;23-86-314;23-98-106;Ark. Rule 19; Ark. Rule 28; Ark. Rule 42; Attorney General Opinion 2004-274; Directive 2-2005*
☐	Received Attestation of compliance with marketing/discriminatory benefit design regulations	
	Market Reform Rules	*PHS 2701; PHS 2702; PHS 2703; PPACA 1302(e); PPACA 1312(c);PPACA 1402; 42 CFR 156; 42 CFR 147*
☐	QHP compliance with market reform rules in accordance with state and federal requirements	
☐	Received QHP Market Reform Attestation of QHP compliance with market reform rules in accordance with state and federal requirements.	
☐	Guaranteed Availability of Coverage	*45 CFR § 147.104*
☐	Guaranteed Renewability of Coverage	*45 CFR §*

		147.106
☐	Single Risk Pool	*45 CFR § 156.80*
☐	Catastrophic Plan Requirements, including but not limited to: • Provides coverage for at least three primary care visits per year before the deductible is met. • No annual limits on the dollar value of EHBs; • Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance; • Plan is offered only in individual market, not in SHOP; • Coverage for emergency services required; and • Does not provide a bronze, silver, gold, or platinum level of coverage.	*45 CFR § 156.155*
	Network Adequacy	*45 CFR 156.230; 45 CFR 156.235; PHS SEC.2702(c) ; PPACA 156.230*
☐	Submission of provider-enrollee ratios for each QHP network	*45 CFR 156.230*
☐	Submission of time/distance measures for each QHP network	*45 CFR 156.230*
☐	Essential community providers listed	*45 CFR 156.235*
☐	Accredited policies and procedures that includes network adequacy	*PHS SEC.2702(c)*
☐	Evaluation of issuer's network OR Attestation detailing issuer's ability to meet network adequacy standards including company policy for ensuring an adequate network	*State Partnership Guidance 1/2013*
☐	Provider directory is available for online publication with indication of providers no longer accepting new patients	*PPACA 156.230*
☐	Provider directory available to individuals in English and Spanish	*PPACA 156.230*
	Rating Areas and Actuarial Value	
☐	Rate-setting practices are consistent with the approved metrics	*PHS SEC.2701(a)*
☐	Attestation of compliance with state rating areas (7 rating areas)	*PHS SEC.2701(b)*
	Service Areas	
☐	QHP service area covers at least one geographic rating area, OR issuer has submitted a hardship waiver that is approved by the Commissioner.	*PPACA 155.1055(a)*
☐	Evaluate that QHP service area is established without regard to racial, ethnic, language, health status related factors, or other specified factors	*PPACA 155.1055(b);* PHS Act 2705
	Receive Rate and Benefit Data and Information	
☐	Plan data and supporting documentation complete	
☐	Issuer submission of data completed before end of open enrollment period	
☐	QHP rate and benefit data and information approved	
	QHP Certification Agreement	
☐	Issuer application and plan data approved	
☐	Submit issuer and plan data to CMS	

☐	CMS Certification Received	
	Issuer or Plan Non Certification	
☐	Notify issuer of non-certification of QHP(s) or Issuer	
☐	Update QHP(s) and Issuer Account Information	

APPENDIX B

DEFINITION OF HABILITATIVE SERVICES

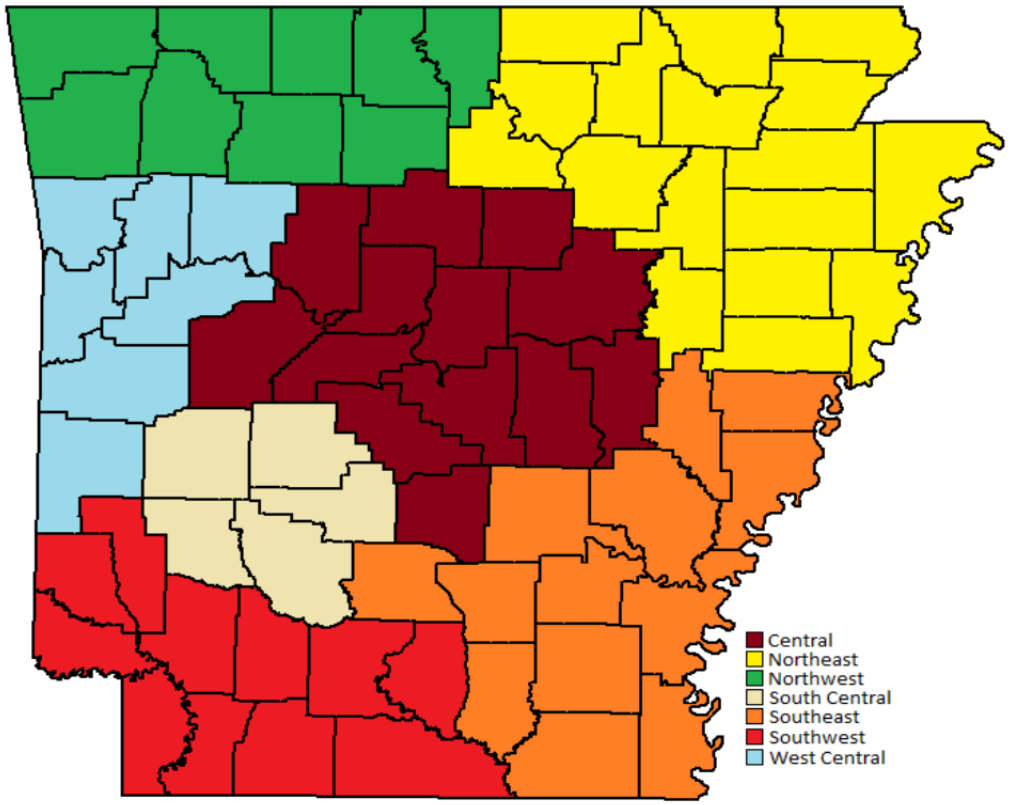
Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

COVERAGE OF HABILITATIVE SERVICES

Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

APPENDIX C

STATE RATING AND SERVICE AREAS



Arkansas Counties by Region

Region				
Central Rating Area 1	Cleburne Lonoke Pulaski Yell	Conway Perry Saline	Faulkner Pope Van Buren	Grant Prairie White
Northeast Rating Area 2	Clay Fulton Jackson Randolph Woodruff	Craighead Greene Lawrence Sharp	Crittenden Independence Mississippi St. Francis	Cross Izard Poinsett Stone
Northwest Rating Area 3	Baxter Madison Washington	Benton Marion	Boone Newton	Carroll Searcy
South Central Rating Area 4	Clark Pike	Garland	Hot Spring	Montgomery
Southeast Rating Area 5	Arkansas Cleveland Jefferson Phillips	Ashley Dallas Lee	Bradley Desha Lincoln	Chicot Drew Monroe
Southwest Rating Area 6	Calhoun Lafayette Ouachita	Columbia Little River Sevier	Hempstead Miller Union	Howard Nevada
West Central Rating Area 7	Crawford Scott Polk	Franklin Sebastian	Johnson	Logan

APPENDIX D

HIGH LEVEL SILVER PLAN COST SHARING VARIATION REQUIREMENT

High-Value Silver Plan
100% FPL - 150% FPL

Overall Deductible:	$150
Service Specific Deductibles:	
Medical	$0
Brand Drugs	$0
Dental	$0
Member Out-of-Pocket Max (all services combined):	$754

General Service Description	Subject to Deductible	Unit of Service	Copays	Coinsurance
Behavioral Health - IP	Yes	Day	$ 140	100%
Behavioral Health - OP	No	Visit	$ 4	100%
Behavioral Health - Professional	No	Visit	$ 4	100%
Durable Medical Equipment	No	Service	$ 4	100%
Emergency Room Services	No	Visit	$ 20	100%
FQHC	No	Visit	$ 8	100%
Inpatient	Yes	Day	$ 140	100%
Lab and Radiology	No	Visit	$ -	100%
Skilled Nursing Facility	Yes	Day	$ 20	100%
Other	No	Visit	$ 4	100%
Other Medical Professionals	No	Visit	$ 4	100%
Outpatient Facility	Yes	Visit	$ -	91%
Primary Care Physician	No	Visit	$ 8	100%
Specialty Physician	No	Visit	$ 10	100%
Pharmacy - Generics	No	Prescription	$ 4	100%
Pharmacy - Preferred Brand Drugs	No	Prescription	$ 4	100%
Pharmacy - Non-Preferred Brand Drugs	No	Prescription	$ 8	100%
Pharmacy - Specialty Drugs (i.e. high-cost)	No	Prescription	$ 8	100%

APPENDIX E

SUMMARY OF CHANGES FROM FEBRUARY 19, 2013 RELEASE

- "Exchange" was changed to "Marketplace" throughout.
- Page 1, A Letter of Intent to cover specific service areas to the Commissioner must be submitted by June 1.
- Page 2-3, Information was added related to the Health Care Independence Program, including the requirement to submit a letter of intent to AID by June 1, 2013 describing the QHP Issuer's intended service areas.
- Page 3-4, General Requirements: Lines numbered 16 and 17 were added to be in compliance with the recently released federal rule.
- Page 4, General Requirements/State Standards: Additional information related to the high value silver plan variations was added. Clarifications to requirements for SAD Issuers and Plans were included.
- Page 7, Network Adequacy/State Standards: A link to the ECP lists was included, as well as information clarifying how the standard would be measured.
- Page 7, Accreditation: Additional information was added related to SAD and clarifying what accreditation information must be submitted.
- Page 8, Service Area: Updated service area requirements.
- Page 8, Rating Areas: The federal definition of rating areas was updated to be in compliance with the recently released federal rule.
- Page 9, Quality Improvement Standards: Requirements to participate n the Arkansas Payment Improvement Initiative and reporting requirements were added.
- Page 10, General Offering Requirement: Information related to requirements for SHOP, child-only plans, mandatory benefit offerings, and high deductible health plan limits, SAD plan rating limitations were all added.
- Page 13, Essential Health Benefit Standards/State Standards: Notification of requirement to provide medically necessary orthodontia and prohibition to offer coverage of elective abortion as an EHB.
- Page 14, Essential Health Benefit Formulary Review: Requirement to provide at least a 72 hour supply of drugs in emergency situations, as well as the requirement to cover additional pharmaceuticals.
- Page 14-15, Nondiscrimination Standards in Marketing and Benefit Design: Marketing must be submitted to AID before it may be used. The original bulletin stated that all

marketing must be prior approved. CMS has since clarified its position that all marketing is not required to be prior approved, but that a state must at a minimum provide for spot checking marketing material. This new standard will allow for the state to be able to maintain compliance with that standard while giving more flexibility to the QHP issuers. Additionally, information related to outlier benefit review was included.

- Page 16, Rate Filing: Information added related to SAD Issuer/Plan rating requirements, outlier analysis Unified Rate Review Template and SHOP rating requirements.
- Page 17, Plan Variation for Individuals Eligible for Cost Sharing: Added information related to SAD Issuers/Plans and requirements for the high level silver plan variation.
- Page 18, Stand Alone Dental Plans: New section related to SAD Issuer/Plan requirements.
- Page 18, Appendix A: Checklist updated to match new information as included above.
- Page 37, Appendix C: Added rating area numbers to match federal templates and updated name to indicate that this is indicative of both rating and service areas.
- Page 38, Appendix D: Added High Level Silver Plan Cost Sharing Variation requirements.

SUMMARY OF CHANGES FROM JUNE 25, 2013 RELEASE

- The State Standard section under Quality Improvement standards was updated to show requirements related to the Arkansas Payment Improvement Initiative.
- Appendix D was updated with new information.