DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 31 2014

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

Dear Mr. Selig:

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

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

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

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

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

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

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

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

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

Sincerely,

Marilyn Tavenner

Enclosures

cc: Bill Brooks, ARA, Region VI

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

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

TITLE: **Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration**

AWARDEE: **Arkansas Department of Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from September 27, 2013 through December 31, 2016. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted subject to the STCs.

1. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Private Option beneficiary's Qualified Health Plan. No waiver of freedom of choice is authorized for family planning providers.

2. **Payment to Providers** **Section1902(a)(13) and Section 1902(a)(30)**

   To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan providing primary coverage for services under the Private Option.

3. **Prior Authorization** **Section 1902(a)(54) insofar as it incorporates Section 1927(d)(5)**

   To permit Arkansas to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours as is currently required in their state policy. A 72-hour supply of the requested medication will be provided in the event of an emergency.

4. **Independence Account Contributions** **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable the state to collect monthly contributions for individuals with incomes between 50 and 133 percent of the federal poverty level (FPL).

5. Comparability **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act.

To the extent necessary to enable the state to impose targeted cost-sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act who are not current with their Independence Account payments.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: **Arkansas Health Care Independence Program (Private Option) Section 1115 Demonstration**

AWARDEE: **Arkansas Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditure under section 1903 shall, for the period of this demonstration be regarded as expenditures under the state's Title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the Arkansas Health Care Independence Program (Private Option) Section1115 demonstration.

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

Requirements Not Applicable to the Expenditure Authority:

1. **Cost Effectiveness** **Section 1902(a)(4) and 42 CFR 435.1015(a)(4)**

   To the extent necessary to permit the state to offer premium assistance and cost sharing reduction payments that are determined to be cost effective using state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00287/6

TITLE: Arkansas Health Care Independence Program (Private Option)

AWARDEE: Arkansas Department of Human Services

I. PREFACE

The following are the amended Special Terms and Conditions (STCs) for the Arkansas Health Care Independence Program (Private Option) section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable Arkansas (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The amended STCs are effective on the date of the signed approval. Enrollment activities for the new adult population began on October 1, 2013 for the Private Option qualified health plan (QHP) with eligibility effective January 1, 2014. Contributions to Independence Accounts (IA) for certain demonstration populations will begin in accordance with the timeframes established in the operational protocols approved by CMS. Enrollment into the demonstration will be statewide and is approved through December 31, 2016.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Populations Affected
V. Private Option Premium Assistance Enrollment
VI. Premium Assistance Delivery System
VII. Benefits
VIII. Cost Sharing
IX. Appeals
X. General Reporting Requirements
XI. General Financial Requirements
XII. Monitoring Budget Neutrality
XIII. Evaluation
XIV. Monitoring
XV. Health Information Technology and Premium Assistance
XVII. T-MSIS

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Private Option demonstration, the state has been providing premium assistance to support the purchase by beneficiaries eligible under the new adult group under the state plan of coverage from QHPs offered in the individual market through the Marketplace. In Arkansas, individuals eligible for coverage under the new adult group are both (1) childless adults ages 19 through 64 with incomes at or below 133 percent of the federal poverty limit (FPL) or (2) parents and other caretakers ages 19 through 64 with incomes between 17 percent and at or below 133 percent of the FPL (collectively Private Option beneficiaries). Arkansas expected approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.

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

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

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

Private Option beneficiaries will receive the state plan Alternative Benefit Plan (ABP). Services will be delivered primarily through the service delivery network of the QHP that they select and, and the QHP will be the primary payer for such services. Beneficiaries will have cost sharing obligations consistent with the state plan.

With this demonstration Arkansas proposes to further the objectives of Title XIX by:

- Promoting continuity of coverage for individuals,
- Improving access to providers,
- Smoothing the "seams" across the continuum of coverage, and
- Furthering quality improvement and delivery system reform initiatives.

Arkansas proposes that the demonstration will provide integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Private Option beneficiaries. The state proposes that the demonstration will also drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace by doubling the size of the population enrolling in QHPs offered through the Marketplace.

The state proposes to demonstrate following key features:

Continuity of coverage and care – For households with members eligible for coverage under Title XIX and Marketplace coverage as well as those who have income fluctuations that cause their eligibility to change year-to-year, or multiple times throughout the year, the demonstration will create continuity of health plans available for selection as well as provider networks. Households may stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, or Advanced Payment Tax Credits/Cost Sharing Reductions (APTC/CSRs). IAs will also be established for individuals with income from 50–133 percent FPL to help smooth the transition out of the Private Option and into private market plans or Medicare. For those who start at a very low income and progress to higher income levels, IAs can provide a consistent approach to the financing and receipt of health care services.

Support equalization of provider reimbursement and improve provider access – The demonstration will support equalization of provider reimbursement across payers, toward the end of expanding provider access and eliminating the need for providers to cross-subsidize. Arkansas Medicaid provides rates of reimbursement lower than Medicare or commercial payers, causing some providers to forego participation in the program and others to "cross subsidize" their Medicaid patients by charging more to private insurers.

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

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** If the eligibility of a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.
    a. Should the state amend the state plan to make any changes to eligibility for this population, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request a corresponding technical correction to the demonstration.

6. **Changes Subject to the Amendment Process.** Changes related to demonstration features including eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other

comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan and/or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
    a. An explanation of the public process used by the State, consistent with the requirements of STC 15, prior to submission of the requested amendment;
    b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
    c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
    d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
    e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the governor or chief executive officer of the State must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 9.
    a. Compliance with Transparency Requirements at 42 CFR §431.412.
    b. As part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.

9. **Demonstration Phase Out.** The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The State must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the State must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation state plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into the revised plan.
b. The State must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.
c. Transition and Phase-out Plan Requirements: The State must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.
d. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210, and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Section 431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR Section 435.916.
e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).
f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can either use its Medical Care

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

11. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.

12. **Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the State must submit a transition plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:
    a. Expiration Requirements. The State must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
    b. Expiration Procedures. The State must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration enrollees as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration enrollee requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR Section 431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
    c. Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the State's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the State's demonstration expiration plan. The State must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
    d. Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling enrollees.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives

of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.

14. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the State's approved state plan, when any program changes to the demonstration are proposed by the State.
    a. In States with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
    b. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section431.408(b)(3)).
    c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

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

IV. POPULATIONS AFFECTED

The State will use this demonstration to ensure coverage for Private Option eligible beneficiaries provided primarily through QHPs offered in the individual market instead of the fee-for-service delivery system that serves the traditional Medicaid population. The State will provide premium assistance to aid individuals in enrolling in coverage through QHPs in the Marketplace for Private Option beneficiaries and establish IAs to address cost sharing requirements and assist in the transition to private insurance or Medicare coverage.

17. **Populations Affected by the Arkansas Health Care Independence (Private Option) Demonstration.** Except as described in STCs 18 and 19, the Arkansas Health Care Independence (Private Option) Demonstration affects the delivery of benefits, as set forth in section 1905(y)(2)(B) of the Act and codified at 42 CFR Section 433.204(a)(2), to adults aged 19 through 64 eligible under the state plan under 1902(a)(10)(A)(i)(VIII) of the Act, 42 CFR Section 435.119. Eligibility and coverage for these individuals is subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid state plan amendments to this eligibility group, including the conversion to a modified adjusted gross income standard on January 1, 2014, will apply to this demonstration.

Table 1 Eligibility Groups

Medicaid State Plan Mandatory Groups	Federal Poverty Level	Funding Stream	Expenditure and Eligibility Group Reporting
New Adult Group	This group includes both the parent and caretakers as well as the childless adults up to 133 percent of the FPL	Title XIX	MEG – 1

18. **Medically Frail Individuals**. Arkansas will institute a process to determine whether an individual is medically frail. The process will be described in the Alternative Benefit state plan. Medically frail individuals will be excluded from the demonstration.
    a. Medically frail individuals will not be subject to cost sharing under the terms of this demonstration, will not have Independence Accounts available and will not be subject to Independence Account requirements or benefits.
    b. The term "medically frail" is inclusive of both individuals who meet the medically frail definition in 42 CFR 440.315(f) and individuals who have exceptional medical needs as determined through the Arkansas health care needs questionnaire.
    c. Individuals excluded from enrolling in QHPs through the Private Option as a result of a determination of medical frailty as that term is defined above will have the option of receiving direct coverage through the state of either the same ABP offered to the new adult group or an ABP that includes all benefits otherwise available under the approved Medicaid state plan (the standard Medicaid benefit package). Direct coverage will be provided through a fee- for-service (FFS) system.

19. **American Indian/Alaska Native Individuals.** Individuals identified as American Indian

or Alaskan Native (AI/AN) will not be required to enroll in QHPs in this demonstration, but can choose to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. AI/AN individuals who elect to participate in the demonstration will not be assigned an IA, instead they will be enrolled in the plan they select and will receive cost sharing protections. Individuals who are AI/AN and who have not opted into the Private Option will receive the ABP available to the new adult group and operated through a fee for service (FFS) system. An AI/AN individual will be able to access covered benefits through Indian Health Service (IHS), Tribal or Urban Indian Organization (collectively, I/T/U) facilities funded through the IHS. Under the Indian Health Care Improvement Act (IHCIA), I/T/U facilities are entitled to payment notwithstanding network restrictions.

V. PRIVATE OPTION PREMIUM ASSISTANCE ENROLLMENT

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

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

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

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

c. Access to Services until QHP Enrollment is Effective. The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.

d. Wrapped Benefits. The notice will also include information on how beneficiaries can use the CIN number to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 37.

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

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

22. **QHP Selection.** The QHP in which Private Option beneficiaries will enroll will be certified through the Arkansas Insurance Department's QHP certification process. The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.

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

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

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

24. Auto-assignment. In the event that an individual is determined eligible for coverage through the Private Option, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's county. Individuals who are auto-assigned will be notified of their assignment, and the effective date of QHP enrollment, and will be given a thirty-day period from the date of enrollment to request enrollment in another plan.

25. Distribution of Members Auto-assigned. In demonstration year one (DY1), Private Option auto-assignments will be distributed among QHP issuers in good standing with the Arkansas Insurance Department offering certified silver-level QHPs certified by the Arkansas Insurance Department with the aim of achieving a target minimum market share of Private Option enrollees for each QHP issuer in a rating region. Specifically, the target minimum market share for a QHP issuer offering silver QHP in a rating region will vary based on the number of competing QHP issuers as follows:

Two QHP issuers: 33 percent of Private Option enrollees in that region.
Three QHP issuers: 25 percent of Private Option enrollees in that region.
Four QHP issuers: 20 percent of Private Option enrollees in that region.
More than four QHP issuers: 10 percent of Private Option enrollees in that region.

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

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

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

28. Memorandum of Understanding. The Arkansas Department of Human Services and the Arkansas Insurance Department have entered into a memorandum of understanding (MOU) with each QHP that will enroll individuals covered under the Demonstration. Areas to be

addressed in the MOU include, but are not limited to:

a. Enrollment of individuals in populations covered by the Demonstration;
b. Payment of premiums and cost-sharing reductions;
c. Reporting and data requirements necessary to monitor and evaluate the Private Option including those referenced in STC 71, ensuring enrollee access to EPSDT and other covered benefits through the QHP;
d. Noticing requirements; and, Audit rights.

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

30. Choice. Each Private Option beneficiary will have the option to choose between at least two silver plans covering only Essential Health Benefits that are offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums.

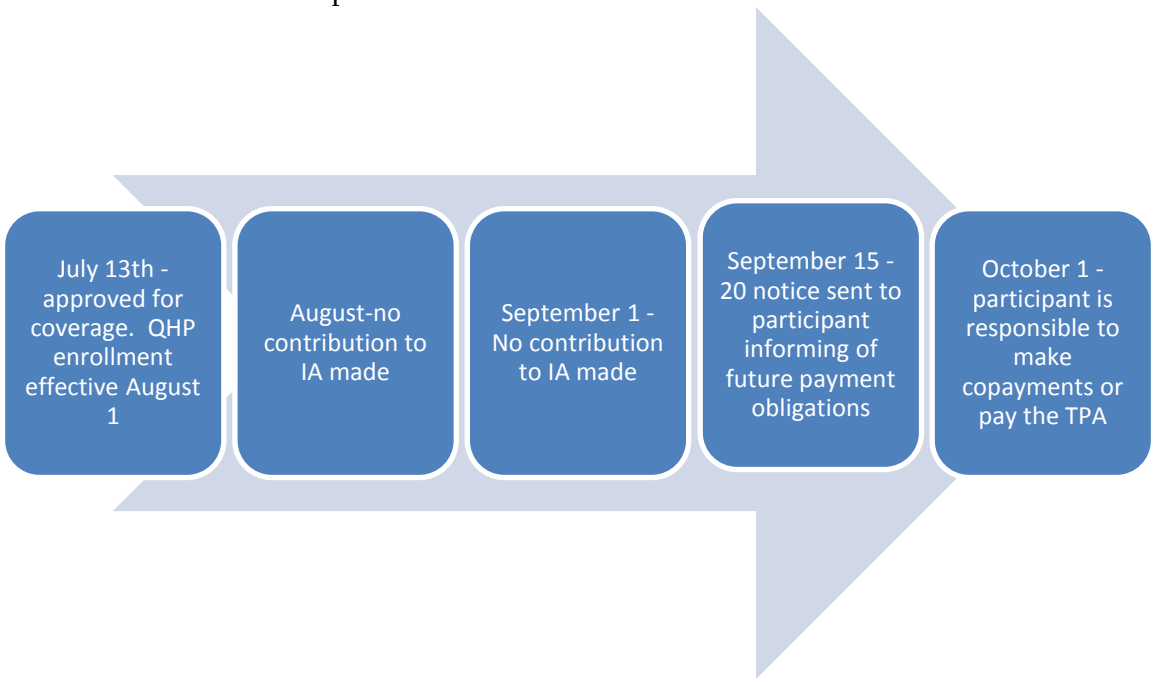
a. Private Option beneficiaries will be able to choose from at least two silver plans covering only Essential Health Benefits that are in each rating area of the State
b. Private Option beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area, and thus all Private Option beneficiaries will have a choice of at least two qualified health plans.
c. The State will comply with Essential Community Provider network requirements, as part of the Qualified Health Plan certification process.
d. Private Option beneficiaries will have access to the same networks as other individuals enrolling in silver level QHPs through the individual Marketplace.

31. Coverage Prior to Enrollment in a QHP. The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for the New Adult Group until the individual's enrollment in the QHP becomes effective.

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

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

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



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

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

VII. BENEFITS

34. **Arkansas Health Care Independence Program (Private Option) Benefits.** Individuals affected by this demonstration will receive benefits as set forth in section 1905(y)(2)(B) of the Act and codified at 42 CFR Section 433.204(a)(2). These benefits are described in the Medicaid state plan.

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

36. **Medicaid Wrap Benefits.** The State will provide through its fee-for-service system wrap-around benefits that are required for the ABP but not covered by qualified health plans. These benefits include non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the

demonstration who are under age 21**.**

37. **Access to Wrap Around Benefits.** In addition to receiving an insurance card from the applicable QHP issuer, Private Option beneficiaries will have a Medicaid CIN through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN will include information about which services Private Option beneficiaries may receive through fee-for-service Medicaid and how to access those services. This information will also be posted on Arkansas Department of Human Service's Medicaid website and be provided through information at the Department of Human Service's call centers and through QHP issuers.

38. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The State must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

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

40. **Access to Non-Emergency Medical Transportation.** For individuals in the eligibility group established under Section 1902(a)(10)(A)(i)(VIII), the State will establish prior authorization for NEMT in the ABP, with the exception of the AI/AN and medically frail individuals.

VIII. COST SHARING

41. **Cost sharing.** Cost sharing for Private Option enrollees must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR Section 447(b).

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

43. **Payment Process for Payment of Cost Sharing Reduction to QHPs.** Agreements with QHP issuers may provide for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost sharing for Private Option beneficiaries.

Such payments will be subject to reconciliation at the conclusion of the benefit year based on actual expenditures by the QHP for cost sharing reduction. If a QHP issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the QHP issuer will be entitled to during reconciliation, the QHP issuer may ask Arkansas' Department of Human Services to adjust the advance payments. Arkansas' reconciliation process will follow 45 CFR Section 156.430 to the extent applicable.

IX. CONTRIBUTIONS TO ARKANSAS INDEPENDENCE ACCOUNTS

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

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

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

Table 2 Contribution Amounts

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

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

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

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

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

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

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

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

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

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

a. No individual may lose eligibility for Medicaid, be denied eligibility for Medicaid, or be denied enrollment in a Private Option health plan for failure to pay cost sharing liabilities.

b. Beneficiaries between 50 percent FPL and 100 percent FPL who do not make monthly contributions to their IAs will be billed only for copayment amounts as specified in the state plan amendment to be submitted by the State. Beneficiaries between 50 percent FPL and 100 percent FPL may not be denied access to services for failure to make contributions into their IA or failure to pay copayment or coinsurance liabilities.

c. Only individuals with incomes greater than 100 percent FPL can be denied medical services for failure to pay copayments or coinsurance. Cost sharing will not exceed the maximum allowed under federal Medicaid regulation.

d. Cost sharing limitations described in 42 CFR 447.56(a) will be applied to all program beneficiaries.

e. Copayment and coinsurance amounts will be consistent with federal requirements regarding Medicaid cost sharing and with the State's approved state plan; copayment and coinsurance amounts are listed in Attachment B.

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

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

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

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

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

X. APPEALS

Beneficiary safeguards of appeal rights will be provided by the State, including fair hearing rights. No waiver will be granted related to appeals. The State must ensure compliance with all federal and State requirements related to beneficiary appeal rights. Pursuant to the Intergovernmental Cooperation Act of 1968, the State may submit a state plan amendment delegating certain responsibilities to the Arkansas Insurance Department or another state agency.

XI. GENERAL REPORTING REQUIREMENTS

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

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

51. Monitoring Calls. CMS will convene periodic conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the Private Option beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.

Areas to be addressed include, but are not limited to:

a. Transition and implementation activities;
b. Stakeholder concerns;
c. QHP operations and performance;
d. Enrollment;
e. Cost sharing;

f. Independence Accounts
g. Quality of care;
h. Beneficiary access,
i. Benefit package and wrap around benefits;
j. Audits;
k. Lawsuits;
l. Financial reporting and budget neutrality issues;
m. Progress on evaluation activities and contracts;
n. Related legislative developments in the State; and
o. Any demonstration changes or amendments the State is considering.

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

a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

53. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the State shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

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

a. All items included in the quarterly report pursuant to STC 46 must be summarized to reflect the operation/activities throughout the DY;
b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
c. Total contributions, withdrawals, balances, and credits related to IAs; and
d. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

55. Final Report. Within 120 days following the end of the demonstration, the State must submit a draft final report to CMS for comments. The State must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XII. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

56. Quarterly Expenditure Reports. The State must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XII of the STCs.

57. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or l0C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 62.

b. Cost Settlements. For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9P Waiver) for the summary sheet sine 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.

c. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against

expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.

e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:

    i. MEG 1 – "New Adult Group"

f. The first Demonstration Year (DY1) will begin on January 1, 2014. Subsequent DYs will be defined as follows:

Table 3 Demonstration Populations

Demonstration Year 1 (DY1)	January 1, 2014	12 months
Demonstration Year 2 (DY2)	January 1, 2015	12 months
Demonstration Year 3 (DY3)	January 1, 2016	12 months

58. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs ("ADM").

59. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements resulting from annual reconciliation) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

60. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for the demonstration populations defined in STC 17. The State must submit a

statement accompanying the quarterly report, which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

61. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The State must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

62. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in STC 64:

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

63. Sources of Non-Federal Share. The State must certify that the matching non-federal share of funds for the demonstration is state/local monies. The State further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-federal

share of funding.

c. The State assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

64. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for federal match.

d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes - including health care provider-related taxes - fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

65. Limit on Title XIX Funding. The State shall be subject to a limit on the amount of federal Title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 63, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire

demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

66. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 63, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

67. Calculation of the Budget Neutrality Limit. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC63 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 63 below.

68. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in STC 66. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

Table 4 Per Capita Cost Estimate

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

a. If the State's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the State may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October

1of the demonstration year for which the adjustment would take effect.

b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
c. The State will not be allowed to obtain budget neutrality "savings" from this population.

69. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

70. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

71. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the State must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Table 5 Cap Thresholds

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality limit plus:	3%
DY 2	Cumulative budget neutrality limit plus:	1.5%
DY 3	Cumulative budget neutrality limit plus:	0%

72. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS.

If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIV. EVALUATION

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

74. Cost-effectiveness. While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the Arkansas Private Option Demonstration using premium assistance when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

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

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

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

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

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The State shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the State will assure no conflict of interest, and a budget for evaluation activities.

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

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

   The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

   i. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
   ii. Premium Assistance beneficiaries will have equal or better access to preventive care services.
   iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.
   iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.
   v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
   vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.

vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
x. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 69 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.

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

   The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered

c. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available.

d. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that

adequately assess the effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and dominator clearly defined. To the extent possible, the State may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under HIT, and from the Medicaid Core Adult sets. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.

e. Data Collection: This discussion shall include:
A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:
    i. Medicaid encounters and claims data,
    ii. Enrollment data, and
    iii. Consumer and provider surveys

f. Assurances Needed to Obtain Data: The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.

g. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.

h. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.

i. Evaluator: This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

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

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

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

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

a. Executive Summary. This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
b. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.
d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.
f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.

80. State Presentations for CMS. The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 71. The State will present on its interim evaluation in conjunction with STC 72. The State will present on its summative evaluation in conjunction with STC 73.

81. Public Access. The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

a. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these

reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

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

83. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

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

85. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

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

XV. MONITORING

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

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

website within 30 days of CMS approval.

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

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

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

90. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XVI. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

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

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

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

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

XVII. T-MSIS REQUIREMENTS

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

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

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

Arkansas Health Care Independence Program ("Private Option")

Proposed Evaluation for Section 1115 Demonstration Waiver

February 20, 2014

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

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Proposed Evaluation for Section 1115 Demonstration Waiver

The State of Arkansas is implementing a novel approach to expanding coverage for individuals newly eligible for Medicaid under the Patient Protection and Affordable Care Act (PPACA). Through a Section 1115 demonstration waiver, the State will utilize premium assistance to secure private health coverage offered on the newly formed individual health insurance marketplace (the Marketplace) to individuals who are ages 19–64 years with incomes at or below 138 percent of the federal poverty level (FPL). As of April 2013, the **Health Care Independence Program** (HCIP), as it is formally known, was projected to enroll approximately 211,000 people.[1] While this projection only included individuals who were currently without insurance, it is also likely that there will be some individuals who are insured but meet the requirements and may therefore enroll.

Authorized by the Arkansas Health Care Independence Act of 2013, the HCIP premium assistance approach is commonly referred to as the "Private Option." This approach is designed to achieve equal access, network availability, quality of care, and opportunities for improved outcomes for HCIP enrollees (i.e., those who would be eligible for traditional, fee-for-service Medicaid through PPACA expansion) when compared with their privately insured counterparts. The waiver demonstration for use of the premium assistance approach through the state's new Health Insurance Marketplace ("the Marketplace") established by the PPACA requires an evaluation to characterize the experience and determine the impact of this new coverage strategy.

While not the only purpose, the core purpose of the evaluation is to support a cost-effectiveness determination. To determine whether or not the Arkansas HCIP is cost effective, the totality of both initial and longer-term costs and other impacts for HCIP enrollees, such as improvements in service delivery and health outcomes, will be compared with cost, service measures, and health outcomes that would have been expected for the same enrollees in the traditional Medicaid program.

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. Arkansas's Medicaid program currently has 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 is implementing 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 two to four carriers have committed to offer qualified health plans (QHPs). HCIP authorizing legislation provides for the use of PPACA funds for premium assistance and requires all Marketplace participating carriers to enroll newly eligible HCIP 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

[1] The Arkansas Center for Health Improvement. *Arkansas Medicaid Program Analysis.* April 2013. Accessed at http://www.achi.net/HCR%20Docs/130408%20Poster%20-%20enrollees%20final.pdf on October 15, 2013.

Consumer Information and Insurance Oversight (CCIIO) requirements for plan actuarial value, cost-sharing reductions, benefit components, and reporting requirements.

2. Section 1115 Waiver: The Health Care Independence Act

The U.S. Supreme Court's June 2012 ruling[2] 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 will use federal Medicaid funding to provide health care benefits to individuals eligible under the PPACA expansion. These individuals will receive coverage via private insurance plans offered through the Marketplace. Commonly known as the "Private Option," the Health Care Independence Act[3] 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.

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
- 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.[4]

Expanding the existing state Medicaid program to nearly all individuals with incomes at or below 138 percent of the federal poverty level (FPL), as set out in the PPACA, would have presented several challenges for Arkansas. First, the newly eligible adults are likely to have frequent income fluctuations that lead to changes in eligibility. In fact, studies indicate that more than 35 percent of adults will experience a change in eligibility within six months of their eligibility determination.[5] Without carefully crafted policy and operational interventions, these frequent changes in eligibility could lead to:

- coverage gaps during which individuals lack any health coverage, even though they are eligible for coverage under Title XIX or Advanced Payment Tax Credits (collectively, along with CHIP, "Insurance Affordability Programs" or "IAPs") and/or
- disruptive changes in benefits, provider networks, premiums, and cost-sharing as individuals transition from one IAP to another.

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[2] 567 U.S. ___ (2012).

[3] The Arkansas Health Care Independence Act of 2013, Act 1497, Act 1498.

[4] Arkansas Department of Health and Human Services. *Health Care Independence (aka Private Option) 1115 Waiver-FINAL*. Accessed at https://www.medicaid.state.ar.us/Download/general/comment/FinalHCIWApp.pdf on September 24, 2013.

[5] Fleming C. Frequent Churning Predicted Between Medicaid and Exchanges. *Health Affairs*. February 2011. Accessed at http://healthaffairs.org/blog/2011/02/04/frequent-churning-predicted-between-medicaid-and-exchanges/ on September 24, 2013.

In addition, if the traditional Medicaid program were expanded to include all individuals with incomes at or below 138 percent FPL, Arkansas would have increased its state Medicaid program population by nearly 40 percent. The state's existing network of participating fee-for-service Medicaid providers is already at capacity. As a result, Arkansas would have been faced with the challenge of increasing providers' capacity to serve Medicaid beneficiaries to ensure adequate access to 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 newly eligible under the PPACA. While reforms associated with the Arkansas Payment Improvement Initiative (www.paymentinitiative.org) are designed to address the quality and cost of care in Medicaid and the private market, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults who will enroll through the expansion.

A. HCIP Eligibility[4]

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

- Adults between the ages of 19 and 65 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 expansion is to 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. HCIP 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 2014–2016. The costs of the program are shared by the federal government through provisions of the PPACA. In years 2014–2016 the federal share will be 100%, followed by 95%, 94%, 93%, and 90% in years 2017, 2018, 2019, and 2020 and beyond, respectively. The state will provide the additional funding beginning in 2017.

In ACHI's comparison of options for extending health insurance coverage to low-income Arkansans, the impact of the Health Care Independence Act on the state and federal budgets were estimated as follows.[6]

State budget:

- State general revenue obligations will be reduced by ~$40 million per year due to avoided uncompensated care.[6]

[6] Arkansas Center for Health Improvement. *Options for Extending Health Care Coverage to Low-Income Arkansans*. Little Rock, AR: ACHI, 2013. Available at http://www.achi.net/HCR%20Docs/130403%20Comparison%20final.pdf, accessed September 25, 2013.

- State spending will increase by $47 million in FY15 with 100% federal support and $275 million in FY20 at 10% state/90% federal match requirement for expansion population.[7]
- Additional premium tax revenue over the first 10 years of the Private Option will generate $436 million.[7]
- The net impact on the state budget is a favorable $670 million over 10 years.[7]

Federal budget:

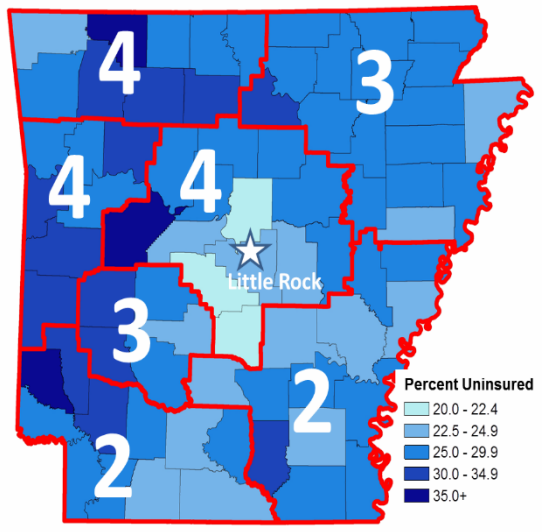
- The federal government will benefit from ~$1.1 billion per year in new taxes and Medicare payment reductions.[8]
- The increase in federal costs for expansion and ongoing Medicaid is projected at $1.59 billion in FY15 and $2.35 billion in FY20.[6]
- The net impact on the federal budget approaches neutrality over 10 years (not including economic stimulant effects).[6]

C. Private Plans Available to Arkansans

The act requires the state to take 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]

An early benefit of this approach can be found in the number of private insurance companies who have expressed their intention to offer plans across the state (Figure 1).[9] As a result, Arkansas citizens living in each region of the state will have a choice of plans from at least two companies.[10] In comparison, neighboring Mississippi had 36 counties without a single plan offered through its health insurance marketplace and has only two participating insurance

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
- QCA Health Plan of Little Rock (QualChoice of Arkansas Inc.)
- Arkansas Health & Wellness Solutions (Ambetter)

[7] Optumas. *Newly Eligible Cost Model Intervention Comparison for Arkansas.* [Actuarial Analysis]. March 2013.
[8] Price C and Saltzman E. *The Economic Impact of the Affordable Care Act in Arkansas.* RAND Corporation, January 2013. Web March 31, 2013.
[9] 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.
[10] 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.

companies.[11]

D. Arkansas' HCIP Proposal[4]

The Private Option is 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 will promote continuity of coverage and expand provider access, while improving efficiency and accelerating multi-payer cost-containment and quality-improvement efforts. Further, it is expected that by providing a source of payment to an estimated 250,000 currently uninsured citizens, an economic impetus will be created that will lead to an increase in the supply of health care services available, particularly in currently underserved areas counties. In fact, a recent study[8] 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.

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.

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 the HCIP, 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 is taking 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.

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[11] Harkey C. *Federal Health Insurance Exchange will Exclude 36 Mississippi Counties from Tax Breaks*. July 2013. Accessed at http://www.wdam.com/story/22757086/federal-heath-insurance-exchange-will-exclude-36-mississippi-counties-from-tax-breaks on September 24, 2013.

"All Payer" Health Care Reform

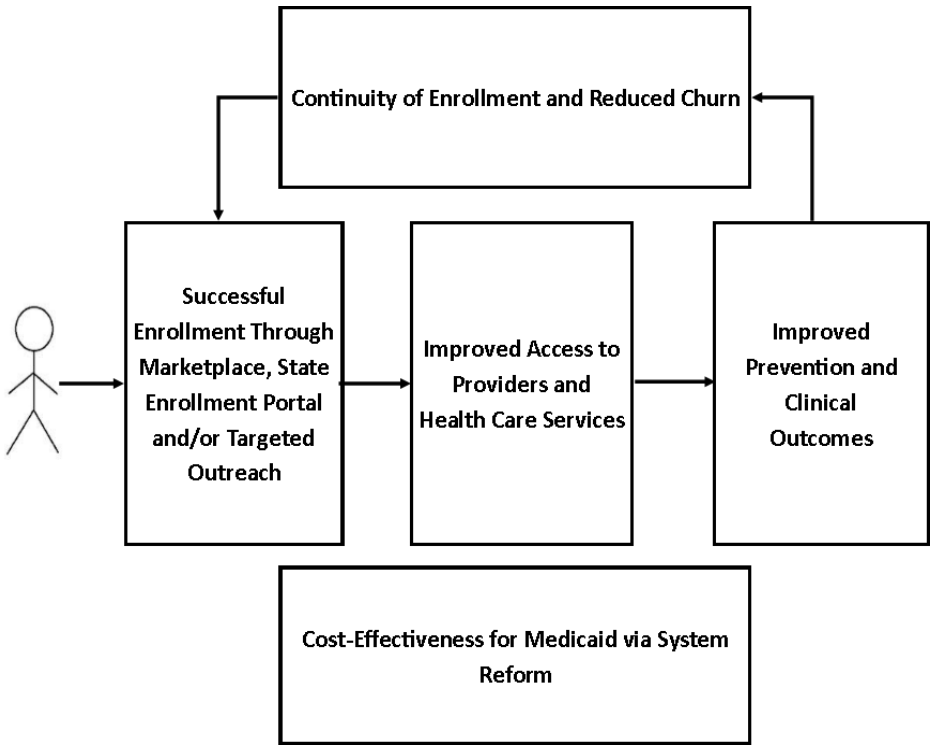
Arkansas is at the forefront of payment innovation and delivery system reform, and the Health Care Independence Act will accelerate and leverage the state's Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort, and the number of privately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

3. Evaluation Strategy

A. Goals and Objectives

The HCIP 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. 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



New enrollees will successfully enroll through the Marketplace, state enrollment portal, and targeted outreach efforts (e.g., Supplemental Nutrition Assistance Program participant engagement). Compared with what would have been in a traditional Medicaid expansion, HCIP 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, newly eligible HCIP individuals 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 HCIP clients' experiences described above will be assessed to determine the cost effectiveness of the HCIP demonstration waiver for Medicaid and the broader impact on the health care system.

B. Hypotheses

Research questions of interest identified in the development and approval process for the HCIP 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 original 12 hypotheses outlined in STC #70 that have been re-organized into the following four 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

***** *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, 2C, and 2D). Appendix 3 provides a table with a complete list of each selected metric with the targeted set of hypotheses it will support.

While these metrics will be the main set for consideration, further refinement is expected after the contractor is selected and preliminary data become available. For example, as a first step the analytic team will need to generate power analyses based on the enrolled populations after the first and second year of the HCIP to determine whether or not there are sufficient sample sizes to support the use of disease specific and age specific metrics. It is anticipated that there will be a core set of measures selected from this 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 and CMS upon initial examination of the enrolled populations and the data available at the start of the evaluation in year 2.

Enrollment

We anticipate enrollment data to be available for HCIP, subsidized tax credit, and full-cost participants in the Marketplace. In addition to enrollment numbers, the method of enrollment—Federally Facilitated Marketplace (FFM), state-based portal, or outreach (e.g., SNAP enrollment)—and the geographic location of enrollees will provide information on the success of outreach and enrollment efforts across the state. 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 method of entry (e.g., enrollment path)
- Total and subgroup enrollment within each market (e.g., geographic uptake variation)

At reenrollment, both the proportion of enrollees who are maintained in HCIP and those who successfully transition coverage as a result of family income changes (either into FFM or from the FFM) will be of key interest. Conversely, those who fail to transition and contribute to "churn"—the discontinuity of coverage due to income eligibility for various programs—will also be monitored as these are the cases that the HCIP is explicitly designed to minimize. Transitions across coverage periods will result in maintenance within the same plan or intentional decisions to change plans. Importantly, the demonstration will assess these types of transitions not only across plan year but also as individuals transition across the 138 percent FPL line into and out of Medicaid eligibility. Orderly transitions based on individual choice are expected and would not indicate a negative event. Disruptions in coverage at transition points are the basis for hypotheses related to continuity and churn. Potential indicators of interest for development and use include the following:

- **Continuity**: Maintenance of enrollment within program, within plan, and across re-enrollment periods without disruption of coverage

- **Reduced churn**: Maintenance of enrollment between programs (e.g., FFM vs. HCIP), within plan, and across re-enrollment periods without disruption of coverage

These data will primarily be used to address hypotheses related to continuity of care.

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) (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 use the CAHPS 5.0H Medicaid Adult survey version. These surveys contain the following categories of metrics that could be used for the current evaluation (see Appendix 2C and 2D for background on CAHPS and Appendix 3 for the candidate list of CAHPS metrics and corresponding hypotheses):

- 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 collected in the second quarter of demonstration year 2 (DY2) and DY3. 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. HCIP).

D. Design Approaches

We propose four strategic approaches to address the hypotheses within this evaluation. These approaches will utilize different comparison groups, metrics, and statistical methods to address the research questions. Importantly, the state is stimulating major health system reform through its multi-payer payment improvement initiative consisting of patient-centered medical homes, payments for episodes of care, and development of health homes for targeted populations. Efforts to isolate the effect of the demonstration from other market transition issues will require thoughtful consideration. In addition, risk adjustment for both family income and health care burden will be a challenge to isolating the effects of HCIP throughout the evaluation. Modeling may be required using family income as a variable to control for relationships associated with financial status. Use of the health plan risk mitigation strategies of HHS—determination of plan eligibility or obligations under the risk corridor, reinsurance, or risk adjustment methodologies—could provide an avenue for developing more robust modeling controlling for confounding factors that could influence outcomes.

The following sections provide information about each of the four 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.

D1. Statewide Comparisons

This approach will compare all individuals in the HCIP to individuals enrolled in traditional Medicaid, controlling for region and individual demographics. Arkansas Medicaid identifies individuals as eligible for services in conjunction with the state's DHS county offices or District Social Security Offices.[12] 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. Traditionally, 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 HCIP enrollees, individuals enrolled in the traditional Medicaid program will have much stricter income requirements and, in many cases, more complex health care needs. Statistical considerations will need to account for these differences.

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

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 multivariate regression models will be fitted for each metric (see Appendix 4). Each model will include a dummy variable "program type" to test the comparison between traditional Medicaid and HCIP. In quasi-experimental studies (i.e., non-randomized experiments) such as the current evaluation, it is important for research designs to control for important differences between the treatment and comparison groups that may affect the dependent variables but are confounding the observed effect of the independent variable of interest. One way to do this is through the use of covariates. Covariates will include, but are not limited to, age, gender, race and ethnicity (where available), known health conditions, income, and geographic region. We will also test the interaction between income and program type to examine moderation effects, particularly given the known differences in income level between the traditional Medicaid program and the newly enrolled beneficiaries in the HCIP. Another way to control for unmeasured variables is to 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 HCIP 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.

D2. Subgroup Pre–Post Comparisons

There are two important subgroups that 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 and women with breast or cervical cancer. 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 during 2012 and 2013 who were enrolled in the traditional Medicaid program, and who upon turning 19 years of age will be eligible to enroll in HCIP. Estimates from 2011 suggest that across this two-year time frame approximately 12,000 youth will qualify for EPSDT services in this age group.

The second subgroup will be women with breast or cervical cancer. In Arkansas, a program called BreastCare provides free breast and cervical cancer screenings and treatment for Arkansas women ages 40–64 years who have no health insurance coverage and who have a household income at or below 200% FPL. During FY2012, this program served more than 12,000 women, 230 of whom were diagnosed with breast or cervical cancer and received treatment. Starting in 2014, women receiving treatment will be served through the HCIP rather than traditional Medicaid. The purpose of this analysis will be to evaluate the continuity of specialty services for women while they were in traditional Medicaid, and compare that with their continuity of services once enrolled in HCIP. It

may also be possible to compare continuity of care across this transition, though it is hypothesized that increased network access may provide opportunities for enrollees to select different providers that they did not previously have access to.

Statistical Analysis

Multiple regression models similar to those used for D1 (above) will be used with this group. In this case, however, 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 the HCIP, where Time 1 (omitted category) will include outcomes associated with enrollment in traditional Medicaid while Times 2, 3, and possibly 4 would be associated with HCIP enrollment. While we intend to use the same control covariates as D1 (above), considerations of sample size will need to be made particularly for the BreastCare program. In this case, a limited set of covariates including age and geographic region may be utilized to maximize power.

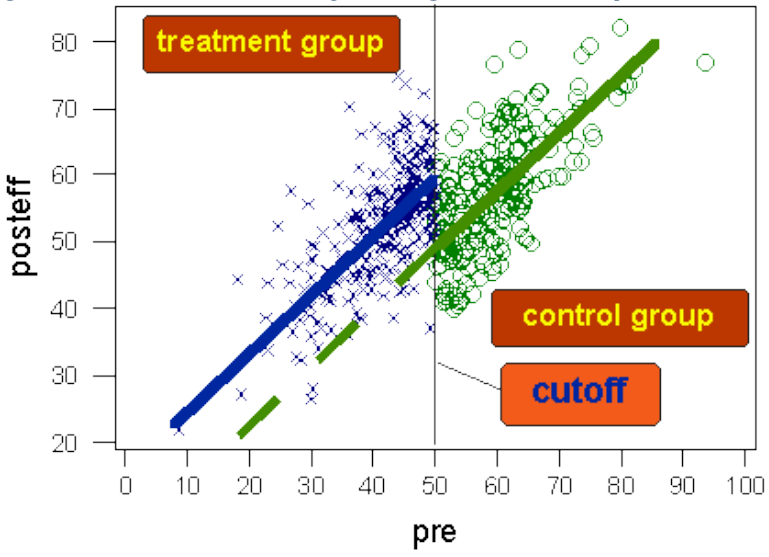
D3. Regression Discontinuity Analysis

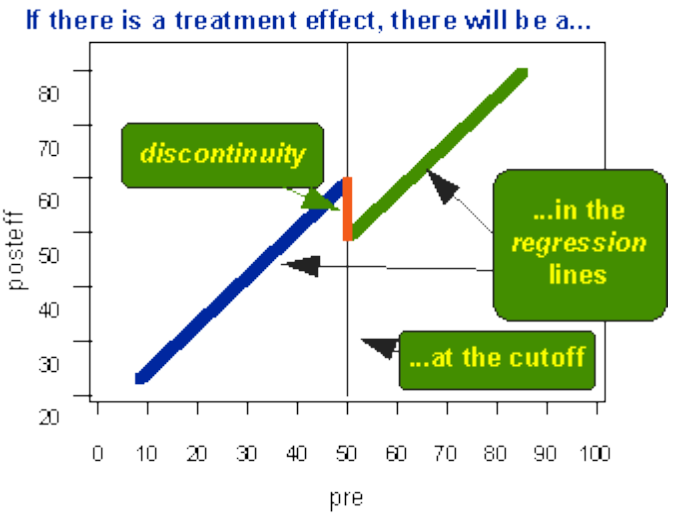
In cases where random assignment to treatment and control groups is not feasible, comparisons can be done by examining subgroups of individuals based on scores just above or below a cutoff value of a predetermined variable. The assumption is that such individuals with similar scores may not differ significantly on the characteristics of interest, even though the cut point places the individuals into different treatment groups. Consider, for example, grade school students enrolled in a summer enrichment program based on mathematics test scores. Those who score 59% or below are enrolled in the summer program, while students scoring at 60% or above do not.

For illustration, consider what the outcome might look like if the program had a positive effect on future mathematics scores. For simplicity, assume that the program, which only enrolls people who score below a certain level, had a constant effect which raised each participant's outcome measure by ten points.

The dashed line (Figure 3) shows what we would expect the treated group's regression line to look like if the program had no effect. A program effect is suggested when we observe a "**jump**" or **discontinuity** in the regression lines at the cutoff point.

Figure 3: Regression-Discontinuity Design with Ten-point Treatment Effect





For the case of Arkansas' HCIP, there are two groups for which this method can be applied. First are low-income parents at the threshold of 17% FPL. Those parents with incomes less than 17% FPL will receive traditional Medicaid benefits, while parents above 17% FPL will enroll in the HCIP. By selecting parents at the threshold (10–17% FPL vs. 18–25% FPL), we can use a regression discontinuity (RD) design to compare metrics.

The second RD group will comprise individuals newly eligible for coverage who will participate in a screening process to determine if they have sufficient medical needs to warrant retention in the traditional Medicaid program. The HCIP authorizing legislation directs DHS to identify those individuals who have exceptional medical needs for whom coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care and to retain them in the traditional Medicaid program. Because no previous claims history or diagnostic roster is available, identification of these individuals will require use of a prospective medical frailty screener.

In consultation with health status and exceptional needs measurement experts at the University of Michigan and the Agency for Healthcare Research and Quality, Arkansas has developed a screening process that seeks 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. The final screener consists of 12 questions that will provide self-reported information; responses will be scored and calibrated to estimate the population who will be retained in the traditional Medicaid program. Downstream refinements to the screener algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

There are two stages to the screening process. At the first stage, individuals with significant limitations for daily living and other "automatic" triggers will be identified. The second stage involves a weighted set of indicators from the remaining set of questions that will be used to identify a cut point around which decisions will be made about eligibility. This cut point provides a unique opportunity to employ regression discontinuity techniques with the individuals who are screened during the second stage.

Statistical Analysis

For each outcome measure that we have selected for evaluation, we regress the posttest scores, Y, on the modified pretest X (X=pretest scores minus the cutoff point), the treatment variable Z, 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.

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 newly 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
    - Endocrinologists
    - Home Health Agencies
    - Hospitals*
    - Obstetricians
    - Oncologists
    - Ophthalmologists

- Psychiatric and State Licensed Clinical Psychologist
- Pulmonologists
- Rheumatologists
- Skilled Nursing Facilities
- Urologists

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

- **Mental Health/Behavioral Health/Substance Abuse (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 (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 the HCIP.

E. Approach for Test of Cost Effectiveness

The Arkansas Demonstration proposes to enhance care received by Medicaid beneficiaries through the use of premium assistance to purchase private coverage from QHPs on the Arkansas Health Insurance Marketplace. Opportunities for enhanced access to primary care and specialty networks, continuity in insurance coverage and provider relationships, improved preventive and chronic care management, enhanced patient experiences in care and improved outcomes are described above. In addition, by nearly doubling the number of individuals who will enroll in QHPs through the Marketplace, the Demonstration is expected to encourage carrier entry, expanded service areas, and competitive pricing in the Marketplace, thereby enabling QHP carriers to better leverage economies of scale to drive pricing down even further.

However, core requirements of the Demonstration are to evaluate the cost effectiveness of utilizing Medicaid funds to procure insurance coverage through premium assistance at scale in the new

Health Insurance Marketplace. The proposed approach summarizes existing knowledge of available comparison groups, anticipated data, and a summary of methodological considerations compiled by staff from the office of the Assistant Secretary for Planning and Evaluation (ASPE) and based on input from Arkansas' waiver team; conversations between Arkansas, ASPE, and CMS.

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. Currently, CMS is exploring making available utilization data from another state to support secondary analyses. 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 #68

"While not the only purpose of the evaluation, a core purposes of the waiver evaluation is to support a determination as to whether a preponderance of evidence about the Arkansas Private Option Demonstration using premium assistance, when considered in its totality, demonstrates cost effectiveness taking into account both initial and longer-term costs and other effects such as improvements in service delivery and health outcomes.

a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.

b. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the Private Option Demonstration compared to a comparable population in Medicaid fee-for-service.

c. The State will compare total costs under the Private Option Demonstration to costs under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.

d. The State will compare changes in access and quality to associated changes in costs in the Private Option. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Arkansas will be determined and compared to improvement efforts undertaken in other delivery systems."

E2. Recommended Approach

The proposed methodology was selected from among a range of analytic options to best address the real-world circumstances under which Arkansas' premium assistance waiver is being demonstrated. Of particular importance, Arkansas has not previously expanded Medicaid with full benefits for the target population under its traditional fee-for-service population; coverage has been limited to either individuals with extreme needs (e.g., the disabled) or those experiencing extreme poverty (e.g., parents of children in families earning at or below 17% FPL). Thus, the lack of directly comparable information will require quasi-experimental methods to address the absence of randomized

enrollment and to recognize existing limits on available data for preferred comparison groups (i.e., matched populations from similar states following a different path to expansion/no expansion). Thus, data availability, research design, and outcome (both cost and effectiveness) measures were considered simultaneously; an effort is underway to understand, before the program is implemented, the analytic framing for the evaluation.

A cost-effectiveness analysis (CEA) of the HCIP Private Option in Arkansas versus enrollment in the regular Medicaid fee-for-service (FFS) program has several important dimensions:[13]

- Perspective and length of follow-up
- Measurement of costs
- Measurement of effectiveness (e.g., continuity in coverage, provider access, health outcomes, quality of coverage, patient experiences)
- Control group identification when randomization is not possible
- Methods for obtaining estimates
- Accounting for uncertainty

Each issue is discussed briefly below.

Perspective and Length of Follow-up

A societal perspective (including net costs to the Marketplace and any out-of-pocket beneficiary costs) would be most comprehensive. However, for policy-making purposes, conducting the analysis from the Medicaid perspective may be sufficient to determine whether in its totality the evaluation demonstrates cost effectiveness (i.e., is either cost saving or attains increases in outcomes that are worth any increase in cost). For simplicity, the remainder of this document will focus on estimation of key components of the incremental cost-effectiveness ratio (ICER) from the Medicaid payer perspective:

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

where *EFFECT* reflects some health outcome that is not easily quantified in monetary terms. Because the goal is to provide immediate feedback to Arkansas and CMS, the ICER can be initially estimated for the first year of program enrollment. As future years are included, discounting (translating of future costs and benefits into current values) would be required.

It is important to note that in many CEAs, a single value measure of effectiveness (e.g. quality-adjusted life years, life years saved, etc.) is used to calculate the ICER. For HCIP, there will be numerous potential measures of effectiveness. Thus, there are at least two choices: find some methods for combining the various effectiveness measures into a single metric, or make more qualitative judgments about the overall balance of the incremental effectiveness measures relative to incremental costs.

[13] Gold MR, Siegel JE, Russell LB, and Weinstein MC. Cost-effectiveness in health and medicine: The report of the Panel on Cost-effectiveness in Health and Medicine. New York: Oxford University Press; 1996.

Costs

Medicaid will pay the QHP premium each month for each person with an income between 18% and 138% of the FPL (except for people who are determined to be medically needy. This premium could include the QHP's administrative costs plus the expected average age-adjusted service cost per enrollee for the plan chosen. Subject to further consideration of the accuracy of the premium to reflect these costs (discussed in more detail below), the premium provides an easy way to measure the costs of the HCIP to Medicaid for the first year of the program. For the control group (also discussed later), Arkansas will also estimate the Medicaid administrative cost per enrollee (avoided claims administration, oversight, appeals, program integrity, and other) and use claims to measure the service costs. Therefore, the numerator of the ICER is:

[Eq. 2] $$COST_{HCIP} - COST_{Control} = Premium_{HCIP} - (Medicaid\ Admin\ Costs + Medicaid\ FFS\ Claim\ Payments)_{Control}$$

The components in Eq. 2 would be summed over all HCIP enrollees and control persons for the first year of the program.

The extent to which the HCIP premium accurately represents the average cost of the HCIP individuals depends on how well the Marketplace predicts service use. The state will rely on its actuaries to develop an accurate representation of HCIP premium costs for each year of the Private Option. Considerations include the following:

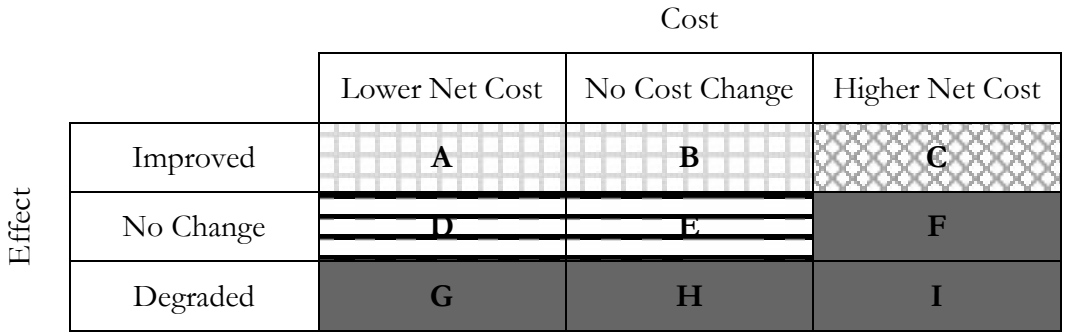
- Premiums set in advance for one year may be greater or less than actual experience; actual experience could lead to increases or decreases in premiums in future years.
- The state is entitled to repayment from carriers for premiums exceeding claims cost plus administration, subject to the minimum loss ratio in effect in the Marketplace, and this calculation and restitution will occur in Year 2 for claims costs and premiums incurred in Year 1.
- While the premiums depend on the experience of ***all*** Marketplace enrollees (not just HCIP), obtaining claims from the Marketplace for the HCIP enrollees as well as the premiums for the second year of the Marketplace will enable a more nuanced analysis of the financial experience for Medicaid during the first year of the HCIP as well as an understanding of the extent to which the second-year experience may be different.

If the incremental difference in costs (Eq. 2) is negative, then on average the HCIP program is cost saving; if the incremental difference is positive, then the HCIP may be cost effective if the program also increased some health outcome measure (e.g., health status, access, experiences) such that the increase in outcome is worth the increase in cost to the Medicaid program. However, even if HCIP is estimated to be cost saving on average for the first year, uncertainty in this estimate should be considered because the estimate is based on a particular group of enrollees in the first year. More specifically, it is unlikely that the HCIP would be 100% certain to be cost saving, so Arkansas might consider cost effectiveness using some estimated measure of effect.

In anticipation of a need to assess the overall balance of the incremental effectiveness measures relative to incremental costs across multiple facets of the Arkansas Demonstration, we propose the following analytic application of potential incremental outcomes for subgroup and total program assessments. As arrayed, three different options for measured effects (improved, no change, degraded) and costs (net decrease, no change, net increase) are anticipated for modeled options (see Figure 4). We anticipate findings resulting in segment A and B as optimal outcomes, D and E as

acceptable outcomes, C warranting policy discussion of the "value" of observed improvements, and results in segment F–I as negative outcomes. As referenced above and described below, different effects principally tested will include a variety of hypotheses for exploration within the Arkansas Demonstration.

Figure 4: Potential Incremental Outcomes for Subgroup and Total Program Assessments



Effects (Health Outcomes)

Standard and single-value measures of health outcome for economic evaluation, such as quality-adjusted life years, may not be feasible for assessment of the HCIP, especially because mortality differences would not likely be detectable within the first year of the program for this population. In this case, the effectiveness measures are appropriately related to the quality of insurance coverage provided in the Marketplace relative to the traditional Medicaid program. Therefore, a variety of measures might be used including those related to continuity of coverage, health status, access, utilization, and enrollee experiences. Another consideration is which measures can reasonably be expected to be affected by coverage over the time horizon for the project. Measures of utilization or process measures of care quality might be observed in a one-year time frame, but impacts on health status measures would likely take longer. One possible measure of effect that might be relevant to the Medicaid program would be reductions in potentially avoidable readmissions. Although the actual cost of hospitalizations is reflected in the numerator of the ICER, hospitalizations involve many unmeasured costs (e.g., pain, discomfort, lost work time, etc.), so reduction in inappropriate/avoidable hospital use is generally beneficial and reflective of health status improvements.[14] Among the characteristics that will be considered in selecting effectiveness measures are the following:

- There is general agreement they measure important aspects of quality for insurance coverage.
- They are likely to be affected by new coverage within a reasonable time frame.
- Data to calculate them will be available at reasonable intervals for both treatment and control groups.

With these criteria in mind, the state will plan to select a representative number of outcomes measures to include in tests of cost effectiveness. These measures will be drawn from those vetted for inclusion in the evaluation of experiences in care, effectiveness of care, utilization, and provider network. Candidate indicators for consideration in testing select hypotheses include the following.

[14] Stearns SC, Rozier RG, Kranz AM, Pahel BT, and Quinonez RB. Cost-effectiveness of Preventive Oral Health Care in Medical Offices for Young Medicaid Enrollees. *Pediatrics & Adolescent Medicine*. 2012;166(10): 945-51.

Hypothesis 4a: Fewer gaps in enrollment, improved continuity of care, and resultant lower administrative costs

For this hypothesis, candidate metrics include the following:

1. Enrollment metrics (AR Medicaid Eval 9 and 10) to be generated from cross-year carrier and Medicaid enrollment inclusive of re-enrollment and transitions of enrollment across the 138% FPL threshhold (e.g., gaps in enrollment coverage)
2. Continuity and accessibility metrics (AR Medicaid Eval 03-08) to be generated from cross-year carrier and Medicaid network provider information for both primary care providers and specialty providers operationalized as a positive event (expanded accessibility, greater PCP/specialty access, greater inferred continuity in PCP attachment) and maintained accessibility across participation years
3. Administrative costs as discussed above from identification and categorization of costs attributed to the state Medicaid plan, incorporated into carrier management, and otherwise required for a traditional Medicaid expansion

Hypothesis 4b: Reduced premium costs in the Marketplace and increased quality of care

Arkansas' Demonstration Waiver incorporated anticipated changes in the Marketplace as a result of Medicaid premium assistance including stabilization of the actuarial risk pool in the private health insurance exchange, deflationary pressure through reduced cost-shifting for Medicaid underpayments to providers, increased plan competition resulting in increased participant choice, and finally enhanced quality of care due to active clinical and network management by private carriers.

1. As discussed above, Marketplace characteristics (e.g., carrier competition, premium costs, actuarial stability) will be operationalized through performance characteristics of the Arkansas Marketplace.
2. Access, quality of care, and patient experiences as previously discussed for both regression discontinuity analyses and statewide assessments will be employed for assessments of quality of care (directionality as appropriate for specific metrics). Total costs of the HCIP will include actual premiums and consider a sensitivity assessment based upon the actuarial projections included in the Demonstration Waiver (e.g., costs private plans would have paid without premium assistance, costs projected for HCIP, costs of additional reductions with maturation of the Arkansas Exchange Marketplace).

Hypothesis 4c: Overall costs for covering beneficiaries

While no comparison group exists to enable measurement of the hypothetical costs of covering the entire expansion population in Arkansas' traditional fee-for-service Medicaid program, original actuarial modeling developed by Optumas employed in waiver development and shared with CMS; planned assessments of experienced quality and costs above; and actual premium costs and concurrent Medicaid costs for DY1, DY2, and DY3 will enable estimates for comparison of total program costs of the Demonstration and alternative hypothetical Medicaid expansion. Subgroup comparisons for delivery costs for

care will be employed building upon cost-effectiveness analyses above. The following are candidate metrics:

1. Statewide projections for delivery costs for care will be modeled building off of sub-group comparisons and modeling efforts to estimate required provider rates for comparable access under expansion assumptions regarding access requirements.
2. Comparison of cost-estimates to actuarial modeling inclusive of sensitivity analyses are anticipated to provide a bounded range of comparative costs between the Arkansas Demonstration and an Arkansas traditional Medicaid expansion.

Control Group Identification and Methods for Obtaining Estimates

HCIP enrollment will not be randomized but instead will occur automatically for all persons with incomes of 18%–138% FPL who were not previously eligible for Medicaid and who are not identified as "high need" based on the medical needs screener. A set of different control groups and analytic methods may be considered to get estimates of the effect of HCIP for different components of the Medicaid population. For example, regression discontinuity methods[15,16,17] could be used to estimate costs and effects for HCIP and control for enrollees at two different thresholds for Hypothesis 4a:

- HCIP enrollees who score close to (but just below) the high-need cutoff (e.g., persons who score in the 80th–90th percentiles of the predicted risk scores) could be compared with the high-need enrollees who are placed in regular Medicaid FFS because they score in the 90th–100th percentiles of the predicted risk scores. (Note: people who qualify automatically for the high-need Medicaid FFS due to characteristics such as specific disabilities will automatically be enrolled in the treatment group, so no controls can be identified among HCIP enrollees; therefore, these FFS enrollees should not be included in the control group.)
- HCIP enrollees who are relatively low income (e.g., 18%–25% FPL) could be compared with Medicaid FFS enrollees just below the low-income threshold (e.g., 10%–17% FPL).

While estimates of the ICER for these two groups would not reflect the effect of HCIP for the full set of HCIP enrollees, they would provide useful estimates for two important and potentially high-cost groups (medically needy and/or extremely low income). The precision of the estimate will depend on the number of people whose high-need measure or income qualify them to be in the analysis (either HCIP treatment or FFS control); it will be possible to estimate 95% confidence intervals for the estimates, but small samples would limit the value/precision of the estimates. Hypotheses 4b and 4c will extract from regression discontinuity approaches applied in hypothesis 4a but also require Arkansas Exchange Marketplace cost information in addition to comparative exchange information from states without premium assistance.

It would desirable, of course, to get an estimate of HCIP for the rest of the Medicaid expansion population (e.g., people not previously eligible for Medicaid who are at 26%–138% FPL and have a predicted risk score of <80%). Given lack of randomization, the control group would need to come

[15] Hahn J, Todd P, and Van der Klaauw W. Identification and Estimation of Treatment Effects with a Regression-Discontinuity Design. *Econometrica*. 2001;69(1): 201-09.
[16] Trochim WMK. The Regression-Discontinuity Design in Health Evaluation. Research Methodology: Strengthening Causal Interpretations of Nonexperimental Data. 1990. http://www.socialresearchmethods.net/research/RD/RD%20in%20Health.pdf.
[17] Sechrest L, Perrin E, and Bunker J. USDHHS, Agency for Health Care Policy and Research, Washington, D.C. http://www.socialresearchmethods.net/research/RD/RD%20in%20Health.pdf.

from another state (either one that previously expanded Medicaid coverage or is currently expanding coverage under PPACA); because Arkansas is using a FFS approach rather than managed care for Medicaid beneficiaries outside the Demonstration, the control state(s) should also use a FFS rather than managed care approach. Georgia, Oklahoma, and Alabama are potential Medicaid FFS states that could be included, while Missouri, Tennessee, and Kentucky are not likely candidates because they utilize a Medicaid managed care approach. To do the analyses, person-level enrollment and claims data from an appropriate control state would need to be obtained, as it seems unlikely that administrative reports would be sufficient to identify the experience for the control patients. Even with these data, it might be necessary to use a statistical approach, such as propensity score matching,[18,19] to identify whether the Medicaid enrollees from the comparison state would have been in the HCIP (e.g., unless the control state has information similar to Arkansas's high-need screener); however, the data available to use this approach may be limited. In total, the potential for bias in the estimated impact from this comparison might be much greater than for the estimates obtained for the high-need and low-income groups using the regression discontinuity approach; however, the estimate might provide some sort of bound or improved understanding of the possible full impact of HCIP enrollment.

Potential Statistical Methods

The choice of statistical methods must be consistent with data availability and choices for the comparison groups. As described above, one set of comparisons for this evaluation may involve individuals close to the thresholds that assign them either to traditional Medicaid or HCIP. The appropriate statistical technique for these situations is known as regression discontinuity designs or RDD. Regression discontinuity analysis applies to situations in which candidates are selected for treatment based on whether their value for a numeric rating exceeds a designated threshold or cut-point. Under an RDD, the effect of an intervention can be estimated as the difference in mean outcomes between treatment and comparison group units, adjusting statistically for the relationship between the outcomes and the variable used to assign units to the intervention, typically referred to as the "forcing" or "assignment" variable (see section D3, above, for more detail on the RDD method).

Accounting for Uncertainty in Estimates

Because the estimates of costs and effects are based on first-year HCIP enrollees and control Medicaid enrollees, the estimates of both the numerator and the denominator of the ICER are subject to sources of uncertainty that are likely correlated. The uncertainty arises because the group of enrollees in one year may differ from groups of enrollees in future years. Methods have been established to address uncertainty in estimates of cost effectiveness.[20,21] For example, the analysis can generate bootstrap replications of the estimates of the ICER; these replications can be used to construct a cost-effectiveness acceptability curve (CEAC) that depicts the probably that HCIP is cost effective at different levels of willingness to pay for an avoidable hospitalization averted.

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[18] Guo S. and Fraser M. Propensity score analysis: statistical methods and applications. Thousand Oaks, CA. 2010.
[19] Rosenbaum PR. and Rubin DB. The Central Role of the Propensity Score in Observational Studies for Causal Effects. *Biometrika.* 1983;70(1): 41-55.
[20] Briggs AH, O'Brien BJ, and Blackhouse G. Thinking outside the box: Recent advances in the analysis and presentation of uncertainty in cost-effectiveness studies. *Annual Review of Public Health.* 2002;23: 377-401.
[21] Chaudhary MA and Stearns SC. Estimating confidence intervals for cost-effectiveness ratios: An example from a randomized trial. *Statistics in Medicine.* 1996;15(13):1447-58.

4. Evaluation Implementation Strategy, Timeline, & Budget

A. Independent Evaluation

An independent third party will be selected, after applicable state procurement, selection, and contracting procedures have been performed, to conduct the interim (DY2) and final (DY3) evaluations. The third party selected for the evaluation will be screened to assure independence and freedom from conflict of interest. The assurance of such independence will be a required condition by the state in awarding the evaluation effort to a third party. The selection of this independent evaluator will be based on their demonstrated capacity to conduct rigorous evaluations similar to the current proposal, qualification of proposed staff, 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

Arkansas has developed and continues to develop strategies to secure needed data inclusive of enrollment, claims, and consumer experience related to the demonstration. We anticipate developing the required data components in concert with the evolution of the HCIP demonstration. For example, we anticipate outreach and enrollment to be a focus in DY1, improved access and utilization in DY2, and clinical outcomes in DY3; re-enrollment and elimination of churn to be an ongoing assessment following DY1; and cost-effectiveness to be a critical DY3 determination.

The Arkansas Insurance Department (AID) has issued guidance that carriers will be required to submit claims for the Marketplace experience inclusive of the demonstration participants—initially required reporting by the end of quarter 1 in DY2 for DY1 experience and on a quarterly basis thereafter. The submission process will utilize 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 (see Appendix 6 for more information). These claims data will be the basis for development of access, utilization, and clinical quality indicators from established and accepted national metrics.

The Division of Medicaid Services (DMS) within the Arkansas Department of Human Services has historic and will have temporal claims data for existing Medicaid enrollees. In addition, DMS conducts the CAHPS with Arkansas Medicaid enrollees on a semi-annual basis.

CMS is exploring availability of additional state data from a comparable state to be used for comparison. If these data become available, the evaluation team will work with CMS to include these data in the evaluation.

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 workplan once they are hired. Though the Demonstration is scheduled for 3 years, we have included a Year 4 in this evaluation proposal to encompass all the required reports that will be submitted subsequent to DY3. The 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.

We propose three major reports and 13 enrollment reports to be completed. The enrollment reports will include information about enrollment patterns, reenrollment patterns, and retention patterns throughout DY1–4. We also propose to include an implementation update at the conclusion of DY1 that will consist of quarterly enrollment updates, market area assessments, and any "transition to market" issues identified through the implementation of HCIP. We anticipate these findings will not only be needed for any programmatic or technical modifications in Arkansas's program but also beneficial should other states pursue a similar Medicaid expansion.

The Interim Evaluation Report will be completed as stipulated in STC 70 after completion of DY2. This report will include findings from data collected including two years of enrollment data, two years of geomapping data, one year of CAHPS data (collected during DY2), and two years of claims data. The Final Evaluation Report will be submitted after completion of DY3. It will include three 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 70.

Table 1. Proposed Project Timeline

	DY 1 (2014)				DY 2 (2015)				DY 3 (2016)				DY 4 (2017)			
	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		
Retention					U					U				U		
Implementation Update					R											
Interim Report										R						
Final Draft Report															R	
Final Summary Report																R
Data Collection & Analysis:																
Enrollment	X X X X X X				X	X	X	X	X	X	X	X	X	X		
Geomapping				X	* * *			X	* * *			X	* * *			
CAHPS					X X X * * * *				X X X * * * *							
Carrier Claims					X * * X * * X * *				X * * X * * X * * X * *				X * * X * * X * * X * *			

U=Non-required Update
R=Required Report
X=Data Collection
* =Data Analysis

D. Budget

To be determined after the scope of the analytic proposal is approved.

5. Supplemental Hypotheses and Future Policy Implications

Additional questions of policy relevance are of interest; however, they are outside of the scope of STC #68 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.

- By using premium assistance to purchase private health insurance on behalf of low-income Americans, how equitable was the access, outcomes, and experiences between Medicaid beneficiaries and their private-sector counterparts (regression discontinuity above and below 138% FPL)?
- 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 Arkansas' use of Supplemental Nutrition Assistance Program eligibility contribute to the stability of the risk pool compared with self-initiated enrollment of newly eligible beneficiaries?
- 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. 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) 2014

C. Consumer Assessment of Healthcare Providers and Systems Survey—Health Plan 5.0

D. Consumer Assessment of Healthcare Providers and Systems Survey—Supplemental Items 4.0

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.

ACHI
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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 70, #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. 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. 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. Experience	viii. Premium Assistance beneficiaries will report equal or better experience 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 c. Continuous access to same providers	v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.

Arkansas Proposed Evaluation Hypotheses	Arkansas Original Terms and Conditions Hypotheses (Section 8, STC 70, #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. 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 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.

* *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

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 5.0H adult survey 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 (2012 for the survey fielded in 2013).

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-9-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-9-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 [C CM], TOTAL SYSTEM OCT09-

1752 IMPLANTATION OR REPLACEMENT OF CARDIAC CONTRACTILITY MODULATION [C CM] 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-9-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