Attachment J
Arkansas Works Special Terms and Conditions (STC) Documents

Date	Description
03/04/2018	Demonstration Approval
09/27/2013	Arkansas Private Option Approval
03/24/2014	Approval Letter for Approved Evaluation Design
09/15/2014	Pending Application
12/30/2014	Demonstration Approval
07/14/2015	AR Technical Corrections Request
08/14/2015	CMS Approval Letter
06/28/2016	Arkansas Works Application
12/07/2016	CMS Extension Approval
06/30/2017	Arkansas Works Amendment Request
05/24/2018	Arkansas Works Eligibility and Enrollment Monitoring Plan for Community Engagement
05/31/2018	Arkansas Works Eligibility and Enrollment Monitoring Plan
02/18/2019	Approved E&E Monitoring Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

March 5, 2018

The Honorable Asa Hutchinson
Governor
State of Arkansas
500 Woodlane Street
Little Rock, Arkansas 72201

Dear Governor Hutchinson:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving Arkansas's request for an amendment to its section 1115 demonstration project, entitled "Arkansas Works." The details of this approval will be transmitted to Cindy Gillespie, Director of the Arkansas Department of Human Services.

I want to express my appreciation for the hard work and commitment to innovation that your team has displayed during this process. At CMS, we are dedicated to empowering states to better serve their residents through state-led reforms that improve health and help lift individuals out of poverty. Your efforts through this demonstration help us to fulfill that promise.

Congratulations to the entire Arkansas team on reaching approval. We look forward to our continued work together through the implementation of these important reforms.

Sincerely,

[redacted]

Seema Verma

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAR - 5 2018

Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Dear Ms. Gillespie:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas's request for an amendment to its section 1115 demonstration project, entitled "Arkansas Works" (Project Number 11-W-00287/6) in accordance with section 1115(a) of the Social Security Act (the Act).

This approval is effective March 5, 2018, through December 31, 2021, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS's approval is subject to the limitations specified in the attached expenditure authorities, waivers, and special terms and conditions (STCs). The state will begin implementation of the community engagement requirement no sooner than June 1, 2018. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as waived or as not applicable to expenditures.

Extent and Scope of Demonstration

The current Arkansas Works section 1115 demonstration project was implemented by the State of Arkansas ("state") in December 2016. The Arkansas Works program provides certain adult Medicaid beneficiaries with premium assistance to purchase qualified health plan (QHP) coverage through the Health Insurance Marketplace. As originally approved, Arkansas Works was designed to leverage the efficiencies and experience of the commercial market to test whether this premium assistance mode improves continuity, access, and quality for Arkansas Works beneficiaries and results in lowering the growth rate of premiums across population groups. The demonstration project also attempts to facilitate transitions between and among Arkansas Works, ESI, and the Marketplace for Arkansas Works enrollees. Approval of this demonstration amendment allows Arkansas, no sooner than June 1, 2018, to require all Arkansas Works beneficiaries ages 19 through 49, with certain exceptions, to participate in and timely document and report 80 hours per month of community engagement activities, such as employment, education, job skills training, or community service, as a condition of continued Medicaid eligibility. Community engagement requirements will not apply to Arkansas Works beneficiaries ages 50 and older so as to ensure alignment and consistency with the state's Supplemental Nutrition Assistance Program (SNAP) requirements. The alignment is appropriate and consistent with the ultimate objective of improving health and well-being for Medicaid beneficiaries.

CMS also is authorizing authorities for additional features, including:

- Removing the requirement to have an approved-hospital presumptive-eligibility state plan amendment (SPA) as a condition of enacting the state's waiver of retroactive eligibility;
- Clarifying the waiver of the requirement to provide new adult group beneficiaries[1] with retroactive eligibility to reflect the state's intent to not provide retroactive eligibility but for the 30 days prior to the date of application coverage; and
- Removing the waiver and expenditure authorities related to the state's mandatory employer-sponsored insurance (ESI) premium assistance program, as the state no longer intends to continue this program.

Under the new community engagement program, the state will test whether coupling the requirement for certain beneficiaries to engage in and report work or other community engagement activities with meaningful incentives to encourage compliance will lead to improved health outcomes and greater independence. CMS is approving the community engagement program based on our determination that it is likely to assist in promoting the objectives of the Medicaid program. The terms and conditions of Arkansas's community engagement requirement that accompany this approval are consistent with the guidance provided to states through State Medicaid Director's Letter (SMD 18-0002), Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued on January 11, 2018. CMS is not at this time approving Arkansas's request to reduce income eligibility for Arkansas Works beneficiaries to 100 percent of the federal poverty level (FPL).

Determination that the demonstration project is likely to assist in promoting Medicaid's Objectives

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstrations are likely to assist in promoting the objectives of Medicaid.

While CMS believes that states are in the best position to design solutions that address the unique needs of their Medicaid-eligible populations, the agency has an obligation to ensure that proposed demonstration programs are likely to better enable states to serve their low-income populations, through measures designed to improve health and wellness, including measures to help individuals and families attain or retain capability for independence or self-care. Medicaid programs are complex and shaped by a diverse set of interconnected policies and components, including eligibility standards, benefit designs, reimbursement and payment policies, information technology (IT) systems, and more. Therefore, in making this determination, CMS considers the proposed demonstration as a whole.

[1] This group includes adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

In its consideration of the proposed changes to Arkansas Works, CMS examined whether the demonstration as amended was likely to assist in improving health outcomes; whether it would address behavioral and social factors that influence health outcomes; and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes. CMS has determined that the Arkansas Works demonstration as amended is likely to promote Medicaid objectives, and that the waivers sought are necessary and appropriate to carry out the demonstration.

1. **The demonstration is likely to assist in improving health outcomes through strategies that promote community engagement and address certain health determinants.**

Arkansas Works supports coordinated strategies to address certain health determinants, as well as promote health and wellness through increased upward mobility, greater independence, and improved quality of life. Specifically, Arkansas Works' community engagement requirement is designed to encourage beneficiaries to obtain and maintain employment or undertake other community engagement activities that research has shown to be correlated with improved health and wellness.[2,3] As noted in CMS' SMDL: 18-0002, these activities have been positively correlated with improvements in individuals' health. CMS has long supported policies that recognize meaningful work as essential to the economic self-sufficiency, self-esteem, well-being, and improved health of people with disabilities.

Given the potential benefits of work and community engagement, we believe that state Medicaid programs should be able to design and test incentives for beneficiary compliance. Under Arkansas's demonstration, the state will encourage compliance by making it a condition of continued coverage. Beneficiaries that successfully report compliance on a monthly basis will have no disruption in coverage. It is only when a beneficiary fails to report compliance for 3 months that the state will dis-enroll the beneficiary for the remainder of the calendar year. Beneficiaries that are disenrolled from their plan will be able to re-enroll through Arkansas Works upon the earlier of turning age 50, qualifying for another category of Medicaid eligibility, or the beginning of a new calendar year.

Arkansas' approach is informed by the state's experience with the voluntary work-referral program in its current demonstration, which the state has not found to be an effective incentive. Since January 2017, certain individuals enrolled in Arkansas Medicaid have been referred to the Arkansas Department of Workforce Services (DWS), which provides a variety of services to assist individuals in gaining employment. Through October 2017, only 4.7 percent of beneficiaries followed through with the referral and accessed DWS services. Of those who accessed DWS services, 23 percent have become employed. This result suggests that referrals alone, without any further incentive, may not be be sufficient to encourage the Arkansas Works

---

[2] Waddell, G. and Burton, AK. Is Work Good For Your Health And Well-Being? (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK

[3] Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper,K. Health effects of employment: a systemic review of prospective studies. BMJournals. Occupational and Environmental Medicine. 2014: 71 (10).

population to participate in community engagement activities. CMS will therefore allow Arkansas to test whether the stronger incentive model is more effective in encouraging participation.

Arkansas has tailored the incentive structure to include beneficiary protections, such as an opportunity to maintain coverage for beneficiaries who report that they failed to meet the community engagement hours due to circumstances that give rise to a good cause exemption, as well as the opportunity to apply and reenroll in Arkansas Works in the beginning of the next plan year. Additionally, if Arkansas determines that a beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, the beneficiary will receive retroactive coverage to the date coverage ended without need for a new application. The impact of this incentive, as well as other aspects of the demonstration, will be assessed through an evaluation designed to measure how the demonstration affects eligibility, and health outcomes over time for persons subject to the demonstration's policies.

2. **The demonstration is expected to strengthen beneficiary engagement in their personal health care.**

CMS believes that it is important for beneficiaries to engage in their personal health care, particularly while they are healthy to prevent illness. Accordingly, CMS supports state testing of policies designed to incentivize beneficiaries to obtain and maintain health coverage before they become sick so they can take an active role in engaging in their personal health care while healthy. Consistent with CMS's commitment to support states in their efforts to align Medicaid and private insurance policies for non-disabled adults to help them prepare for private coverage (stated in the letter to governors on March 14, 2017), this amendment removes the requirement that Arkansas provide hospitals with an opportunity to conduct presumptive eligibility (consistent with Section 1902(a)(47)(B)) as a condition of its waiver of retroactive eligibility. It further clarifies the waiver of the requirement to provide new adult group beneficiaries with retroactive eligibility but for the 30 days prior to the date of application coverage. With respect to the waiver of retroactive eligibility, through this approval, we are testing whether eliminating 2 of the 3 months of retroactive coverage will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. This feature of the amendment is intended to increase continuity of care by reducing gaps in coverage when beneficiaries churn on and off of Medicaid or sign up for Medicaid only when sick with the ultimate objective of improving beneficiary health.

Consideration of Public Comments

Both Arkansas and CMS received comments during the state and federal public comment periods. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all the public comments it received, when evaluating whether the demonstration project as a whole was likely to assist in promoting the objectives of the Medicaid program, and whether the waiver authorities sought were necessary and appropriate to implement the demonstration. In addition, CMS took public comments submitted during the federal comment period into account as it worked with Arkansas to develop the STCs that

accompany this approval that will bolster beneficiary protections, including specific state assurances around these protections to further support beneficiaries.

Opposing commenters expressed general disagreement with efforts to modify Arkansas Works. Some offered more specific feedback regarding individual elements of the demonstration or the impact of certain provisions on distinct populations. Some commenters expressed the desire to see greater detail regarding how the program would be operationalized, particularly with respect to provisions like the community engagement requirements. Other comments expressed concerns that these requirements would be burdensome on families or create barriers to coverage. The state has pledged to do beneficiary outreach and education on how to comply with the new community engagement requirements, and intends to use an online reporting system to make reporting easy for enrollees. Further, CMS intends to monitor state-reported data on how the new requirements are impacting enrollment.

Many commenters indicated that many beneficiaries not qualifying for Medicaid on the basis of disability may still have issues gaining and maintaining employment due to their medical or behavioral health conditions. To mitigate these concerns, Arkansas assures that it will provide these beneficiaries reasonable modifications, which could include the reduction of or exemption from community engagement hours. This is a condition of approval, as provided in the STCs.

Some commenters expressed concern that Arkansas's proposal "lacked sufficient detail to permit informed public comments." To ensure meaningful public input at the Federal level, and to facilitate the demonstration application process for States, CMS utilizes standardized demonstration application requirements so that the public, including those with disabilities, and CMS can meaningfully assess states' applications. Upon receipt of Arkansas' proposal, CMS followed its standard protocols for evaluating the completeness of the application and determined that Arkansas application was complete. We continue to believe that Arkansas submitted sufficient detail to permit meaningful public input.

Many commenters who opposed the community engagement requirement emphasized that the community engagement requirements would be burdensome for individuals and families or create barriers to coverage for non-exempt people who might have trouble accessing care. We believe that the community engagement requirements create appropriate incentives for beneficiaries to gain employment. Given that employment is positively correlated with health outcomes, it furthers the purposes of the Medicaid statute to test and evaluate these requirements as a means to improve beneficiaries' health and to promote beneficiary independence. However, CMS has included provisions in these STCs to ensure that CMS may withdraw waivers or expenditure authorities at any time if federal monitoring of data indicates that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and Title XXI, including if data indicates that the community engagement features of this demonstration may not adequately incentivize beneficiary participation or are unlikely to result in improved health outcomes, or that other demonstration features are not operating as intended. In efforts to support beneficiaries, CMS will require Arkansas to provide written notices to beneficiaries that include information such as how to ensure that they are in compliance with the community engagement requirements, how to appeal an eligibility denial, and how to access primary and preventive care during the non-eligibility

period. The state will also implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements.

Additional comments characterized the provisions to terminate coverage for failure to participate in the community engagement process as "causing disruptions in care." CMS and Arkansas acknowledged these concerns and Arkansas will be exempting from the requirement those individuals who are medically frail, as well as those whom a medical professional has determined are unable to work due to illness or injury. The state will implement an outreach strategy to inform beneficiaries about how to report compliance with the community engagement requirements. In addition, monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities.

Several commenters expressed concern about the potential 9-month length of the non-eligibility period. This would only occur where (i) an individual fails to fulfill his or her community engagement obligations in the first month of a calendar year and then after receiving a notice from the State in the second month, fails to respond to that notice by rectifying the situation or seeking an exemption, (ii) the same individual fails to fulfill his or her community engagement obligations in the second month of a calendar year and then after receiving a notice from the State in the third month, fails to respond to that notice by rectifying the situation or seeking an exemption, and (iii) the same individual fails to fulfill his or her community engagement obligations in the third month of a calendar year and then after receiving a notice from the State in the fourth month, fails to respond to that notice by rectifying the situation or seeking an exemption. The program provides the individual with three opportunities to rectify the situation or seek an exemption. Any system that requires individuals to fulfill certain requirements as a condition of receiving benefits necessarily places some degree of responsibility on these individuals. We believe that the overall health benefits to the effected population through community engagement outweigh the health-risks with respect to those who fail to respond and who fail to seek exemption from the programs limited requirements.

Some comments pointed out that the maximum non-eligibility period is longer than what has been proposed in other state demonstration applications, and does not offer any way to regain eligibility during the non-eligibility period. CMS acknowledges this and Arkansas will be required to monitor and report to CMS certain metrics on compliance rates and health outcomes. CMS will closely monitor this data, and retains the right to suspend, amend or terminate the demonstration if the agency determines that it is not meeting its stated objectives.

Other commenters expressed concern about Arkansas' current eligibility and application operations and their impact on beneficiaries who may reapply for eligibility after serving their disenrollment period for non-compliance with community engagement. To help mitigate these concerns, CMS has added additional assurances to the STCs and Arkansas will submit for CMS approval an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration which will allow CMS to track Arkansas' compliance with the assurances described in the STCs, including several related to eligibility and application processing systems. The state may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed the application processing monitoring plan for completeness and determined that the

state has addressed all of the required elements in a reasonable manner. As part of this requirement, CMS will require that Arkansas provide status updates on the implementation of the eligibility and enrollment monitoring plan in the state's quarterly reports.

Finally, many comments expressed concern over the waiver of retroactive eligibility, citing disruptions in care for beneficiaries and potential financial burdens for both providers and beneficiaries. Arkansas had previously received approval for a conditional waiver of retroactive coverage conditioned upon the state coming into compliance with statutory and regulatory requirements related to eligibility determinations. CMS has determined the state has met these requirements. CMS believes that a more limited period of retroactive eligibility will encourage beneficiaries to obtain and maintain health coverage, even when they are healthy. As such, with this amendment we are testing whether this limited retroactive eligibility period supports increased continuity of care by reducing gaps in coverage when beneficiaries churn on and off Medicaid or sign up for Medicaid only when sick and whether this feature will improve health outcomes.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the 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 Ms. Tia Witherspoon. She is available to answer any questions concerning your section 1115 demonstration. Ms. Witherspoon's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Tia. Witherspoon@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Witherspoon and Mr. Bill Brooks, Associate Regional Administrator, in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Mr. Bill Brooks
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
1301 Young Street, Suite 833
Dallas, TX 75202

If you have questions regarding this approval, please contact Ms. Judith Cash, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Thank you for all your work with us, as well as stakeholders in Arkansas, over the past months to reach approval.

Sincerely,

[redacted]

Seema Verma

Enclosures

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: **Arkansas Works 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 Works Section 1115 demonstration.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Arkansas Works section 1115 demonstration, including the granting of the waiver and expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Social Security Act.
The following expenditure authorities shall enable Arkansas to implement the Arkansas Works section 1115 demonstration:

1. **Premium Assistance and Cost Sharing Reduction Payments.** Expenditures for part or all of the cost of private insurance premiums in the individual market, and for payments to reduce cost sharing under such coverage for certain beneficiaries as described in these STCs.

2. **Community Engagement Reporting.** Expenditures to the extent necessary to enable Arkansas to allow a beneficiary to report monthly their community engagement qualifying activities or exemptions using only an online portal as described in these STCs, in a manner inconsistent with requirements under section 1943 of the Act as implemented in 42 CFR 435.907(a).

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, with respect to beneficiaries through qualified health plans, 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 as described in these STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

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

TITLE: **Arkansas Works 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 March 5, 2018 through December 31, 2021. 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 for the Arkansas Works Section 1115 demonstration, 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 beneficiary's Qualified Health Plan. No waiver of freedom of choice is authorized for family planning providers.

2. Payment to Providers **Section 1902(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.

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, and for expedited review in exigent circumstances within 24 hours, rather than 24 hours for all circumstances 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. Premiums **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable Arkansas to collect monthly premium payments, for beneficiaries with incomes above 100 up to and including 133 percent of the federal poverty level (FPL) as described in these STCs.

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

To the extent necessary to enable the state to impose targeted cost sharing on beneficiaries as described in these STCs.

6. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to not provide beneficiaries in table 1 retroactive eligibility but for 30 days prior to the date of the application for coverage under the demonstration.

7. Provision of Medical Assistance **Section 1902(a)(8) and Sections 1902(a)(10)**

To the extent necessary to enable Arkansas to terminate eligibility for, and not make medical assistance available to, Arkansas Works beneficiaries who fail to comply with community engagement requirements, as described in these STCs, unless the beneficiary is exempted as described in these STCs.

8. Eligibility **Section 1902(a)(10)**

To the extent necessary to enable Arkansas to require community engagement as a condition of eligibility as described in these STCs.

To the extent necessary to enable Arkansas to prohibit re-enrollment and deny eligibility, for up to nine months for Arkansas Works program beneficiaries who are disenrolled for failure to timely report community engagement qualifying activities and exemptions for three months, subject to qualifying catastrophic events described in these STCs.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Arkansas Works**

AWARDEE: **Arkansas Department of Human Services**

I. PREFACE

The following are the amended Special Terms and Conditions (STCs) for the Arkansas Works section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Arkansas Department of Human Services (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. Enrollment into the demonstration is statewide and is approved through December 31, 2021. 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. Arkansas Works Program Population Affected
VI. Premium Assistance Delivery System
VII. Benefits
VIII. Premiums & Cost Sharing
IX. Appeals
X. Community Engagement Requirements
XI. General Reporting Requirements
XII. General Financial Requirements
XIII. Monitoring Budget Neutrality
XIV. Evaluation
XV. Monitoring
Attachments

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Arkansas Works 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 qualified health plans (QHPs) offered in the individual market through the Marketplace. Enrollment activities for the new adult population began on October 1, 2013 for QHPs with eligibility effective January 1, 2014. Beginning in 2014, individuals eligible for

coverage under the new adult group are described at Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and are further specified in the state plan (collectively Arkansas Works beneficiaries). Arkansas Works beneficiaries receive a state plan Alternative Benefit Plan ("ABP").

Effective January 1, 2017, Arkansas Works beneficiaries with incomes above 100 percent of the FPL are charged monthly premium payments. The state will test innovative approaches to promoting community engagement and work, encouraging movement up the economic ladder, and facilitating transitions between and among Arkansas Works, employer sponsored insurance (ESI), and the Marketplace for Arkansas Works beneficiaries. The state will institute community engagement requirements as a condition of Arkansas Works eligibility. Once community engagement requirements are fully implemented, including that beneficiaries have been adequately notified of the requirements, the state will implement an outreach strategy to inform beneficiaries about how to report compliance with the community engagement requirements. In addition, monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities. Arkansas will also provide reasonable accommodations for beneficiaries who request assistance due to barriers to accessing the online portal for reporting. Arkansas Works beneficiaries who are ages 19-49 must work or engage in specified educational, job training, or job search activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who fail to meet the community engagement requirements or reporting requirements for any three months during a plan year will be disenrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year. After the beneficiary receives notification of disenrollment for either noncompliance with community engagement requirements or for failure to report, eligible beneficiaries may request a good cause exemption as described in these STCs. If Arkansas determines the beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, the beneficiary will receive retroactive coverage to the date coverage ended without need for a new application. Arkansas will act on the request for good cause exemption and, if approved, restore the beneficiary's coverage within 5 business days of receiving the request.

Finally, the state will eliminate its ESI premium assistance program under the demonstration. All Arkansas Works beneficiaries who were enrolled in ESI premium assistance and who remain eligible for Arkansas Works will transition to QHP coverage.

Over the demonstration period, the state seeks to demonstrate several demonstration goals. The state's goals will inform the state's evaluation design hypotheses, subject to CMS approval, as described in these STCs. The state's goals include, and are not limited to the following:

- Providing continuity of coverage for individuals,
- Improving access to providers,
- Improving continuity of care across the continuum of coverage,
- Requiring beneficiaries to pay a monthly premium to promote more efficient use of health care services,

- Improving health outcomes and promoting independence through employment and community engagement, and
- Furthering quality improvement and delivery system reform initiatives that are successful across population groups.

Arkansas proposes that the demonstration will provide integrated coverage for low-income Arkansans, leveraging the efficiencies and experience of the private market to improve continuity, access, and quality for Arkansas Works beneficiaries that should ultimately result in lowering the rate of growth in premiums across population groups. 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 at least doubling the size of the population enrolling in QHPs offered through the Marketplace.
The state proposes to demonstrate the following key features:

Continuity of coverage and care - The demonstration will allow qualifying households to stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, or Advanced Premium Tax Credits/Cost Sharing Reductions (APTC/CSRs).

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.

Integration, efficiency, quality improvement and delivery system reform - Arkansas is proposing taking an integrated and market-based approach to covering uninsured Arkansans. It is anticipated that QHPs will bring the experience of successful private sector models that can improve access to high quality services and lead delivery system reform. One of the benefits of this demonstration should be to gain a better understanding of how the private sector uses incentives to engage individuals in healthy behaviors.

Promoting community engagement and personal responsibility- By testing innovative approaches to promoting community engagement as a condition of eligibility, the demonstration aims to incentivize employment.

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 provide the state with additional notice of the changes.

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.

   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.** If not otherwise specified in these STCs, changes related to demonstration features including eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, 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 that meets federal requirements at 42 CFR 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

a. Compliance with Transparency Requirements at 42 CFR Section 431.412.

b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 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, if applicable. 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. **Prior CMS Approval**. 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 calendar 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 is entitled to 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 demonstration 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, continued benefits as a result of participant's appeals and administrative costs of disenrolling participants.

10. Pre-Approved Transition and Phase Out Plan. The state may elect to submit a draft transition and phase-out plan for review and approval at any time, including prior to when a date of termination has been identified. Once the transition and phase-out plan has been approved, implementation of the plan may be delayed indefinitely at the option of the state.

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 beneficiaries.

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 beneficiaries as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration beneficiary 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 beneficiaries.

13. Withdrawal of Demonstration 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, including if federal monitoring of data indicates that the community engagement features of this demonstration may not adequately incentivize beneficiary participation or are unlikely to result in improved health outcomes, or that other demonstration features are not operating as intended. 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 beneficiaries.

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

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the State's approved state plan, when any program changes to the demonstration are proposed by the State.

a. In States with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

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

17. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ARKANSAS WORKS PROGRAM POPULATIONS AFFECTED

The State will use this demonstration to ensure coverage for Arkansas Works 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 Arkansas Works beneficiaries in enrolling in coverage through QHPs in the Marketplace.

18. Populations Affected by the Arkansas Works Demonstration. Except as described in STCs 19 and 20, the Arkansas Works demonstration affects 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 Arkansas Works beneficiaries 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 (MAGI) 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 adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIlI) of the Social Security Act	Title XIX	MEG - 1

19. **Medically Frail Individuals.** Arkansas has instituted a process to determine whether a beneficiary is medically frail. The process is described in the Alternative Benefit state plan. Beneficiaries excluded from enrolling in QHPs through the Arkansas Works 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 beneficiaries 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.

20. **American Indian/Alaska Native Individuals.** Beneficiaries 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 a QHP. New applicants will be subject to provisions of STC 21 and coverage will begin 30 days prior to the date an application is submitted for coverage. Beneficiaries who are AI/AN and who have not opted into a QHP will receive the ABP through a fee for service (FFS) system. An AI/AN beneficiary 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.

21. **Retroactive Eligibility.** The state will provide coverage effective 30 days prior to the date of submitting an application for coverage for beneficiaries in table 1.

V. ARKANSAS WORKS PREMIUM ASSISTANCE ENROLLMENT

22. **Arkansas Works.** For Arkansas Works beneficiaries, except as noted in STCs 19 and 20, enrollment in a QHP is a condition of receiving benefits.

23. **Notices.** Arkansas Works beneficiaries will receive a notice or notices from Arkansas Medicaid or its designee advising them of the following:

a. QHP Plan Selection. The notice will include information regarding how Arkansas Works 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. State Premiums and Cost-Sharing. The notice will include information about the beneficiary's premium and cost-sharing obligations, if any, as well as the quarterly cap on premiums and cost-sharing.

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 access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid and what phone numbers to call or websites to visit to access wrapped services.

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

f. Identification of Medically Frail. The notice will include information describing how Arkansas Works beneficiaries who believe they are medically frail can request a determination of whether they are exempt from the ABP. The notice will also include alternative benefit plan options.

g. Timely and adequate notice concerning adverse actions. The notice must give beneficiaries timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid in accordance with 42 CFR 435.919.

24. **QHP Selection.** The QHPs in which Arkansas Works beneficiaries enroll are certified through the Arkansas Insurance Department's QHP certification process. The QHPs available for selection by the beneficiary are determined by the Medicaid agency.

25. **Auto-assignment.** In the event that an beneficiary is determined eligible for coverage through the Arkansas Works QHP premium assistance program, but does not select a plan, the State will auto-assign the beneficiary to one of the available QHPs in the beneficiary's rating area. Beneficiaries 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.

26. Distribution of Members Auto-assigned. Arkansas Works QHP 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.

27. Changes to Auto-assignment Methodology. The state will advise CMS prior to implementing a change to the auto-assignment methodology.

28. Disenrollment. Beneficiaries may be disenrolled from the demonstration if they are determined to be medically frail after they were previously determined eligible.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

29. Memorandum of Understanding for QHP Premium Assistance. The Arkansas Department of Human Services and the Arkansas Insurance Department have entered into a memorandum of understanding (MOU) with each QHP that enrolls beneficiaries. Areas to be addressed in the MOU include, but are not limited to:

a. Enrollment of beneficiaries in populations covered by the demonstration;

b. Payment of premiums and cost-sharing reductions, including the process for collecting and tracking beneficiary premiums;

c. Reporting and data requirements necessary to monitor and evaluate the Arkansas Works including those referenced in STC 79, ensuring beneficiary access to EPSDT and other covered benefits through the QHP;

d. Requirement for QHPs to provide, consistent with federal and state laws, claims and other data as requested to support state and federal evaluations, including any corresponding state arrangements needed to disclose and share data, as required by 42 CFR 431.420(f)(2), to CMS or CMS' evaluation contractors.

e. Noticing requirements; and

f. Audit rights.

30. Qualified Health Plans. The State will use premium assistance to support the purchase of coverage for Arkansas Works beneficiaries through Marketplace QHPs.

31. Choice of QHPs. Each Arkansas Works beneficiary required to enroll in a QHP 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. Arkansas Works 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. Arkansas Works beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area and that meet the purchasing guidelines established by the State in that year, and thus all Arkansas Works beneficiaries will have a choice of at least two QHPs.

c. The State will comply with Essential Community Provider network requirements, as part of the QHP certification process.

d. Arkansas Works beneficiaries will have access to the same networks as other beneficiaries enrolling in QHPs through the individual Marketplace.

32. Coverage Prior to Enrollment in a QHP. The State will provide coverage through fee-for-service Medicaid from the date a beneficiary is determined eligible until the beneficiary's enrollment in the QHP becomes effective.

a. For beneficiaries who enroll in a QHP (whether by selecting the QHP or through auto-assignment) between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP enrollment.

b. For beneficiaries who enroll in a QHP (whether by selecting the QHP or through auto-assignment) 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).

33. 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.

34. NEMT. Non-emergency medical transport services will be provided through the State's fee-for-service Medicaid program. See STC 41 for further discussion of non-emergency medical transport services.

VII. BENEFITS

35. Arkansas Works Benefits. Beneficiaries 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.

36. Alternative Benefit Plan. The benefits provided under an alternative benefit plan for the new adult group are reflected in the State ABP state plan.

37. 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 QHPs. These benefits include non-emergency transportation and Early Periodic Screening Diagnosis

and Treatment (EPSDT) services for beneficiaries participating in the demonstration who are under age 21.

38. Access to Wrap Around Benefits. In addition to receiving an insurance card from the applicable QHP issuer, Arkansas Works 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 Arkansas Works beneficiaries may receive through fee-for-service Medicaid and how to access those services. This information is also posted on Arkansas Department of Human Service's Medicaid website and will be provided through information at the Department of Human Service's call centers and through QHP issuers.

39. 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).

40. Access to Federally Qualified Health Centers and Rural Health Centers. Arkansas Works beneficiaries will have access to at least one QHP in each service area that contracts with at least one FQHC and RHC.

41. Access to Non-Emergency Medical Transportation. The state will establish prior authorization for NEMT in the ABP. Beneficiaries served by IHS or Tribal facilities and medically frail beneficiaries will be exempt from such requirements.

42. Incentive Benefits. To the extent an amendment is approved by CMS, Arkansas will offer an additional benefit not otherwise provided under the Alternative Benefit Plan for Arkansas Works beneficiaries who make timely premium payments (if above 100 percent FPL) and engage with a primary care provider (PCP). Arkansas Works beneficiaries with incomes at or below 100 percent FPL and others who are exempt from premiums will be eligible for an incentive benefit at the time the amendment is approved.

VIII. PREMIUMS & COST SHARING

43. Premiums & Cost Sharing. Cost sharing for Arkansas Works beneficiaries 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 447.56(a).

44. Premiums & Cost Sharing Parameters for the Arkansas Works Program. With the approval of this demonstration:

a. Beneficiaries up to and including 100 percent of the FPL will have no cost sharing.

b. Beneficiaries above 100 percent of the FPL will have cost sharing consistent with Medicaid requirements.

c. Beneficiaries above 100 percent of the FPL will be required to pay monthly premiums of up to 2 percent of household income.

d. Premiums and cost-sharing will be subject to an aggregate cap of no more than 5 percent of family monthly or quarterly income.

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

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

45. 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 Arkansas Works 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.

46. Grace Period/Debt Collection. Arkansas Works beneficiaries will have two months from the date of the payment invoice to make the required monthly premium contribution. Arkansas and/or its vendor may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the individual's earnings for beneficiaries at any income level. The state and/or its vendor may not "sell" the debt for collection by a third party.

IX. APPEALS

47. 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 has submitted a state plan amendment delegating certain responsibilities to the Arkansas Insurance Department.

X. COMMUNITY ENGAGEMENT REQUIREMENTS

48. **Overview**. Subject to these STCs, the state will implement a community engagement requirement as a condition of continued eligibility for Arkansas Works members below the age of 50 who are not otherwise subject to an exemption described in STC 49 or 53(a). To maintain Medicaid eligibility, non-exempt members will be required to participate in specified activities that may include employment, education or community services, as specified in these STCs. The work requirements will be implemented no sooner than June 1, 2018, and the state will provide CMS with notice 30 days prior to its implementation.

49. **Exempt Populations**. The Arkansas Works beneficiaries below are exempt from the community engagement requirements. Beneficiaries who report, in accordance with 42 CFR 435.945(a) that they meet one or more of the following exemptions will not be required to complete community engagement related activities to maintain eligibility:

- Beneficiaries identified as medically frail (under 42 CFR 440.315(f) and as defined in the alternative benefit plan in the state plan)
- Beneficiaries who are pregnant or 60 days post-partum
- Full time students
- Beneficiary is exempt from Supplemental Nutrition Assistance Program (SNAP) community engagement requirements
- Beneficiary is exempt from Transitional Employment Assistance (TEA)[1] Cash Assistance community engagement requirements
- Beneficiary receives TEA Cash Assistance
- Beneficiary is incapacitated in the short-term, is medically certified as physically or mentally unfit for employment, or has an acute medical condition validated by a medical professional that would prevent him or her from complying with the requirements
- Beneficiary is caring for an incapacitated person
- Beneficiary lives in a home with his or her minor dependent child age 17 or younger
- Beneficiary is receiving unemployment benefits
- Beneficiary is currently participating in a treatment program for alcoholism or drug addiction

Beneficiaries who report that they meet one or more of the above listed exemptions will not be required to complete community engagement related qualifying activities to maintain eligibility. Upon initial notice that a beneficiary must commence community engagement activities, the beneficiary may report an exemption at any time, via electronic submission. Consistent with STC 52, Arkansas will also provide web sites that comply with federal disability rights laws and reasonable accommodations for beneficiaries who are unable to report, or have difficulty reporting, work activities to ensure that they have an equal opportunity to report their participation

[1] Arkansas' Temporary Assistance for Needy Families (TANF) program.

50. Qualifying Activities. Arkansas Works beneficiaries who are not exempt under STC 49 may satisfy their community engagement requirements through a variety of activities, including but not limited to:

- Employment or self-employment, or having an income that is consistent with being employed or self-employed at least 80 hours per month[2]
- Enrollment in an educational program, including high school, higher education, or GED classes
- Participation in on-the-job training
- Participation in vocational training
- Community Service
- Participation in independent job search (up to 40 hours per month)
- Participation in job search training (up to 40 hours per month)
- Participation in a class on health insurance, using the health system, or healthy living (up to 20 hours per year)
- Participation in activities or programs available through the Arkansas Department of Workforce Services
- Participation in and compliance with SNAP/Transitional Employment Assistance (TEA) employment initiative programs.

51. Hour Requirements. Arkansas Works beneficiaries must complete at least 80 hours per calendar month of one, or any combination, of the qualifying activities listed in STC 50. Beneficiaries will be required to electronically report into the online portal by the 5th of each month for the previous month's qualifying activities. Arkansas will also provide reasonable accommodations to ensure that beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act, who are unable to report, or have difficulty reporting, work activities to ensure that they have an equal opportunity to report their participation and therefore to have an equal opportunity to participate in, and benefit from, the program. If the state is unable to provide such a modification to the reporting requirements as required by federal law, then the state must follow the requirements of STC 52, which would require that the state provide a modification in the form of an exemption from participation.

52. Reasonable Modifications. Arkansas must provide reasonable accommodations related to meeting the community engagement requirements for beneficiaries with disabilities protected by the ADA, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The state must also provide reasonable modifications for program protections and procedures, including but not limited to, assistance with demonstrating eligibility for good cause exemptions;

[2] Arkansas minimum wage is used as a proxy amount to determine this income standard. As of 2017, minimum wage is $8.50 per hour. Multiplied by 80 hours per month, an individual is considered to be in compliance with the community engagement requirements if they have income or earnings of at least $736 per month.

appealing disenrollments; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications. The reasonable modifications must include exemptions from participation where an individual is unable to participate or report for disability-related reasons, modification in the number of hours of participation required where an individual is unable to participate for the otherwise-required number of hours, and provision of support services necessary to participate, where participation is possible with supports. In addition, the state should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed.

53. Non-Compliance. Beneficiaries who are subject to community engagement and reporting requirements and do not comply with the requirements will lose eligibility for Arkansas Works consistent with the terms of these STCs. Beneficiaries who submit an appeal request or report a good cause exemption prior to disenrollment will maintain services as provided under 42 CFR 431.230.

Beneficiaries who fail to meet the required community engagement hours or fail to report for any month within a coverage year before they are disenrolled for non-compliance will receive timely and adequate monthly notices in writing to inform them of non-compliance and how to come into compliance.

a. **Good Cause Exemption.** The state will not count any month of non-compliance with the community engagement requirement or reporting requirements toward the three months under this STC for beneficiaries who demonstrate good cause for failing to meet the community engagement hours otherwise required for that month. The circumstances constituting good cause must have occurred during the month for which the beneficiary is seeking a good cause exemption. . The recognized good cause exemptions include, but are not limited to, at a minimum, the following verified circumstances:

    i. The beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or an immediate family member who was living in the home with the beneficiary experiences a hospitalization or serious illness;

    ii. The beneficiary experiences the birth, or death, of a family member living with the beneficiary;

iii. The beneficiary experiences severe inclement weather (including a natural disaster) that renders him or her unable to meet the requirement; or

iv. The beneficiary has a family emergency or other life-changing event (e.g., divorce or domestic violence).

b. **Disenrollment Effective Date.** Disenrollment for non-compliance with the community engagement requirements is effective the first day of the month after proper notice is provided during the third month of non-compliance, unless an appeal is timely filed as specified in STC 54(i) or a good cause exemption is requested as specified in STC 53(a).

c. **Re-enrollment Following Non-Compliance.** If the beneficiaries are non-compliant with the community engagement requirements or reporting requirements for any three months, eligibility will be terminated until the next plan year, when they must file a new application to receive an eligibility determination. At this time, their previous noncompliance with the community engagement requirement will not be factored into the state's determination of their eligibility. A beneficiary who is disenrolled pursuant to this STC can reapply at any time for coverage and will be eligible to enroll with an effective date consistent with the regulations at 42 CFR. 435.915, (1) if she or he is determined eligible for another eligibility group, or (2) the beneficiary would have qualified for a good cause exemption at the time of disenrollment and Arkansas determines the beneficiary's failure to comply or report compliance was the result of a catastrophic event or circumstances beyond the beneficiary's control, Such beneficiaries who experienced catastrophic events or circumstances beyond their control will receive retroactive coverage to the date coverage ended without need for a new application. Arkansas will act on the request for good cause exemption and, if approved, restore the beneficiary's coverage within 5 business days of receiving the request.

54. Community engagement requirements: State Assurances. Prior to implementation of community engagement requirements as a condition of eligibility, the state will:

a. Maintain mechanisms to stop payments to a QHP when a beneficiary is terminated for failure to comply with program requirements.

b. Ensure that there are processes and procedures in place to seek data from other sources including SNAP and Temporary Assistance for Needy Families (TANF), and that the state uses available systems and data sources to verify that beneficiaries are meeting community engagement requirements.

c. To the extent that it is required by SNAP, beneficiaries who participate in both SNAP and Arkansas Works will have the option of reporting community engagement activities through either program. If a beneficiary reports activities through SNAP, Arkansas will transfer the individual's file to Arkansas Works to

satisfy reporting for both programs. In accordance with all applicable federal and state reporting requirements, beneficiaries enrolled in and compliant with a SNAP work requirement, as well as individuals exempt from a SNAP work requirement, will be considered to be complying with the Arkansas Works community engagement requirements without further need to report.

d. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:

    i. When community engagement requirements will commence for that specific beneficiary;

    ii. Whether a beneficiary is exempt, how the beneficiary must apply for and document that she or he meets the requirements for an exemption, and under what conditions the exemption would end;

    iii. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are available to assist beneficiaries in meeting community engagement requirements;

    iv. Information about how community engagement hours will be counted and documented;

    v. What gives rise to disenrollment, what disenrollment would mean for the beneficiary, including how it could affect redetermination, and how to avoid disenrollment, including how to apply for a good cause exemption and what kinds of circumstances might give rise to good cause;

    vi. If a beneficiary is not in compliance for a particular month, that the beneficiary is out of compliance, and, if applicable, how the beneficiary can be in compliance in the month immediately following;

    vii. If a beneficiary has eligibility denied, how to appeal, and how to access primary and preventive care during the non-eligibility period.

    viii. If a beneficiary has requested a good cause exemption, that the good cause exemption has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.

e. Conduct active outreach and education beyond standard noticing for Arkansas Works beneficiaries for successful compliance with community engagement requirements as clients move toward self-sufficiency and economic security.

f. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions or alternative compliance standards from the community engagement requirements and/or additional mitigation strategies, so that the community engagement requirements will not be impossible or unreasonably burdensome for beneficiaries to meet in impacted areas.

g. Develop and maintain an ongoing partnership with the Arkansas Department of Workforce Services to assist Arkansas Works recipients with complying with community engagement requirements and moving toward self-sufficiency.

h. Leverage the ongoing partnership with QHPs participating in the Arkansas Works premium assistance model for continued outreach, education and encouragement to comply with community engagement requirements.

i. Provide full appeal rights, consistent with all federal statute and regulation, prior to disenrollment and observe all requirements for due process for beneficiaries who will be disenrolled for failing to comply with the applicable community engagement requirements, including allowing beneficiaries the opportunity to raise additional issues in a hearing (in addition to whether the beneficiary should be subject to termination) or provide additional documentation through the appeals process.

j. Maintain timely processing of applications to avoid further delays in accessing benefits once the disenrollment period is over.

k. If a beneficiary has requested a good cause exemption, the state must provide timely notice that the good cause exemption has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.

l. Comply with the screening and eligibility determination requirements in 42 CFR 435.916(f).

m. Establish beneficiary protections, including assuring that Arkansas Works beneficiaries do not have to duplicate requirements to maintain access to all public assistance programs that require community engagement and employment.

n. With the assistance of other state agencies including the Arkansas Department of Workforce Services and other public and private partners, DHS will make good faith efforts to screen, identify, and connect Arkansas Works beneficiaries to existing community supports that are available to assist beneficiaries in meeting community engagement requirements, including available non-Medicaid assistance with transportation, child care, language access services and other supports; and connect beneficiaries with disabilities as defined in the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection

and Affordable Care Act with services and supports necessary to enable them to meet and report compliance with community engagement requirements.

o. The State makes the general assurance that it is in compliance with protections for beneficiaries with disabilities under ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act.

p. Consider the impact of any reporting obligations on persons without access to the Internet. To the extent practicable, the State shall ensure that the availability of Medicaid services will not been diminished under this demonstration for individuals who lack access to the Internet.

q. The state will provide each beneficiary who has been disenrolled from Arkansas Works with information on how to access primary care and preventative care services at low or no cost to the individual. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. Arkansas shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.

r. The state must submit an eligibility and enrollment monitoring plan within 90 calendar days after approval of the community engagement amendment of this demonstration. CMS will work with the state if we determine changes are necessary to the state's submission, or if issues are identified as part of the review. Once approved, the eligibility and enrollment monitoring plan will be incorporated into the STCs as Attachment A. The state will provide status updates on the implementation of the eligibility and enrollment monitoring plan in the quarterly reports. Should the state wish to make additional changes to the eligibility and enrollment monitoring plan, the state should submit a revised plan to CMS for review and approval. The state may not take adverse action on a beneficiary for failing to complete community engagement requirements until CMS has reviewed and approved the revised eligibility and enrollment monitoring plan for completeness and determined that the state has addressed all of the required elements in a reasonable manner.

Plan Requirements. At a minimum, the eligibility and enrollment monitoring plan will describe the strategic approach and detailed project implementation plan, including metrics, timetables and programmatic content where applicable, for defining and addressing how the state will comply with the assurances described in these STCs, as well as the assurances listed within this STC. Where possible, metrics baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

i. Send timely and accurate notices to beneficiaries, including sufficient ability for beneficiaries to respond to notices.

ii. Assure application assistance is available to beneficiaries (in person and by phone).

iii. Assure processes are in place to accurately identify including but not limited to the following data points :

a. Number and percentage of individuals required to report each month

b. Number and percentage of beneficiaries who are exempt from the community engagement requirement.

c. Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements

d. Number and percentage of beneficiaries granted good cause exemption from reporting requirements

e. Number and percentage of beneficiaries who requested reasonable accommodations

f. Number and percentage and type of reasonable accommodations provided to beneficiaries

g. Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements

h. Number and percentage of beneficiaries disenrolled for failing to report

i. Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements

j. Number and percentage of community engagement appeal requests from beneficiaries

k. Number, percentage and type of community engagement good cause exemptions requested

l. Number, percentage and type of community engagement good cause exemptions granted

m. Number, percentage and type of reporting good cause exemptions requested

n. Number, percentage and type of reporting good cause exemptions granted

o. Number and percentage of applications made in-person, via phone, via mail and electronically.

iv. Maintain an annual renewal process, including systems to complete ex parte renewals and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.

v. Maintain ability to report on and process applications in-person, via phone, via mail and electronically.

vi. Maintain compliance with coordinated agency responsibilities under 42 CFR 435.120, including the community engagement online portal under 42 CFR 435.1200(f)(2).

vii. Assure timeliness of transfers between Medicaid and other insurance programs at any determination, including application, renewal, or non-eligibility period.

viii. The state's plan to implement an outreach strategy to inform beneficiaries how to report compliance with the community engagement requirements including how monthly notices will provide information on resources available to beneficiaries who may require assistance reporting community engagement activities.

XI. GENERAL REPORTING REQUIREMENTS

55. Deferral for Failure to Submit Timely Demonstration Deliverables. The state agrees that CMS may issue deferrals in the amount of $5,000,000 (federal share) per deliverable when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension in which to submit the required deliverable. Extension requests that extend beyond the fiscal quarter in which the deliverable was due must include a Corrective Action Plan (CAP).

i. CMS may decline the extension request.

ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

56. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall 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. Pursuant to 42 CFR 431.420(c),the state must include a summary of the comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

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

58. Compliance with Federal Systems Innovation. As federal systems continue to evolve and incorporate 1115 demonstration reporting and analytics, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to are provided; and

c. Submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

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.

59. 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 XIII of the STCs.

60. 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 67.

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 beneficiaries that are collected by the state from beneficiaries 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 2Demonstration 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
Demonstration Year 4 (DY4)	January 1, 2017	12 months
Demonstration Year 5 (DY5)	January 1, 2018	12 months
Demonstration Year 6 (DY6)	January 1, 2019	12 months
Demonstration Year 7 (DY7)	January 1, 2020	12 months
Demonstration Year 8 (DY8)	January 1, 2021	12 months

61. 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").

62. 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.

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

a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under STC 86, 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.

64. 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.

65. 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 66:

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.

66. 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.

67. 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.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State 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

68. 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 69, 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.

69. 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 70, but not at risk for the number of beneficiaries 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.

70. 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 STC 70 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 71 below.

71. 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 73. 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 3 Per Capita Cost Estimate

MEG	TREND	DY 4 - PMPM	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM
New Adult Group	4.7%	$570.50	$597.32	$625.39	$654.79	$685.56

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 1 of 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.

72. 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 9), 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.

73. 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.

74. 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 4 Cap Thresholds

Year	Cumulative target definition	Percentage
DY 4	Cumulative budget neutrality limit plus:	0%
DY 5	Cumulative budget neutrality limit plus:	0%
DY 6	Cumulative budget neutrality limit plus:	0%
DY 7	Cumulative budget neutrality limit plus:	0%
DY 8	Cumulative budget neutrality limit plus:	0%

75. 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.

76. Impermissible DSH, Taxes or Donations. The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves

the right to make adjustments to the budget neutrality expenditure limit if CMS determines that any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

XIV. EVALUATION

77. Evaluation Design and Implementation. The State shall submit a draft evaluation design for Arkansas Works to CMS no later than 120 days after the award of the demonstration amendment. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the Health Care Independence Program. The state must submit a final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval.

78. 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.

79. 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 Works 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 Arkansas Works 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 Arkansas Works 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 Arkansas Works. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Arkansas will be determined and compared to improvement efforts undertaken in other delivery systems.

80. Evaluation Requirements. 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.

81. 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. Additional hypotheses relative to the new and revised components of the demonstration will also be included in the state's evaluation design.

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 77 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
xiii. Incentive benefits offered to Arkansas Works beneficiaries will increase primary care utilization.

These hypotheses should be addressed in the demonstration reporting described in STC 86 and 87 with regard to progress towards the expected outcomes.

b. Data: This discussion shall include:

i. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;
ii. Method of data collection;
iii. Frequency and timing 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

c. **Study Design**: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies 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. To the extent possible, the former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. 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

d. **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.

e. **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.

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, and the deliverables

outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.

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.

j. **State additions**: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

82. Interim Evaluation Report. The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending December 31, 2021. The Interim Evaluation Report shall include the same core components as identified in STC 81 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments. The state will submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Interim Evaluation Report should be posted to the state's website with the application for public comment. Also refer to Attachment C for additional information on the Interim Evaluation Report.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration, the research questions, hypotheses and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state will submit the final Interim Evaluation Report sixty (60) days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

83. Summative Evaluation Reports.

a. The state shall provide the summative evaluation reports described below to capture the different demonstration periods.

i. The state shall provide a Summative Evaluation Report for the Arkansas Private Option demonstration period September 27, 2013 through December 31, 2016. This Summative Evaluation Report is due July 1, 2018, i.e., eighteen months following the date by which the demonstration would have ended except for this extension.

ii. The state shall submit a draft summative evaluation report for the Arkansas Works demonstration period starting January 1, 2017 through December 31, 2021. The draft summative evaluation report must be submitted within 18 months of the end of the approved period (December 31, 2021). The summative evaluation report must include the information in the approved evaluation design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final summative evaluation report within 60 days of receiving comments from CMS on the draft.
b. The final summative evaluation report must be posted to the state's Medicaid website within 30 days of approval by CMS.

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

i. **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.

ii. **Demonstration Description**. This includes a description of the demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

iii. **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.

iv. **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.

v. **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.

vi. **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.

84. 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 75. The State will present on its interim evaluation in conjunction with STC 79. The State will present on its summative evaluation in conjunction with STC 80.

85. Public Access. The State shall post the final documents (e.g. Quarterly Reports, Annual Reports, Final Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the State Medicaid website within 30 days of approval by CMS.

86. Additional Publications and Presentations. 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 to comment or review some or all of these notifications and reviews.

87. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate timely and 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. Failure to cooperate with federal evaluators in a timely manner, including but not limited to entering into data use agreements covering data that the state is legally permitted to share, providing a technical point of contact, providing data dictionaries and record layouts of any data under control of the state that the state is legally permitted to share, and/or disclosing data may result in

CMS requiring the state to cease drawing down federal funds until satisfactory cooperation, until the amount of federal funds not drawn down would exceed $5,000,000.

XV. MONITORING

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

89. Quarterly Reports. The state must submit three Quarterly Reports and one compiled Annual Report each DY.

a. The state will submit the reports following the format established by CMS. All Quarterly Reports and associated data must be submitted through the designated electronic system(s). The Quarterly Reports are due no later than 60 days following the end of each demonstration quarter, and the compiled Annual Report is due no later than 90 days following the end of the DY.

b. 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.

c. 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.

d. The Quarterly Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section. The reports shall provide sufficient information for CMS to understand implementation progress and operational issues associated with the demonstration and whether there has been progress toward the goals of the demonstration.

i. **Operational Updates -** The reports shall provide sufficient information to document 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. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.

ii. **Performance Metrics -** Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

iii. **Budget Neutrality and Financial Reporting Requirements -** The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

iv. **Evaluation Activities and Interim Findings**. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, 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 for monitoring and evaluation of the demonstration.

e. The Annual Report must include all items included in the preceding three quarterly reports, which must be summarized to reflect the operation/activities throughout the whole DY. All items included in the quarterly report pursuant to STC 86 must be summarized to reflect the operation/activities throughout the DY. In addition, the annual report must, at should include the requirements outlined below.

i. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
ii. Total contributions, withdrawals, balances, and credits; and,
iii. Yearly unduplicated enrollment reports for demonstration beneficiaries for each DY (beneficiaries include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

90. Final Report. Within 120 days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Close-Out report.

c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.

d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 6.

ATTACHMENT A

Eligibility and Enrollment Monitoring Plan

Arkansas Works – Work and Community Engagement Amendment

Strategic Approach

Overview

Arkansas plans to test innovative and administratively efficient approaches to promoting personal responsibility, encouraging improved health and well-being and movement up the economic ladder by requiring work and community engagement as a condition of continued eligibility in the Arkansas Works program. Based on enrollment as of March 2, 2018, approximately 69,000 out of 278,734 individuals currently enrolled in Arkansas Works will be expected to participate in monthly approved work activities. Arkansas has designed the work and community engagement requirement for Arkansas works to closely align with requirements in the Supplemental Nutrition Assistance Program (SNAP). SNAP work requirements can be reviewed in online policy through the following link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Once work requirements are fully implemented, Arkansas Works beneficiaries who are ages 19-49 must work or engage in specified educational, job training, job search or community service activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who are subject to work requirements will be required to demonstrate that they are meeting the work requirements on a monthly basis. Arkansas Works beneficiaries who fail to meet the work requirements for any three months during a plan year will be dis-enrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year.

External Partnering for Success

Arkansas plans to build on the innovation of the premium assistance model by partnering with insurance carriers who provide qualified health plans for Arkansas Works beneficiaries. The carriers will leverage their current care coordination and outreach activities to encourage work and assist Arkansas Works beneficiaries to engage in activities that satisfy the work and community engagement requirement as one of the steps to promoting overall healthy living. The relationship between DHS and carriers is outlined in a Memorandum of Understanding.

The Arkansas Department of Human Services (DHS) has had a long-standing partnership with the Arkansas Department of Workforce Services (DWS). Together, we have jointly administered the Temporary Assistance for Needy Families (TANF) program in Arkansas for more than a decade. Act 1705 of the 85th Arkansas General Assembly transferred the TANF block grant from DHS to DWS. Responsibilities of each agency in the operation of the program are documented through a Memorandum of Understanding that is updated annually. As part of the agreement, Arkansas DHS provides eligibility and enrollment services for the Transitional Employment Assistance (TEA) program

while Arkansas DWS provides case management services to help move beneficiaries toward self-sufficiency. Arkansas DHS staff conducts eligibility interviews, explain program requirements, and authorize TEA coverage in the DHS legacy system called ANSWER. The ANSWER system automatically creates an electronic referral to Arkansas DWS staff that also has access to the ANSWER eligibility system. Arkansas DWS staff communicates with Arkansas DHS staff when changes in eligibility are needed. Act 1 of the 90th Arkansas General Assembly Second Extraordinary Session required Arkansas DHS to refer all Arkansas Works beneficiaries with income at or below 50% of the federal poverty level to Arkansas DWS for free job search and job training assistance. In compliance with this law, we expanded that partnership in January 2017 to include a referral to obtain job search assistance and training opportunities available at the Arkansas DWS for all Arkansas Works beneficiaries. Arkansas DWS has physical locations in thirty-two out of seventy-five counties and statewide services available online by accessing the following link: www.arjoblink.arkansas.gov or www.dws.arkansas.gov. Arkansas DHS and DWS exceeded the requirement of the law by referring all recipients approved or renewed in the Arkansas Works program each month to DWS. The referral language was added to the approval and renewal notices. To track and monitor the effectiveness of the referral process, Arkansas DHS and DWS began exchanging monthly files to identify those who were referred that actually accessed services at DWS. In addition to identifying those who accessed DWS services, we also identified whether or not they were reported by employers to DWS as newly hired individuals. We obtained data through this process that demonstrates that Arkansas Works beneficiaries who had accessed services at Arkansas DWS were more likely to find work. Over the last 12 months, 347,949 Arkansas Works enrollees have received a referral to DWS. Of that number, 16,900 have accessed services at DWS. Additionally, 27% of those who accessed services at DWS have been reported by employers as new hires compared to 12% of those who did not access services at DWS. See Attachment 1 for the most recent rolling 12 month Arkansas Works – DWS referral report. We will further expand this partnership to serve Arkansas Works beneficiaries with a work or community engagement requirement. Arkansas DHS will continue to provide referrals and information about services available through the Arkansas DWS in all of our notices related to the Arkansas Works program. Attachment 2 is a sample Arkansas Works notice that contains the DWS referral language that is included in all Arkansas Works notices. Arkansas DWS will also send follow-up letters to Arkansas Works beneficiaries who have a work and community engagement requirement. A sample copy of the DWS follow up letter that is sent to Arkansas Works beneficiaries with work and community engagement requirements will be provided once finalized. Arkansas DWS will provide career assessment, job-search assistance, and referrals for training as appropriate. The Workforce Opportunities and Innovation Act of 2014 (WIOA) placed heightened emphasis on coordination and collaboration at the Federal, State, local, and tribal levels to ensure a streamlined and coordinated service delivery system for job seekers, (from low income families including those with disabilities), and employers.

Job seekers can also explore training programs offered through the extensive Eligible Training Provider List. They can discuss education, training, and apprenticeship programs through Arkansas DWS-WIOA, their partners, and determine if they would qualify to participate in any of those opportunities. Since Arkansas Works participants are considered low income, they could be eligible for those services

(Funding and slots availability, and additional requirements may apply). Arkansas Works recipients will also have access to attain Career Readiness Certifications (CRCs), create professional resumes, and other universal job services to help be effective in their job-search activities. The following screenings and assessments available in the Arkansas Workforce Integrated Network System (ARWINS) for Arkansas Works recipients:

- A basic screener to determine if the client could be eligible for UI, targeted WIOA programs, computer literacy
- Assessments that will help determine job-seeker Characteristics like Abilities, Occupational Interests, Work Values, Skills, Knowledge, and high demand occupation matches based on current education and experience levels
- Assessments that will help determine if the job-seeker has any barriers as related to Transportation, Child Care, Legal, Domestic Violence, and Homelessness

The assessments are voluntary and there is a prescribed path. The job-seeker is encouraged to take the path, but the individual will not be forced to take those assessments.

Arkansas DHS has also leveraged our current contract for Medicaid beneficiary relations with the Arkansas Foundation for Medical Care (AFMC) to provide outreach and education about the work and community engagement requirement. AFMC will do active outreach to educate Arkansas Works beneficiaries who need to complete work and community engagement activities to make sure they understand the requirements. AFMC will also provide education and assistance to beneficiaries on how to properly and timely report their activities and to direct them to the Arkansas Department of Workforce Services, Supplemental Nutrition Assistance Program (SNAP) Employment and Training providers, or other resources as appropriate to help them comply with work requirements. Contractual requirements for work and community engagement include an outreach period 30 days prior to the beginning of work and community engagement requirements for existing Arkansas Works beneficiaries. Outreach and education methods will include outbound phone contact as well as an inbound integrated voice response system where beneficiaries can receive education about work and community engagement requirements. All scripts and materials used by AFMC will be approved by DHS. AFMC will also spend the first 12 days conducting outreach and education after an Arkansas Works beneficiary is approved with work and community engagement requirements. AFMC must successfully contact and educate 30% of existing Arkansas Works beneficiaries and 40% of newly approved Arkansas Works beneficiaries. To facilitate the successful outreach and education, AFMC staff has received training and access to our Curam eligibility system and will be receiving a daily and monthly file containing Arkansas Works beneficiaries with work and community engagement requirements and their current status related to these activities. AFMC is required to make a minimum of two attempts by a live agent to contact beneficiaries by phone when a phone number is available. Additional attempts and methods used by AFMC to reach their contractual obligations are not specified. AFMC will be required to provide DHS with results of outreach efforts through various reports.

Arkansas implemented the requirement to work in the Supplemental Nutrition Assistance Program (SNAP) statewide in January 2016. The Arkansas Department of Human Services has partnered with the United States Department of Agriculture Food and Nutrition Services since that time to expand the SNAP Employment and Training Program in Arkansas. Participation in SNAP Employment and Training is one option available to SNAP recipients as a means to comply with SNAP work requirements. SNAP recipients may also comply on their own through work, education, training, or community service and volunteerism activities. Arkansas has expanded the availability of SNAP Employment and Training from thirteen to fifty out of seventy-five counties since January 2016. In each of these counties DHS has either a contract or sub grant agreement in place with at least one SNAP Employment and Training provider with a physical location to provide employment and training services. DHS is currently in negotiations with additional providers to add an additional fifteen counties by the end of 2018. DHS has commitments from the providers who will cover these additional counties and we are awaiting approval from the USDA Food and Nutrition Services to implement this additional expansion. Point in time data comparison in March 2018 between the SNAP program and Arkansas Works has shown that approximately twenty-two to twenty-five percent of Arkansas Works beneficiaries also receive SNAP. We plan to leverage the expanded SNAP Employment and Training program to assist individuals who are dually eligible for SNAP and Arkansas Works to meet work and community engagement requirements by referring them to SNAP Employment and Training providers as appropriate for assistance with job search and training. SNAP Employment and Training providers already attempt to reach and engage SNAP recipients. SNAP recipients who are also enrolled in Arkansas Works may satisfy work and community engagement requirements in both programs by participating in SNAP Employment and Training. A list of our current SNAP Employment and Training providers is provided as Attachment 3. A map showing the current SNAP E & T coverage is provided as Attachment 4. Proposed expanded SNAP E & T coverage by the end of 2018 is provided as Attachment 5. Dual SNAP and Arkansas Works beneficiaries will be allowed to satisfy the work and community engagement requirement for both programs by participating in and reporting in either the SNAP or the Arkansas Works program. They will not be required to comply with or report separately to both programs to maintain continued eligibility. The Arkansas Works program, SNAP, and the Transitional Employment Assistance programs reside in separate eligibility systems operated by Arkansas DHS. Working with contracted developers for both systems, Arkansas DHS has developed a process whereby data files will be exchanged between these systems daily to update exemption and compliance information in both programs without manual intervention by the beneficiaries or DHS staff. User acceptance testing to validate this process is underway.

Online Reporting

Arkansas has enhanced the innovation and administrative efficiency of the work and community engagement requirement by planning and designing an online portal for beneficiaries to report their work activities, exemptions, and other household changes. This portal is actually an enhancement of the Curam eligibility system that has already passed CMS readiness review standards. DHS required through contract with Curam developers that the portal is mobile device friendly and ADA compliant. The access.arkansas.gov online portal complies with 42 CFR 435.1200 f (2). Beneficiaries will use an email address and password to access the online portal. Rather than providing verification of exempt or

compliant status with paper documentation, beneficiaries will enter and attest to the information submitted through the online portal. These attestations will be evaluated through a robust quality assurance process (See Quality Assurance and Fraud Process). Use of the portal promotes work and community engagement goals by reinforcing basic computer skills, internet navigation, and communication via email. This approach is administratively efficient to implement. The eligibility system processes information submitted via the online portal automatically without worker intervention. This allows Arkansas to implement the work and community engagement requirement without additional resources. Individuals, who are disabled, including mental and physical disability, will be exempt from work and community engagement requirements and will not be at risk for losing coverage. Arkansas DHS will provide reasonable accommodations to assist individuals with the online reporting requirement. Beneficiaries may receive in-person assistance through the local DHS county offices. All notices provide instructions to contact the Access Arkansas Call Center or a county office for help regarding work and community engagement requirements.

Arkansas DHS has also developed a "Registered Reporter" process to assist individuals with their online reporting requirements. Individuals may become a registered reporter by reviewing specified online training material, signing a Registered Reporter Acknowledgement Form and emailing that form to Arkansas DHS. The beneficiary must also authorize the reporter to serve in that role. To promote this as an additional reporting support for Arkansas Works beneficiaries, Arkansas DHS will announce this process through a press release and schedule meetings and webinars with stakeholder agencies. Information on the process and training is available on our public SharePoint site at the following link: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Operational update: In December 2018, Arkansas DHS launched an Arkansas Works Helpline to further assist individuals with their online reporting requirements. As of December 19, 2018, individuals may contact our county offices or call our toll-free number 855-372-1084 to report directly to Arkansas DHS by phone. Beneficiaries may now report the types and hours of work and community engagement activities that they participate in, report changes in exemption status, and renew existing exemptions by phone directly to DHS staff who will key the information into the system. This is in addition to receiving in-person assistance in the DHS county offices, from registered reporters, or through self-service using the online portal.

Outcome Monitoring

Arkansas DHS will develop reports that track the following information related to the Arkansas Works program:

- Number and percentage of individuals required to report each month
- Number and percentage of beneficiaries who are exempt from the community engagement requirement
- Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements

- Number and percentage of beneficiaries granted good cause exemption from reporting requirements
- Number and percentage of beneficiaries who requested reasonable accommodations
- Number and percentage and type of reasonable accommodations provided to beneficiaries
- Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements
- Number and percentage of beneficiaries disenrolled for failing to report
- Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements
- Number and percentage of community engagement appeal requests from beneficiaries
- Number, percentage and type of community engagement good cause exemptions requested
- Number, percentage and type of community engagement good cause exemptions granted
- Number, percentage and type of reporting good cause exemptions requested
- Number, percentage and type of reporting good cause exemptions granted
- Number of appeals of dis-enrollments for non-compliance with community engagement
- Number of appeals for dis-enrollments for failure to comply with the reporting requirements
- Number and percentage of applications made in-person, via phone, via mail and electronically.

All of the data required to produce these reports is owned by Arkansas DHS, with the exception of the good cause exemption reports and the work and community engagement appeal requests; these reports will be system-generated from the eligibility system data warehouse. Requirements, design, and delivery of these reports are covered by the Arkansas DHS contractual agreement with the eligibility system developer. A database outside of the eligibility system is being developed by DHS to track and report all good cause exemption metrics. Appeal metrics will be tracked and provided by the DHS Office of Chief Counsel Appeals and Hearings section. These reports will be compiled monthly and will be reported to CMS quarterly. Documentation on design requirements for each report will be available at a later date when report development is complete.

Implementation Plan and Timeline

Planning, policy and system development, partner and stakeholder engagement, and resource availability assessment (See Community Resource and Supports Availability Mapping) began in January 2017 and have been ongoing.

Upon approval of the work and community engagement amendment, Arkansas began finalizing plans and testing of the process to implement the requirement on June 1, 2018. Based on data as of March 2, 2018, there were 171,449 Arkansas Works beneficiaries ages 19 – 49. Approximately 69,000 have no initial exemption identified through system data. Due to the number of beneficiaries impacted, Arkansas will phase in work requirements by age group. Beginning June through September 2018, beneficiaries ages 30 – 49 at or below federal poverty level will be phased in to the work requirement. 19 – 29 year olds at or below federal poverty level will be phased in during 2019 between January and April.

Operational update: The phase in plan for 2019 was adjusted to include implementing beneficiaries ages 30 – 49 in households with income above 100% FPL as well as all beneficiaries ages 19 – 29.

Additionally, beneficiaries ages 19 – 29 will be phased in over six months between January and June 2019 rather than four months.

Based on the same data, there were 125,242 Arkansas Works beneficiaries ages 30 – 49. Of those, 38,321 have no exemption identified through system data. Arkansas has chosen to phase in this group over four months based on when their cases are due for renewal. The chart below depicts the month the work requirement begins, the renewal months and number of beneficiaries affected.

Month Work Requirement Begins	**Renewal Months**	**Approximate #of beneficiaries required to report work activities**
June 2018	Jan, Feb, Mar	9,152
July 2018	April, May, June	9,341
August 2018	July, August, September	8,682
September 2018	Oct, Nov, Dec	11,146
Data date: 3/2/2018	TOTAL	38,321

The planning, testing, implementation, and monitoring timeline is provided below:

- **March 15, 2018** – Mass notice will be issued to all Arkansas Works beneficiaries informing them of the change in the program and upcoming implementation of work and community engagement requirements. The notice will instruct them that no additional action is required at that time and will encourage them to provide an email address to Arkansas DHS if they have not already.
- **March 30, 2018** – The Arkansas Works online portal will go live. Beneficiaries will be able to begin linking their secure online accounts and reporting exemptions.
- **April 1, 2018** – New Arkansas Works beneficiaries ages 30 – 49 approved beginning April 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **April 1 – 8, 2018** – Work requirement begin months will be set for beneficiaries 30 – 49 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- **April 13, 2018** –The first data file of Arkansas Works beneficiaries containing specific information regarding work and community engagement details will be provided to Arkansas DWS, the Medicaid Beneficiary Relations provider, and QHP carriers. Outreach and education will begin. Updated files will be provided weekly thereafter.
- **May 8, 2018** – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in June 2018 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of June 2018. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.

- **June 1, 2018** – Implementation of mandatory work requirements begins for individuals ages 30 - 49.
- **June 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in July 2018 will be mailed individually tailored notices.
- **June 26, 2018** – The Post Award Forum will be held at 10:00 AM at the Hillary Rodham Clinton Children's Library and Learning Center, 4800 W. 10th Street, Little Rock, AR 72204.
- **July 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in August will be mailed individually tailored notices.
- **August 8, 2018** - Arkansas Works beneficiaries ages 30 - 49 who are scheduled to begin the work and community engagement requirement in September 2018 will be mailed individually tailored notices.
- **August 30, 2018** – Monitoring phase begins and first quarterly report will be posted to the Arkansas DHS website.
- **November 1, 2018** - New Arkansas Works beneficiaries ages 19 - 29 approved beginning November 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **November 1 – 8, 2018** - Work requirement phase in will be set based on renewal months for beneficiaries 19 - 29 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- **November 30, 2018** – Second quarterly monitoring report will be submitted to CMS.
- **December 8, 2018** - Arkansas Works beneficiaries ages 19 – 29 and beneficiaries ages 30 – 49 with household income above 100% FPL who are scheduled to begin the work and community engagement requirement in January 2019 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of January 2019. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
- **January 1, 2019** – Implementation of mandatory work requirements begins for individuals ages 19 – 29 and individuals ages 30 – 49 with household income above 100% FPL.
- **January 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in February 2019 will be mailed individually tailored notices.
- **February 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in March 2019 will be mailed individually tailored notices.
- **February 28, 2019** – Third quarterly monitoring report will be submitted to CMS.
- **March 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in April 2019 will be mailed individually tailored notices.

- **April 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in May 2019 will be mailed individually tailored notices.
- **April 30, 2019** – Fourth quarterly monitoring report will be submitted to CMS.
- **May 8, 2019** – The final group of Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in June 2019 will be mailed individually tailored notices.

Arkansas Works Application and Renewal Overview

Applications for healthcare coverage are accepted through multi-channels including online, by phone, in person, and by mail. Application assistance is provided by Arkansas DHS staff both in person and by phone. No changes are needed to the current process for applications related to the addition of the work and community engagement requirement. Assistance is provided in local offices to those who need assistance completing applications. Arkansas DHS also maintains a contract with a vendor who provides interpretation and translation services. This service is accessible statewide and each county office can access the vendor as needed to assist individuals. Arkansas DHS also accepts applications from incarcerated individuals up to forty-five days prior to release. The Arkansas Department of Corrections has contracted with a vendor to assist exiting inmates with the application process for Medicaid prior to release. Applications received from beneficiaries who lost eligibility due to non-compliance with work and community engagement requirements will be denied if received prior to the yearly open enrollment period. Applications received during open enrollment will be processed with coverage beginning on January 1 of the following year for beneficiaries that are otherwise eligible. The State's reasonable accommodation process will be available in a procedural desk guide developed for Medicaid eligibility caseworkers and administrative staff and will be posted online once complete.

Renewals are conducted monthly through an ex-parte process. Beneficiaries whose renewals cannot be completed ex-parte are sent specific notices to provide information that is needed to complete the renewal. Beneficiaries are not required to complete forms that require information that has been previously provided or is available to DHS. Arkansas Works beneficiaries who are subject to work and community engagement requirements will have their renewals completed by the same method as beneficiaries who are not subject to work and community engagement activities. Work activity reporting continues through the online portal with no interruption or change to the reporting process during renewal. Being non-compliant in the month a beneficiary's case is due for renewal does not prevent the ex-parte renewal process from occurring.

Arkansas monitors Medicaid timeliness with data and conducts a weekly Medicaid Eligibility Operations meeting to review progress and develop strategies to address any issues that arise. Weekly management reports are reviewed by the team during each meeting. Timeliness reports can be provided along with other quarterly reports. Additional information is also reported to CMS monthly through Performance Indicators.

Arkansas DHS completes daily electronic account transfers to the federally facilitated marketplace for individuals determined to be ineligible for Medicaid. No changes to this process are necessitated by the addition of the work and community engagement process.

Work and Community Engagement Overview and Operational Approach

Population Subject to Work Requirements
Once work requirements are implemented in June of 2018, on a rolling, phased in basis, Arkansas Works beneficiaries ages 19 to 49 who do not meet established exemption criteria will be required to meet work requirements as a condition of continued Arkansas Works eligibility. Work requirements will not apply to Arkansas Works beneficiaries ages 50 and older. Work and Community Engagement Requirements will be promulgated according to the State's Administrative Procedures Act in Medicaid eligibility rules. Link to the promulgated Medicaid eligibility manual: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Exemption from Work Requirements
Arkansas Works beneficiaries meeting one of the criteria described in the STCs will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including employment and self-employment of at least 80 hours a month, medical frailty, exemption from the SNAP work requirement, receipt of TEA Cash Assistance, and receipt of unemployment benefits. Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval. Detailed information about exemptions from work and community engagement requirements can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Allowed Work Activities and Work Activity Hour Calculations
Arkansas Works beneficiaries ages 19 – 49 who are not exempt must engage in 80 hours of monthly work and community engagement activities. Arkansas Works beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of activities as deemed appropriate by the state. Arkansas Works beneficiaries must demonstrate electronically on a monthly basis that they are meeting the work requirement. Detailed information about allowed work and community engagement activities can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Disenrollment for Failure to Meet Work Requirement
Beneficiaries who are subject to work requirements will lose eligibility for Arkansas Works if they fail to meet work requirements for any three consecutive or non-consecutive months during the coverage year. Effective the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage, following proper notice and due process, and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to re-enroll in Arkansas Works. Arkansas Works beneficiaries whose coverage has been terminated due to non-compliance may apply for and receive coverage in other Medicaid categories if eligible during the lockout period. Notices of denial and closure due to non-compliance with work and community engagement requirements will contain information about how to access primary and

preventive care services at low or no cost at free health clinics and community health centers (See Community Resource and Supports Mapping). Closure of the Arkansas Works case will be transmitted to the InterChange Medicaid Management Information System. Termination of the QHP premium payment is automated in the InterChange system.

Beneficiary Work and Community Engagement Online Reporting Requirements

Beneficiaries must use the online portal to report exemptions and completion of work and community engagement activities. The work and community engagement portal is part of the existing eligibility system. Information entered into the portal is seamlessly processed by the eligibility system with no additional beneficiary or DHS staff requirement to re-key or transfer the information into the system. Exemptions must only be re-attested to at the required intervals specified above. Completion of work activities must be entered and attested to monthly. Individuals will have until the 5th day of the following month to attest for the previous month. The online portal is secure, mobile device friendly, and compliant with the ADA. The portal requires an email address and password to access. To assist beneficiaries prepare for this requirement, Arkansas DHS and our Access Arkansas Call Center have conducted a campaign over the last several months where we encourage beneficiaries to provide an email address. We have also offered information about how to obtain free email addresses and assistance with setting up email addresses. We have been able to collect several thousand email addresses during this effort. The portal allows beneficiaries to reset passwords through self-service. Technical assistance will also be available through our Access Arkansas Call Center for website and password issues. Beneficiaries who require assistance using the portal can receive assistance from several sources, including Arkansas DHS staff, Call Center Agents, Arkansas DWS staff, or their QHP carrier. Arkansas DHS worked with the University of Arkansas for Medical Sciences Health Literacy team to help develop language for work and community engagement notices and fliers. Similar verbiage was used on the portal for consistency and understanding at lower literacy levels. Arkansas DHS maintains a contract for language interpretation and translation. Beneficiaries who need assistance with languages other than English will be assisted in the local DHS county offices. Each notice and flier regarding work and community engagement direct beneficiaries who need help to contact our toll-free call center or local DHS County office. The portal will be available daily between 7 AM and 9 PM except for times when it is necessary to take the portal offline for system upgrades. Those outages when necessary are scheduled over weekends for minimal disruption. The website displays a notice each time the portal is offline for maintenance. The State will make every effort not to schedule maintenance during the first through the fifth of each month for beneficiaries who need to report the previous month's activities before the reporting deadline.

Upon logging into the portal, beneficiaries will be able to see their work and community engagement status for the current reporting month as well as history for the year to date. They will be able to update and confirm their contact information and household composition. Beneficiaries will know immediately upon submission if they have entered enough information to be considered compliant or exempt for the reporting month. If they have not yet completed 80 hours, the portal will display the

number of hours needed to become compliant. Each portal screen includes information about the method for calculating completed hours for that activity.

Good Cause Exemptions / Catastrophic Events

Beneficiaries who have experienced a catastrophic event during a month they were required to complete work activities will be exempt from work requirements or reporting by requesting and being granted a good cause exemption. Circumstances that may lead to an approved good cause exemption are outline in the STCs and include but are not limited to a natural disaster, hospitalization or serious illness, birth or death of a family member living in the home and domestic violence. Beneficiaries who have lost coverage due to non-compliance with the work and community engagement requirement will have their cases reinstated without a new application if they are granted a good cause exemption and are otherwise eligible. Information about good cause exemptions and how to request these is provided in all work and community engagement notices. Verification of the catastrophic event which caused the beneficiary not to complete and/or report required activities will be required as part of the good cause approval process. DHS staff may use discretion to waive the verification in cases such as natural disaster when the event is known to the general public.

Interim Period Prior to Work and Community Engagement Requirement – Outreach and Education

Newly approved Arkansas Works beneficiaries who are subject to the work and community engagement requirement will have an interim period of up to 59 days prior to beginning work activities. The work requirement will begin on the first of the second month after the month of approval. For example, a non-exempt beneficiary approved in the Arkansas Works program on any day during the month of April will be required to begin completing work activities on June 1st. Through our implementation plan, existing beneficiaries will also have an interim period after notification before they are required to begin completing and reporting work activities. The interim period will be used to conduct outreach to beneficiaries to educate them on all aspects of the work requirement including using the online portal, connecting with the Arkansas Department of Workforce Services and other resources to assist them with compliance with work activities. The outreach will be done through a multi-media and multi-partner approach that includes Arkansas DHS, Arkansas DWS, our Medicaid Beneficiary Relations provider, and QHP carriers. This outreach effort also involves social media including Facebook and Twitter. Over the last several months, Arkansas DHS has developed several educational tools regarding work and community engagement requirements that are intended to assist beneficiaries and partners alike. These tools include a computer-based training on the Arkansas Works program and the work and community engagement requirement. Tutorials on linking their secure account on the portal, entering work activity and exemption information on the portal have also been developed. This Arkansas Works toolkit will be available online to the public so that partners and beneficiaries can access the information as needed. Link to Arkansas Works education and Outreach information: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Operational Update: Enhanced Outreach and Education

In our ongoing efforts to monitor this program and adjust our operational approach to help beneficiaries successfully engage in the work and community engagement requirement, Arkansas DHS launched and Arkansas Works Helpline to assist individuals with their online reporting requirement by phone directly to DHS through our toll-free phone number in December 2018. Beneficiaries may now report the types and hours of work and community engagement activities that they participate in, report changes in exemption status, and renew existing exemptions by phone directly to DHS staff who will key the information into the system. In addition to helping inbound callers, this team is also conducting proactive outreach to beneficiaries identified through various monitoring reports to offer them additional assistance. This team makes proactive calls to beneficiaries who have reported some activities, but not enough to meet the 80-hour requirement as well as beneficiaries who have exemptions that ended and have not been renewed. This team provides education to connect beneficiaries with additional options for meeting the requirement and uses the Resource Dashboard to help guide the discussion.

Work and Community Engagement Notices

In addition to traditional postal mail, Arkansas DHS will communicate with Arkansas Works beneficiaries who have provided email addresses through an electronic message to a secure inbox. Notices content will meet all requirements in the standards, terms, and conditions reflected in the approved 1115 waiver amendment. With the exception of good cause exemption denials, all notices related to the work and community engagement requirement are automated and system-generated in real time. This automation ensures that timely and adequate notice requirements are met. Specific notices related to work and community engagement requirements have been developed and contain detailed information for beneficiaries.

Until good cause exemption functionality can be developed in our eligibility system, notices of either approval or denial of a good cause exemption will be manually generated and uploaded to the electronic case record. A separate tracking website will be developed and maintained for Arkansas DHS staff to use to track good cause exemption requests for noncompliance with work activities or reporting requirements until this capability is achieved in the eligibility system to meet CMS monitoring and reporting requirements included in the approved waiver amendment.

Community Resource and Supports Availability and Mapping

Arkansas DHS has been working with a team of partners and stakeholders for several months to identify community engagement resources throughout the state. This team includes Arkansas DHS, Arkansas DWS, Arkansas Center for Health Improvement, representatives from each Arkansas Works qualified health plan carrier, the Arkansas Hospital Association, the University of Arkansas for Medical Sciences, and the Arkansas Department of Career Education. Input and participation is open to interested stakeholder organizations. As a result of this effort, an Arkansas Works Interactive Resource Map has been developed for users to click county by county for specific information on local resource availability. The resource map contains information on work and employment services, education and training opportunities, and volunteerism opportunities. The resource map also contains information on

locations with public access to computers and free Wi-Fi and other supportive resources such as public transportation, substance abuse treatment, housing, and more. Public access to computers is being provided by Arkansas DHS, Arkansas DWS, Arkansas libraries and other community organizations. We are also actively engaging other state agencies and non-profit agencies to assess their willingness and capacity to provide support to Arkansas Works beneficiaries in this and other ways. Arkansas DHS has lead on this project. Locations where beneficiaries and former beneficiaries can access free and reduced cost health care have also been collected and made available in this map. DHS will include information in notices for individuals who lose coverage due to non-compliance in addition to sharing this information through social media. This resource map will be available to the public online in the Arkansas Works information SharePoint site and will be updated quarterly and as new information becomes available. Link to Arkansas Works Information: https://ardhs.sharepointsite.net/ARWorks/default.aspx

Quality Assurance and Fraud Process

Arkansas DHS will conduct a monthly quality assurance process to validate exemptions and work activities that have been attested to by beneficiaries as a special effort in addition to normal PERM and MEQC requirements. The quality assurance process will include reviewing a statistically valid random sample to achieve a 95% (+ / - 3% variance) level of confidence. In addition to these quality assurance reviews, Arkansas DHS will review data on attestations monthly and quarterly from the universe of Arkansas Works beneficiaries who are subject to work and community engagement requirements to identify trends and potential anomalies that should also be reviewed for accuracy. Based on the outcomes of these reviews, the quality assurance process will be enhanced with additional reviews in error prone areas. The quality assurance component will be promulgated in Medicaid eligibility rules. Specific quality assurance processes will be outlined in a procedural desk guide for DHS staff. If inaccuracies are discovered during the quality assurance process, appropriate action will be taken to remove months of exemption or compliance. If this results in three months of non-compliance for the calendar year, the Arkansas Works case will be closed and referred for investigation as potential fraud and overpayment.

Appeal Process

Beneficiaries will be provided full appeal rights with regard to work and community engagement requirements just as they have for other Medicaid eligibility determinations. The process will be the same regardless for the reason for appeal. Each notice contains information about beneficiaries' rights to appeal and how to request an appeal. Requests for appeal that are received in county offices are forwarded to the DHS Office of Chief Counsel Appeals and Hearings Unit who schedule and conduct appeal hearings and render decisions.

Data Exchange between Programs and Partners

To ensure that dual Arkansas Works and SNAP beneficiaries have no additional compliance or reporting requirements, Arkansas DHS will use data exchanges between systems to record compliance and exemption information. This data exchange is currently in the final stages of testing. SNAP and Arkansas Works beneficiaries may choose to comply through either program.

To ensure a robust outreach and education process, a weekly data file will be shared with Arkansas DWS, our Medicaid Beneficiary Relations provider, and each QHP carrier. Information provided to carriers will be limited to Arkansas Works beneficiaries that are members of their individual plans. The file will contain information on each beneficiary that includes contact information, work and community engagement exemption and compliance information, type of exemption, number of months of cumulative non-compliance, compliance status for the current month, and renewal month. This level of detail will allow our partners to conduct specific outreach and education encouraging beneficiaries to participate and complete work activities.

Summary

Arkansas appreciates the opportunity to help our fellow Arkansans begin to move up the economic ladder through the Arkansas Works program with work and community engagement requirements. We have put a great amount of thought and effort into the policy and operational design of this program to make it as successful as possible. We have developed a strong team of partners ready to help these beneficiaries take the steps toward self-sufficiency. We appreciate the continued support and partnership from the Centers for Medicare and Medicaid Services to help us implement this program and look forward to reporting our progress as implementation continues.

ATTACHMENT B
Copayment Amounts[3]

General Service Description	Cost Sharing for Beneficiaries with Incomes >100% FPL
Behavioral Health - Inpatient	$60
Behavioral Health - Outpatient	$4
Behavioral Health - Professional	$4
Durable Medical Equipment	$4
Emergency Room Services	-
FQHC	$8
Inpatient	$60
Lab and Radiology	-
Skilled Nursing Facility	$20
Other	$4
Other Medical Professionals	$4
Outpatient Facility	-
Primary Care Physician	$8
Specialty Physician	$10
Pharmacy - Generics	$4
Pharmacy - Preferred Brand Drugs	$4
Pharmacy - Non-Preferred Brand Drugs, including specialty drugs	$8

No copayments for individuals at or below 100% FPL.

[3] Beneficiaries with incomes above 100% FPL will also be required to pay monthly premiums of up to 2 percent of household income.

ATTACHMENT C
Preparing the Interim and Summative Evaluation Reports

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-25-25
Baltimore, Maryland 21244-1850

Office of the Administrator

September 27, 2013

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

Dear Mr. Allison:

The Centers for Medicare & Medicaid Services is approving Arkansas' request for a three-year Medicaid premium assistance demonstration, entitled Arkansas Health Care Independence Program (Private Option), (Project Number 11-W-00287/6). The demonstration is approved in accordance with section 1115(a) of the Social Security Act (the Act) and is effective on the date of the signed approval. Through this demonstration and associated state plan amendments, the state will offer coverage to adults in Arkansas under 133 percent of the federal poverty level. The demonstration provides authority to Arkansas to offer coverage to most of the newly eligible adults through what Arkansas refers to as "the private option"; that is, through Medicaid premium assistance in qualified health plans (QHPs) offering coverage in the Marketplace. Enrollment for the new adult population will begin on October 1, 2013, with eligibility effective on January 1, 2014.

The terms of the demonstration have been incorporated into the accompanying Special Terms and Conditions (STCs), waivers and expenditure authorities for the demonstration approval. The demonstration will serve individuals aged 19-64 who are not medically frail, and will provide a state plan approved Alternative Benefit Plan (ABP) through a QHP selected by the beneficiary. Those excluded from the demonstration as medically frail will receive direct coverage from the state, through the ABP generally available to the new adult group or an ABP that includes benefits otherwise available through the state plan. In addition, American Indians and Alaska Natives will be excluded from the demonstration unless they elect to be included; those excluded will receive direct coverage from the state through the same ABP generally available to the new adult group. Beneficiaries' cost-sharing obligations will be consistent with state plan requirements and vary by income. Beneficiaries will access services that are not available in the QHP package through the state Medicaid agency in coordination with the QHP; these services include non-emergency medical transportation (NEMT), out-of-network family planning, and early and periodic screening and diagnostic treatment (EPSDT) services for 19- and 20-year-olds. We have granted waiver authority to ensure that prior authorization for prescription drugs will be completed within 72 hours. As agreed, the demonstration will include a strong evaluation component that will test whether this model yields improvements in care and costs.

The CMS approval of the demonstration is conditioned upon compliance with the enclosed set of STCs defining the nature, character, and extent of anticipated federal involvement in the project.
Page 2 – Mr. Andy Allison

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. A copy of the STCs, waiver, and expenditure authorities are enclosed.

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 and CHIP Services
Mail Stop S2-02-26
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 and CHIP Services, at (410) 786-5647.

Thank you for all your work with us, as well as stakeholders in Arkansas, over the past several months on developing this important demonstration, and congratulations on its approval.

Sincerely,

/s/

Marilyn Tavenner

Enclosures

cc: Cindy Mann, CMCS
Eliot Fishman, CMCS
Jennifer Ryan, CMCS
Bill Brooks, ARA, Region VI
Diane Gerrits, CMCS
Vanessa Sammy, CMCS

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.

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

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 expenditures under section 1903 shall, for the period of this demonstration extension 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) Section 1115 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).

Requirements Not Applicable to the Expenditure Authority:

1. **Cost Effectiveness** **Section 1902(a)(4)**
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 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 not otherwise matchable, 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 STCs are effective on the date of the signed approval. Enrollment activities for the new adult population will begin on October 1, 2013 for the Private Option qualified health plan (QHP) with eligibility effective January 1, 2014. 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
XVI. T-MSIS

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Private Option demonstration, the State will provide 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 between the ages of 19 through 64 with incomes between 17 percent and 133 percent of the FPL (collectively Private Option beneficiaries). Arkansas expects approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.

Private Option beneficiaries will receive the State plan Alternative Benefit Plan (ABP) primarily through a QHP that they select and 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).

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.

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; and

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

   e. A description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration**. sstatetates 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 §431.206, §431.210, and §431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR Section 435.916.

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).

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

10. **Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 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 Section 431.408(b)(3)).

    c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

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

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.

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.

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, unless the individual chooses to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration.

    a. 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.

    b. 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 is 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) are excluded from this demonstration unless an individual chooses to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted in to the Private Option will receive the ABP generally available to the new adult group through a operated through an FFS system. An AI/AN individual, whether receiving direct coverage or coverage through a QHP 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-enrollment process in the event that the beneficiary does not select a plan.

b. 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.

c. 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 36.

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

e. 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 will begin to enroll during the initial QHP enrollment period (October 1, 2013 – March 31, 2014) 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 enter the State's web-based portal. They will then have an opportunity to complete the health care needs questionnaire, to be assessed for medical frailty as defined in STC 18.

d. Individuals who are determined eligible to receive coverage through the Private Option will enter the State's web-based portal to shop among QHPs available to Private Option eligible individuals and to select a QHP.

e. The State's MMIS will capture their plan selection information and will transmit the 834 enrollment transactions to the QHP issuers.

f. QHP issuers will issue insurance cards to Private Option enrollees.

g. The State's MMIS will pay premiums on behalf of beneficiaries directly to the QHP issuer.

h. State MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; the individual is determined to be medically frail and excluded from the Private Option; and will have the option of receiving either the ABP operated through FFS or the ABP that is the Medicaid State plan.

i. 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.

24. **Auto-assignment.** For Private Option beneficiaries who do not select a QHP, the eligible individual will be assigned a QHP and Arkansas Medicaid will notify the new enrollee of the effective date of his or her QHP enrollment. Individuals who are auto-assigned will be notified of their assignment 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 shall enter into a memorandum of understanding (MOU) with each QHP that will enroll individuals covered under the Demonstration within 60 days of the effective date of the STCs. 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 70, 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 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 in each rating area of the State.

    b. Private Option beneficiaries will be permitted to choose among all silver plans 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).

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.

VIII. COST SHARING

40. **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).

41. **Cost Sharing Parameters for the Arkansas Premium Assistance program.** With the approval of this Demonstration:

    a. Enrollees under 100 percent of the FPL and AI/AN will have no cost sharing.
    b. Enrollees at 100 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.

42. **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. 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.

X. GENERAL REPORTING REQUIREMENTS

43. 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.

44. 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.

45. 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:

1. Transition and implementation activities;
2. Stakeholder concerns;
3. QHP operations and performance;
4. Enrollment;
5. Cost sharing;
6. Quality of care;
7. Beneficiary access,
8. Benefit package and wrap around benefits;
9. Audits;
10. Lawsuits;
11. Financial reporting and budget neutrality issues;
12. Progress on evaluation activities and contracts;
13. Related legislative developments in the State; and
14. Any demonstration changes or amendments the State is considering.

46. 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.

47. **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.

48. **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; and
    c. 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;

49. **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.

XI. 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.

50. **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.

51. **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 (form 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. To the extent Arkansas collects premiums, 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:

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

52. **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").

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

54. **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.

55. **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.

56. 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 63:

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.

57. Sources of Non-Federal Share. The State must certify that the matching non-federal share of funds for the demonstration are 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.

58. 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.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

59. 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 62, 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.

60. 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 62, 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.

61. **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 STC 62 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.

62. **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 65. 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.

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.

63. **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.

64. **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.

65. **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.

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%

66. **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.

XIII. EVALUATION

67. **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.

68. 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.

69. 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, 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.

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

1. 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 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.

a. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:

1. Comparisons of provider networks;
2. Consumer satisfaction and other indicators of consumer experience;
3. Provider experience ; and
4. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

b. 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:

1. 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 encounter 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.

71. **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.

72. **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.

73. 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.

74. 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 70. The State will present on its interim evaluation in conjunction with STC 71. The State will present on its summative evaluation in conjunction with STC 72.

75. **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.

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

77. **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.

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

79. **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.

80. **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.

XIV. MONITORING

81. **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.

82. **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.

83. **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.

84. **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.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

85. 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.

XVI. 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

MAR 2 4 2014

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

Dear Mr. Allison:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas' proposed evaluation design for the Section 1115 Demonstration titled Arkansas Health Care Independence Program (Private Option) (Project Number 11-W-00287/6) received on February 20, 2014.

You may now post the approved evaluation design on the state Medicaid website pursuant to paragraph 75 of the Special Terms and Conditions (STCs).

Per paragraph 70 of the STCs, Arkansas is required to provide a budget for evaluation activities. CMS requests to receive this additional information within 30 days of this approval. Your project officer for this demonstration is Ms. Leila Ashkeboussi. She is available to answer any questions concerning your section 1115 demonstration. Ms. Ashkeboussi's contact information is:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-02-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (202) 205-4730
E-mail: Leila.Ashkeboussi@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Bill Brooks, Associate Regional Administrator for the Division of Medicaid and Children's Health in the 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

We look forward to continuing to partner with you and your staff on the Arkansas Private Option demonstration.

Sincerely,

[redacted]

Diane T. Gerrits
Director
Division of State Demonstrations and Waivers

cc:
Cindy Mann, CMCS
Eliot Fishman, CMCS
Bill Brooks, ARA, Region VI
Vanessa Sammy, CMCS
Andrea Casart, CMCS

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.

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

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.

---

[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:

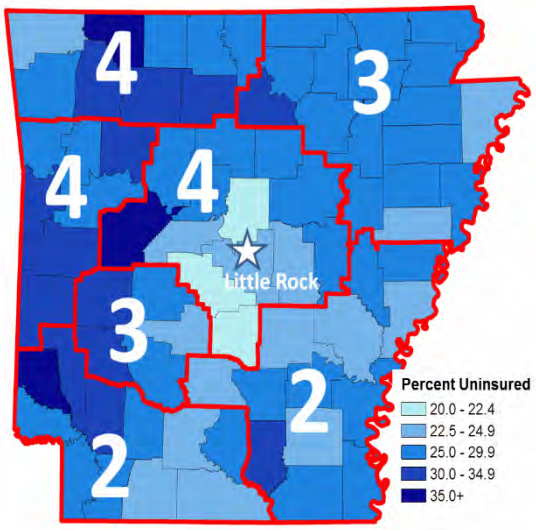
- The federal government will benefit from ~$1.1 billion per year in new taxes and Medicare payment reductions.[8]
- The increase in federal costs for expansion and ongoing Medicaid is projected at $1.59 billion in FY15 and $2.35 billion in FY20.[6]
- The net impact on the federal budget approaches neutrality 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.

---

[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

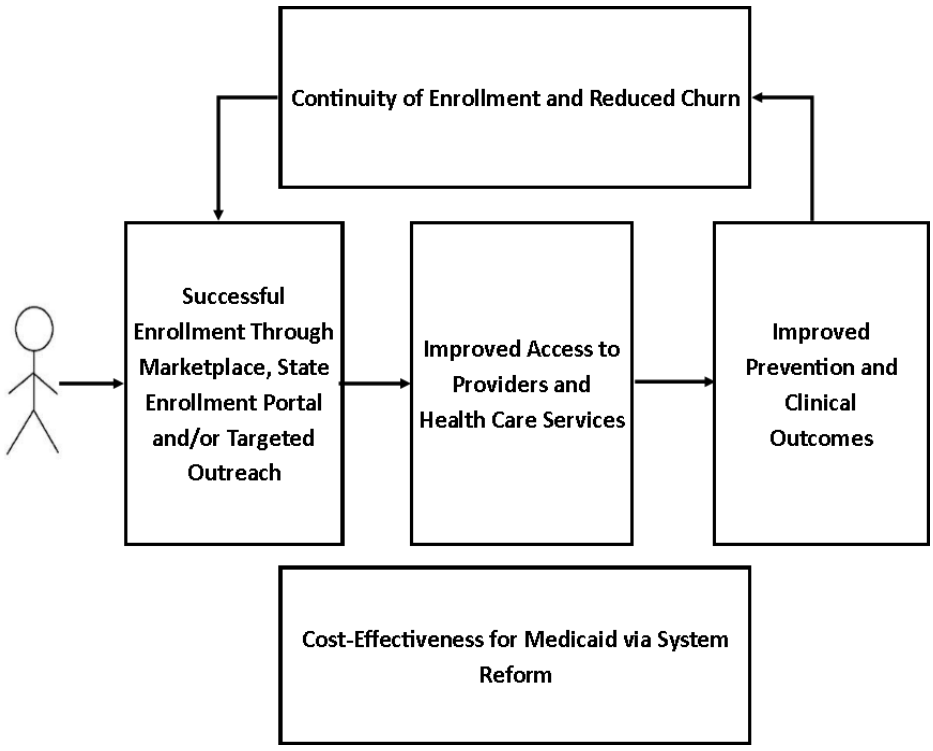
Arkansas is at the forefront of payment innovation and delivery system reform, and the Health Care Independence Act will accelerate and leverage the state's Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort, and the number of privately 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.

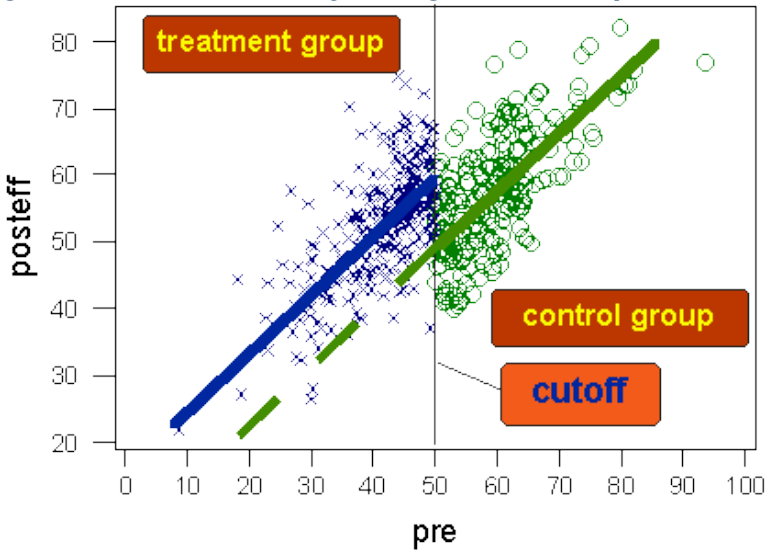
D3. Regression Discontinuity Analysis

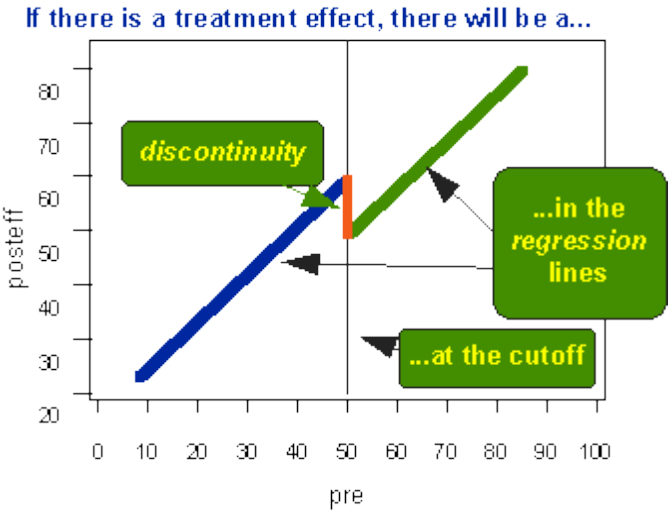
In cases where random assignment to treatment and control groups is not feasible, comparisons can be done by examining subgroups of individuals based on scores just above or below a cutoff value of a predetermined variable. The assumption is that such individuals with similar scores may not differ significantly 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:

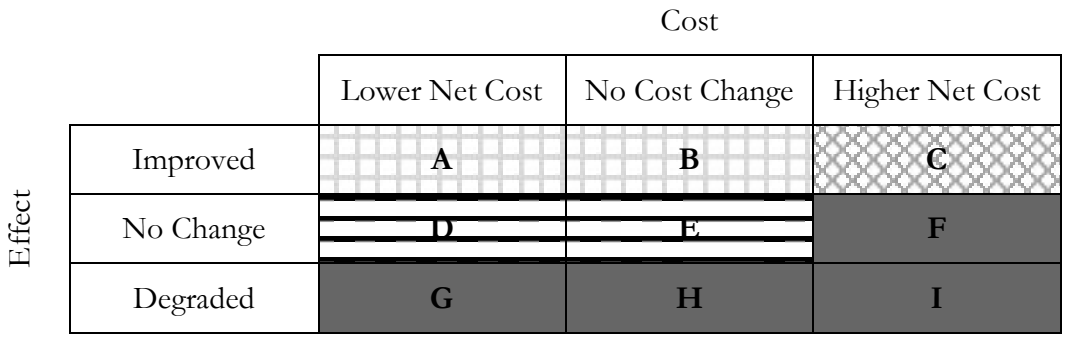
- Premiums set in advance for one year may be greater or less than actual experience; actual experience could lead to increases or decreases in premiums in future years.
- The state is entitled to repayment from carriers for premiums exceeding claims cost plus administration, subject to the minimum loss 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.

---

[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
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

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

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory
Little Rock, Arkansas 72201
www.achi.net

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

Appendix 2B—Selected Measures from Healthcare Effectiveness Data and Information Set (HEDIS) 2014

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

Origin: HEDIS 2014

Description:

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

Numerator

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

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

Denominator

The eligible population.

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

Origin: HEDIS 2014

Description:

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

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

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

Numerator

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

Denominator

The eligible population.

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

Origin: HEDIS 2014

Description:

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

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

Annual monitoring for members on digoxin.

Annual monitoring for members on diuretics.

Annual monitoring for members on anticonvulsants.

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

Numerators

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

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

Annual monitoring for members on Digoxin

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

Annual monitoring for members on Diuretics

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

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

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

Annual monitoring for members on Anticonvulsants

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

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

Origin: HEDIS 2014

Description:

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

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

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

Numerator

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

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

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

- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set

Denominator

The eligible population (report each age stratification separately).

Measure: Frequency of Selected Procedures (FSP)

Origin: HEDIS 2014

Description:

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

Selected Procedures

Tonsillectomy

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

Bariatric weight loss surgery

- Report the number of bariatric weight loss surgeries.

Hysterectomy

- Report abdominal and vaginal hysterectomy separately.

Cholecystectomy

- Report open and laparoscopic cholecystectomy separately.

Back surgery

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

Percutaneous Coronary Intervention (PCI)

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

Cardiac Catheterization

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

Coronary Artery Bypass Graft (CABG)

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

Prostatectomy

- Report the number of prostatectomies.

Total Hip Replacement

- Report the number of total hip replacements.

Total Knee Replacement

- Report the number of total knee replacements.

Carotid Endarterectomy

- Report the number of carotid endarterectomies.

Mastectomy

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

Lumpectomy

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

Measure: Ambulatory Care (AMB)

Origin: HEDIS 2014

Description:

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

Outpatient Visits

ED Visits

Outpatient Visits

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

ED Visits

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

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

Exclusions (required)

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

Note

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

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

Origin: HEDIS 2014

Description:

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

Total inpatient

Maternity

Surgery

Medicine

Product Lines

Report the following tables for each applicable product line:

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

Appendix 2C

Consumer Assessment of Healthcare Providers and Systems Survey

Health Plan 5.0

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Consumer Assessment of Healthcare Providers and Systems Survey

Selected measures from the CAHPS 5.0 Health Plan survey are being used according to the Agency for Healthcare Research and Quality's protocol. The survey is attached.

CAHPS® Health Plan Surveys

Version: Adult Commercial Survey 5.0

Language: English

Notes

- **Release of 5.0 version:** The CAHPS Health Plan Surveys were updated in the Spring of 2012. The updates are limited to minor changes to the wording of several items and a change in the placement of one item. These edits reflect the CAHPS Consortium's most recent findings from testing of related survey instruments. For specific information about the updates to this survey, please read **CAHPS Health Plan Surveys: Overview of the Questionnaires,** which is available at https://www.cahps.ahrq.gov/Surveys-Guidance/HP/Get-Surveys-and-Instructions.aspx.
- **Supplemental items:** Survey users may add questions to this survey. A document with supplemental items developed by the CAHPS Consortium and descriptions of major item sets are available in the **Health Plan Surveys and Instructions** (http://www.cahps.ahrq.gov/Surveys-Guidance/HP/Get-Surveys-and-Instructions.aspx).

Instructions for Front Cover

- Replace the cover of this document with your own front cover. Include a user-friendly title and your own logo.
- Include this text regarding the confidentiality of survey responses:

  Your Privacy is Protected. All information that would let someone identify you or your family will be kept private. {VENDOR NAME} will not share your personal information with anyone without your OK. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders.

  Your Participation is Voluntary. You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get.

  What To Do When You're Done. Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the envelope to [INSERT VENDOR ADDRESS].

  If you want to know more about this study, please call XXX-XXX-XXXX.

Instructions for Format of Questionnaire

Proper formatting of a questionnaire improves response rates, the ease of completion, and the accuracy of responses. The CAHPS team's recommendations include the following:

- If feasible, insert blank pages as needed so that the survey instructions (see next page) and the first page of questions start on the right-hand side of the questionnaire booklet.
- Maximize readability by using two columns, serif fonts for the questions, and ample white space.
- Number the pages of your document, but remove the headers and footers inserted to help sponsors and vendors distinguish among questionnaire versions.

Find additional guidance in **Preparing a Questionnaire Using the CAHPS Health Plan Survey,** which is available at https://www.cahps.ahrq.gov/Surveys-Guidance/HP/Get-Surveys-and-Instructions.aspx.

Survey Instructions

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes → **If Yes, go to #1 on page 1**
☐ No

1. Our records show that you are now in {INSERT HEALTH PLAN NAME}. Is that right?

[1] ☐ Yes → **If Yes, go to #3**
[2] ☐ No

2. What is the name of your health plan?

Please print: _____

_____

Your Health Care in the Last 12 Months

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

3. In the last 12 months, did you have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?

[1] ☐ Yes
[2] ☐ No → **If No, go to #5**

4. In the last 12 months, when you **needed care right away**, how often did you get care as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

5. In the last 12 months, did you make any appointments for a **check-up or routine care** at a doctor's office or clinic?

[1] ☐ Yes
[2] ☐ No → **If No, go to #7**

6. In the last 12 months, how often did you get an appointment for a **check-up or routine care** at a doctor's office or clinic as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

7. In the last 12 months, **not** counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

☐ None → **If None, go to #10**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

8. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?

- ☐ 0 Worst health care possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best health care possible

9. In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

Your Personal Doctor

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

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #17**

11. In the last 12 months, how many times did you visit your personal doctor to get care for yourself?

- ☐ None → **If None, go to #16**
- ☐ 1 time
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more times

12. In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

13. In the last 12 months, how often did your personal doctor listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

14. In the last 12 months, how often did your personal doctor show respect for what you had to say?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

15. In the last 12 months, how often did your personal doctor spend enough time with you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

☐ 0 Worst personal doctor possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best personal doctor possible

Getting Health Care From Specialists

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

17. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you make any appointments to see a specialist?

1 ☐ Yes
2 ☐ No → **If No, go to #21**

18. In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19. How many specialists have you seen in the last 12 months?

☐ None → **If None, go to #21**
☐ 1 specialist
☐ 2
☐ 3
☐ 4
☐ 5 or more specialists

20. We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?

- ☐ 0 Worst specialist possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best specialist possible

Your Health Plan

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

21. In the last 12 months, did you get information or help from your health plan's customer service?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #24**

22. In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

23. In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

24. In the last 12 months, did your health plan give you any forms to fill out?

[1] ☐ Yes
[2] ☐ No → **If No, go to #26**

25. In the last 12 months, how often were the forms from your health plan easy to fill out?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

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

☐ 0 Worst health plan possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best health plan possible

About You

27. In general, how would you rate your overall health?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

28. In general, how would you rate your overall **mental or emotional** health?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

29. In the past 12 months, did you get heath care 3 or more times for the same condition or problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to #31**

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

[1] ☐ Yes
[2] ☐ No

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

[1] ☐ Yes
[2] ☐ No → **If No, go to #33**

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

[1] ☐ Yes
[2] ☐ No

33. What is your age?

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

34. Are you male or female?

[1] ☐ Male
[2] ☐ Female

35. What is the highest grade or level of school that you have completed?

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

36. Are you of Hispanic or Latino origin or descent?

[1] ☐ Yes, Hispanic or Latino
[2] ☐ No, not Hispanic or Latino

37. What is your race? Mark one or more.

[1] ☐ White
[2] ☐ Black or African American
[3] ☐ Asian
[4] ☐ Native Hawaiian or Other Pacific Islander
[5] ☐ American Indian or Alaska Native
[6] ☐ Other

38. Did someone help you complete this survey?

[1] ☐ Yes
[2] ☐ No → **Thank you. Please return the completed survey in the postage-paid envelope.**

39. How did that person help you? Mark one or more.

[1] ☐ Read the questions to me
[2] ☐ Wrote down the answers I gave
[3] ☐ Answered the questions for me
[4] ☐ Translated the questions into my language
[5] ☐ Helped in some other way

Please print: _____

_____

_____

Thank you.

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

Appendix 2D

Consumer Assessment of Healthcare Providers and Systems Survey

Supplemental Items 4.0

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Consumer Assessment of Healthcare Providers and Systems Survey

Selected measures from the CAHPS 4.0 Supplemental Items survey are being used according to the Agency for Healthcare Research and Quality's protocol. The survey is attached.

CAHPS® Health Plan Survey 4.0

Supplemental Items for the Adult Questionnaires

Language: English

File name: 1157a_engadultsupp_40.doc
Last updated: September 28, 2009 .

TABLE OF CONTENTS

Important instructions

Placing Supplemental Items in the Core Questionnaires. After you copy one or more supplemental items into the core questionnaire:

- **Fix the formatting** of the items as needed to fit into the two-column format.
- **Renumber** the supplemental item and **ALL** subsequent items so that they are consecutive.
- **Revise ALL skip instructions** in the questionnaire to make sure they point the respondent to the correct item number.

Definition of Health Providers. If you choose to use one or more supplemental items that refer to other health providers, please insert this definition before the first of these items: "A health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, or anyone else you would see for health care."

Behavioral Health

Insert MH1 – MH4 after core question 8. For Medicaid, reference period should be stated as "In the last 6 months."

MH1. In general, how would your rate your overall **mental or emotional health**?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

MH2. In the last 12 months, did you need any treatment or counseling for a personal or family problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

MH3. In the last 12 months, how often was it easy to get the treatment or counseling you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

MH4. Using any number from 0 to 10, where 0 is the worst treatment or counseling possible and 10 is the best treatment or counseling possible, what number would you use to rate all your treatment or counseling in the last 12 months?

☐ 0 Worst treatment or counseling possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best treatment or counseling possible

Chronic Conditions

CC1 – CC23 – For Medicaid, reference period should be stated as "In the last 6 months," except for CC21.

Insert CC1 – CC4 after core question 9.

CC1. Is this person a general doctor or a specialist doctor?

[1] ☐ General doctor (Family practice or internal medicine)
[2] ☐ Specialist doctor

CC2. How many months or years have you been going to your personal doctor?

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

CC3. Do you have a physical or medical condition that seriously interferes with your ability to work, attend school, or manage your day-to-day activities?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 10**

CC4. Does your personal doctor understand how any health problems you have affect your day-to-day life?

[1] ☐ Yes
[2] ☐ No

Insert CC5 after core question 18.

CC5. In the last 12 months, how many times did you go to specialists for care for yourself?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more

Insert CC6 – CC8 after core question 14. Please refer to instructions at the front of this document about defining "health providers."

CC6. We want to know how you, your doctors, and other health providers make decisions about your health care.

In the last 12 months, were any decisions made about your health care?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

CC7. In the last 12 months, how often were you involved as much as you wanted in these decisions about your health care?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC8. In the last 12 months, how often was it easy to get your doctors or other health providers to agree with you on the best way to manage your health conditions or problems?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Insert CC9 – CC14 after core question 8.

CC9. In the last 12 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?

[1] ☐ Yes
[2] ☐ No → **If No, go to question CC11**

CC10. In the last 12 months, how often was it easy to get the medical equipment you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC11. In the last 12 months, did you have any health problems that needed special **therapy**, such as physical, occupational, or speech therapy?

[1] ☐ Yes
[2] ☐ No → **If No, go to question CC13**

CC12. In the last 12 months, how often was it easy to get the special therapy you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC13. Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks.

In the last 12 months, did you need someone to come into your home to give you home health care or assistance?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

CC14. In the last 12 months, how often was it easy to get home health care or assistance through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Measures of Health Status

Insert CC15 – CC17 after core question 28.

CC15. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, dressing, or getting around the house?

[1] ☐ Yes
[2] ☐ No

CC16. Because of any impairment or health problem, do you need help with your routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

[1] ☐ Yes
[2] ☐ No

CC17. Do you have a physical or medical condition that seriously interferes with your independence, participation in the community, or quality of life?

[1] ☐ Yes
[2] ☐ No

Insert CC18 – CC22 after core question 28.

CC18. In the last 12 months, have you been a patient in a hospital overnight or longer?

[1] ☐ Yes
[2] ☐ No

CC19. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 29**

CC20. Is this condition a problem that has lasted for at least 3 months? Do **not** include pregnancy.

[1] ☐ Yes
[2] ☐ No

CC21. Do you now need to take medicine prescribed by a doctor? Do **not** include birth control.

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 29**

CC22. Is this to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

[1] ☐ Yes
[2] ☐ No

Claims Processing

Insert CP1 – CP3 before core question 20. For Medicaid, reference period should be stated as "In the last 6 months." Please note that CP1 and CP2 repeat questions that appear in the HEDIS® set.

CP1. Claims are sent to a health plan for payment. You may send in the claims yourself, or doctors, hospitals, or others may do this for you. In the last 12 months, did you or anyone else send in any claims for your care to your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 20**
[3] ☐ Don't know → **If Don't know, go to core question 20**

CP2. In the last 12 months, how often did your health plan handle your claims correctly?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always
[5] ☐ Don't know

CP3. In the last 12 months, before you went for care, how often did your health plan make it clear how much you would have to pay?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Communication

Insert C1 after core question 12. For Medicaid, reference period should be stated as "In the last 6 months."

C1. In the last 12 months, how often did you have a hard time speaking with or understanding your personal doctor because you spoke different languages?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Cost Sharing

Insert CSH1 after core question 27.

CSH1. People can pay for their health insurance directly or out of their pay check. Do you or your family pay any part of the cost of your health insurance?

[1] ☐ Yes
[2] ☐ No

Covered By Multiple Plans

Insert MP1 after core question 2. If HP1 is included, insert after HP1.

MP1. Not counting dental insurance, are you covered by any other health plan?

[1] ☐ Yes
[2] ☐ No

Dental Care*

Insert D1 – D3 after core question 8. For Medicaid, reference period should be stated as "In the last 6 months."

D1. In the last 12 months, did you get care from a dentist's office or dental clinic?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

D2. In the last 12 months, how many times did you go to a dentist's office or dental clinic for care for yourself?

☐ None → **If None, go to core question 9**
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more

* The CAHPS family of products includes a CAHPS Dental Plan Survey. For more information, go to https://www.cahps.ahrq.gov/content/products/Dental/PROD_Dental_Intro.asp.

D3. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate all your dental care in the last 12 months?

☐ 0 Worst dental care possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best dental care possible

Health Plan

Insert HP1 after core question 2.

HP1. How many months or years **in a row** have you been in this health plan?

[1]☐ Less than 1 year
[2]☐ At least 1 year but less than 2 years
[3]☐ At least 2 years but less than 5 years
[4]☐ At least 5 years but less than 10 years
[5]☐ 10 years or more

Insert HP2 – HP7 after core question 21. For Medicaid, reference period should be stated as "In the last 6 months." Please note that HP2 – HP7 repeat questions that appear in the HEDIS set.

HP2. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

[1]☐ Yes
[2]☐ No → **If No, go to core question 22**

HP3. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

HP4. Sometimes people need services or equipment beyond what is provided in a regular or routine office visit, such as care from a specialist, physical therapy, a hearing aid, or oxygen.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for a health care service or equipment?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

HP5. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

HP6. In some health plans the amount you pay for a prescription medicine can be different for different medicines, or can be different for prescriptions filled by mail instead of at the pharmacy.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for specific prescription medicines?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

HP7. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

HEDIS® Set

[Updated for HEDIS 2010]

The HEDIS Set is composed of items that the National Committee for Quality Assurance (NCQA) added to the core questionnaire to create their version of the CAHPS Health Plan Survey, known as CAHPS 4.0H. Survey sponsors can add these items to their questionnaire whether or not they are submitting results to NCQA. Please note that some of these items are repeated in other supplemental sets.

For Medicaid, reference period should be stated as "In the last 6 months." Please refer to instructions at the front of this document about defining "health providers."

Insert H1 – H4 after core question 7.

H1. In the last 12 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

H2. Choices for your treatment or health care can include choices about medicine, surgery, or other treatment. In the last 12 months, did a doctor or other health provider tell you there was more than one choice for your treatment or health care?

1☐ Yes
2☐ No → **If No, go to core question 8**

H3. In the last 12 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?

1☐ Definitely yes
2☐ Somewhat yes
3☐ Somewhat no
4☐ Definitely no

H4. In the last 12 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?

1☐ Definitely yes
2☐ Somewhat yes
3☐ Somewhat no
4☐ Definitely no

Insert H5 – H6 after core question 14.

H5. In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?

1☐ Yes
2☐ No → **If No, go to core question 15**

H6. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

Insert H7 – H12 after core question 21.

H7. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

1☐ Yes
2☐ No → **If No, go to question H9**

H8. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

(H9 is the same as HP4)

H9. Sometimes people need services or equipment beyond what is provided in a regular or routine office visit, such as care from a specialist, physical therapy, a hearing aid, or oxygen.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for a health care service or equipment?

[1] ☐ Yes
[2] ☐ No → **If No, go to question H11**

(H10 is the same as HP5)

H10. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

(H11 is the same as HP6)

H11. In some health plans, the amount you pay for a prescription medicine can be different for different medicines, or can be different for prescriptions filled by mail instead of at the pharmacy.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for specific prescription medicines?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

(H12 is the same as HP7)

H12. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Insert H13 – H15 after core question 26.

(H13 is the same as CP1)

H13. Claims are sent to a health plan for payment. You may send in the claims yourself, or doctors, hospitals, or others may do this for you. In the last 12 months, did you or anyone else send in any claims for your care to your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 27**
[3] ☐ Don't know → **If Don't know, go to core question 27**

H14. In the last 12 months, how often did your health plan handle your claims quickly?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always
[5] ☐ Don't know

(H15 is the same as CP2)

H15. In the last 12 months, how often did your health plan handle your claims correctly?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always
[5] ☐ Don't know

Insert H16 to H25 after core question 28.

H16. Have you had a flu shot since September 1, 2010?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

H17. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

[1] ☐ Every day
[2] ☐ Some days
[3] ☐ Not at all → **If Not at all, go to question H21**
[4] ☐ Don't know → **If Don't know, go to question H21**

H18. In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

H19. In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

H20. In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

H21. Do you take aspirin daily or every other day?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

H22. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

H23. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

[1] ☐ Yes
[2] ☐ No

H24. Are you aware that you have any of the following conditions? Check all that apply.

[1] ☐ High cholesterol
[2] ☐ High blood pressure
[3] ☐ Parent or sibling with heart attack before the age of 60

H25. Has a doctor ever told you that you have any of the following conditions? Check all that apply.

[1] ☐ A heart attack
[2] ☐ Angina or coronary heart disease
[3] ☐ A stroke
[4] ☐ Any kind of diabetes or high blood sugar

Interpreter

Insert I1 – I2 after core question 8. For Medicaid, reference period should be stated as "In the last 6 months."

I1. An interpreter is someone who repeats or signs what one person says in a language used by another person.

In the last 12 months, did you need an interpreter to help you speak with doctors or other health providers?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

I2. In the last 12 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Insert I3 after core question 37.

I3. What language do you **mainly** speak at home?

[1] ☐ English
[2] ☐ [INSERT LANGUAGE 2]
[3] ☐ [INSERT LANGUAGE 3]
[4] ☐ [INSERT LANGUAGE 4]

Medicaid Enrollment

Insert ME1 to ME4 before core question 20. If you are including both ME1 and ME3 in your questionnaire, change the skip instruction for ME1 to "No → **If No, go to question ME3."**

ME1. Some states pay health plans to care for people covered by {Medicaid/State name for Medicaid}. With these health plans, you may have to choose a doctor from the plan list or go to a clinic or health care center on the plan list.

Are you covered by a health plan like this?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 20**

ME2. Did you choose your health plan or were you told which plan you were in?

[1] ☐ You chose your plan
[2] ☐ You were told which plan you were in

ME3. You can get information about plan services in writing, by telephone, on the Internet, or in-person. Did you get any information about your health plan **before** you signed up for it?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 20**

ME4. How much of the information you were given before you signed up for the plan was correct?

[1] ☐ All of it
[2] ☐ Most of it
[3] ☐ Some of it
[4] ☐ None of it

People With Mobility Impairments

For Medicaid, reference period should be stated as "In the last 6 months."

Your Personal Doctor

Insert IM1 – IM10 after core question 15.

IM1. In the last 12 months, did you visit your personal doctor for care?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 16**

IM2. When you visited your personal doctor's office in the last 12 months, how often were you examined on the examination table?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM3. When you visited your personal doctor's office in the last 12 months, how often did someone weigh you?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM4. When you visited your personal doctor's office in the last 12 months, did you try to use the restroom?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM6**

IM5. In the last 12 months, how often was it easy to move around the restroom at your personal doctor's office?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM6. In the last 12 months, did you and your personal doctor talk about pain?

[1] ☐ Yes
[2] ☐ No

IM7. In the last 12 months, how often did pain limit your ability to do the things you needed to do?

[1] ☐ Never → **If Never, go to question IM9**
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM8. In the last 12 months, do you think that your personal doctor understood the impact that pain has on your life?

[1] ☐ Yes
[2] ☐ No

IM9. In the last 12 months, how often did fatigue limit your ability to do the things you needed to do?

[1] ☐ Never → **If Never, go to core question 16**
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM10. In the last 12 months, do you think that your personal doctor understood the impact that fatigue has on your life?

[1] ☐ Yes
[2] ☐ No

Your Health Plan

Insert IM11 – IM19 after core question 27.

IM11. In the last 12 months, did you need physical or occupational therapy?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM13**

IM12. In the last 12 months, how often was it easy to get this kind of therapy through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM13. In the last 12 months, did you need speech therapy?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM15**

IM14. In the last 12 months, how often was it easy to get speech therapy through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM15. Mobility equipment includes things like a wheelchair, scooter, walker, or cane. In the last 12 months, have you used any mobility equipment to move around your home or community?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

IM16. In the last 12 months, did you try to get your mobility equipment repaired through your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM18**

IM17. In the last 12 months, how often was it easy to get your mobility equipment repaired through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM18. In the last 12 months, did you try to get or replace any mobility equipment through your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

IM19. In the last 12 months, how often was it easy to get or replace the mobility equipment that you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

About You

Insert IM20 – IM21 after core question 32.

IM20. A quarter mile is about 5 city blocks or 0.4 kilometers. In the last 12 months, were you able to walk that far?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 33**

IM21. In the last 12 months, did you have difficulty or need assistance to walk that far?

[1] ☐ Yes
[2] ☐ No

Personal Doctor

Insert PD1 – PD2 after core question 15.

PD1. Did you have the same personal doctor **before** you joined this health plan?

[1] ☐ Yes → **If Yes, go to core question 16**
[2] ☐ No

PD2. Since you joined your health plan, how often was it easy to get a personal doctor you are happy with?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Pregnancy Care

Insert P1 – P3 after core question 14. Remove core question 34 from the Adult Questionnaire, as it is duplicated in P1.

P1. Are you male or female?

[1] ☐ Male → **If Male, go to core question 15**
[2] ☐ Female

P2. Are you pregnant now?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

P3. A health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, a mid-wife, or anyone else you would see for health care when you are pregnant.

Have you been to a doctor or other health provider for a pregnancy care check-up for **this** pregnancy?

[1] ☐ Yes
[2] ☐ No

Prescription Medicine

Insert PM1 – PM3 after core question 27. For Medicaid, reference period should be stated as "In the last 6 months."

PM1. In the last 12 months, did you get any new prescription medicines or refill a prescription?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

PM2. In the last 12 months, how often was it easy to get your prescription medicine from your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

PM3. In the last 12 months, how often did you get the prescription medicine you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Quality Improvement

For Medicaid, reference period should be stated as "In the last 6 months."

Access to Routine Care

Insert AR1 – AR2 after core question 6. Please refer to instructions at the front of this document about defining "health providers."

AR1. In the last 12 months, **not** counting the times you needed health care right away, how many days did you usually have to wait between making an appointment and actually seeing a health provider?

1☐ Same day
2☐ 1 day
3☐ 2 to 3 days
4☐ 4 to 7 days
5☐ 8 to 14 days
6☐ 15 to 30 days
7☐ 31 to 60 days
8☐ 61 to 90 days
9☐ 91 days or longer

AR2. In the last 12 months, how often did you have to wait for an appointment because the health provider you wanted to see worked limited hours or had few available appointments?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

Access to Specialist Care

Insert AS1 after core question 17, which should be modified to include the skip instructions presented below.

17. In the last 12 months, how often was it easy to get appointments with specialists?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always → **If Always, go to core question 18**

AS1 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

AS1. Were any of the following a reason it was not easy to get an appointment with a specialist?

		Yes	No
a)	Your doctor did not think you needed to see a specialist	1☐	2☐
b)	Your health plan approval or authorization was delayed	1☐	2☐
c)	You weren't sure where to find a list of specialists in your health plan or network	1☐	2☐
d)	The specialists you had to choose from were too far away	1☐	2☐
e)	You did not have enough specialists to choose from	1☐	2☐
f)	The specialist you wanted did not belong to your health plan or network	1☐	2☐
g)	You could not get an appointment at a time that was convenient	1☐	2☐
h)	Some other reason	1☐	2☐

Please specify: _____

_____

After Hours Care

Insert AH1 – AH3 after core question 8.

AH1. After hours care is health care when your usual doctor's office or clinic is closed. In the last 12 months, did you need to visit a doctor's office or clinic for after hours care?

1☐ Yes
2☐ No → **If No, go to core question 9**

AH2. In the last 12 months, how often was it easy to get the after hours care you thought you needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always → **If No, go to core question 9**

AH3 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

AH3. Were any of the following a reason it was not easy to get the after hours care you thought you needed?

		Yes	No
a)	You did not know where to go for after hours care	1☐	2☐
b)	You weren't sure where to find a list of doctor's offices or clinics in your health plan or network that are open for after hours care	1☐	2☐
c)	The doctor's office or clinic that had after hours care was too far away	1☐	2☐
d)	Office or clinic hours for after hours care did not meet your needs	1☐	2☐
e)	Some other reason	1☐	2☐

Please specify: _____

_____

Calls to Personal Doctor's Office

Insert C1 – C5 after core question 14.

CO1. In the last 12 months, did you phone your personal doctor's office **during** regular office hours to get help or advice for yourself?

1☐ Yes
2☐ No → **If No, go to question CO3**

CO2. In the last 12 months, when you phoned during regular office hours, how often did you get the help or advice you needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

CO3. In the last 12 months, did you phone your personal doctor's office **after** regular office hours to get help or advice for yourself?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

CO4. In the last 12 months, when you phoned after regular office hours, how often did you get the help or advice you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always → **If Always, go to core question 15**

CO5 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

CO5. Were any of the following a reason you did not get the help or advice you thought you needed when you phoned after regular office hours?

		Yes	No
a)	You did not know what number to call	[1] ☐	[2] ☐
b)	You left a message but no one returned your call	[1] ☐	[2] ☐
c)	You could not leave a message at the number you phoned	[1] ☐	[2] ☐
d)	Another doctor was covering for your personal doctor	[1] ☐	[2] ☐
e)	Some other reason	[1] ☐	[2] ☐

Please specify: _____

_____

Coordination of Care from Other Health Providers

Insert OHP1 – OHP5 after core question 14. Please note that OHP1 – OHP2 repeat questions that appear in the HEDIS set. Please refer to instructions at the front of this document about defining "health providers."

OHP1. In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

OHP2. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

OHP3. In the last 12 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?

1☐ Yes
2☐ No → **If No, go to core question 15**

OHP4. In the last 12 months, who helped to coordinate your care?

1☐ Someone from your health plan
2☐ Someone from your doctor's office or clinic
3☐ Someone from another organization
4☐ A friend or family member
5☐ You

OHP5. How satisfied are you with the help you received to coordinate your care in the last 12 months?

1☐ Very dissatisfied
2☐ Dissatisfied
3☐ Neither dissatisfied nor satisfied
4☐ Satisfied
5☐ Very satisfied

Customer Service

Insert CS1 – CS2 after core question 23, which should be modified to include the skip instructions presented below. Core question 24 also provides useful drill-down data on consumer encounters with customer service.

23. In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

[1]☐ Never
[2]☐ Sometimes
[3]☐ Usually
[4]☐ Always → **If Always, go to question CS2**

CS1 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

CS1. Were any of the following a reason you did not get the information or help you needed from your health plan's customer service?

		Yes	No
a)	You had to call several times before you could speak with someone	[1]☐	[2]☐
b)	The information customer service gave you was not correct	[1]☐	[2]☐
c)	Customer service did not have the information you needed	[1]☐	[2]☐
d)	You waited too long for someone to call you back	[1]☐	[2]☐
e)	No one called you back	[1]☐	[2]☐
f)	Some other reason	[1]☐	[2]☐

Please specify: _____

_____

CS2. How many calls did it take for you to get the help or information you needed from your health plan's customer service?

[1]☐ 1 call
[2]☐ 2
[3]☐ 3
[4]☐ 4
[5]☐ 5 or more calls
[6]☐ You are still waiting for help

Health Plan Information and Materials

Insert PW1 – PW8 after core question 21. Please note that PW1 – PW2 repeat questions that appear in the HEDIS set. If you use PW4 or PW8, please refer to instructions at the front of this document about defining "health providers."

(PWI is the same as HP2)

PW1. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

PW2. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

PW3. In the last 12 months, how often was it easy to use the information on how your health plan works?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always → **If Always, go to question PW6**

PW4 and PW5 were designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

PW4. What kind of information was **not** easy to use?

		Yes	No
a)	Benefits and coverage for doctor or specialist visits	1☐	2☐
b)	Benefits and coverage for pharmacy	1☐	2☐
c)	Getting a referral to a specialist	1☐	2☐
d)	After hours or urgent care	1☐	2☐
e)	Choosing a health provider	1☐	2☐
f)	Getting care outside your network	1☐	2☐
g)	Something else	1☐	2☐

Please specify: _____

_____

PW5. Where did you get that information? Mark one or more.

		Yes	No
a)	From your health plan	1☐	2☐
b)	From your employer	1☐	2☐
c)	From your doctor's office	1☐	2☐
d)	From some other source	1☐	2☐
e)	Not sure where you got it	1☐	2☐

PW6. When you looked for information in the last 12 months, did you go to your health plan's Internet site?

1☐ Yes
2☐ No → **If No, go to core question 22**

PW7. How useful was the information you found on your health plan's Internet site?

1☐ Not at all useful
2☐ A little useful
3☐ Somewhat useful
4☐ Very useful

PW8. In the last 12 months, did you use information on your health plan's Internet site to choose a doctor, specialist, or group of health providers?

[1] ☐ Yes
[2] ☐ No

Referrals

Insert R1 before core question 17. For Medicaid, reference period should be stated as "In the last 6 months."

R1. In the last 12 months, how often was it easy to get a referral to a specialist that you needed to see?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Relation to Policyholder

Insert RP1 after core question 37.

RP1. Health insurance plans are usually in one person's name, the policyholder. Are you the policyholder?

[1] ☐ Yes
[2] ☐ No

Transportation

Insert T1 – T3 after core question 27. For Medicaid, reference period should be stated as "In the last 6 months."

T1. Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage.

In the last 12 months, did you phone your health plan to get help with transportation?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

T2. In the last 12 months, when you phoned to get help with transportation from your health plan, how often did you get it?

[1] ☐ Never → **If Never, go to core question 28**
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

T3. In the last 12 months, how often did the help with transportation meet your needs?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Utilization

Insert UT1 after core question 6. For Medicaid, reference period should be stated as "In the last 6 months."

UT1. In the last 12 months, how many times did you go to an emergency room to get care for yourself?

☐ None
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more

Insert UT2 after core question 19. For Medicaid, reference period should be stated as "In the last 6 months."

UT2. In the last 12 months, was the specialist you saw most often the same doctor as your personal doctor?

[1] ☐ Yes
[2] ☐ No

Appendix 3

Metrics and Hypotheses

HCIP Waiver Evaluation Planning: State's Medicaid Reporting Measures

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

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

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

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost
22	HEDIS	Ambulatory Care (Outpatient ER)	Utilization for selected procedures per 1000 enrollees	Medical claims	X			
23	HEDIS	Inpatient Utilization—General Hospital/ Acute Care	Inpatient service use by age	Medical claims	X			
24	CAHPS-4; NQF 0006	Got care for illness/injury as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
25	CAHPS-6; NQF 0006	Got non-urgent appointment as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
26	CAHPS-9; NQF 0006	How often it was easy to get necessary care, tests, or treatment	Survey based assessment of enrollee experiences	Survey	X			
27	CAHPS-10; NQF 0006	Have a personal doctor	Survey based assessment of enrollee experiences	Survey	X			
28	CAHPS-18; NQF 0006	Got appointment with specialists as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
29	CAHPS-HP1; NQF 0007	Number of months or years in a row enrolled in health plan	Survey based assessment of enrollee experiences	Survey			X	
30	CAHPS-8; NQF 0007	Rating of all health care	Survey based assessment of enrollee experiences	Survey		X		
31	CAHPS-16; NQF 0007	Rating of personal doctor	Survey based assessment of enrollee experiences	Survey		X		
32	CAHPS-20; NQF 0007	Rating of specialist	Survey based assessment of enrollee experiences	Survey		X		
33	CAHPS-26; NQF 0007	Rating of health plan	Survey based assessment of enrollee experiences	Survey		X		
34	CAHPS-I1; NQF 0007	Needed interpreter to help speak with doctors or other health providers	Survey based assessment of enrollee experiences	Survey	X			
35	CAHPS-I2; NQF 0007	How often got an interpreter when needed one	Survey based assessment of enrollee experiences	Survey	X			
36	CAHPS-PD1; NQF 0007	Had same personal doctor before joining plan	Survey based assessment of enrollee experiences	Survey		X	X	

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost
37	CAHPS-PD2; NQF 0007	Easy to get personal doctor you were happy with	Survey based assessment of enrollee experiences	Survey		X		
38	CAHPS-AR1; NQF 0007	Days wait time between making appointment and seeing provider	Survey based assessment of enrollee experiences	Survey	X			
39	CAHPS-AR2; NQF 0007	How often had to wait for appointment because of provider's lack of hours/availability	Survey based assessment of enrollee experiences	Survey	X			
40	CAHPS-R1; NQF 0007	Easy to get a referral to a specialist	Survey based assessment of enrollee experiences	Survey	X	X		
41	CAHPS-UT1; NQF 0007	Times visited emergency room	Survey based assessment of enrollee experiences	Survey	X	X		
42	AR Medicaid Eval 02	Non-emergency transportation access	Use of non-emergency transportation services	Transportation data	X			
43	AR Medicaid Eval 03	Continuity of PCP care	Consistent use of the same primary care provider over time--proportion of primary care visits with same PCP	Medical claims	X		X	
44	AR Medicaid Eval 04	Continuity of Specialist care	Consistent use of the same specialist provider over time--proportion of type specific same specialist visits over time	Medical claims	X		X	
45	AR Medicaid Eval 05	PCP Network Adequacy	Adequacy of primary care provider network for enrolled populations--proportion of service area without primary care coverage within 30 miles	Carrier / Medicaid geomaps	X			
46	AR Medicaid Eval 06	PCP Network Accessibility	Accessibility of primary care provider network for enrolled popluations--proportion of enrollees with primary care accessibile within 30 miles	Carrier / Medicaid geomaps	X			
47	AR Medicaid Eval 07	Specialist network adequacy	Adequacy of specialist provider network for enrolled populations--proportion of service area without specialist coverage within 60 miles	Carrier / Medicaid geomaps	X			
48	AR Medicaid Eval 08	Specialist network accessibility	Accessibility of specialist network for enrolled populations--proportion of enrollees with specialist accessible within 60 miles	Carrier / Medicaid geomaps	X			
49	AR Medicaid Eval 09	Total and subgroup enrollment within carrier (e.g., market penetration)	Carrier, and carrier by market specific enrollment data	Enrollment			X	

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost
50	AR Medicaid Eval 10	Total and subgroup enrollment within each plan (e.g., plan differentiation)	Carrier, and carrier by market, and carrier by market by plan specific enrollment data	Enrollment			X	
51	AR Medicaid Eval 11	Total and subgroup enrollment within each method of entry (e.g., enrollment path)	Carrier specific enrollment path	Enrollment			X	
52	AR Medicaid Eval 12	Total and subgroup enrollment within each market (e.g., geographic uptake variation)	Carrier by market specific enrollment path	Enrollment			X	
53	AR Medicaid Eval 13	Total and Subgroup Medicaid Clinical costs	Direct payments by state Medicaid per enrollee	Cost				X
54	AR Medicaid Eval 14	Total and Subgroup Medicaid Administrative costs	Direct administrative costs attributed per enrollee	Cost				X
55	AR Medicaid Eval 15	Total and Subgroup Plan Admin Costs per Enrollee	Direct wrap costs attributed per enrollee	Cost				X
56	AR Medicaid Eval 16	Total startup programmatic costs (e.g., medical needs screener)	Total Program Start Costs	Cost				X
57	AR Medicaid Eval 17	Total startup programmatic costs (e.g., medical needs screener)	Direct Premium Assistance paid per enrollee	Cost				X
58	AR Medicaid Eval 18	Total and Subgroup Plan Admin Costs per Enrollee	Estimated plan administrative costs for premium assistance	Cost				X
59	AR Medicaid Eval 19	Arkansas Program Characteristics	Arkansas specific health insurance exchange program characteristics (e.g., number of plans per market area, actuary risk, average 2nd lowest premium cost)	Cost				X
60	AR Medicaid Eval 20	Contiguous State Program Characteristics	Contiguous state specific health insurance exchange program characteristics	Cost				X
61	AR Medicaid Eval 21	Regional average program characteristics	Regional average state specific health insurance exchange program characteristics	Cost				X

Appendix 4

Candidate Metrics by Approach

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Candidate Metrics by Approach

This table attributes the metrics that are referenced in Appendix 3 to the corresponding analytical design approach that will be used to address each of the evaluation hypotheses.

Hypotheses	Design Approach		
	Subgroup Comparison	Regression Discontinuity	Statewide Comparison
1—Access			
a. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.		2, 3, 4, 10, 16, 20	1, 2, 3, 4, 10, 16, 20-22, 24-28, 43-48, 37-40, 45-48
b. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.	22, 41	22, 41	22, 41
c. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.		4, 23	4-8, 23
d. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.	18, 43-47		
e. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.	42	42	42
2—Care/Outcomes			
a. Premium Assistance beneficiaries will have equal or better access to preventive care services. (P – Primary Prevention; S – Secondary Prevention; T – Tertiary Prevention)		P: 2, 3 S: 9, 10 T: 11-13, 18-19	P: 1-3 S: 9-10 T: 11-13, 17-19
b. Premium Assistance beneficiaries will report equal or better experience in the care provided.			24-28, 30-35, 37-40

3—Continuity			
a. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.		49-52	29, 49-52
b. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.		49-52	29, 36(m), 43-44, 49-52
4—Cost Effectiveness			
a. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.		2-4, 9-13, 16, 18-20, 22-23, 41-42, 54, 56-58	1-13, 16-28, 30-35, 37-52, 54, 56-58
b. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.		2-4, 9-13, 16, 18-20, 22-23, 41-42, 59-61	1-13, 16-28, 30-35, 37-52, 59-61
c. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.		53-57	53-57

m = modification

Appendix 5

Arkansas Insurance Department Network Adequacy Guidelines and Targets

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Appendix 5
AID Network Adequacy Guidelines and Targets

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

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

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

Accreditation

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

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

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

Time and Distance Targets

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

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

GeoAccess Map Guidelines

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

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

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

Performance Metric Guidelines for Non-Accredited Carriers

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

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

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

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

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

Network Access Policies and Procedures for Non-Accredited Carriers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Standards for Essential Community Providers (ECPs)

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

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

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

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

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

Inclusion of School-Based Providers

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

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

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

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

Provider Directories

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

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

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

Specialty Services

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

Appendix 6

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

June 25, 2013

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

BULLETIN NO. 3B-2013

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

FROM: ARKANSAS INSURANCE DEPARTMENT

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

DATE: June 25, 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Accreditation	

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

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

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

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

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

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

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

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

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

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

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

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

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

[redacted]

June, 25 2013

JAY BRADFORD, COMMISSIONER
ARKANSAS INSURANCE DEPARTMENT

DATE

APPENDIX A

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

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

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

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

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

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

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

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

APPENDIX B

DEFINITION OF HABILITATIVE SERVICES

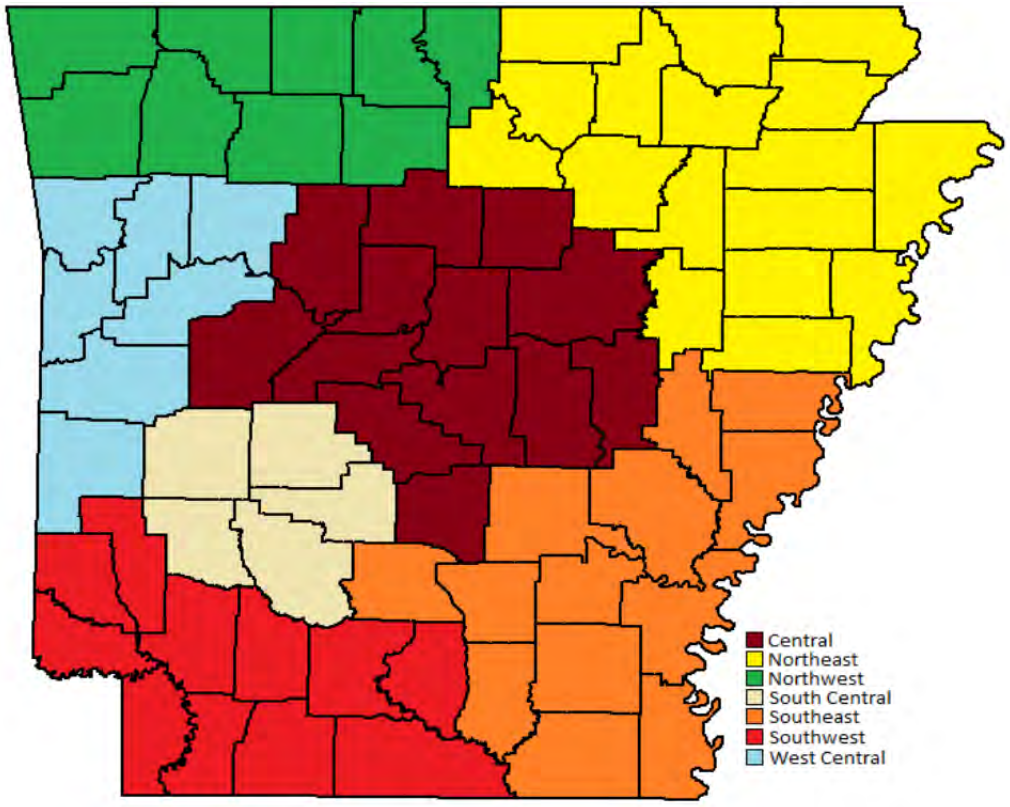
Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

COVERAGE OF HABILITATIVE SERVICES

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

APPENDIX C

STATE RATING AND SERVICE AREAS



Arkansas Counties by Region

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

APPENDIX D

HIGH LEVEL SILVER PLAN COST SHARING VARIATION REQUIREMENT

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

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

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

APPENDIX E

SUMMARY OF CHANGES FROM FEBRUARY 19, 2013 RELEASE

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

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

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

SUMMARY OF CHANGES FROM JUNE 25, 2013 RELEASE

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Medicaid Director's Office

P.O. Box 1437, Slot S401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197

September 15, 2014

The Honorable Sylvia Mathews Burwell
Secretary of the U.S. Department of Health and Human Services
202 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary:

As you know, Arkansas's Health Care Independence Program has been very successful in expanding health coverage. To date, more than 205,000 Arkansans have gained health coverage through this innovative demonstration program. According to a survey recently conducted by Gallup, Arkansas saw the biggest decline of all states in its uninsured rate, which has dropped from 22 percent to 12 percent.

Today, we respectfully submit an amendment to the Special Terms and Conditions for the Arkansas Health Care Independence Program section 1115(a) Medicaid demonstration.

These amendments propose three substantive changes to the Arkansas Health Care Independence Program, as required by Act 257 of 2014, the appropriation Act for the Division of Medical Services. Specifically, Act 257 includes special language that requires the Department of Human Services to submit and seek approval for the following revisions to the Health Care Independence Program to be effective no later than February 1, 2015: (1) approval of a limited state designed non-emergency transportation benefit for Health Care Independence Program enrollees; (2) approval of a model to create and utilize Independence Accounts; and (3) application of cost-sharing to Health Care Independence Program enrollees with incomes above 50% of the federal poverty level.

We appreciate your ongoing assistance and cooperation and look forward to your continued support of the Health Care Independence Program. Please do not hesitate to contact me if you have any questions or need additional information.

Sincerely,

[redacted]

Dawn Stehle
Director, Division of Medical Services
Arkansas Department of Human Services

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 a 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 between the ages of 19 through 64 with incomes between 17 percent and 133 percent of the FPL (collectively Private Option beneficiaries). Arkansas expects 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 participants with incomes between 50 percent and 133 percent of the FPL will receive an Independence Account administered by a third party administrator (TPA) for use to cover copayments and coinsurance. The State will ensure that the IA is funded beyond the individual contribution level 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 a rollover of funds to offset future QHP premium payments, 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 above 100 percent FPL will make contributions of $10-$25 per month to their IA, depending on income. Individuals at this income level who fail to make contributions 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 new adult population with incomes between 50 percent and 100 percent FPL will contribute $5 per month to their IA. Individuals at this income level who fail to make a monthly contribution will not be required to make copayments or coinsurance at the point of service, but they will be billed for Medicaid-level copayments by the TPA. If the individual fails to pay the TPA, any previously accrued rollover balances in the IAs will be used to pay the debt. Once those funds have been used, the individual will incur a debt to the State. The participants can avoid future Medicaid-level copayments by making the monthly $5 contribution to their IA.
Private Option beneficiaries will receive the State plan Alternative Benefit Plan (ABP) primarily through a QHP that they select and 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. 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 promotes independence and self-sufficiency by providing participants with the possibility of having additional funds to be used to pay future private market premiums. IA funds will provide stability to individuals as they move into the private market, helping to sustain them in the private market for a longer period of time and, in turn, reducing their reliance on public health care coverage programs. The demonstration also provides both positive incentives and realistic consequences related to the individual's adherence to IA program requirements.

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 §431.206, §431.210, and §431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR Section 435.916.

   e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and State public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).

   f. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with

terminating the demonstration including services and administrative costs of dis-enrolling 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 dis-enrolling 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 dis-enrolling 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 dis-enrolling enrollees.

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

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the demonstration are proposed by the State.

a. In States with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment

rates.

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

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 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. 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.

b. 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 is 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) are excluded from this demonstration unless an individual chooses 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 enrolled in IAs or issued an IA card; instead, they will be enrolled in the 100% Actuarial Value Silver Plan, regardless of income. Individuals who are AI/AN and who have not opted in to the Private Option will receive the ABP generally available to the new adult group through and operated through a FFS system. An AI/AN individual, whether receiving direct coverage or coverage through a QHP 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 notice 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, and the incentives and penalties that apply to the IAs, including the consequences if contributions are not paid. The notice 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 timeframes established in the approved IA 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 enter the State's web-based portal. They will then have an opportunity to complete the health care needs questionnaire, 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 enter the State's web-based portal to shop among QHPs available to Private Option eligible individuals and to select a QHP.

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. For individuals who will be enrolled in IAs, an IA will be established with the TPA and the IA card will be sent to enrollees, .

h. The State's MMIS will pay premiums on behalf of beneficiaries directly to the QHP issuer.

i. The TPA will pay copayments and coinsurance on behalf of beneficiaries to the provider for individuals enrolled in IAs.

j. State MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; the individual is determined to be medically frail and excluded from the Private Option; and will have the option of receiving either the ABP operated through FFS or the ABP that is the Medicaid State plan.

k. For individuals who will be enrolled in IAs, the TPA will continue to pay, copayments and coinsurance until the individual is determined to no longer be eligible to participate in the IA program or the individual is determined to be medically frail. If an individual fails to make contributions to the IA, the effect on TPA payment of copayments and coinsurance on behalf of the individual depends on whether the individual has income above or below 100 percent FPL.

- For participants 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, but will bill the participant for Medicaid copayments. If the participant fails to pay the amount billed by the TPA, the TPA will deduct the copayment amounts from remaining IA balances. When there are not enough funds in the IA to cover the amount billed by the TPA, the participant will incur a debt to the State.

- For participants with incomes greater than 100 percent FPL who do not make contributions to the IA, the TPA will not pay copayments or coinsurance for services received. The participant will be required to pay 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.

l. 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.

24. Auto-assignment. For Private Option beneficiaries who do not select a QHP, the eligible individual will be assigned a QHP and Arkansas Medicaid will notify the new enrollee of

the effective date of his or her QHP enrollment. Individuals who are auto-assigned will be notified of their assignment 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).

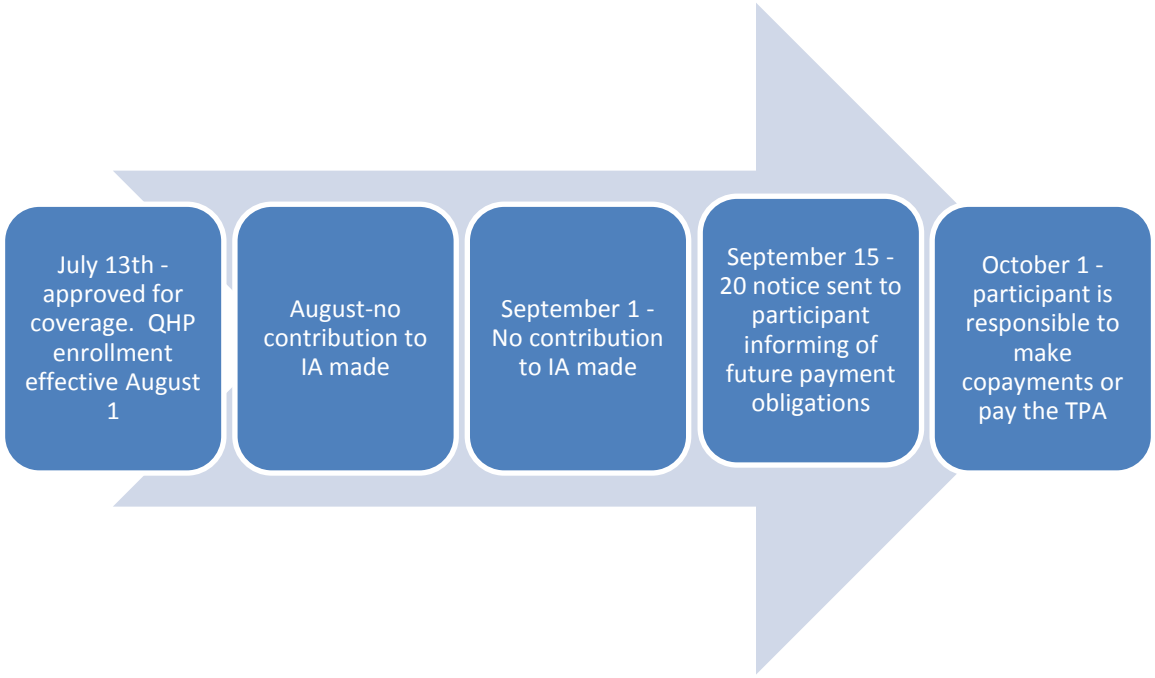
b. For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).

c. For individuals who will be enrolled in IAs, once contributions to the IA are required, Participants must make their initial contribution prior to the end of the second month after their QHP coverage becomes effective.

- For participants with incomes between 50 and 100 percent FPL who do not make contributions to the IA by 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 billing the participant for Medicaid copayments or deduct the copayment amounts from remaining IA balances.

- For participants with incomes greater than 100 percent FPL who do not make contributions to the IA by 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 shown 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, consistent with these STCs.

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 service limits for Non-Emergency Medical Transportation, except that medically frail individuals will not be subject to limits on Non-Emergency Medical Transportation. Individuals who are not medically frail, however, will be subject to a limit of eight (8) trip legs per year. Individuals may request additional units of non-emergency medical transportation through an extension of benefits process.

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 and AI/AN 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.

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. All cost sharing will be in compliance with Medicaid requirements that are set forth in statute, regulation and policies, except as modified by the waivers and terms and conditions granted for this 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.

44. Arkansas Health Care Independence Program Independence Account Contributions. Private Option beneficiaries with incomes greater than 50 percent FPL will make monthly contributions to IAs. These IAs will track and record beneficiary contributions and liabilities. Participants also have the opportunity to receive incentives for proper management of these accounts, as specified in the Protocols. A TPA will administer and manage the IAs and associated cards. There will be one statewide TPA, which will be selected in accordance with state procurement rules.

Private Option beneficiaries will make contributions and receive incentives as described below:

Table 2 Contribution Requirements

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

a. The new adult population with incomes between 50 percent and 100 percent FPL will contribute $5 per month to their IA. The State will also contribute funds to ensure the account covers the individual's copayment and coinsurance obligations. Participants at this income level who make their contributions will not be billed by the TPA for copayments for services received during the month following the contribution. Participants who contribute to the IA for at least 6 non-consecutive months will also be eligible to receive a rollover of funds to offset future QHP premium payments, contributions to employer-sponsored insurance, or Medicare premiums (for individuals over

age 64), so long as the individual resides in Arkansas. Participants will accrue up to $15 in rollover funds for each month they make a timely contribution to the IA. Rollover funds will be capped at $200. Individuals who do not make a monthly contribution will be billed by the TPA for Medicaid copayment amounts incurred by the individual. If the individual fails to pay the TPA, any previously accrued balances in the IAs will be used to pay the debt. Once those funds have been exhausted, 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 ensure that the IAs contain enough funds to cover all copayment and coinsurance obligations. Participants will pay their QHP copayments and coinsurance obligations through the IA. After contributing to the IA for at least 6 non-consecutive months, individuals will be eligible to receive a rollover of funds to offset future QHP premium payments, contributions to employer-sponsored insurance, or Medicare premiums (for individuals over age 64), so long as the individual resides in Arkansas. Participants will accrue up to $15 in rollover funds for each month they make a timely contribution to the IA. Rollover funds will be capped at $200. Individuals who fail to make the contributions will be required to pay QHP copayments or coinsurance at the point of service in order to receive services.

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

a. 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. Beneficiaries between 50 percent FPL and 100 percent FPL who fail to 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.

b. 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.

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

d. Copayment and coinsurance amounts will be consistent with federal requirements regarding Medicaid cost sharing and with the State's approved State Plan.

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 to enhance the program's incentives and consequences for program enrollees who are not complying with CMS-approved requirements.

48. Independence Account Protocol. The State must submit a draft IA Protocol to CMS for review and approval prior to implementing additional changes to the IA program. The state's submission must be no later than 30 days prior to the planned implementation. The initial set of Protocols 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. Rules to ensure that roll over IA funds may only be disbursed for the Enrollee's QHP premiums, contributions to employer-sponsored insurance, or Medicare premiums (for individuals over age 64), for individuals residing in Arkansas.

c. The strategy and operational description of how IA debits and credits will be accurately tracked.

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 administration of the remaining IA balances.

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:

1. Transition and implementation activities;
2. Stakeholder concerns;
3. QHP operations and performance;
4. Enrollment;
5. Cost sharing;
6. Independence Accounts
6. Quality of care;
7. Beneficiary access,
8. Benefit package and wrap around benefits;
9. Audits;
10. Lawsuits;
11. Financial reporting and budget neutrality issues;
12. Progress on evaluation activities and contracts;
13. Related legislative developments in the State; and
14. 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 rollover funds 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 (form 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. To the extent Arkansas collects premiums, premiums and other applicable cost sharing contributions 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	
Demonstration Year 3 (DY3)	January 1, 2016	

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) 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:

1. 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.

a. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:

    1. Comparisons of provider networks;
    2. Consumer satisfaction and other indicators of consumer experience;
    3. Provider experience; and
    4. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

b. 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:

1. 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.

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 expenditures under section 1903 shall, for the period of this demonstration extension 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) Section 1115 demonstration.

1. Premium Assistance, Cost Sharing Reduction Payments, and Contributions made to Independence Accounts. Expenditures for (1) part or all of the cost of private insurance premiums; (2) for payments and contributions to reduce cost sharing, whether directly to Qualified Health Plans or to IAs; and (3) contributions to IAs to be used as rollover funds to offset costs of commercial coverage or Medicare once an individual leaves the Private Option for certain individuals eligible under the approved state plan new adult group described in section 1902(a)(10)(A)(i)(XVIII).

Requirements Not Applicable to the Expenditure Authority:

1. **Cost Effectiveness** **Section 1902(a)(4)**
   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 & 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.

2. **Payment to Providers** **Section 1902(a)(13)**
   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** **1902(a)(10)(B)**

To the extent necessary to enable the State to offer additional benefits in the form of payments to Independence Accounts to a portion of the demonstration-eligible population enrolled in a Private Option plans.

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) with incomes greater than 50% of the federal poverty level.

To the extent necessary to enable the State to impose different amounts of cost-sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) who are Private Option Enrollees than on individuals who are served through fee-for-service Medicaid.

To the extent necessary to enable the State to limit access to non-emergency medical transportation for non-medically frail individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII).

Overview of Public Notice Process

Public Notice

The public notice was published in The Arkansas Democrat Gazette on August 1st, 2nd, and 3rd, 2014. The Arkansas Democrat Gazette is the largest newspaper in the state of Arkansas. The full text of the public notice is attached here.

The public notice was also posted on the homepage of the Arkansas Division of Medical Services at the following
link: https://www.medicaid.state.ar.us/general/comment/demowaivers.aspx#PONotice

Additionally, the public notice was sent by email to stakeholders on the public health committee.

Public Hearings

The state held the following two public hearings:

Thursday, August 7, 2014, 5:30 p.m. – 7:30 p.m.
University of Arkansas Cooperative Extension Service Auditorium
2301 S. University Avenue
Little Rock, AR 72204

Friday, August 8, 2014, 5:30 p.m. – 7:30 p.m.
Henslee Conference Center, Classrooms J & R
Jefferson Regional Medical Center
1600 West 40th Avenue
Pine Bluff, AR 71603

Individuals were able to attend both hearings either in person or by webinar.

Summary of Comments and Responses on Proposed Amendment to Arkansas 1115 Waiver

General Comments

Comment 1: One commenter expressed concern that the changes to Arkansas's 1115 waiver would create unfunded liabilities for the state and requested that the State estimate the scope of the unfunded liabilities.

Answer 1: The State recognizes that the programmatic changes could have budgetary implications in the future. As part of the initial approval process for the Demonstration, Arkansas estimated the annual expenditures under the Private Option and released these numbers to the public. The State will revise these estimates to account for programmatic changes proposed in the amendment. The State will ensure that there is sufficient funding available for the program.

Independence Accounts

Comment 2: One commenter stated that the proposed Independence Account program seemed complicated and questioned why the state legislature would require such a program.

Answer 2: The State acknowledges that the Independence Account program is somewhat complex, but is designed to promote beneficiary accountability while complying with federal Medicaid law. The State will develop notices and educational materials to ensure that beneficiaries understand how the Independence Accounts operate.

Comment 3: One commenter opposed the State's plan to require that individuals with incomes above 100% FPL who fail to make monthly contributions pay co-payments or co-insurance at the point of service. The commenter stated that the QHP cost-sharing could exceed Medicaid levels and that individuals may be deterred from seeking care.

Answer 3: Currently, individuals with incomes above 100% FPL pay co-payments and co-insurance at the point of service, and those co-payments and co-insurance amounts are consistent with federal Medicaid law. The Independence Account program does not increase beneficiaries' exposure to cost-sharing. Instead, the monthly contributions to the Independence Accounts increases the predictability of beneficiaries' health care expenditures. Any co-payments or co-insurance that beneficiaries with incomes above 100% FPL must pay at the point of service will be consistent with federal Medicaid requirements as they are today.

Comment 4: One commenter asked how the deductible will be handled using the Independence Accounts and whether the QHP issuers will need to make administrative changes.

Answer 4: Based on the points raised by this commenter, the State will not shift coverage for the deductible into the Independence Accounts. The deductible will handled year 2 of the

Demonstration in the same way as in year 1. QHP issuers will not need to make administrative changes.

Comment 5: One commenter suggested that the State develop a provider education plan to ensure that providers are aware of how Independence Accounts operate.

Answer 5: The State will develop provider education materials and will work closely with QHP issuers to ensure that these materials are disseminated to providers participating in the issuers' networks.

Comment 6: One commenter suggested that the State align the implementation of the Independence Accounts with the beginning of the new plan year on January 1, 2015. This commenter also suggested that the mailing of materials related to the Independence Accounts be coordinated with the QHP issuers.

Answer 6: The State intends to implement the Independence Accounts on January 1, 2015, to the extent feasible. The State will also work with QHP carriers to coordinate the mailing of any materials to the extent feasible.

Comment 7: One commenter stated that individuals do not generally pay co-insurance at the point of service and questioned how the providers will bill for co-insurance at the point of service. The commenter also asked how the TPA would distinguish between payments due under co-payments or co-insurance.

Answer 7: By "at the point of service" the State meant that the individual would make a payment to the provider in the normal course. For co-payments, that may mean that an individual makes a payment before leaving the doctor's office. For co-insurance, the beneficiaries may use the Independence Accounts to cover any co-insurance billed by the QHP issuer or provider.

Comment 8: One commenter asked whether the Independence Accounts may be used to cover costs associated with out-of-network providers.

Answer 8: No, the State does not intend to permit individuals to use their Independence Accounts to cover costs of services rendered by out-of-network providers.

Comment 9: One commenter asked whether the State will require that QHP issuers provide contact information for the TPA or any other information about the Independence Accounts.

Answer 9: The State will work closely with issuers regarding any requirements related to the Independence Accounts, including any requirements related to communications.

Comment 10: One commenter asked how the issuers will handle refunds related to coordination of benefit recoveries.

Answer 10: The State will work closely with issuers, beneficiaries, and the TPA to create a process to address recoveries.

Non-Emergency Medical Transportation

Comment 11: One commenter expressed concern about limiting the scope of non-emergency medical transportation (NEMT). Specifically, the commenter noted that requiring that beneficiaries who are not medically frail to request approval if they need more than eight trip legs per year could cause beneficiaries to forgo medical treatment. The commenter also noted that the State has not yet released details on how individuals may request additional trip legs.

Answer 11: The State is developing the process for beneficiaries to request additional trip legs, and the State will announce additional details once the process has been finalized. The State intends to use the authorization process to ensure that NEMT services are used appropriately, not with the specific goal of reducing NEMT by a specific amount.

Comment 12: A commenter speculated that limitations on NEMT would increase emergency room use and asked whether the Independence Accounts would reimburse for emergency room services after an individual had reached the limit on NEMT.

Answer 12: The State is not placing a strict limitation on NEMT; instead, it will implement an authorization process to evaluate requests for additional units of NEMT on a case-by-case basis. The Independence Accounts will not be used to reimburse for emergency room utilization.

Other

Comment 13: One commenter suggested that the State modify its auto-assignment methodology to auto-assign individuals only to the two lowest-cost plans in a given area.

Answer 13: The State intends to retain its current approach to auto-assignment, but it will revisit the auto-assignment methodology for 2016.

Appendix: Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers of Medicare and Medicaid Services (CMS) a written request to amend the Health Care Independence 1115 Demonstration waiver and to hold public hearings to receive comments on the amendments to the Demonstration.

The State will request amendments to the Health Care Independence 1115 Demonstration waiver to implement the following: (1) Independence Accounts for individuals with incomes above 50% of the federal poverty level (FPL), (2) cost-sharing for individuals with incomes from 50-100% FPL, and (3) changes to the State's non-emergency medical transportation (NEMT) benefit for individuals participating in the Demonstration.

Individuals receiving coverage through the Health Care Independence 1115 Demonstration waiver (referred to as "Private Option enrollees ") with incomes above 50% of the FPL will be enrolled in Independence Accounts. Individuals will make contributions to the Independence Accounts of $5 - $25 per month, depending on income. These individuals will use their Independence Account to pay their deductible, co-payments, and co-insurance for health care services, up to the out-of-pocket maximum. Individuals who make at least six timely monthly contributions will be eligible to receive $15 in rollover funds for each month in which they make a timely contribution. Individuals may use the rollover funds to offset Qualified Health Plan (QHP) premiums or the employee contribution to employer-sponsored insurance when they transition out of the Private Option, so long as they remain Arkansas residents.

Individuals who fail to make their monthly contributions will be subject to either co-payments or co-insurance for services they receive. Private Option enrollees with incomes above 100% FPL who fail to make their monthly contributions will pay QHP-level cost-sharing at the point-of-service, like they have under the Private Option in 2014. Private Option enrollees with incomes 50-100% FPL who fail to make monthly contributions will continue to use their Independence Account cards at the point of service, but the State's vendor will bill these individuals for Medicaid level co-payments after they receive the service. Individuals who fail to pay these co-payments will accrue a debt to the State. Any rollover funds the individual has accumulated will be reduced to offset their debt, and the State may seek to collect any remaining debt from the individuals directly.

The State also intends to implement limits on non-emergency medical transportation for all individuals eligible for coverage under Section 1902(a)(10)(A)(i)(VIII) who are not medically frail. Individuals can request trips in excess of the limit through an extension of benefits process.

The State will request the following waivers to implement the changes to the Demonstration:

- § 1902(a)(14): To enable the State to collect monthly contributions for individuals with incomes between 50 and 138 percent of the Federal Poverty Level (FPL).

- § 1902(a)(10)(B): (1) To enable the State to offer additional benefits in the form of payments to Independence Accounts to a portion of the demonstration-eligible population enrolled in a Private Option plans; (2) To enable the State to impose targeted cost sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) with incomes greater than 50% of the federal poverty level; (3)To enable the State to impose different amounts of cost-sharing on individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) who are Private Option Enrollees than on individuals who are served through fee-for-service Medicaid; and (4) To enable the State to limit access to non-emergency medical transportation for non-medically frail individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII).

The amendments to the Demonstration will further the objectives of Title XIX by promoting accountability, personal responsibility, and transparency, and encouraging and rewarding responsible choices. The Independence Accounts will also provide stability to individuals as they move into the private market, helping to sustain them in the private market for a longer period of time and, in turn, reducing their reliance on public health care coverage programs.

The amendments to the Demonstration will be statewide and will operate during calendar years 2015 and 2016. The State anticipates that approximately 225,000 individuals will be eligible for the Demonstration, with a significant portion of those individuals participating in the Independence Accounts. The State expects that, over the life of the Demonstration, covering Private Option enrollees will be comparable to what the costs would have been for covering the same group of Arkansas adults using traditional Medicaid.

The Demonstration, including the proposed amendments, will test hypotheses related to provider access, churning, emergency room use, cost-comparability, usage of Medicaid wrap benefits, quality improvement, preventive services, and uncompensated care costs.

The complete version of the current draft of the Demonstration application is available for public review at https://www.medicaid.state.ar.us/InternetSolution/General/comment/demowaivers.aspx. The Demonstration application may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

Public comments may be submitted until midnight on September 1, 2014. Comments may be submitted by email to hciw@arkansas.gov or by regular mail to PO Box 1437, S-295, Little Rock, AR 72203-1437.

To view comments that others have submitted, please visit https://www.medicaid.state.ar.us/InternetSolution/General/comment/demowaivers.aspx. Comments may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

The State will host two public hearings during the public comment period.

Little Rock
Thursday, August 7, 2014, 5:30 p.m. – 7:30 p.m.
University of Arkansas Cooperative Extension Service, Auditorium
2301 S. University Avenue
Little Rock, AR 72204

Webinar:
Topic: Private Option waiver hearing
Date and Time: Thursday, August 7, 2014 5:30 pm, Central Daylight Time (Chicago, GMT-05:00)
Event number: 668 542 885
Event password: ARDHS
Event address for
attendees: https://afmcevents.webex.com/afmcevents/onstage/g.php?d=668542885&t=a

Pine Bluff
Friday, August 8, 2014, 5:30 p.m. – 7:30 p.m.
Jefferson Regional Medical Center, Henslee Conference Center, Classrooms J & R
1600 West 40th Avenue
Pine Bluff, AR 71603

Webinar:
Topic: Private Option waiver hearing
Date and Time: Friday, August 8, 2014 5:30 pm, Central Daylight Time (Chicago, GMT-05:00)
Event number: 667 062 139
Event password: ARDHS
Event address for
attendees: https://afmcevents.webex.com/afmcevents/onstage/g.php?d=667062139&t=a

Individuals may access the hearing on August 7th and 8th, 2014 by webinar. To participate by webinar, please register at:
https://afmcevents.webex.com/afmcevents/onstage/g.php?d=664738225&t=a.

202813759.1

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:

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.

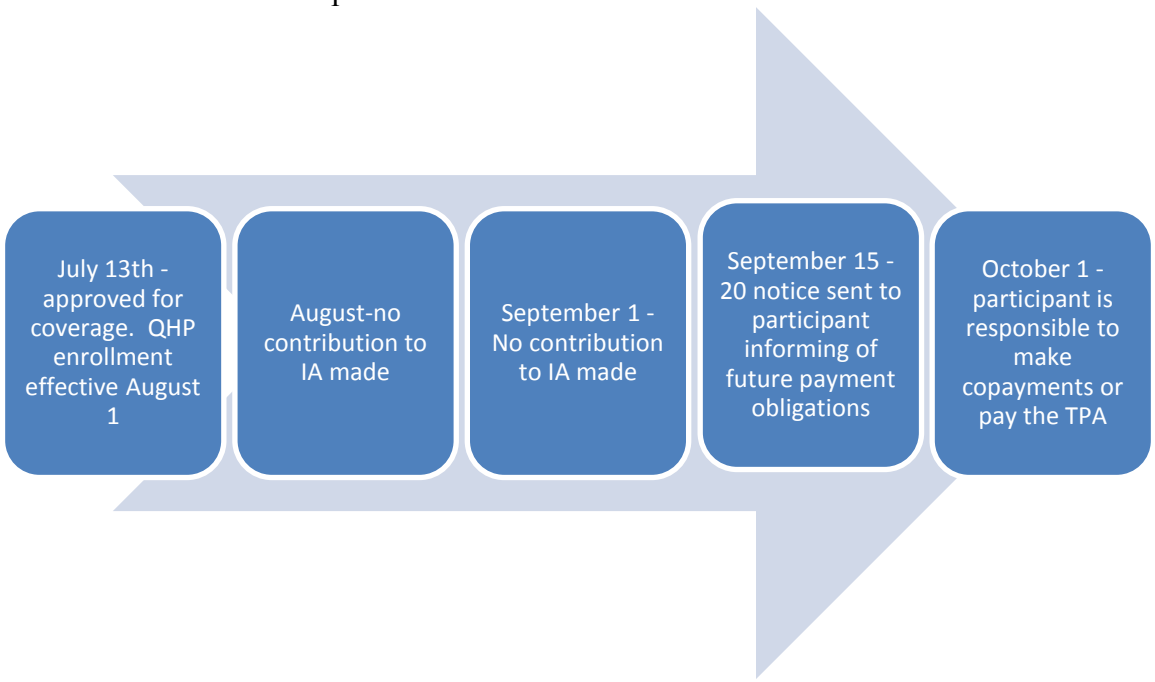
a. Private Option beneficiaries will be able to choose from at least two silver plans covering only Essential Health Benefits that are in each rating area of the State
b. Private Option beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered 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.

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

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.

---

[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:

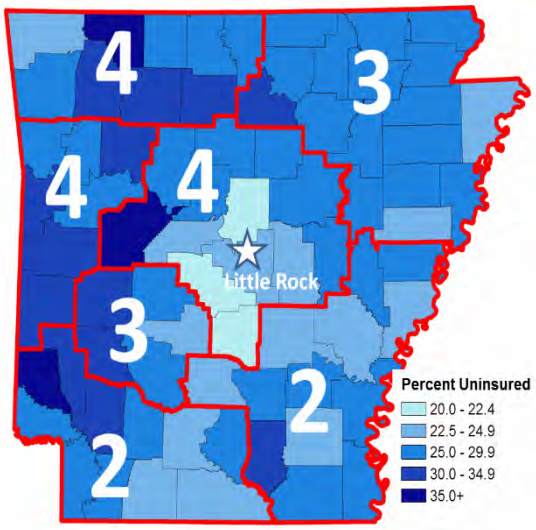
- The federal government will benefit from ~$1.1 billion per year in new taxes and Medicare payment reductions.[8]
- The increase in federal costs for expansion and ongoing Medicaid is projected at $1.59 billion in FY15 and $2.35 billion in FY20.[6]
- The net impact on the federal budget approaches neutrality 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.

---

[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

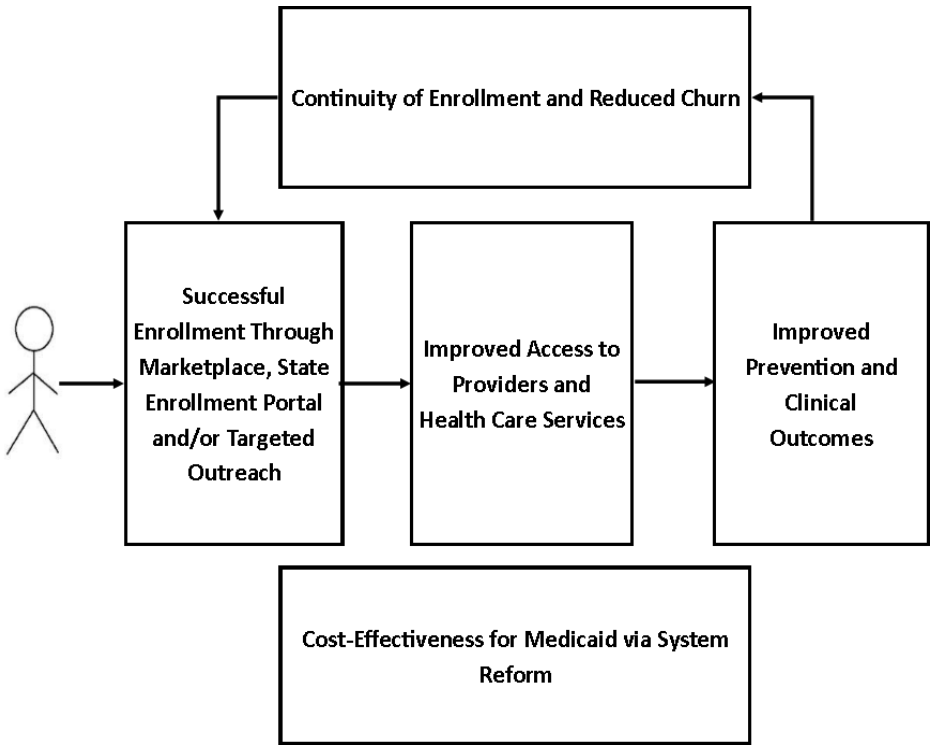
Arkansas is at the forefront of payment innovation and delivery system reform, and the Health Care Independence Act will accelerate and leverage the state's Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort, and the number of privately 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.

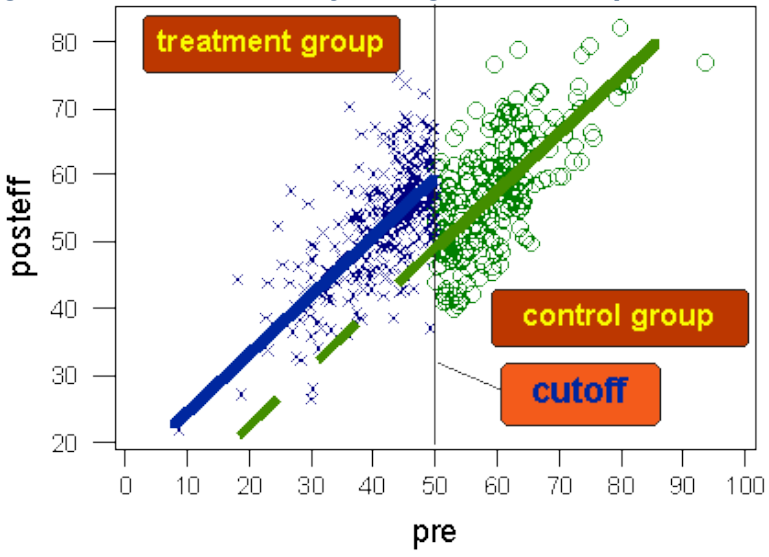
D3. Regression Discontinuity Analysis

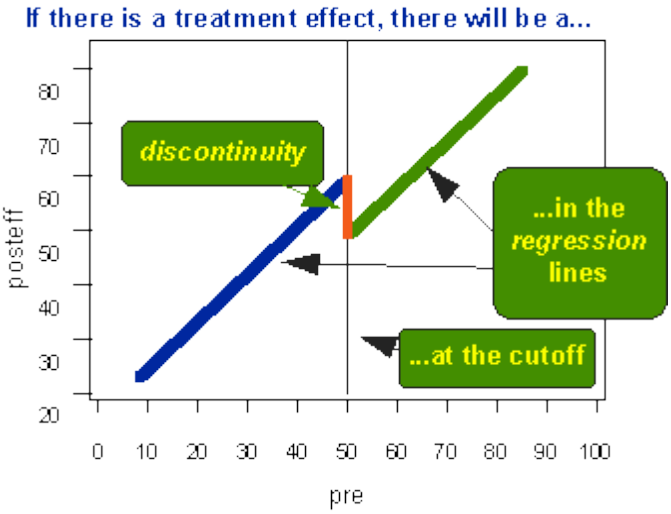
In cases where random assignment to treatment and control groups is not feasible, comparisons can be done by examining subgroups of individuals based on scores just above or below a cutoff value of a predetermined variable. The assumption is that such individuals with similar scores may not differ significantly 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:

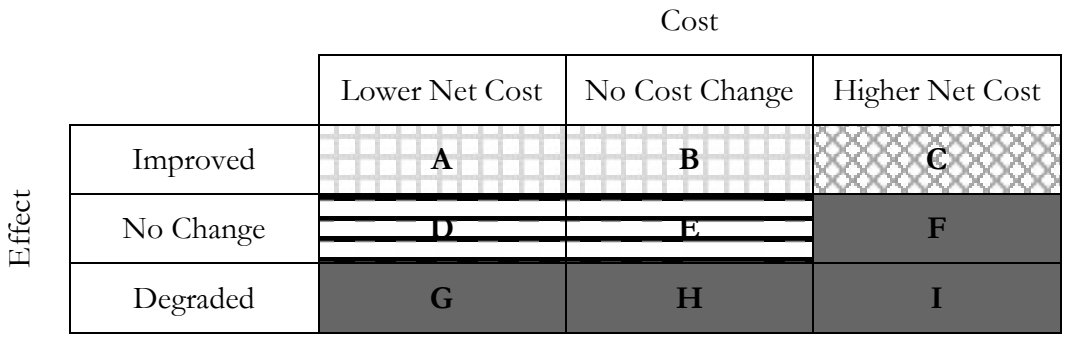
- Premiums set in advance for one year may be greater or less than actual experience; actual experience could lead to increases or decreases in premiums in future years.
- The state is entitled to repayment from carriers for premiums exceeding claims cost plus administration, subject to the minimum loss 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.

---

[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
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

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

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory
Little Rock, Arkansas 72201
www.achi.net

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

Appendix 2B—Selected Measures from Healthcare Effectiveness Data and Information Set (HEDIS) 2014

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

Origin: HEDIS 2014

Description:

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

Numerator

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

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

Denominator

The eligible population.

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

Origin: HEDIS 2014

Description:

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

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

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

Numerator

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

Denominator

The eligible population.

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

Origin: HEDIS 2014

Description:

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

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

Annual monitoring for members on digoxin.

Annual monitoring for members on diuretics.

Annual monitoring for members on anticonvulsants.

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

Numerators

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

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

Annual monitoring for members on Digoxin

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

Annual monitoring for members on Diuretics

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

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

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

Annual monitoring for members on Anticonvulsants

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

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

Origin: HEDIS 2014

Description:

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

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

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

Numerator

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

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

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

- Ambulatory Visits Value Set
- Other Ambulatory Visits Value Set

Denominator

The eligible population (report each age stratification separately).

Measure: Frequency of Selected Procedures (FSP)

Origin: HEDIS 2014

Description:

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

Selected Procedures

Tonsillectomy

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

Bariatric weight loss surgery

- Report the number of bariatric weight loss surgeries.

Hysterectomy

- Report abdominal and vaginal hysterectomy separately.

Cholecystectomy

- Report open and laparoscopic cholecystectomy separately.

Back surgery

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

Percutaneous Coronary Intervention (PCI)

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

Cardiac Catheterization

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

Coronary Artery Bypass Graft (CABG)

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

Prostatectomy

- Report the number of prostatectomies.

Total Hip Replacement

- Report the number of total hip replacements.

Total Knee Replacement

- Report the number of total knee replacements.

Carotid Endarterectomy

- Report the number of carotid endarterectomies.

Mastectomy

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

Lumpectomy

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

Measure: Ambulatory Care (AMB)

Origin: HEDIS 2014

Description:

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

Outpatient Visits

ED Visits

Outpatient Visits

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

ED Visits

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

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

Exclusions (required)

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

Note

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

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

Origin: HEDIS 2014

Description:

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

Total inpatient

Maternity

Surgery

Medicine

Product Lines

Report the following tables for each applicable product line:

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

Appendix 2C

Consumer Assessment of Healthcare Providers and Systems Survey

Health Plan 5.0

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Consumer Assessment of Healthcare Providers and Systems Survey

Selected measures from the CAHPS 5.0 Health Plan survey are being used according to the Agency for Healthcare Research and Quality's protocol. The survey is attached.

CAHPS® Health Plan Surveys

Version: Adult Commercial Survey 5.0

Language: English

Notes

- **Release of 5.0 version:** The CAHPS Health Plan Surveys were updated in the Spring of 2012. The updates are limited to minor changes to the wording of several items and a change in the placement of one item. These edits reflect the CAHPS Consortium's most recent findings from testing of related survey instruments. For specific information about the updates to this survey, please read **CAHPS Health Plan Surveys: Overview of the Questionnaires,** which is available at https://www.cahps.ahrq.gov/Surveys-Guidance/HP/Get-Surveys-and-Instructions.aspx.
- **Supplemental items:** Survey users may add questions to this survey. A document with supplemental items developed by the CAHPS Consortium and descriptions of major item sets are available in the **Health Plan Surveys and Instructions** (http://www.cahps.ahrq.gov/Surveys-Guidance/HP/Get-Surveys-and-Instructions.aspx).

Instructions for Front Cover

- Replace the cover of this document with your own front cover. Include a user-friendly title and your own logo.
- Include this text regarding the confidentiality of survey responses:

  Your Privacy is Protected. All information that would let someone identify you or your family will be kept private. {VENDOR NAME} will not share your personal information with anyone without your OK. Your responses to this survey are also completely **confidential**. You may notice a number on the cover of the survey. This number is used **only** to let us know if you returned your survey so we don't have to send you reminders.

  Your Participation is Voluntary. You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get.

  What To Do When You're Done. Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the envelope to [INSERT VENDOR ADDRESS].

  If you want to know more about this study, please call XXX-XXX-XXXX.

Instructions for Format of Questionnaire

Proper formatting of a questionnaire improves response rates, the ease of completion, and the accuracy of responses. The CAHPS team's recommendations include the following:

- If feasible, insert blank pages as needed so that the survey instructions (see next page) and the first page of questions start on the right-hand side of the questionnaire booklet.
- Maximize readability by using two columns, serif fonts for the questions, and ample white space.
- Number the pages of your document, but remove the headers and footers inserted to help sponsors and vendors distinguish among questionnaire versions.

Find additional guidance in **Preparing a Questionnaire Using the CAHPS Health Plan Survey,** which is available at https://www.cahps.ahrq.gov/Surveys-Guidance/HP/Get-Surveys-and-Instructions.aspx.

Survey Instructions

Answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes → **If Yes, go to #1 on page 1**
☐ No

1. Our records show that you are now in {INSERT HEALTH PLAN NAME}. Is that right?

[1] ☐ Yes → **If Yes, go to #3**
[2] ☐ No

2. What is the name of your health plan?

Please print: _____

_____

Your Health Care in the Last 12 Months

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

3. In the last 12 months, did you have an illness, injury, or condition that **needed care right away** in a clinic, emergency room, or doctor's office?

[1] ☐ Yes
[2] ☐ No → **If No, go to #5**

4. In the last 12 months, when you **needed care right away**, how often did you get care as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

5. In the last 12 months, did you make any appointments for a **check-up or routine care** at a doctor's office or clinic?

[1] ☐ Yes
[2] ☐ No → **If No, go to #7**

6. In the last 12 months, how often did you get an appointment for a **check-up or routine care** at a doctor's office or clinic as soon as you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

7. In the last 12 months, **not** counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

☐ None → **If None, go to #10**
☐ 1 time
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more times

8. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?

- ☐ 0 Worst health care possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best health care possible

9. In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

Your Personal Doctor

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

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #17**

11. In the last 12 months, how many times did you visit your personal doctor to get care for yourself?

- ☐ None → **If None, go to #16**
- ☐ 1 time
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more times

12. In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

13. In the last 12 months, how often did your personal doctor listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

14. In the last 12 months, how often did your personal doctor show respect for what you had to say?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

15. In the last 12 months, how often did your personal doctor spend enough time with you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

☐ 0 Worst personal doctor possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best personal doctor possible

Getting Health Care From Specialists

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

17. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you make any appointments to see a specialist?

1 ☐ Yes
2 ☐ No → **If No, go to #21**

18. In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

19. How many specialists have you seen in the last 12 months?

☐ None → **If None, go to #21**
☐ 1 specialist
☐ 2
☐ 3
☐ 4
☐ 5 or more specialists

20. We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?

- ☐ 0 Worst specialist possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best specialist possible

Your Health Plan

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

21. In the last 12 months, did you get information or help from your health plan's customer service?

- [1] ☐ Yes
- [2] ☐ No → **If No, go to #24**

22. In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

23. In the last 12 months, how often did your health plan's customer service staff treat you with courtesy and respect?

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

24. In the last 12 months, did your health plan give you any forms to fill out?

[1] ☐ Yes
[2] ☐ No → **If No, go to #26**

25. In the last 12 months, how often were the forms from your health plan easy to fill out?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

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

☐ 0 Worst health plan possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best health plan possible

About You

27. In general, how would you rate your overall health?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

28. In general, how would you rate your overall **mental or emotional** health?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

29. In the past 12 months, did you get heath care 3 or more times for the same condition or problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to #31**

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

[1] ☐ Yes
[2] ☐ No

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

[1] ☐ Yes
[2] ☐ No → **If No, go to #33**

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

[1] ☐ Yes
[2] ☐ No

33. What is your age?

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

34. Are you male or female?

[1] ☐ Male
[2] ☐ Female

35. What is the highest grade or level of school that you have completed?

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

36. Are you of Hispanic or Latino origin or descent?

[1] ☐ Yes, Hispanic or Latino
[2] ☐ No, not Hispanic or Latino

37. What is your race? Mark one or more.

[1] ☐ White
[2] ☐ Black or African American
[3] ☐ Asian
[4] ☐ Native Hawaiian or Other Pacific Islander
[5] ☐ American Indian or Alaska Native
[6] ☐ Other

38. Did someone help you complete this survey?

[1] ☐ Yes
[2] ☐ No → **Thank you. Please return the completed survey in the postage-paid envelope.**

39. How did that person help you? Mark one or more.

[1] ☐ Read the questions to me
[2] ☐ Wrote down the answers I gave
[3] ☐ Answered the questions for me
[4] ☐ Translated the questions into my language
[5] ☐ Helped in some other way

Please print: _____

_____

_____

Thank you.

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

Appendix 2D

Consumer Assessment of Healthcare Providers and Systems Survey

Supplemental Items 4.0

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Consumer Assessment of Healthcare Providers and Systems Survey

Selected measures from the CAHPS 4.0 Supplemental Items survey are being used according to the Agency for Healthcare Research and Quality's protocol. The survey is attached.

CAHPS® Health Plan Survey 4.0

Supplemental Items for the Adult Questionnaires

Language: English

File name: 1157a_engadultsupp_40.doc
Last updated: September 28, 2009 .

TABLE OF CONTENTS

Important instructions

Placing Supplemental Items in the Core Questionnaires. After you copy one or more supplemental items into the core questionnaire:

- **Fix the formatting** of the items as needed to fit into the two-column format.
- **Renumber** the supplemental item and **ALL** subsequent items so that they are consecutive.
- **Revise ALL skip instructions** in the questionnaire to make sure they point the respondent to the correct item number.

Definition of Health Providers. If you choose to use one or more supplemental items that refer to other health providers, please insert this definition before the first of these items: "A health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, or anyone else you would see for health care."

Behavioral Health

Insert MH1 – MH4 after core question 8. For Medicaid, reference period should be stated as "In the last 6 months."

MH1. In general, how would your rate your overall **mental or emotional health**?

[1] ☐ Excellent
[2] ☐ Very good
[3] ☐ Good
[4] ☐ Fair
[5] ☐ Poor

MH2. In the last 12 months, did you need any treatment or counseling for a personal or family problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

MH3. In the last 12 months, how often was it easy to get the treatment or counseling you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

MH4. Using any number from 0 to 10, where 0 is the worst treatment or counseling possible and 10 is the best treatment or counseling possible, what number would you use to rate all your treatment or counseling in the last 12 months?

☐ 0 Worst treatment or counseling possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best treatment or counseling possible

Chronic Conditions

CC1 – CC23 – For Medicaid, reference period should be stated as "In the last 6 months," except for CC21.

Insert CC1 – CC4 after core question 9.

CC1. Is this person a general doctor or a specialist doctor?

[1] ☐ General doctor (Family practice or internal medicine)
[2] ☐ Specialist doctor

CC2. How many months or years have you been going to your personal doctor?

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

CC3. Do you have a physical or medical condition that seriously interferes with your ability to work, attend school, or manage your day-to-day activities?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 10**

CC4. Does your personal doctor understand how any health problems you have affect your day-to-day life?

[1] ☐ Yes
[2] ☐ No

Insert CC5 after core question 18.

CC5. In the last 12 months, how many times did you go to specialists for care for yourself?

☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more

Insert CC6 – CC8 after core question 14. Please refer to instructions at the front of this document about defining "health providers."

CC6. We want to know how you, your doctors, and other health providers make decisions about your health care.

In the last 12 months, were any decisions made about your health care?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

CC7. In the last 12 months, how often were you involved as much as you wanted in these decisions about your health care?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC8. In the last 12 months, how often was it easy to get your doctors or other health providers to agree with you on the best way to manage your health conditions or problems?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Insert CC9 – CC14 after core question 8.

CC9. In the last 12 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?

[1] ☐ Yes
[2] ☐ No → **If No, go to question CC11**

CC10. In the last 12 months, how often was it easy to get the medical equipment you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC11. In the last 12 months, did you have any health problems that needed special **therapy**, such as physical, occupational, or speech therapy?

[1] ☐ Yes
[2] ☐ No → **If No, go to question CC13**

CC12. In the last 12 months, how often was it easy to get the special therapy you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

CC13. Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks.

In the last 12 months, did you need someone to come into your home to give you home health care or assistance?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

CC14. In the last 12 months, how often was it easy to get home health care or assistance through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Measures of Health Status

Insert CC15 – CC17 after core question 28.

CC15. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, dressing, or getting around the house?

[1] ☐ Yes
[2] ☐ No

CC16. Because of any impairment or health problem, do you need help with your routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

[1] ☐ Yes
[2] ☐ No

CC17. Do you have a physical or medical condition that seriously interferes with your independence, participation in the community, or quality of life?

[1] ☐ Yes
[2] ☐ No

Insert CC18 – CC22 after core question 28.

CC18. In the last 12 months, have you been a patient in a hospital overnight or longer?

[1] ☐ Yes
[2] ☐ No

CC19. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 29**

CC20. Is this condition a problem that has lasted for at least 3 months? Do **not** include pregnancy.

[1] ☐ Yes
[2] ☐ No

CC21. Do you now need to take medicine prescribed by a doctor? Do **not** include birth control.

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 29**

CC22. Is this to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

[1] ☐ Yes
[2] ☐ No

Claims Processing

Insert CP1 – CP3 before core question 20. For Medicaid, reference period should be stated as "In the last 6 months." Please note that CP1 and CP2 repeat questions that appear in the HEDIS® set.

CP1. Claims are sent to a health plan for payment. You may send in the claims yourself, or doctors, hospitals, or others may do this for you. In the last 12 months, did you or anyone else send in any claims for your care to your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 20**
[3] ☐ Don't know → **If Don't know, go to core question 20**

CP2. In the last 12 months, how often did your health plan handle your claims correctly?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always
[5] ☐ Don't know

CP3. In the last 12 months, before you went for care, how often did your health plan make it clear how much you would have to pay?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Communication

Insert C1 after core question 12. For Medicaid, reference period should be stated as "In the last 6 months."

C1. In the last 12 months, how often did you have a hard time speaking with or understanding your personal doctor because you spoke different languages?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Cost Sharing

Insert CSH1 after core question 27.

CSH1. People can pay for their health insurance directly or out of their pay check. Do you or your family pay any part of the cost of your health insurance?

[1] ☐ Yes
[2] ☐ No

Covered By Multiple Plans

Insert MP1 after core question 2. If HP1 is included, insert after HP1.

MP1. Not counting dental insurance, are you covered by any other health plan?

[1] ☐ Yes
[2] ☐ No

Dental Care*

Insert D1 – D3 after core question 8. For Medicaid, reference period should be stated as "In the last 6 months."

D1. In the last 12 months, did you get care from a dentist's office or dental clinic?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

D2. In the last 12 months, how many times did you go to a dentist's office or dental clinic for care for yourself?

☐ None → **If None, go to core question 9**
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more

* The CAHPS family of products includes a CAHPS Dental Plan Survey. For more information, go to https://www.cahps.ahrq.gov/content/products/Dental/PROD_Dental_Intro.asp.

D3. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate all your dental care in the last 12 months?

☐ 0 Worst dental care possible
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10 Best dental care possible

Health Plan

Insert HP1 after core question 2.

HP1. How many months or years **in a row** have you been in this health plan?

[1]☐ Less than 1 year
[2]☐ At least 1 year but less than 2 years
[3]☐ At least 2 years but less than 5 years
[4]☐ At least 5 years but less than 10 years
[5]☐ 10 years or more

Insert HP2 – HP7 after core question 21. For Medicaid, reference period should be stated as "In the last 6 months." Please note that HP2 – HP7 repeat questions that appear in the HEDIS set.

HP2. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

[1]☐ Yes
[2]☐ No → **If No, go to core question 22**

HP3. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

HP4. Sometimes people need services or equipment beyond what is provided in a regular or routine office visit, such as care from a specialist, physical therapy, a hearing aid, or oxygen.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for a health care service or equipment?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

HP5. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

HP6. In some health plans the amount you pay for a prescription medicine can be different for different medicines, or can be different for prescriptions filled by mail instead of at the pharmacy.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for specific prescription medicines?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

HP7. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

HEDIS® Set

[Updated for HEDIS 2010]

The HEDIS Set is composed of items that the National Committee for Quality Assurance (NCQA) added to the core questionnaire to create their version of the CAHPS Health Plan Survey, known as CAHPS 4.0H. Survey sponsors can add these items to their questionnaire whether or not they are submitting results to NCQA. Please note that some of these items are repeated in other supplemental sets.

For Medicaid, reference period should be stated as "In the last 6 months." Please refer to instructions at the front of this document about defining "health providers."

Insert H1 – H4 after core question 7.

H1. In the last 12 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

H2. Choices for your treatment or health care can include choices about medicine, surgery, or other treatment. In the last 12 months, did a doctor or other health provider tell you there was more than one choice for your treatment or health care?

1☐ Yes
2☐ No → **If No, go to core question 8**

H3. In the last 12 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?

1☐ Definitely yes
2☐ Somewhat yes
3☐ Somewhat no
4☐ Definitely no

H4. In the last 12 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?

1☐ Definitely yes
2☐ Somewhat yes
3☐ Somewhat no
4☐ Definitely no

Insert H5 – H6 after core question 14.

H5. In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?

1☐ Yes
2☐ No → **If No, go to core question 15**

H6. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

Insert H7 – H12 after core question 21.

H7. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

1☐ Yes
2☐ No → **If No, go to question H9**

H8. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

(H9 is the same as HP4)

H9. Sometimes people need services or equipment beyond what is provided in a regular or routine office visit, such as care from a specialist, physical therapy, a hearing aid, or oxygen.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for a health care service or equipment?

[1] ☐ Yes
[2] ☐ No → **If No, go to question H11**

(H10 is the same as HP5)

H10. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

(H11 is the same as HP6)

H11. In some health plans, the amount you pay for a prescription medicine can be different for different medicines, or can be different for prescriptions filled by mail instead of at the pharmacy.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for specific prescription medicines?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

(H12 is the same as HP7)

H12. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Insert H13 – H15 after core question 26.

(H13 is the same as CP1)

H13. Claims are sent to a health plan for payment. You may send in the claims yourself, or doctors, hospitals, or others may do this for you. In the last 12 months, did you or anyone else send in any claims for your care to your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 27**
[3] ☐ Don't know → **If Don't know, go to core question 27**

H14. In the last 12 months, how often did your health plan handle your claims quickly?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always
[5] ☐ Don't know

(H15 is the same as CP2)

H15. In the last 12 months, how often did your health plan handle your claims correctly?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always
[5] ☐ Don't know

Insert H16 to H25 after core question 28.

H16. Have you had a flu shot since September 1, 2010?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

H17. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

[1] ☐ Every day
[2] ☐ Some days
[3] ☐ Not at all → **If Not at all, go to question H21**
[4] ☐ Don't know → **If Don't know, go to question H21**

H18. In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

H19. In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

H20. In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

H21. Do you take aspirin daily or every other day?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

H22. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

[1] ☐ Yes
[2] ☐ No
[3] ☐ Don't know

H23. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

[1] ☐ Yes
[2] ☐ No

H24. Are you aware that you have any of the following conditions? Check all that apply.

[1] ☐ High cholesterol
[2] ☐ High blood pressure
[3] ☐ Parent or sibling with heart attack before the age of 60

H25. Has a doctor ever told you that you have any of the following conditions? Check all that apply.

[1] ☐ A heart attack
[2] ☐ Angina or coronary heart disease
[3] ☐ A stroke
[4] ☐ Any kind of diabetes or high blood sugar

Interpreter

Insert I1 – I2 after core question 8. For Medicaid, reference period should be stated as "In the last 6 months."

I1. An interpreter is someone who repeats or signs what one person says in a language used by another person.

In the last 12 months, did you need an interpreter to help you speak with doctors or other health providers?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 9**

I2. In the last 12 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Insert I3 after core question 37.

I3. What language do you **mainly** speak at home?

[1] ☐ English
[2] ☐ [INSERT LANGUAGE 2]
[3] ☐ [INSERT LANGUAGE 3]
[4] ☐ [INSERT LANGUAGE 4]

Medicaid Enrollment

Insert ME1 to ME4 before core question 20. If you are including both ME1 and ME3 in your questionnaire, change the skip instruction for ME1 to "No → **If No, go to question ME3."**

ME1. Some states pay health plans to care for people covered by {Medicaid/State name for Medicaid}. With these health plans, you may have to choose a doctor from the plan list or go to a clinic or health care center on the plan list.

Are you covered by a health plan like this?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 20**

ME2. Did you choose your health plan or were you told which plan you were in?

[1] ☐ You chose your plan
[2] ☐ You were told which plan you were in

ME3. You can get information about plan services in writing, by telephone, on the Internet, or in-person. Did you get any information about your health plan **before** you signed up for it?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 20**

ME4. How much of the information you were given before you signed up for the plan was correct?

[1] ☐ All of it
[2] ☐ Most of it
[3] ☐ Some of it
[4] ☐ None of it

People With Mobility Impairments

For Medicaid, reference period should be stated as "In the last 6 months."

Your Personal Doctor

Insert IM1 – IM10 after core question 15.

IM1. In the last 12 months, did you visit your personal doctor for care?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 16**

IM2. When you visited your personal doctor's office in the last 12 months, how often were you examined on the examination table?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM3. When you visited your personal doctor's office in the last 12 months, how often did someone weigh you?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM4. When you visited your personal doctor's office in the last 12 months, did you try to use the restroom?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM6**

IM5. In the last 12 months, how often was it easy to move around the restroom at your personal doctor's office?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM6. In the last 12 months, did you and your personal doctor talk about pain?

[1] ☐ Yes
[2] ☐ No

IM7. In the last 12 months, how often did pain limit your ability to do the things you needed to do?

[1] ☐ Never → **If Never, go to question IM9**
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM8. In the last 12 months, do you think that your personal doctor understood the impact that pain has on your life?

[1] ☐ Yes
[2] ☐ No

IM9. In the last 12 months, how often did fatigue limit your ability to do the things you needed to do?

[1] ☐ Never → **If Never, go to core question 16**
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM10. In the last 12 months, do you think that your personal doctor understood the impact that fatigue has on your life?

[1] ☐ Yes
[2] ☐ No

Your Health Plan

Insert IM11 – IM19 after core question 27.

IM11. In the last 12 months, did you need physical or occupational therapy?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM13**

IM12. In the last 12 months, how often was it easy to get this kind of therapy through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM13. In the last 12 months, did you need speech therapy?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM15**

IM14. In the last 12 months, how often was it easy to get speech therapy through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM15. Mobility equipment includes things like a wheelchair, scooter, walker, or cane. In the last 12 months, have you used any mobility equipment to move around your home or community?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

IM16. In the last 12 months, did you try to get your mobility equipment repaired through your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to question IM18**

IM17. In the last 12 months, how often was it easy to get your mobility equipment repaired through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

IM18. In the last 12 months, did you try to get or replace any mobility equipment through your health plan?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

IM19. In the last 12 months, how often was it easy to get or replace the mobility equipment that you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

About You

Insert IM20 – IM21 after core question 32.

IM20. A quarter mile is about 5 city blocks or 0.4 kilometers. In the last 12 months, were you able to walk that far?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 33**

IM21. In the last 12 months, did you have difficulty or need assistance to walk that far?

[1] ☐ Yes
[2] ☐ No

Personal Doctor

Insert PD1 – PD2 after core question 15.

PD1. Did you have the same personal doctor **before** you joined this health plan?

[1] ☐ Yes → **If Yes, go to core question 16**
[2] ☐ No

PD2. Since you joined your health plan, how often was it easy to get a personal doctor you are happy with?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Pregnancy Care

Insert P1 – P3 after core question 14. Remove core question 34 from the Adult Questionnaire, as it is duplicated in P1.

P1. Are you male or female?

[1] ☐ Male → **If Male, go to core question 15**
[2] ☐ Female

P2. Are you pregnant now?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

P3. A health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, a mid-wife, or anyone else you would see for health care when you are pregnant.

Have you been to a doctor or other health provider for a pregnancy care check-up for **this** pregnancy?

[1] ☐ Yes
[2] ☐ No

Prescription Medicine

Insert PM1 – PM3 after core question 27. For Medicaid, reference period should be stated as "In the last 6 months."

PM1. In the last 12 months, did you get any new prescription medicines or refill a prescription?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

PM2. In the last 12 months, how often was it easy to get your prescription medicine from your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

PM3. In the last 12 months, how often did you get the prescription medicine you needed through your health plan?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Quality Improvement

For Medicaid, reference period should be stated as "In the last 6 months."

Access to Routine Care

Insert AR1 – AR2 after core question 6. Please refer to instructions at the front of this document about defining "health providers."

AR1. In the last 12 months, **not** counting the times you needed health care right away, how many days did you usually have to wait between making an appointment and actually seeing a health provider?

1☐ Same day
2☐ 1 day
3☐ 2 to 3 days
4☐ 4 to 7 days
5☐ 8 to 14 days
6☐ 15 to 30 days
7☐ 31 to 60 days
8☐ 61 to 90 days
9☐ 91 days or longer

AR2. In the last 12 months, how often did you have to wait for an appointment because the health provider you wanted to see worked limited hours or had few available appointments?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

Access to Specialist Care

Insert AS1 after core question 17, which should be modified to include the skip instructions presented below.

17. In the last 12 months, how often was it easy to get appointments with specialists?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always → **If Always, go to core question 18**

AS1 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

AS1. Were any of the following a reason it was not easy to get an appointment with a specialist?

		Yes	No
a)	Your doctor did not think you needed to see a specialist	1☐	2☐
b)	Your health plan approval or authorization was delayed	1☐	2☐
c)	You weren't sure where to find a list of specialists in your health plan or network	1☐	2☐
d)	The specialists you had to choose from were too far away	1☐	2☐
e)	You did not have enough specialists to choose from	1☐	2☐
f)	The specialist you wanted did not belong to your health plan or network	1☐	2☐
g)	You could not get an appointment at a time that was convenient	1☐	2☐
h)	Some other reason	1☐	2☐

Please specify: _____

_____

After Hours Care

Insert AH1 – AH3 after core question 8.

AH1. After hours care is health care when your usual doctor's office or clinic is closed. In the last 12 months, did you need to visit a doctor's office or clinic for after hours care?

1☐ Yes
2☐ No → **If No, go to core question 9**

AH2. In the last 12 months, how often was it easy to get the after hours care you thought you needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always → **If No, go to core question 9**

AH3 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

AH3. Were any of the following a reason it was not easy to get the after hours care you thought you needed?

		Yes	No
a)	You did not know where to go for after hours care	1☐	2☐
b)	You weren't sure where to find a list of doctor's offices or clinics in your health plan or network that are open for after hours care	1☐	2☐
c)	The doctor's office or clinic that had after hours care was too far away	1☐	2☐
d)	Office or clinic hours for after hours care did not meet your needs	1☐	2☐
e)	Some other reason	1☐	2☐

Please specify: _____

_____

Calls to Personal Doctor's Office

Insert C1 – C5 after core question 14.

CO1. In the last 12 months, did you phone your personal doctor's office **during** regular office hours to get help or advice for yourself?

1☐ Yes
2☐ No → **If No, go to question CO3**

CO2. In the last 12 months, when you phoned during regular office hours, how often did you get the help or advice you needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

CO3. In the last 12 months, did you phone your personal doctor's office **after** regular office hours to get help or advice for yourself?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

CO4. In the last 12 months, when you phoned after regular office hours, how often did you get the help or advice you needed?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always → **If Always, go to core question 15**

CO5 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

CO5. Were any of the following a reason you did not get the help or advice you thought you needed when you phoned after regular office hours?

		Yes	No
a)	You did not know what number to call	[1] ☐	[2] ☐
b)	You left a message but no one returned your call	[1] ☐	[2] ☐
c)	You could not leave a message at the number you phoned	[1] ☐	[2] ☐
d)	Another doctor was covering for your personal doctor	[1] ☐	[2] ☐
e)	Some other reason	[1] ☐	[2] ☐

Please specify: _____

_____

Coordination of Care from Other Health Providers

Insert OHP1 – OHP5 after core question 14. Please note that OHP1 – OHP2 repeat questions that appear in the HEDIS set. Please refer to instructions at the front of this document about defining "health providers."

OHP1. In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 15**

OHP2. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

OHP3. In the last 12 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?

1☐ Yes
2☐ No → **If No, go to core question 15**

OHP4. In the last 12 months, who helped to coordinate your care?

1☐ Someone from your health plan
2☐ Someone from your doctor's office or clinic
3☐ Someone from another organization
4☐ A friend or family member
5☐ You

OHP5. How satisfied are you with the help you received to coordinate your care in the last 12 months?

1☐ Very dissatisfied
2☐ Dissatisfied
3☐ Neither dissatisfied nor satisfied
4☐ Satisfied
5☐ Very satisfied

Customer Service

Insert CS1 – CS2 after core question 23, which should be modified to include the skip instructions presented below. Core question 24 also provides useful drill-down data on consumer encounters with customer service.

23. In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

[1]☐ Never
[2]☐ Sometimes
[3]☐ Usually
[4]☐ Always → **If Always, go to question CS2**

CS1 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

CS1. Were any of the following a reason you did not get the information or help you needed from your health plan's customer service?

		Yes	No
a)	You had to call several times before you could speak with someone	[1]☐	[2]☐
b)	The information customer service gave you was not correct	[1]☐	[2]☐
c)	Customer service did not have the information you needed	[1]☐	[2]☐
d)	You waited too long for someone to call you back	[1]☐	[2]☐
e)	No one called you back	[1]☐	[2]☐
f)	Some other reason	[1]☐	[2]☐

Please specify: _____

_____

CS2. How many calls did it take for you to get the help or information you needed from your health plan's customer service?

[1]☐ 1 call
[2]☐ 2
[3]☐ 3
[4]☐ 4
[5]☐ 5 or more calls
[6]☐ You are still waiting for help

Health Plan Information and Materials

Insert PW1 – PW8 after core question 21. Please note that PW1 – PW2 repeat questions that appear in the HEDIS set. If you use PW4 or PW8, please refer to instructions at the front of this document about defining "health providers."

(PWI is the same as HP2)

PW1. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 22**

PW2. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

PW3. In the last 12 months, how often was it easy to use the information on how your health plan works?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always → **If Always, go to question PW6**

PW4 and PW5 were designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

PW4. What kind of information was **not** easy to use?

		Yes	No
a)	Benefits and coverage for doctor or specialist visits	1☐	2☐
b)	Benefits and coverage for pharmacy	1☐	2☐
c)	Getting a referral to a specialist	1☐	2☐
d)	After hours or urgent care	1☐	2☐
e)	Choosing a health provider	1☐	2☐
f)	Getting care outside your network	1☐	2☐
g)	Something else	1☐	2☐

Please specify: _____

_____

PW5. Where did you get that information? Mark one or more.

		Yes	No
a)	From your health plan	1☐	2☐
b)	From your employer	1☐	2☐
c)	From your doctor's office	1☐	2☐
d)	From some other source	1☐	2☐
e)	Not sure where you got it	1☐	2☐

PW6. When you looked for information in the last 12 months, did you go to your health plan's Internet site?

1☐ Yes
2☐ No → **If No, go to core question 22**

PW7. How useful was the information you found on your health plan's Internet site?

1☐ Not at all useful
2☐ A little useful
3☐ Somewhat useful
4☐ Very useful

PW8. In the last 12 months, did you use information on your health plan's Internet site to choose a doctor, specialist, or group of health providers?

[1] ☐ Yes
[2] ☐ No

Referrals

Insert R1 before core question 17. For Medicaid, reference period should be stated as "In the last 6 months."

R1. In the last 12 months, how often was it easy to get a referral to a specialist that you needed to see?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Relation to Policyholder

Insert RP1 after core question 37.

RP1. Health insurance plans are usually in one person's name, the policyholder. Are you the policyholder?

[1] ☐ Yes
[2] ☐ No

Transportation

Insert T1 – T3 after core question 27. For Medicaid, reference period should be stated as "In the last 6 months."

T1. Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage.

In the last 12 months, did you phone your health plan to get help with transportation?

[1] ☐ Yes
[2] ☐ No → **If No, go to core question 28**

T2. In the last 12 months, when you phoned to get help with transportation from your health plan, how often did you get it?

[1] ☐ Never → **If Never, go to core question 28**
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

T3. In the last 12 months, how often did the help with transportation meet your needs?

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Utilization

Insert UT1 after core question 6. For Medicaid, reference period should be stated as "In the last 6 months."

UT1. In the last 12 months, how many times did you go to an emergency room to get care for yourself?

☐ None
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 to 9
☐ 10 or more

Insert UT2 after core question 19. For Medicaid, reference period should be stated as "In the last 6 months."

UT2. In the last 12 months, was the specialist you saw most often the same doctor as your personal doctor?

[1] ☐ Yes
[2] ☐ No

Appendix 3

Metrics and Hypotheses

HCIP Waiver Evaluation Planning: State's Medicaid Reporting Measures

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

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

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

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost
22	HEDIS	Ambulatory Care (Outpatient ER)	Utilization for selected procedures per 1000 enrollees	Medical claims	X			
23	HEDIS	Inpatient Utilization—General Hospital/ Acute Care	Inpatient service use by age	Medical claims	X			
24	CAHPS-4; NQF 0006	Got care for illness/injury as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
25	CAHPS-6; NQF 0006	Got non-urgent appointment as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
26	CAHPS-9; NQF 0006	How often it was easy to get necessary care, tests, or treatment	Survey based assessment of enrollee experiences	Survey	X			
27	CAHPS-10; NQF 0006	Have a personal doctor	Survey based assessment of enrollee experiences	Survey	X			
28	CAHPS-18; NQF 0006	Got appointment with specialists as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
29	CAHPS-HP1; NQF 0007	Number of months or years in a row enrolled in health plan	Survey based assessment of enrollee experiences	Survey			X	
30	CAHPS-8; NQF 0007	Rating of all health care	Survey based assessment of enrollee experiences	Survey		X		
31	CAHPS-16; NQF 0007	Rating of personal doctor	Survey based assessment of enrollee experiences	Survey		X		
32	CAHPS-20; NQF 0007	Rating of specialist	Survey based assessment of enrollee experiences	Survey		X		
33	CAHPS-26; NQF 0007	Rating of health plan	Survey based assessment of enrollee experiences	Survey		X		
34	CAHPS-I1; NQF 0007	Needed interpreter to help speak with doctors or other health providers	Survey based assessment of enrollee experiences	Survey	X			
35	CAHPS-I2; NQF 0007	How often got an interpreter when needed one	Survey based assessment of enrollee experiences	Survey	X			
36	CAHPS-PD1; NQF 0007	Had same personal doctor before joining plan	Survey based assessment of enrollee experiences	Survey		X	X	

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost
37	CAHPS-PD2; NQF 0007	Easy to get personal doctor you were happy with	Survey based assessment of enrollee experiences	Survey		X		
38	CAHPS-AR1; NQF 0007	Days wait time between making appointment and seeing provider	Survey based assessment of enrollee experiences	Survey	X			
39	CAHPS-AR2; NQF 0007	How often had to wait for appointment because of provider's lack of hours/availability	Survey based assessment of enrollee experiences	Survey	X			
40	CAHPS-R1; NQF 0007	Easy to get a referral to a specialist	Survey based assessment of enrollee experiences	Survey	X	X		
41	CAHPS-UT1; NQF 0007	Times visited emergency room	Survey based assessment of enrollee experiences	Survey	X	X		
42	AR Medicaid Eval 02	Non-emergency transportation access	Use of non-emergency transportation services	Transportation data	X			
43	AR Medicaid Eval 03	Continuity of PCP care	Consistent use of the same primary care provider over time--proportion of primary care visits with same PCP	Medical claims	X		X	
44	AR Medicaid Eval 04	Continuity of Specialist care	Consistent use of the same specialist provider over time--proportion of type specific same specialist visits over time	Medical claims	X		X	
45	AR Medicaid Eval 05	PCP Network Adequacy	Adequacy of primary care provider network for enrolled populations--proportion of service area without primary care coverage within 30 miles	Carrier / Medicaid geomaps	X			
46	AR Medicaid Eval 06	PCP Network Accessibility	Accessibility of primary care provider network for enrolled popluations--proportion of enrollees with primary care accessibile within 30 miles	Carrier / Medicaid geomaps	X			
47	AR Medicaid Eval 07	Specialist network adequacy	Adequacy of specialist provider network for enrolled populations--proportion of service area without specialist coverage within 60 miles	Carrier / Medicaid geomaps	X			
48	AR Medicaid Eval 08	Specialist network accessibility	Accessibility of specialist network for enrolled populations--proportion of enrollees with specialist accessible within 60 miles	Carrier / Medicaid geomaps	X			
49	AR Medicaid Eval 09	Total and subgroup enrollment within carrier (e.g., market penetration)	Carrier, and carrier by market specific enrollment data	Enrollment			X	

Metric Number	Indicator	Metric Name	Description	Data Source	1. Access	2. Outcomes	3. Continuity	4. Cost
50	AR Medicaid Eval 10	Total and subgroup enrollment within each plan (e.g., plan differentiation)	Carrier, and carrier by market, and carrier by market by plan specific enrollment data	Enrollment			X	
51	AR Medicaid Eval 11	Total and subgroup enrollment within each method of entry (e.g., enrollment path)	Carrier specific enrollment path	Enrollment			X	
52	AR Medicaid Eval 12	Total and subgroup enrollment within each market (e.g., geographic uptake variation)	Carrier by market specific enrollment path	Enrollment			X	
53	AR Medicaid Eval 13	Total and Subgroup Medicaid Clinical costs	Direct payments by state Medicaid per enrollee	Cost				X
54	AR Medicaid Eval 14	Total and Subgroup Medicaid Administrative costs	Direct administrative costs attributed per enrollee	Cost				X
55	AR Medicaid Eval 15	Total and Subgroup Plan Admin Costs per Enrollee	Direct wrap costs attributed per enrollee	Cost				X
56	AR Medicaid Eval 16	Total startup programmatic costs (e.g., medical needs screener)	Total Program Start Costs	Cost				X
57	AR Medicaid Eval 17	Total startup programmatic costs (e.g., medical needs screener)	Direct Premium Assistance paid per enrollee	Cost				X
58	AR Medicaid Eval 18	Total and Subgroup Plan Admin Costs per Enrollee	Estimated plan administrative costs for premium assistance	Cost				X
59	AR Medicaid Eval 19	Arkansas Program Characteristics	Arkansas specific health insurance exchange program characteristics (e.g., number of plans per market area, actuary risk, average 2nd lowest premium cost)	Cost				X
60	AR Medicaid Eval 20	Contiguous State Program Characteristics	Contiguous state specific health insurance exchange program characteristics	Cost				X
61	AR Medicaid Eval 21	Regional average program characteristics	Regional average state specific health insurance exchange program characteristics	Cost				X

Appendix 4

Candidate Metrics by Approach

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Candidate Metrics by Approach

This table attributes the metrics that are referenced in Appendix 3 to the corresponding analytical design approach that will be used to address each of the evaluation hypotheses.

Hypotheses	Design Approach		
	Subgroup Comparison	Regression Discontinuity	Statewide Comparison
1—Access			
a. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.		2, 3, 4, 10, 16, 20	1, 2, 3, 4, 10, 16, 20-22, 24-28, 43-48, 37-40, 45-48
b. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.	22, 41	22, 41	22, 41
c. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.		4, 23	4-8, 23
d. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.	18, 43-47		
e. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.	42	42	42
2—Care/Outcomes			
a. Premium Assistance beneficiaries will have equal or better access to preventive care services. (P – Primary Prevention; S – Secondary Prevention; T – Tertiary Prevention)		P: 2, 3 S: 9, 10 T: 11-13, 18-19	P: 1-3 S: 9-10 T: 11-13, 17-19
b. Premium Assistance beneficiaries will report equal or better experience in the care provided.			24-28, 30-35, 37-40

3—Continuity			
a. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.		49-52	29, 49-52
b. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.		49-52	29, 36(m), 43-44, 49-52
4—Cost Effectiveness			
a. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.		2-4, 9-13, 16, 18-20, 22-23, 41-42, 54, 56-58	1-13, 16-28, 30-35, 37-52, 54, 56-58
b. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.		2-4, 9-13, 16, 18-20, 22-23, 41-42, 59-61	1-13, 16-28, 30-35, 37-52, 59-61
c. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.		53-57	53-57

m = modification

Appendix 5

Arkansas Insurance Department Network Adequacy Guidelines and Targets

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Appendix 5
AID Network Adequacy Guidelines and Targets

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

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

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

Accreditation

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

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

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

Time and Distance Targets

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

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

GeoAccess Map Guidelines

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

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

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

Performance Metric Guidelines for Non-Accredited Carriers

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

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

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

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

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

Network Access Policies and Procedures for Non-Accredited Carriers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Standards for Essential Community Providers (ECPs)

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

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

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

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

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

Inclusion of School-Based Providers

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

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

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

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

Provider Directories

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

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

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

Specialty Services

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

Appendix 6

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

June 25, 2013

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

ACHI
Arkansas Center for Health Improvement

1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

BULLETIN NO. 3B-2013

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

FROM: ARKANSAS INSURANCE DEPARTMENT

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

DATE: June 25, 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Accreditation	

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

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

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

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

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

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

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

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

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

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

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

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

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

[redacted]

June, 25 2013

JAY BRADFORD, COMMISSIONER
ARKANSAS INSURANCE DEPARTMENT

DATE

APPENDIX A

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

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

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

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

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

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

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

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

APPENDIX B

DEFINITION OF HABILITATIVE SERVICES

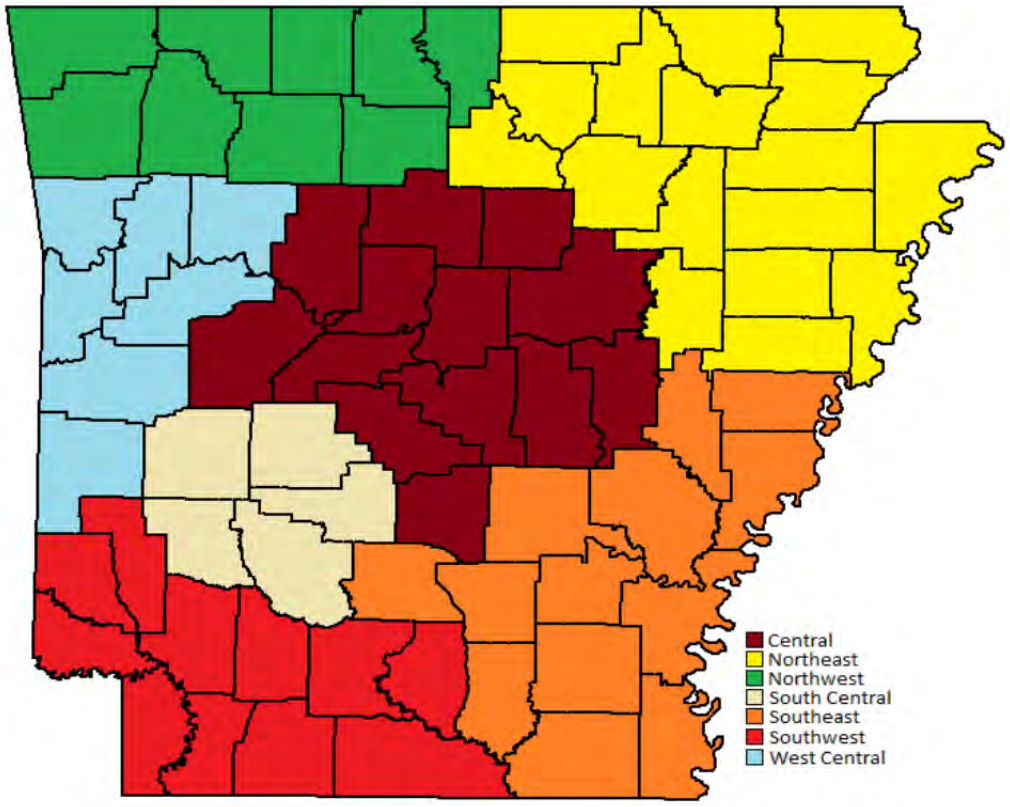
Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

COVERAGE OF HABILITATIVE SERVICES

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

APPENDIX C

STATE RATING AND SERVICE AREAS



Arkansas Counties by Region

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

APPENDIX D

HIGH LEVEL SILVER PLAN COST SHARING VARIATION REQUIREMENT

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

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

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

APPENDIX E

SUMMARY OF CHANGES FROM FEBRUARY 19, 2013 RELEASE

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

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

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

SUMMARY OF CHANGES FROM JUNE 25, 2013 RELEASE

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

ATTACHMENT B

Copayment and Coinsurance Amounts

General Service Description	QHP-Level Cost Sharing	Cost Sharing Applicable for Individuals with Incomes from 50-100% FPL Who Do Not Make Monthly Contributions
Behavioral Health – Inpatient	$140/day	$75/stay
Behavioral Health – Outpatient	$4	$4
Behavioral Health – Professional	$4	$4
Durable Medical Equipment	$4	$4
Emergency Room Services	-	-
FQHC	$8	$4
Inpatient	$140/day	$75/stay
Lab and Radiology	-	$4
Skilled Nursing Facility	$20/day	$75/stay
Other	$4	$4
Other Medical Professionals	$4	$4
Outpatient Facility	-	$4
Primary Care Physician	$8	$4
Specialty Physician	$10	$4
Pharmacy – Generics	$4	$4
Pharmacy – Preferred Brand Drugs	$4	$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	$8	$8

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Director

P.O. Box 1437, Slot S201 · Little Rock, AR 72203-1437
501-682-8650 · Fax: 501-682-6836 · TDD: 501-682-8820

July 14, 2015

Ms. Leila Ashkeboussi
Project Officer
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Ms. Ashkeboussi and Mr. Brooks:

On behalf of the Arkansas Department of Human Services, I would like to request the following technical corrections to the Special Terms and Conditions ("STCs") for the Arkansas Health Care Independence Program (or "Private Option") (Project Number 11-W-00287/6):

- **Program Description and Objectives:** As you know, the 2015 Arkansas General Assembly suspended the application of any additional cost sharing requirements that were to be effective on or after January 31, 2015, under the Health Care Independence Program to Medicaid beneficiaries with incomes below 100% of the federal poverty level (FPL). As a result, Independence Accounts (IAs) are not currently being implemented for individuals with incomes below 100% FPL. To reflect our implementation efforts and ensure consistency between the STCs and the IA Operational Protocol, I request that the waiver be modified as follows:
    - Third paragraph: I request that the sentence beginning, "The new adult population with incomes above 100 percent FPL…" be amended to read, "The new adult population with incomes above 100 percent FPL will be required to make contributions to their IA consistent with the amounts specified in the IA Operational Protocol, depending on income."
    - Fourth paragraph: I request that the sentence beginning, "The new adult population with incomes between 50 percent and 100 percent FPL…" be modified as follows: "To the extent that the State establishes IAs for individuals with incomes between 50 percent and 100 percent FPL, the new adult population with incomes between 50 percent and 100 percent FPL may be required to contribute to their IA consistent with the amounts specified in the IA Operational Protocol.
    - Ninth paragraph: I request that the sentence beginning, "IAs will also be established for individuals with income from 50-133 percent FPL…" be modified to, " IAs may be established for individuals with income from 50-133 percent FPL as specified in the IA Operational Protocol to help smooth the transition out of the Private Option and into private market plans or Medicare."

- **STC 23.** To ensure consistency between the STCs and the IA Operational Protocol, in the thirteenth paragraph, (k.i), I request that the sentence beginning, "For individuals with incomes between 50 and 100 percent FPL who do not make contributions to the IA…" be modified to, "In the event the State establishes IAs for the new adult population with incomes between 50 and 100 percent FPL, for individuals at this income level who do not make contributions to the IA…"
- **STC 31.** To ensure consistency between the STCs and the IA Operational Protocol, in the fifth paragraph, (c.i), I request the sentence beginning, "For individuals with incomes between 50 and 100 percent FPL who do not make contributions to the IA…" be modified to "In the event the State establishes IAs for the new adult population with incomes between 50 and 100 percent FPL, individuals at this income level 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…."
- **STC 42.** To ensure consistency between the STCs and the IA Operational Protocol, I request amending letter (b) to read, "As specified in the IA Operational Protocol, enrollees at 50 percent of the FPL and above may 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."
- **STC 44.** To ensure consistency between the STCs and the IA Operational Protocol, I request that the waiver be modified as follows:
    - First paragraph: I request that the clause beginning "Private Option beneficiaries with incomes greater than 50 percent FPL will be required to make monthly contributions into IAs" be changed to "Private Option beneficiaries with incomes greater than 50 percent FPL may be required to make monthly contributions into IAs."
    - Second paragraph: I request that the sentence, "Private Option beneficiaries will make contributions up to the amounts described below," be re-worded to read, "Private Option beneficiaries will make contributions up to the amounts described in the IA Operational Protocol."
    - Table 2: I request that Table 2 be deleted from the STCs since contribution amounts are inconsistent with those specified in the IA Operational Protocol.
    - Third paragraph, (a): I request that the sentence, "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" be re-worded to "The new adult population with incomes between 50 percent and 100 percent FPL may have an option in which they contribute to an IA consistent with the IA Operational Protocol.
    - Third paragraph, (a): Please add a clause to the sentence beginning, "The State will also contribute funds…" to say, "To the extent that the State establishes IAs for individuals with incomes between 50 percent and 100 percent FPL, the State will also contribute funds to ensure the account covers the individual's QHP copayment and coinsurance obligations.
    - Sixth paragraph, (b): Please revise the sentence, "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)" to "The new adult population with incomes above 100 percent FPL through 133 percent FPL will contribute according to the amount specified in the IA Operational Protocol for their income level."

- **STC 45.** To ensure consistency between the STCs and the Independence Account Operational Protocol, in the second paragraph (b), I request adding the clause, "In the event the State establishes

IAs for the new adult population with incomes between 50 percent and 100 percent FPL," at the beginning of the sentence, "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."

- **Attachment B.** To ensure consistency between the STCs, its attachments, and the Independence Account Operational Protocol, I request amending the table header reading, "Cost Sharing Applicable for Individuals with Incomes from 50-100% FPL Who Do Not Make Monthly Contributions" to "Cost Sharing Applicable for Individuals with Incomes from 50-100% FPL Who Do Not Make Monthly Contributions in the Event the State Establishes Independence Accounts for the New Adult Population at this Income Level."

Please let me know if you have any questions regarding these requests or if you would like to discuss them further.

Finally, thank you to you and your staff for their diligence in working with Arkansas throughout the implementation of this important demonstration. I look forward to continuing this collaborative effort to provide high quality health coverage for Arkansans.

Sincerely,

[redacted]

John Selig
Director, Arkansas Department of Human Services

cc: Joseph W. Thompson, MD, MPH
Andy Slavitt, CMS
Vikki Wachino, CMCS
Eliot Fishman, CMCS
Julia Hinckley, CMCS
Andrea Casart, CMCS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

August 14, 2015

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 the Arkansas Healthcare Independence Accounts Operational Protocol for the Arkansas Independence Program ("Private Option") section 1115 demonstration (Project Number: 11-W-00287/6). Per the Special Terms and Conditions (STCs), within 120 days, the state must submit a progress report that verifies the Independence Accounts are operating in accordance with this approved protocol.

Your project officer for this demonstration is Ms. Leila Ashkeboussi. She is available to answer any questions concerning your section 1115 demonstration. Ms. Ashkeboussi's contact information is:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3135
E-mail: Leila.Ashkeboussi@cms.hhs.gov

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

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

We look forward to continuing to partner with you and your staff on the Private Option demonstration.

Sincerely,

/s/

Eliot Fishman
Director
State Demonstrations Group

Enclosures

ATTACHMENT C

Arkansas Healthcare Independence Accounts
Operational Protocol

Purpose

This document describes the background and requirements for the implementation and operation of the Arkansas Healthcare Independence Accounts (HIA).

Background

The Arkansas HIA is a health care savings instrument through which participant cost-sharing requirements, which include co-pays and coinsurance, will be satisfied, monitored and communicated to the beneficiary. The HIAs provide a unique educational opportunity for low-income participants to learn about commercial health insurance principles through the use of financial incentives and a low-risk cost sharing program. The Arkansas Department of Human Services (the Department) has established uniform standards and expectations for the HIA's operation through this Operational Protocol and by contract as appropriate.

The 2015 Arkansas General Assembly suspended the application of any additional cost sharing requirements that were to be effective on or after January 31, 2015, under the Health Care Independence Program to Medicaid beneficiaries with incomes below 100% FPL. Therefore, while the amended Standard Terms and Conditions address the policies related to copayments and IAs for participants with incomes below 100% FPL, these provisions related to those below 100% FPL will not be implemented until further notice. Consequently, procedures for participants with incomes below 100% FPL are not included in this Protocol. The State will update this Protocol and notify CMS at least 30 days before implementing IAs and copayments for those with incomes below 100% FPL.

Third Party Administrator

Arkansas has contracted with a third party administrator (TPA) to provide the following functions related to the administration of the HIA operations:

- establish and operate the HIAs for all eligible Health Care Independence Program (HCIP) participants
- accept contributions from HCIP participants and deposit and maintain those funds in the HIA account
- deliver HIA cards to HCIP participants
- process all financial transactions associated with HIA operations
- pay providers the amounts they are due resulting from HCIP participants using the HIA card to cover their cost sharing obligations
- establish a rollover process to issue accumulated credits to HCIP participants who leave the HCIP program
- accept fund transfers from the Department, and apply those funds to the appropriate accounts

- track individual contributions to the HIA program
- create and distribute periodic account activity reports to HIA participants

Use of MyIndyCard

Once the participant selects or is assigned to a qualified health plan (QHP), the State will notify the TPA to enroll the participant into an HIA. The TPA will send the HCIP participants their debit card identified as the "MyIndyCard" and a user guide, which will provide information on how to activate and use the card. The participants will activate their MyIndyCard by phone or internet. Once activated, the card will be used by the HCIP participant to cover all in-network cost sharing. The card will not cover out-of network payments and the participant will be responsible to pay any non-covered, out-of-network out-of-pocket costs.

Participant Education and Access to Information

All new applicants will receive an initial welcome letter and a pocket guide that explains the cost sharing obligation, enrollment into an HIA, notice that the MyIndyCard will soon be received, and a brief explanation of the HIA program. The pocket guide, which will be enclosed with the welcome letter, will include information regarding:

- how to activate the MyIndyCard when it arrives
- points of contact should the participant have problems with the MyIndyCard
- where the card should be used
- where payments into the HIAs should be made.

Every HCIP participant will also receive a detailed user guide along with their first MyIndyCard that provides information on the HIA process. The user guide will provide information about the MyIndyCard which will be used to pay participant cost sharing. The user guide will explain:

- the overall program and the HIAs
- how to use the MyIndyCard
- what to do if the MyIndyCard is lost
- the monthly statements related to the use of the card
- how and when to make the monthly contribution to the HIA
- addressing failures to make monthly contributions
- the meaning of important terms
- the toll-free phone number for the MyIndyCard call center for questions concerning the use of the card and payment options
- the MyIndyCard website address to access downloadable resources for card users, such as guides to understanding the monthly statement and general FAQs concerning the program and participation benefits

The guide will also provide a link to access additional information regarding incentive payment opportunities for HIA credits.

Periodically, the pocket guide will be enclosed with the monthly statement. This will help participants maintain easy access to information regarding the use of the MyIndyCard and HIA payments.

The HCIP participant can also obtain information over the internet at www.MyIndyCard.org. The website will include a short educational video that explains how the MyIndyCard works.

The pocket guide and user guide can be viewed and download at the following website: www.MyIndyCard.org/resources

Appeals and Issue Resolution

HCIP participants will have access to the standard Medicaid fair hearing process for complaints regarding (1) the amount of monthly contributions owed; (2) whether a monthly contribution was made; (3) whether a debt is owed to the State; and (4) the rollover balance accrued. No modifications to the existing processes are needed.

If an HIA participant believes there is an error on the monthly statement, the HIA participant may use the TPA's informal issue resolution process prior to filing a formal appeal.

When a participant calls to inquire about a payment for the HIA program that is not reflected on the monthly statement, the customer service representative asks for their name and telephone number and follows the process listed below:

Process for Monthly Contribution Questions or Disputes

Step 1: Collect Information from Participant

When a participant calls to inquire about a monthly payment for the HIA program, the customer service representatives asks the following:

1. What is your name?
2. What is your telephone number?
3. When did you make your payment?
4. How did you make your payment?
    a. Did you include your monthly remit slip?
    b. Did you make the payment or did someone make it on your behalf?
    c. From where did you mail the payment?
    d. Confirm the date (or range) when the payment was mailed

Step 2: Investigate Missing Payment

1. If payment was made by money order or check, check the daily bank file starting on the day the payment was mailed for the following:
    a. Payments with the participant's name and account number (if present)
    b. Receipts that match the payment amount but do not have an account number or a monthly remit slip
        i. If a non-identified payment exists, check the envelope (in the image file) to determine post mark location. Compare post mark location to

on envelop with information provided by Participant to determine if there is a match.

1. If there is a match, apply payment to the account

c. Payments that may have been applied to the wrong account number (search by name).

d. Payments made by one family member but for multiple participants

2. If the payment was made online, check for the following:
    i. If there was a NSF for the account
    ii. If there was a network timeout (which would be noted by a process incomplete status)
    iii. If the transaction was cancelled by the Participant

Step 3: Follow Up with Participant

1. Follow up with participant to obtain any additional information that may be necessary.
2. If we are unable to find their payment, ask them to resend, and we will apply it manually to ensure their card works for the upcoming month.

Monthly Statements

A monthly statement will be issued to each HCIP participant on the 25th of the month. The monthly statement will provide the following information:

- The HIA payment amount that is due
- The payment due date
- When the last payment was made
- The date of a missed payment
- The number and the amount of copayments and coinsurance paid for the prior month
- A reminder to make the next monthly contribution to the HIA

The monthly statement will be mailed, or the participant can choose to receive the statement by email.

An annotated sample of the monthly statement is provided in the user guide.

Payments

HCIP participants who meet the contribution requirements will pay their QHP copayments and coinsurance obligations through the HIA. There will be 3 payment levels depending on the HCIP participant's income. The levels are outlined in Table 1.

Table 1 Contribution Requirements

INCOME RANGE	>100% -115% FPL	>115%-129% FPL	>129%-133% FPL
CONTRIBUTION	$10	$15	$15

The TPA will provide multiple options for HCIP participants to remit monthly contributions. These options will include online payments, check, cashier's check and money orders. There are no restrictions on who can make the monthly payment into the HIA.

Monthly statements mailed to the HCIP participant will inform the participant that payments are due by the 20th of the following month. This information can also be obtained online by checking the HIA or by phone contact with the TPA. See the time line in the Implementation section below for dates when initial payments will be due.

Tracking of HIA Debits and Credits

The TPA will provide processing for all HIA cards and financial transactions. The TPA card transaction processing system will have the capability to recognize if the participant is eligible for the HIA program and is up-to-date on HIA contributions, based on eligibility information received from the MMIS and participant contribution information within the TPA contractor's systems.

The TPA will provide monthly reports to the State with both aggregate financial reports and detailed reporting of financial accounts and transactions at the individual participant level. The TPA will develop an on-line view for state personnel into the TPA records after the basic components of the card issuance, participant interfaces, and financial management systems are operational.

Addressing Failures to Make Monthly Contributions

When a HCIP participant with income greater than 100% FPL does not make a monthly payment by the 20th of the month, their MyIndyCard will be deactivated effective the first of the following month. The individual will pay copayments and coinsurance at the provider site. If the individual restarts contribution payments, the card will be reactivated to cover QHP-level copayments or coinsurance at the point of service for the month following payment. For example, if the participant does not make a payment in March, they will be required to cover copayment and coinsurance at their provider site for any service provided in April. If they make their payment in April, they can use their card to pay any copayments and coinsurance in the month of May.

Tracking of Out of Pocket Expenses

Tracking of out-of-pocket expenditures is not necessary for individuals making contributions to the Independence Accounts because the maximum quarterly contribution is $45, which is below the quarterly cap for individuals with incomes of 100% FPL.

Use of Credits

The TPA will configure the HIA processing system to restrict the use of credits retained after the end of the participant's eligibility for the program. The fund credits will be used only for services identified by the State, including QHP premium payments, contributions to employer-sponsored insurance, or Medicare premiums (for individuals over age 64). No later than June 1, 2015, the TPA contractor will demonstrate the process for issuing accumulated credits to HCIP participants who leave the HCIP program.

The following process has been developed for issuing accumulated credits for HIA participants who become ineligible for the demonstration.

- The daily process for loading files into the TPA's system includes a screen for terminated participants who have accumulated credits.
- The system flags any terminated individuals who have accumulated credits.
- TPA staff will contact those participants to determine if the individual is enrolled in coverage offered in Arkansas or by an Arkansas-based employer.
- After the TPA confirms enrollment in a qualifying plan, the TPA will issue a check in the amount of the accumulated credits to the insurance carrier or employer to offset the participant's premiums or contributions.

Implementation

The implementation schedule applies to both existing HCIP participants and those who enroll on or after the effective date of the Demonstration amendment. Implementation of the HIA program will be phased in based on the following schedule:

Activity	**Date**
Arkansas submits operational protocol to CMS (30 days prior to implementation)	December 2
HP auto-transfer occurs	December 16 or once STCs are approved
The TPA DataPath mails MyIndyCard, user guide, and pocket guide	December 23
MyIndyCard turned on	January 1
DataPath sends first invoice	January 25
First payment due	February 20

STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

June 28, 2016

The Honorable Sylvia Mathews Burwell
Secretary of the U.S. Department of Health and Human Services
330 Independence Avenue, S.W., Room 4257
Washington, DC 20201

Dear Madam Secretary:

On behalf of the citizens of Arkansas, I am pleased to submit to the U.S. Department of Health and Human Services (DHHS) the enclosed Section 1115 demonstration waiver extension and amendment application. Authorized by provisions in the Arkansas Works Act of 2016, the demonstration will replace the current Health Care Independence Program when it expires on December 31, 2016, with Arkansas Works—a new approach to health coverage for Arkansans.

Arkansas's 1115 waiver demonstration has been successful in furthering the objectives of Title XIX and improving the health insurance Marketplace for all Arkansans—particularly the 240,000 covered through the Demonstration. To date, it has fulfilled its goals of promoting continuity of care, improving access to providers, smoothing the "seams" across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives.

Building upon these accomplishments, I have worked with the Arkansas General Assembly to design Arkansas Works—a more innovative program that aims to strengthen the State's individual premium assistance model, while also instituting reforms to encourage employer-based insurance, incentivize work and work opportunities, promote personal responsibility, and enhance program integrity. Specifically, Arkansas is requesting to extend its 1115 waiver demonstration through December 31, 2021, with the following changes:

- Implementing a premium assistance program for employer-sponsored insurance
- Instituting premiums for Arkansas Works beneficiaries with incomes above 100% of the federal poverty level and terminating Independence Accounts

500 WOODLANE STREET, SUITE 250 • LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345
www.governor.arkansas.gov

- Incentivizing timely premium payment and completion of healthy behaviors
- Eliminating retroactive coverage
- Instituting procedures for expeditious termination of the waiver
- Providing for work referrals

We appreciate the longstanding partnership with your department, and we look forward to your continued support as we develop innovative approaches to providing high quality coverage and encouraging progression up the economic ladder.

Sincerely,

[redacted]

Asa Hutchinson

500 Woodlane Street, Suite 250 • Little Rock, AR 72201
Telephone (501) 682-2345
www.governor.arkansas.gov

Section I - Historical Narrative Summary of the Demonstration

Includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

Introduction

In September 2013, Arkansas was the first state in the nation to obtain approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 waiver to use premium assistance to purchase individual qualified health plans (QHPs) offered through the Health Insurance Marketplace (Marketplace) for individuals eligible for expanded coverage under Title XIX of the Social Security Act. Arkansas's Health Care Independence Program (HCIP) extended QHP coverage to 240,000 individuals who are either (1) childless adults between the ages of 19 and 64 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 64 with incomes between 17 and 138% FPL who are not enrolled in Medicare.

Arkansas's 1115 waiver demonstration ("Demonstration") has been successful in furthering the objectives of Title XIX and improving the Marketplace for all Arkansans, but Governor Asa Hutchinson and the Arkansas General Assembly have opted for a more innovative program that strengthens the QHP premium assistance model by emphasizing personal responsibility, promoting work, and enhancing program integrity. To that end, Arkansas proposes to replace the HCIP when it expires on December 31, 2016 with Arkansas Works—a new approach to health coverage for Arkansans.

Arkansas Works was developed through a close collaboration between Governor Hutchinson and a bipartisan Health Reform Legislative Task Force[1] culminating in the enactment of the Arkansas Works Act of 2016 (the "Act"). The Act authorizes the Arkansas Works program to be implemented under an amendment to the State's existing 1115 waiver. Arkansas Works is intended to modernize the State's Medicaid program so that it is a fiscally sustainable, cost-effective, and opportunity-driven program. The program is designed to:

- Empower individuals to improve their economic security and achieve self-reliance;
- Build on private market competition and value-based purchasing models; and
- Strengthen the ability of employers to recruit and retain productive employees.

As required under the Arkansas Works Act, the State will continue using premium assistance to purchase QHPs offered through the individual market in the Marketplace for those eligible for expanded coverage under Title XIX, in addition to implementing new coverage features. The Act directs the State to implement strategies to provide health care for low-income and other vulnerable populations in a manner that will:

- Encourage employer-based insurance;
- Incentivize work and work opportunities;

[1] The Health Reform Legislative Task Force was established under the Arkansas Health Reform Act of 2015.

- Promote personal responsibility; and,
- Enhance program integrity.

If approved, this waiver request would authorize the State to implement the unique features of Arkansas Works and continue its 1115 Demonstration through 2021.

Overview of Preliminary Results of Arkansas's Expansion Demonstration

Preliminary evidence indicates that the Demonstration has achieved its goals of promoting coverage, improving provider access, integrating private and public programs, and further improving quality. Since implementation of the Affordable Care Act (ACA) in 2014, Arkansas has experienced a 12.9 percentage point decrease in uninsured residents—tied for the largest drop among all states.[2] The current Demonstration has leveraged the efficiencies of the private market to improve access and quality for Demonstration beneficiaries. To date, Arkansas's Demonstration has fulfilled its goals of:

- **Promoting continuity of coverage for individuals.** The Demonstration has contributed to expanded health plan participation in the Marketplace and achieved continuous availability of health plans and provider networks, with all but one carrier in one of the seven market regions continuing to offer plans year-to-year. With household income transitions across the 138% FPL threshold, families can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid or Advanced Premium Tax Credits.
- **Improving access to providers.** The Demonstration interim evaluation report, which can be found on the Arkansas Center for Health Improvement website, documents enhanced provider access for individuals in the Demonstration compared to those in the traditional Medicaid program. In addition, for most indicators assessed during the first year, individuals enrolled in QHPs achieved higher rates of obtaining preventive clinical services. Provider payment rates under QHPs are higher than those offered under the Medicaid State Plan and are correlated with increased availability of care, as documented in the interim evaluation report.
- **Smoothing the "seams" across the continuum of coverage.** Enrollment in the Demonstration has resulted in full QHP essential health benefits (EHBs) being available to Medicaid beneficiaries who previously had a limited benefit (e.g., pregnant women, those with breast and cervical cancer).
- **Furthering quality improvement and delivery system reform initiatives.** At the forefront of payment innovation and delivery system reform, Arkansas has required all carriers offering QHPs in the Marketplace to participate in the Arkansas Health Care Payment Improvement Initiative (AHCPII)—an innovative, multi-payer initiative to improve quality and reduce costs statewide. The Demonstration has accelerated and leveraged the AHCPII through two mechanisms. First, by increasing the number of carriers participating in the effort, the system transformation goals and objectives are

[2] Gallup, "Arkansas, Kentucky Set Pace in Reducing Uninsured Rate," Feb. 4, 2016, http://www.gallup.com/poll/189023/arkansas-kentucky-set-pace-reducing-uninsured-rate.aspx/.

being reinforced. Second, the number of individuals, approximately 350,000, benefiting from a direct application of these reforms is increased due to QHP participation.

The Demonstration has also succeeded in promoting competition, driving down prices, and decreasing uncompensated care costs in the Arkansas health care market. To date, its impact on the State has included:

- **Creating a larger and younger risk pool.** Demonstration enrollees comprise approximately 80% of the Arkansas Marketplace and are on average younger than other Arkansas Marketplace enrollees. A healthier risk pool has driven down premium rates for all Marketplace enrollees.
- **Creating more competitive premium pricing for all individuals purchasing coverage through the Marketplace.** Since 2014, premium prices in Arkansas have increased at a slower rate than those nationally. From 2015 to 2016, premiums for the second lowest cost silver plan in Arkansas increased by an average of 4.3%, as compared to an average of 7.5% for all states using HealthCare.gov.[3] From 2014 to 2015, premiums across all QHPs in the State decreased by an average of 2%.[4]
- **Decreasing uncompensated care.** Arkansas has seen sharp declines in uncompensated care costs. From 2013 to 2014, there were substantial decreases in uninsured hospital admissions (49%), emergency room visits (39%), and visits at hospital outpatient clinics (46%). In addition, Arkansas hospitals experienced a 55% decrease in uncompensated care losses during this time.[5]

Demonstration Features

The following section provides an overview of features of the Demonstration and notes how the State will approach each of these features under Arkansas Works.

Demonstration Eligibility

a) Eligibility Criteria

To be eligible to participate in Arkansas Works through the Demonstration, an individual must: (1) be a childless adult between 19 and 64 years of age, with an income at or below 138% of the FPL who is not enrolled in Medicare and not incarcerated **or** be a parent between 19 and 64 years of age, with an income between 17-138% FPL who is not enrolled in Medicare and not incarcerated and (2) be a United States citizen or a documented, qualified alien. However, individuals determined to be medically frail/have exceptional medical needs for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care are not eligible for the Demonstration, unless they have access to cost-effective employer-sponsored insurance (ESI) and elect to receive the alternative

[3] CMS, "2016 Marketplace Affordability Snapshot," Oct. 26, 2015, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-26-2.html.

[4] Arkansas Insurance Department, "2015 Projected Qualified Health Plan Individual Premium Rates for Arkansas," Oct. 3, 2014, https://static.ark.org/eeuploads/hbe/NEWS_RELEASE_2015_rate_release.pdf.

[5] Arkansas Hospital Association, "Private Option Eases Hospitals' Financial Struggles," July 2015, http://www.arkhospitals.org/Misc.%20Files/APO7-9-15.pdf.

benefit plan (ABP) through ESI.[6] When determining whether an individual is eligible for Arkansas Works, Arkansas applies the same eligibility standards and methodologies as those articulated in the State Plan.

Participation in the Demonstration is mandatory for eligible individuals. Most Arkansas Works eligible individuals will receive Title XIX coverage through the State's mandatory QHP premium assistance program. Arkansas Works eligible individuals ages 21 or over with access to cost-effective ESI through an employer that elects to participate in the State's ESI premium assistance program will be required to receive Title XIX coverage through their ESI plan. Those who decline coverage through QHPs or ESI premium assistance are not permitted to receive benefits through the State Plan.

Table 1. Eligibility for Arkansas Works Demonstration

Description	Income	Age	Exceptions[7]
Adults in Section VIII Group	*Childless Adults:* 0-138% FPL *Parents:* 17-138% FPL	19-64	▪ Dual eligibles ▪ Individuals who are medically frail/have exceptional medical needs who do not have access to cost-effective ESI ▪ Individuals who are medically frail/have exceptional medical needs who have access to cost-effective ESI through a participating employer and choose to receive standard Medicaid coverage under the State Plan ▪ Incarcerated individuals

b) Demonstration Enrollment Data

The State estimates that approximately 272,000 individuals will be enrolled in Arkansas Works by 2021.

Benefits

a) Benefit Package

Arkansas Works enrollees will receive the ABP, as defined in Arkansas's State Plan. The State provides through its fee-for-service Medicaid program wrap-around benefits that are in the ABP but not covered by ESI or QHPs. For Arkansas Works enrollees covered through QHPs, the State provides wrap-around coverage for non-emergency transportation and Early Periodic Screening

[6] ESI premium assistance is a new feature of Arkansas Works. In the first year of ESI premium assistance, only small group, non-grandfathered plans for which the employer covers at least 25% of the premiums may be considered cost effective. In future years of ESI premium assistance, large group and small group grandfathered plans may also be considered cost effective.

[7] The State's request to waive the requirement to provide retroactive coverage applies to the entire new adult group, including those individuals who are medically frail.

Diagnosis and Treatment (EPSDT) services for individuals participating in the Demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT services to the extent such services are not covered under the QHP). For Arkansas Works enrollees covered through ESI, the State seeks a waiver of the requirement to provide non-emergency transportation. Additionally, if family planning services are accessed at out-of-network providers, the State's fee-for-service Medicaid program will cover those services for both ESI and QHP enrollees, as required under federal Medicaid law. Because of Arkansas's Any Willing Provider Law, few such providers are outside of private insurance carrier networks.

To administer the wrap-around benefits described above, Arkansas Works beneficiaries have a Medicaid client identification number (CIN) through which providers may bill Medicaid for wrap-around benefits as necessary and secondary to their QHP or ESI coverage. Arkansas Works' eligibility notices include information about which services Arkansas Works beneficiaries may receive through fee-for-service Medicaid and how to access those services. Similar information is provided on Arkansas Medicaid's website. Staff at the Arkansas Medicaid beneficiary call centers are trained to provide information regarding the scope of wrap-around benefits and how to access them. Finally, Arkansas Medicaid has worked and will continue to work closely with carriers to ensure that the carriers' call center staffs are aware that Arkansas Works beneficiaries have access to certain services outside of their QHP or ESI coverage and that staff can direct the Arkansas Works beneficiaries to the appropriate resources to learn more about wrap-around services.

b) Appeals Process

Arkansas Works beneficiaries will use the appeals process established by their ESI or QHP to appeal denials of benefits covered under the ESI or QHP. (Arkansas Works beneficiaries will continue to use the Medicaid appeals process for denials of wrapped benefits.) All ESI and QHPs must comply with federal standards governing internal insurance coverage appeals. Additionally, all ESI and QHPs must comply with State standards governing external review of insurance coverage appeals, which in turn are approved as meeting the requirements imposed under the ACA. Arkansas Works beneficiaries will have access to two levels of appeals: an internal review process by their ESI or QHP and an external review process by a Qualified Independent Review Organization that has been selected by the Arkansas Insurance Department (AID).

If an enrollee is dissatisfied with the decision after the external appeal, he/she may request review by AID. Medicaid delegates the authority to conduct fair hearings for Arkansas Works enrollees to AID. AID is a part of the Executive Branch, and thus it is a sister agency to Medicaid. AID has the discretion to permit the individual to call witnesses and cross-examine witnesses. Consistent with the requirements for fair hearings, the Commissioner will permit Arkansas Works enrollees, in all cases, to call and cross-examine witnesses.

Premiums, Cost Sharing, and Independence Accounts

a) Enrollees with Incomes at or Below 100% FPL

Individuals with incomes at or below 100% FPL will have no cost-sharing obligations in Arkansas Works.

b) Enrollees with Incomes Above 100% FPL

Under Arkansas Works, the State will institute premiums of up to 2% of household income for enrollees with incomes between 100 to 138% FPL. With the implementation of enrollee premiums, the State will eliminate Independence Accounts; Section II of this application describes the State's approach for instituting premiums (and terminating the Independence Accounts). Individuals with incomes between 100 to 138% FPL will continue to be subject to point-of-service cost sharing consistent with Medicaid limits. The State will ensure that Arkansas Works beneficiaries' aggregate cost sharing does not exceed the quarterly limit of 5% of household income.

c) Exempt Populations

Pregnant women and American Indians/Alaskan Natives will be exempt from cost sharing under Arkansas Works.

d) Cost-Sharing Reductions & Cost-Sharing Wraps

For Arkansas Works enrollees covered through QHPs, the State pays QHP issuers advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost sharing for Arkansas Works beneficiaries. The advance monthly CSR payments are calculated in the same way for individuals with incomes between 138 and 250% FPL who are eligible for federal CSRs and for individuals with incomes at or below 138% FPL enrolled in QHPs through Arkansas Works; the only difference is that the Department of Health and Human Services (HHS) makes the federal CSR payments and Arkansas Medicaid makes the Arkansas Works CSR payments. These payments are subject to reconciliation based on actual CSRs that are utilized. In the Spring of 2016, each QHP issuer reported actual CSR amounts for benefit years 2014 and 2015 to HHS (for members receiving APTCs/CSRs) and Arkansas Medicaid (for members enrolled in the Demonstration) to reconcile these amounts with the advance payments. The Arkansas Medicaid process for such reconciliations is modeled on the HHS process. The State will use the same reconciliation process in Arkansas Works.

As is discussed further below in Section II, for Arkansas Works enrollees covered through ESI, the State will wrap cost-sharing at the point of service. Enrollees will have an Arkansas Works card that specifies the Medicaid-permitted cost-sharing levels. At the point-of-service, enrollees will present both their ESI card and their Arkansas Works card. The provider will collect the Medicaid-permitted cost sharing from the enrollee and will bill the State for the balance.

Eligibility and Enrollment Processes

a) Identification of Individuals who are Medically Frail/Have Exceptional Medicaid Needs

The State will assess whether individuals potentially eligible for Arkansas Works coverage are medically frail/have exceptional medical needs. For both the QHP and ESI premium assistance programs, the State has developed a process for making mid-year transitions to traditional Medicaid for individuals obtaining false negatives and for individuals with emerging medical

needs that lead to a predictable and significant need for additional benefits during the plan year.

b) Enrollment Process

i. ***All enrollees***

Individuals eligible for Arkansas Works will enroll through the following process:

- Individuals submit the single streamlined application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost-Sharing Reductions—electronically, via phone, by mail, or in-person.
- An eligibility determination is made through either the Federally Facilitated Marketplace (FFM) or the Arkansas Eligibility & Enrollment Framework (EEF).
- State determines whether individual is medically frail.
- State conducts choice counseling for individuals who have screened medically frail.
- The State matches them against a list of employed individuals whose employers:
    - Offer cost-effective ESI, and
    - Participate in the ESI premium assistance program.

ii. ***Individuals who do not have access to cost-effective ESI through an employer participating in the ESI premium assistance program or are ages 19 to 20***

- According to an individual's medical frailty status:
    - *Individuals who are not medically frail.* These individuals will be required to enroll in QHPs.
    - *Individuals who are medically frail.* These individuals will receive either the ABP or the standard Medicaid benefit package through fee-for-service Medicaid.
- Individuals required to receive coverage through QHPs will shop and enroll in coverage through the following process:
    - Individuals will be directed on the web-based portal to a page where they may shop among QHPs available to Arkansas Works eligible individuals. They may select a plan on this portal.
    - MMIS captures their plan selection information and transmits the 834 enrollment transactions to the carriers.
    - Carriers issue insurance cards to Arkansas Works enrollees.
    - MMIS pays premiums on behalf of beneficiaries directly to the carriers.
    - MMIS premium payments continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be more effectively treated due to complexity of need through the fee-for-service Medicaid program.
    - In the event that an individual is determined eligible for QHP coverage through Arkansas Works, but does not select a plan, the State auto-

assigns the enrollee to one of the available QHPs in the beneficiary's county.

iii. ***Individuals ages 21 and over who have access to cost-effective ESI through an employer participating in the ESI premium assistance program***

- According to an individual's medical frailty status:
  - *Individuals who are not medically frail.* These individuals will be required to enroll in ESI premium assistance.
  - *Individuals who are medically frail.* Individuals who have selected the ABP will be required to receive coverage through their ESI plan. Individuals who have selected standard Medicaid benefit package will receive coverage through Medicaid fee-for-service.
- For all individuals required to receive coverage through ESI:
  - The State's vendor administering the ESI premium assistance program will work with the individual's employer to effectuate enrollment in ESI premium assistance.
  - The ESI carriers will issue insurance cards to Arkansas Works enrollees.
  - The vendor will administer ESI premium assistance payments.

c) Coverage Prior to QHP or ESI Enrollment

The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for Medicaid until the individual's enrollment in the QHP or ESI becomes effective.

d) QHP Plan Selection and Purchasing Guidelines

Under AID's regulatory authority, the State assures that Arkansas Works beneficiaries enrolling in QHP coverage are able to choose from at least two high-value silver plans in each rating area of the State. Additionally, AID evaluates network adequacy, including QHP compliance with Essential Community Provider network requirements, as part of the QHP certification process. As a result, Arkansas Works beneficiaries covered through QHP premium assistance have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the access the general population in the geographic area has. Providers are reimbursed for care provided to Arkansas Works beneficiaries at the rates the providers have negotiated with the QHP.

The State has implemented policies to further ensure cost-effective QHP purchasing and judicious use of taxpayer funds. The State is employing purchasing guidelines to ensure the purchase of both competitively-priced and cost-effective plans. The State's approach to ensuring that ESI coverage is cost-effective is outlined in Section II.

e) Auto-Assignment Methodology

Arkansas Works beneficiaries who do not select a QHP within 42 days are assigned a QHP using the State's auto-assignment methodology. The State auto-assigns these individuals only to those plans that meet its purchasing guidelines and are committed to remaining in the Marketplace. Individuals are auto-assigned to the lowest cost qualifying silver-level plan covering only EHBs for each carrier in their service area. Auto-assignments are distributed among qualifying issuers offering AID-certified, EHB-only, silver-level QHPs with the aim of achieving a target minimum market share of Arkansas Works enrollees for each issuer in a service area. The target minimum market share in a service area varies based on the number of competing issuers as follows:

- Two issuers: 33% of Arkansas Works participants in that service area;
- Three issuers: 25% of Arkansas Works participants in that service area;
- Four issuers: 20% of Arkansas Works participants in that service area;
- More than four issuers: 10% of Arkansas Works participants in that service area.

Individuals will be auto-assigned to issuers until the issuers enroll the lesser of the number of individuals needed to hit the target minimum market share or the maximum number of enrollees permitted by AID.

Individuals who are auto-assigned are notified of their assignment and are given a thirty-day period to request enrollment in another plan, consistent with the timeframes for changing coverage that are currently found in Arkansas's commercial market.

f) Notices

Upon enrollment in coverage offered under Title XIX, Arkansas Works beneficiaries receive a notice from Arkansas Medicaid advising them on:

- ESI premium assistance program (if offered cost-effective ESI)
- QHP plan selection process (if not offered cost-effective ESI)
- How to access services until ESI or QHP enrollment is effective
- How to access wrapped benefits
- Appeals
- Exemption from the ABP

g) Memorandum of Understanding with QHP Carriers

Each year of the Demonstration, Arkansas Medicaid enters into a memorandum of understanding (MOU) with the QHP carriers to outline the process for verifying plan enrollment and paying premiums. Under the terms of the MOU, the QHP carrier provides a roster of its enrollees who are covered under Title XIX. After verifying this information, the MMIS transmits payment for premiums to the QHP carrier.

Section II - Changes Requested to the Demonstration

If changes are requested, a narrative of the changes being requested along with the objective of the change and the desired outcomes.

Arkansas is seeking to implement the following changes to its Demonstration to incentivize work; increase personal responsibility; enhance program integrity; and support employer-based insurance coverage.

1. **Implementing a Premium Assistance Program for ESI**
   One of the fundamental goals of Arkansas Works is to strengthen the State's employer-based insurance market as a whole. Arkansas intends to create a mandatory Arkansas Works ESI premium assistance program— distinct from Arkansas's existing Health Insurance Premium Payment program—to decrease churn between ESI and QHP coverage as individuals' incomes fluctuate.

   In the first year of ESI premium assistance, employers offering small group, non-grandfathered plans for which the employer covers at least 25% of the premiums may opt in to the ESI premium assistance program. These plans may be considered cost effective. Employers interested in participating in the ESI premium assistance program will notify the State or its designee that that their plans meet cost-effectiveness criteria defined by the State. (These will be the only plans considered cost-effective for the purposes of ESI premium assistance.) In future years of ESI premium assistance, employers offering large group and small group grandfathered plans may also be permitted to opt in to the program provided their plans are cost effective. As the ESI premium assistance program extends to large employers, the State will modify its cost-effectiveness criteria.

   Individuals ages 21 and older with access to cost-effective ESI through employers that participate in the ESI premium assistance program will be required to enroll in coverage through ESI premium assistance; individuals who are 19- or 20-years old will not be eligible for ESI premium assistance coverage. Medically frail individuals/those with exceptional medical needs will be required to enroll in ESI premium assistance if they have selected the ABP; medically frail individuals who have selected the standard Medicaid benefit package will not be eligible to receive coverage through ESI premium assistance. In future years of the program, the State may expand the population eligible for ESI premium assistance to spouses or dependents of Medicaid-eligible individuals with access to cost-effective ESI.

   As required by federal Medicaid law, the State's fee-for-service Medicaid program will wrap family planning services that are accessed at out-of-network providers. The State will seek a waiver of the federal requirement to provide non-emergency transportation services for Arkansas Works enrollees receiving coverage through ESI premium assistance.

Arkansas Works enrollees obtaining coverage through ESI premium assistance will be subject to the same premiums as Arkansas Works enrollees receiving coverage through QHPs (i.e., individuals enrolled in ESI premium assistance with incomes above 100% FPL will be subject to premiums of up to 2% of household income as described in more detail below). Participating employers will be required to cover at least 25% of the ESI premiums. The State will cover up to 75% of the total cost of the ESI premiums. Individuals with incomes above 100% FPL who are enrolled in Arkansas Works ESI premium assistance coverage will be subject to point-of-service cost sharing at the same levels as individuals with incomes above 100% FPL who are enrolled in Arkansas Works QHP coverage. The State will wrap any cost sharing in the enrollee's ESI plan beyond Medicaid limits. Individuals with incomes at or below 100% FPL who are enrolled in ESI premium assistance will not be subject to cost sharing; the State will wrap all cost sharing imposed through the ESI plan.

All individuals enrolled in coverage through ESI premium assistance will receive two insurance cards—an ESI plan card and an Arkansas Works card. All enrollees will use the Arkansas Works card to cover their ESI plan deductible. Individuals with incomes above 100% FPL will use the Arkansas Works card to cover cost sharing above Medicaid-permissible amounts. Individuals with incomes at or below 100% FPL will use the Arkansas Works card to cover all cost sharing.

2. Instituting Premiums for Arkansas Works Beneficiaries with Incomes above 100% FPL

To encourage personal responsibility, Arkansas will require that Arkansas Works enrollees with incomes above 100% FPL pay monthly premiums.[8] New adults outside of Arkansas Works (e.g., medically frail new adults receiving coverage through the fee-for-service Medicaid program or individuals who have not yet enrolled in a QHP) will not be subject to premiums.

Arkansas Works enrollees with incomes above 100% FPL will be subject to premiums of up to 2% of household income. For the purpose of administrative simplicity, the State will set premiums at a fixed amount, meaning that enrollees with incomes between 100-138% FPL will be subject to premiums of up to 2% of household income.

Individuals who do not pay their premiums in a timely manner (within a 90-day grace period) will incur a debt to the State. Carriers will be responsible for collecting premiums from Arkansas Works enrollees covered through QHP premium assistance. The State will adjust its monthly advance CSR payment to carriers to reflect the possibility of unpaid premiums. At the end of each plan year, the State will account for unpaid premiums through the CSR reconciliation process. For individuals enrolled in ESI premium assistance, premiums will be paid through a paycheck deduction.

[8] Premiums may be paid directly by an enrollee or on behalf of an enrollee by a third party, such as an enrollee's employer or a not-for-profit organization.

3. Terminating Independence Accounts

Arkansas will require monthly premiums for individuals with incomes above 100% FPL in lieu of monthly contributions to Independence Accounts previously authorized under the Demonstration.

Arkansas has conducted a comprehensive noticing and education campaign to inform beneficiaries of the termination of the Independence Account program. Arkansas has sent enrollees notices informing them that their MyIndyCards will be deactivated. The notices included information on:

- Timing of last required monthly Independence Account contribution and deactivation of MyIndyCards
- Toll-free phone number and email address for MyIndyCard customer service for questions about deactivation of cards
- Receipt of credits that have accumulated in the Independence Account

4. Incentivizing Timely Premium Payment and Completion of Healthy Behaviors

Arkansas seeks to encourage personal responsibility and further the objectives of the State's Healthy, Active Arkansas initiative. Under Arkansas Works, Arkansas will create a new incentive benefit (e.g., dental services) for the new adult population. This benefit will only be available to enrollees who make timely premium payments (if required) and achieve healthy behavior standards.

- ***Arkansas Works enrollees with incomes above 100% FPL.*** Arkansas Works enrollees with incomes above 100% FPL who make three consecutive months of timely premium payments (i.e., within a 90-day grace period) will be eligible to receive an incentive benefit. To retain this incentive benefit, these enrollees must pay all premiums timely and must visit a primary care provider (PCP) during each calendar year (assuming at least six months of enrollment in Arkansas Works during that calendar year). For individuals covered through QHP premium assistance, carriers will monitor whether enrollees are paying premiums timely and whether individuals have visited a PCP. In the event that an individual enrolled in QHP coverage has failed to pay premiums timely or failed to see a PCP, carriers will inform Arkansas Medicaid. For individuals covered through ESI premium assistance, premiums will be paid through a paycheck deduction. As a result, all ESI premium assistance enrollees with incomes above 100% FPL will be making timely premium payments. Individuals enrolled in ESI premium assistance coverage will attest to whether they have visited a PCP during each calendar year. Arkansas Medicaid will issue notices to those who have either failed to pay premiums timely or who failed to visit a PCP informing them that they will no longer be eligible for the incentive benefit. They will be disenrolled from the incentive benefit as of the first of the next month for failure to pay premiums and as of January 1 for failure to visit a PCP. To regain access to the incentive benefit, individuals must pay all back due premiums. QHP carriers will monitor whether individuals have paid back due premiums and inform Arkansas

Medicaid when an Arkansas Works enrollee has repaid premiums owed. Individuals who have repaid premiums will be permitted to re-enroll in in the incentive benefit at the beginning the following plan year, assuming they have visited a PCP.

- ***Arkansas Works enrollees with incomes at or below 100% FPL.*** Arkansas Works enrollees with incomes at or below 100% FPL will be eligible for an incentive benefit at the time of Arkansas Works implementation (for currently enrolled new adults) or at the time of Arkansas Works enrollment (for new enrollees). To retain this incentive benefit, Arkansas Works enrollees must visit a PCP during each calendar year (assuming at least six months of enrollment in Arkansas Works during that calendar year). Prior to open enrollment, QHP carriers will determine whether individuals who have been enrolled in Arkansas Works for at least six months have visited a PCP during that calendar year. Carriers will inform Arkansas Medicaid of any individual covered through QHP premium assistance who has failed to visit a PCP during the calendar year. Individuals covered through ESI premium assistance will attest to whether they have visited a PCP during each calendar year. Arkansas Medicaid will issue notices to those who failed to visit a PCP informing them that they will no longer be eligible for the incentive benefit. They will be disenrolled from the incentive benefit effective January 1 of the new coverage year and will be unable to receive the incentive benefit until the beginning of the next coverage year, provided that they visit a PCP as required.

Individuals will have the right to appeal any decision that they are not eligible for the incentive benefit, using the standard Medicaid appeals process.

5. Eliminating Retroactive Coverage

To better align with commercial health insurance coverage, Arkansas is requesting a waiver of the requirement to provide three months retroactive coverage to beneficiaries in the new adult group. Individuals in the new adult group will become eligible for coverage under Title XIX at the time of application.

6. Instituting Procedures for Expeditious Termination of Waiver

To give Arkansas the flexibility to terminate its waiver expeditiously in the event that the federal government reduces the Federal Medical Assistance Percentage (FMAP) for the new adult group, the State plans to submit to CMS a waiver transition and phase-out plan shortly after waiver approval. Once approved, the transition and phase-out plan would then sit "on the shelf" unless and until a reduction in FMAP causes the State to terminate the Demonstration.

Within 30 days of a reduction in FMAP for the new adult group, the State would notify CMS of its intent to activate the transition and phase-out plan. After notifying CMS of its intent to terminate the Demonstration, the State would immediately begin (1) community outreach; (2) producing the approved notices; and (3) conducting administrative reviews of Medicaid eligibility for affected beneficiaries to determine whether they qualify for Medicaid through

another eligibility category and to ensure ongoing coverage for eligible beneficiaries. Coverage under the Demonstration would terminate within 120 days of a reduction in FMAP.

7. Providing Work Referrals

Finally, all eligible Arkansas Works beneficiaries will receive information regarding and referrals to work and work training opportunities through the Department of Workforce Services. Ultimately, as individuals receiving this referral become employed, the State expects that many will transition out of the Arkansas Works program to ESI and private, individual market coverage.

Section III - Requested Waivers and Expenditure Authorities

A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current demonstration.

1) Provide a list of proposed waivers and expenditure authorities.

Waivers

- § 1902(a)(23)(A): To make premium assistance for QHPs in the Marketplace and for ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the beneficiary's QHP or ESI.
- § 1902(a)(13) and § 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 QHP or ESI providing primary coverage for services under Arkansas Works.
- § 1902(a)(54) insofar as it incorporates Section 1927(d)(5): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.
- § 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.
- § 1902(a)(14) insofar as it incorporates § 1916 and §1916A: To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the federal poverty level.
- § 1902(a)(34): To enable the State not to provide medical coverage to beneficiaries in the new adult group for any time prior to the first day of the month in which an individual applies.

- § 1902(a)(4) insofar as it incorporates 42 CFR § 431.53: To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.

Expenditure Authorities

- 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.
- ESI Premium Assistance Payments. To cover up to 75% of the cost of ESI premiums for individuals participating in the Arkansas Works ESI premium assistance program.
- Health Credit Expenditures. To issue health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.

2) Describe why the State is requesting the waiver or expenditure authority, and how it will be used.

Table 2. Arkansas Waiver and Expenditure Authority Requests

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver/ Expenditure Authority Request?
Waivers			
§ 1902(a)(23)(A)	To make premium assistance for QHPs in the Marketplace or ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Arkansas Works beneficiary's QHP or ESI plan.	This waiver authority will allow the State to require that populations identified in this application receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the State to align the network available to Arkansas Works beneficiaries with the network offered to QHP and ESI enrollees who are not Medicaid beneficiaries.	Modified request

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver/ Expenditure Authority Request?
§ 1902(a)(13) and § 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 QHP or ESI providing primary coverage for services under Arkansas Works.	This waiver authority will allow the State to leverage payment rates negotiated in the commercial market.	Modified request
§ 1902(a)(54) insofar as it incorporates Section 1927(d)(5)	To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the State to align prior authorization standards for Arkansas Works beneficiaries with standards in the commercial market.	Currently approved
§ 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	This waiver will allow the State to impose cost sharing only on the Arkansas Works population.	Modified request
§ 1902(a)(14) insofar as it incorporates § 1916 and §1916A	To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the FPL.	This waiver authority will allow the State to align premium requirements for Arkansas Works beneficiaries with those in the commercial market.	Modified request
§ 1902(a)(34)	To enable the State not to provide medical coverage to beneficiaries in the new adult group for any time prior to the first day of the month in which an individual	This waiver authority will allow the State to align the start date of coverage for beneficiaries in the new adult group with standards in the commercial market.	New request

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Reason for Waiver/Expenditure Authority Request	Currently Approved Waiver/ Expenditure Authority Request?
	applies.		
§ 1902(a)(4) insofar as it incorporates 42 CFR 431.53	To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.	This waiver authority will allow the State to align benefits for Arkansas Works beneficiaries enrolled in coverage through ESI premium assistance to benefits offered to other individuals enrolled in ESI plans.	New request
Expenditure Authorities			
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 Social Security Act.	This expenditure authority will allow the State 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 Social Security Act.	Currently approved
ESI Premium Assistance Payments	To pay up to 75% of premiums for ESI.	This expenditure authority will allow the State to pay up to 75% of premiums for ESI.	New request
Health Credit Expenditures	To issue health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.	This expenditure authority will allow the State to issue health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.	New request

Section IV - Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

Summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration, such as the CMS Form 416 EPSDT/CHIP report.

Because Arkansas uses QHPs to provide coverage under the Demonstration, much of the quality initiative activities for Demonstration enrollees are tied to ACA quality requirements for QHPs. All QHPs must be accredited in categories including clinical quality measures and patient experience ratings. Additionally, QHPs must implement a quality improvement strategy to prevent hospital readmissions, improve health outcomes, reduce health disparities, and achieve other quality improvement goals. According to the timeline set by federal guidance, all QHPs will be required to report to the Marketplace, enrollees, and prospective enrollees on health plan performance quality measures according to the federally-developed quality rating system.

In 2015, Arkansas's Federally Facilitated Marketplace partnership engaged in a QHP quality rating pilot using 2014 survey information and medical information from patient encounters with a doctor or hospital that QHPs gathered as part of their accreditation requirements. The report generated from the pilot contained ratings for each QHP based on patient experience and recommended care provided on a rating scale of 0% - 100%. For patient experience, patients were asked about how they felt about the care they received from their doctors and their health insurance provider—i.e., provider quality, access to care, customer service, and value of plan. For recommended care provided, ratings were based on measures that focused on: (1) whether the appropriate tests were given to the appropriate patients; (2) whether medications were properly managed; and (3) quality of any follow-up care. The report included ratings by category and overall ratings for each QHP. It was made available via the AID website prior to 2016 plan year open enrollment.

In 2015, the Arkansas Federally Facilitated Marketplace partnership also engaged in a broader evaluation of the year one (2014) Marketplace governance, outreach and education and QHP activities, including perspectives via survey from HCIP enrollees and other QHP enrollees.[9] Authored by the University of Arkansas for Medical Sciences' College of Public Health, the evaluation examined the effectiveness of processes and procedures used in implementing the Marketplace in Arkansas and the outcomes achieved. Surveys of patients, hospitals, clinics, and behavioral health providers were conducted. Key outcomes of interest for purposes of this section of the Demonstration waiver extension application are as follows:

[9] University of Arkansas for Medical Sciences, Fay W. Boozman College of Public Health & Arkansas Foundation for Medical Care, *Arkansas State Partnership Health Insurance Marketplace: Year One Evaluation,* 2015.

- For Marketplace enrollees, approximately 53% had insurance in the six months prior to obtaining health insurance coverage in the Marketplace compared to 27% in the Demonstration.
- Demonstration enrollees were much less likely to have had any health insurance coverage since becoming an adult, with 45.1% reporting receiving health insurance coverage for the first time since turning 18 years of age. In contrast, 20.1% of enrollees in the Marketplace reported receiving insurance for the first time as an adult.
- In terms of impact on health care providers, hospitals benefited from decreased uncompensated care costs with 77.8% of responding hospitals reporting a decrease following implementation.
- Approximately 22-27% of clinics and behavioral health providers reported a decrease in uncompensated care costs.
- Most hospitals reported no change in patient volume following Marketplace implementation, and more hospitals reported a decrease in volume compared to an increase in volume.
- Twenty-five percent of clinics reported increases in patient volume, while 11% of behavioral providers reported an increase compared to 6% that reported a decrease in volume.

Beginning in 2015, QHPs were required to participate in the Arkansas Patient-Centered Medical Home (PCMH) program. QHP enrollees including Demonstration enrollees were attributed to a PCMH either by choice or a QHP-elected method. PCMH clinics are provided with per-member per-month (PMPM) support to implement a team-based care delivery model and comprehensively manage enrollees' health needs by meeting milestones in practice transformation and achieving quality standards. To receive PMPM support, PCMH clinics must meet practice transformation activities by required deadlines including:

- Ensuring that at least 80% of high-priority enrollees have a care plan with documentation of current problems, a plan of care integrating contributions from the health care team including behavioral health, instructions for follow-up, and assessment of progress.
- Providing 24/7 live voice access to care from an on-call medical professional.
- Reporting clinical quality measure data for controlling high blood pressure, diabetes indicators, and weight assessment for children and adolescents (body-mass index).

Quality measures and targets in the PCMH program include:

- Ensuring that at least 76% of high-priority of enrollees were seen by the attributed PCMH at least twice in the past 12 months.
- Ensuring that at least 40% of enrollees who had an acute inpatient hospital stay were seen by the attributed PCMH within 10 days of discharge.
- Ensuring that at least 49% of congestive heart failure beneficiaries were prescribed beta-blockers.

The improved care coordination through the PCMH program across participating public and private payers has resulted in increased pediatric wellness visits, hemoglobin A1c testing,

breast cancer screenings, improved attention deficit hyperactive disorder (ADHD) management, and thyroid medication management.

Section V - Financial Data

Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.

The budget neutrality approach recognizes that the population covered by this Demonstration, known as "Arkansas Works beneficiaries," represents a hypothetical population for budget neutrality purposes. Hypothetical populations are individuals that otherwise could have been made eligible for Medicaid under: 1) section 1902(r)(2), 2) 1931(b), or 3) 1902(a)(10)(A)(i)(VIII) (as modified by Section 2001 of the ACA), via a State Plan Amendment. The calendar year 2016 (CY16) budget neutral PMPM and the PMPM cost of emerging CY16 experience are projected forward at the following trend rates: 6.5% from CY16 to CY17, 6.0% from CY17 to CY18, 5.5% from CY18 to CY19, 5.0% from CY19 to CY20, and 4.7% from CY20 to CY21. Trend rates have increased over the rate used in the initial waiver application due to the large growth in pharmacy cost and utilization that is occurring nationwide.

Projected enrollment is identical in the without waiver and with waiver scenarios since the Demonstration does not expand eligibility and is not expected to increase take-up amongst the expansion-eligible population. Enrollment growth has been modeled at 2.5% annually, based on actual experience under the Arkansas waiver combined with the expansion population growth experience of other states (Maryland, North Dakota, Colorado, and Oregon).

To determine the hypothetical enrollment associated with the Arkansas Works beneficiaries, Optumas reviewed current enrollment in Arkansas's HCIP. This enrollment was projected forward at an annual growth rate of 2.5%. The annual growth rate is based on review of Arkansas program enrollment trends as well as the experience of other expansion states, including Maryland, North Dakota, Colorado, and Oregon. As mentioned previously, the same enrollment growth rate is applied to the with waiver and without waiver scenarios.

To determine the potential cost for this population, Optumas utilized the previous budget neutral amounts and the emerging experience. The without waiver amounts are calculated using the previous budget neutral without waiver amounts and projecting them forward. The annual trend rates are: 6.5% from CY16 to CY17, 6.0% from CY17 to CY18, 5.5% from CY18 to CY19, 5.0% from CY19 to CY20, and 4.7% from CY20 to CY21—for an aggregate trend of 5.54% over the next five years of the Demonstration. Trend rates have increased from the previous submission to account for the nationwide increase in pharmacy costs and utilization. The ultimate trend at the end of the extension period is the same figure that was used in the initial budget neutrality submission, reflecting the return of pharmacy trend rates to pre-2012 levels.

The State's actuaries, Optumas, reviewed experience from across the country to determine the appropriate trend rate, and found that the 4.7% growth rate in the previous waiver submission did not adequately account for recent pharmacy cost and utilization growth. States across the nation are seeing pharmacy costs grow at a double-digit rate annually, and the original waiver's 4.7% growth rate is not sufficiently robust to account for observed pharmacy increases. As pharmacy growth normalizes, trend rates return to the magnitude of the previous submission. The trend rate is supported by review of the experience other states. Optumas discussed the rate of cost growth with the Arkansas Department of Human Services, and the assumed non-pharmacy growth rate of 4.5% is in line with their experience. Optumas also reviewed pharmacy and non-pharmacy cost growth rates for other states, such as Nebraska, Oregon, Maryland, and Colorado, and determined a double-digit pharmacy trend rate is consistent with other states' experiences. The with waiver cost projections apply the same annual growth rate to the emerging experience under the waiver.

The with waiver cost projection also incorporates the anticipated collection of member co-premiums. Optumas modeled a collection amount of premiums up to 2% of household income from all individuals with incomes over 100% FPL.[1] Adjusting for the portion of the HCIP enrollees with incomes over 100% FPL and an assumed collection rate results in the collection amount being valued at an average of $0.49 PMPM to $0.52 PMPM across the Demonstration timeframe. The collection rate used in modeling is based on reviewing the experience of other states with a member co-premium. Other aspects of the program cost, such as the advance CSR payments and the services provided via a fee-for-service wrap, are handled identically as the original budget neutrality submission. The other new features of Arkansas Works are not expected to have a cost impact on the Demonstration for the new adult group, so no adjustment is made to the with waiver scenario. Combining the projected enrollment with the expected premium yielded the projected costs for the hypothetical population in both the without and with waiver scenarios. Additional detail on the budget neutrality projections is attached as Appendix A.

Section VI - Evaluation

An evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

The interim evaluation report for the Demonstration is available on the Arkansas Center for Health Improvement website. A preliminary summative report for the HCIP is due 180 days after the transition from the HCIP to Arkansas Works on December 31, 2016, with a final summative report due 360 days after the transition date of December 31, 2016. The final

[1] Enrollees with incomes between 100-138% FPL will be subject to premiums of up to 2% of household income. Optumas based its budget neutrality projections on a two-person household.

summative report will include an executive summary, Demonstration description, study design, discussion of findings and conclusions, policy implications, discussion of interaction with other State initiatives, and derivative research publications to demonstrate scientific and academic rigor.

Evaluation activities during the extension period will include a continuation of assessment of the research questions and hypotheses related to QHP premium assistance that address the goals of improving access, reducing churn, and improving quality of care, thereby leading to enhanced health outcomes. Experience from the interim evaluation report regarding available data and evaluation approach has led to a consolidation and refinement of hypotheses for QHP premium assistance as described the table below. Additional research questions and hypotheses will assess new features of Arkansas Works including, mandatory ESI premium assistance, premium exposure for Arkansas Works beneficiaries with incomes between 100-138% FPL, access to incentive benefits, and elimination of retroactive coverage. The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

Table 3. Evaluation Hypotheses under Consideration

Hypothesis	Evaluation Approach	Data Sources
QHP Premium Assistance Continued Hypotheses		
1. QHP premium assistance beneficiaries will have equal or better access to health care compared with what they would have otherwise had in the traditional Medicaid fee-for-service system over time.	Compare differences in perceived and realized measures of access between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures will include perceptions of timeliness and ease of access to primary care physicians and specialists, transportation barriers, and time to first visit.	i. CAHPS survey ii. QHP and Medicaid claims data
2. QHP premium assistance beneficiaries will have equal or better care and outcomes compared with what they would have otherwise had in the traditional Medicaid fee-for-service system over time.	Compare differences in receipt of needed preventive, emergent, and specialty care and utilization of non-emergent emergency room or preventive hospital visits between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures include established HEDIS metrics for appropriate screening, other quality indicators, and actual utilization of health care services.	i. CAHPS survey ii. QHP and Medicaid claims data

Hypothesis	Evaluation Approach	Data Sources
3. QHP premium assistance beneficiaries will have better continuity of care compared with what they would have otherwise had in the traditional fee-for-service Medicaid system over time.	Compare differences in attrition and churn between beneficiaries enrolled in QHPs and those in traditional fee-for-service Medicaid. Measures include: • Percentage of the enrolled population dropped from coverage who did not re-enroll, and • Months of gaps in coverage and the associated health care consequences of these gaps in coverage.	i. Insurance transition survey ii. Monthly enrollment data file
Waiver Extension Hypotheses		
ESI Premium Assistance-Specific Hypotheses		
4. Use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance.	Program impact assessment based upon employer participation and allocations of premium assistance	i. Enrollment and premium payment data
5. Availability of ESI premium assistance will recruit employers to newly offer ESI.	Gather employer and employee perceptions and realities of the benefits of coverage through ESI compared to providing the same benefits through QHP premium assistance.	i. Qualitative interviews and focus groups with small group employers ii. Premium payment and benefit utilization data
6. Continuity of coverage under ESI premium assistance will be improved compared to QHP premium assistance.	Compare attrition and churn between QHP and ESI premium assistance.	i. Enrollment data ii. Premium payment data
Arkansas Works Full Population Hypotheses		
7. The incentive benefits in Arkansas Works will: a) Increase participation rates for premium contributions compared to historical experience with Independence Accounts; and b) Increase wellness visit utilization.	Compare rates of 2015-16 Independence Account participation vs. 2017-21 premium payment participation; compare 2015-16 vs. 2017-21 wellness visit utilization rates.	i. Premium collection and transaction data ii. QHP and Medicaid provider and claims data

Hypothesis	Evaluation Approach	Data Sources
8. Arkansas Works QHP and ESI premium assistance beneficiaries will have equal or fewer gaps in insurance coverage compared with what they would have otherwise had in the traditional fee-for-service Medicaid system over time.	Compare attrition and churn between premium assistance beneficiaries covered through QHPs or ESI and traditional fee-for-service Medicaid beneficiaries over time.	i. Enrollment data ii. Premium payment data
9. Arkansas Works beneficiaries receiving coverage through either QHP or ESI premium assistance will maintain continuous access to the same providers.	Compare provider access for QHP and ESI premium assistance beneficiaries to those enrolled in traditional fee-for-service Medicaid.	i. CAHPS survey ii. QHP and Medicaid claims data

Section VII - Compliance with Public Notice Process

Documentation of the State's compliance with the public notice process set forth in §431.408 of this subpart, including the post-award public input process described in §431.420(c) of this subpart, with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

1) Start and end dates of the state's public comment period.

The State's comment period was from May 18, 2016 to June 17, 2016.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Arkansas certifies that it provided public notice of the application on the State's Medicaid website (https://www.medicaid.state.ar.us/) beginning on May 18, 2016. Arkansas also certifies that it provided notice of the proposed Demonstration in the *Arkansas Democrat-Gazette*—the newspaper of widest circulation in Arkansas—on May 18, 19, and 20. A copy of the notice that appeared in the newspaper is included here in Section VIII.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Arkansas certifies that it convened two public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, Arkansas held the following hearings:

- *Little Rock – May 26, 2016, from 11 am – 1 pm.* Dawn Stehle, Arkansas's Medicaid Director, provided an overview of the Demonstration. Individuals could also access this public hearing by teleconference and webinar.
- *Pine Bluff – June 1, 2016 from 5:30 pm – 7:30 pm*. Dawn Stehle provided an overview of the Demonstration. Individuals could also access this public hearing by teleconference and webinar.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

Arkansas certifies that it used an electronic mailing list to provide notice of the proposed Demonstration to the public. Specifically, Arkansas Medicaid provided notice through email lists of key stakeholders, including payers, providers, and advocates. Arkansas also posted the link to the application on the Department of Human Services' Twitter feed.

5) Comments received by the state during the 30-day public notice period.

Arkansas received nine comments during the public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

We attach here at Appendix B a document summarizing and responding to the comments received. In addition, we have included all public comments received in Appendix C.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Arkansas contains no federally recognized tribes or Indian health programs. As a result, tribal consultation was not required.

Section VIII – Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) a written application requesting approval to replace the existing program

authorized under Arkansas's Health Care Independence Program Demonstration with Arkansas Works.

Arkansas's 1115 waiver demonstration ("Demonstration") has been successful in furthering the objectives of Title XIX and improving the health insurance Marketplace for all Arkansans—particularly the 240,000 covered through the Demonstration—and Governor Asa Hutchinson and the Arkansas General Assembly have opted for a more innovative program that strengthens the individual premium assistance model by emphasizing personal responsibility, promoting work, and enhancing program integrity. To that end, Arkansas proposes to replace its current Health Care Independence Program when it expires on December 31, 2016 with Arkansas Works—a new approach to health coverage for Arkansans.

To implement Arkansas Works, the State will use premium assistance to purchase either cost-effective employer-sponsored insurance (ESI) or qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for expanded coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare. Individuals in two groups—(1) those who are medically frail or (2) other individuals with exceptional medical needs for whom coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care—will not participate in the Demonstration, unless they have access to cost-effective ESI and choose to receive the Alternative Benefit Plan (ABP). All individuals covered through the Demonstration are referred to as "Arkansas Works beneficiaries."

Arkansas Works beneficiaries will receive the ABP through either their ESI or the QHP that they select. Arkansas Works beneficiaries with incomes above 100% FPL will continue to pay cost-sharing, consistent with the State Plan. Arkansas Works beneficiaries with incomes above 100% FPL will no longer be required to contribute to Independence Accounts; instead, they will be required to pay premiums, consistent with the premiums for populations with comparable incomes purchasing coverage through the Marketplace.

The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals (and in the longer run, families), improving access to providers, smoothing the "seams" across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives. Additionally, the Demonstration will:

- Encourage employer-based insurance;
- Incentivize work and work opportunities;
- Promote personal responsibility; and
- Enhance program integrity.

The Demonstration will be statewide and will operate during calendar years 2017 through 2021. The State anticipates that approximately 272,000 individuals will enroll in the Demonstration by 2021. The State expects that, over the life of the Demonstration, covering

Arkansas Works beneficiaries will be comparable to what the costs would have been for covering the same group of Arkansas adults using traditional Medicaid.

The Demonstration will test hypotheses related to access to care, quality of care, churning, cost-comparability, availability of ESI, incentive benefits, and the elimination of retroactive coverage.

The State will request the following waivers and expenditure authorities to operate the Demonstration:

Waivers

- § 1902(a)(23)(A): To make premium assistance for QHPs in the Marketplace and for ESI mandatory for Demonstration enrollees and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the beneficiary's QHP or ESI.
- § 1902(a)(13) and § 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 or ESI providing primary coverage for services under Arkansas Works.
- § 1902(a)(54) insofar as it incorporates Section 1927(d)(5): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.
- § 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.
- § 1902(a)(14) insofar as it incorporates § 1916 and §1916A: To the extent necessary to enable the State to collect monthly premiums for individuals with incomes between 100 and 138 percent of the federal poverty level (FPL).
- § 1902(a)(34): To enable the State not to provide medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which an individual applies.
- § 1902(a)(4) insofar as it incorporates 42 CFR § 431.53: To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance.

Expenditure Authorities

- 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.
- ESI Premium Assistance Payments. To cover up to 75% of the cost of ESI premiums for individuals participating in the Arkansas Works ESI premium assistance program.

- Limited-Purpose Health Credit Expenditures. To issue limited-purpose health credits to eligible enrollees who made a required number of contributions prior to Independence Account termination.

The State continues to evaluate whether it will request other waivers or expenditure authorities.

The complete version of the current draft of the Demonstration application will be available for public review as of Wednesday, May 18, at **https://www.medicaid.state.ar.us/General/comment/demowaivers.aspx.** The Demonstration application may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

Public comments may be submitted until midnight on June 17, 2016. Comments may be submitted by email to **HCIW@Arkansas.gov** or by regular mail to PO Box 1437, S-295, Little Rock, AR 72203-1437.

To view comments that others have submitted, please visit **https://www.medicaid.state.ar.us/general/comment/comment.aspx**
Comments may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

The State will host two public hearings during the public comment period.

Little Rock
Thursday, May 26, 2016
11:00 AM – 1:00 PM
University of Arkansas
Cooperative Extension Service
2301 S University Avenue
Little Rock, Arkansas, 72204

Pine Bluff
Wednesday, June 1, 2016
5:30 – 7:30 PM
Jefferson Regional Medical Center

Classrooms J & R
1600 W 40th Avenue
Pine Bluff, Arkansas, 71603

Individuals may access the hearing by webinar. To participate by webinar, please register at: https://attendee.gotowebinar.com/register/5714384405162657281

Dawn Stehle
Director
Division of Medical Services

4501545928 EL

APPENDIX A

BUDGET NEUTRALITY SUBMISSION

ARKANSAS 1115 WAIVER EXTENSION APPLICATION
APPENDIX A

Original Figures

	Budget Neutrality Without Waiver			
	CY14	**CY15**	**CY16**	**Three Year Total**
Member Months	1,567,481	2,405,931	2,881,476	6,854,888
Medicaid Services PMPM	$ 477.63	$ 500.08	$ 523.58	$ 504.83

	With Waiver			
	CY14	**CY15**	**CY16**	**Three Year Total**
Member Months	1,567,481	2,405,931	2,881,476	6,854,888
QHP Services PMPM	$ 487.90	$ 489.48	$ 501.89	$ 494.34
Wrap Services PMPM	$ 4.98	$ 4.67	$ 3.80	$ 4.37
Total PMPM	$ 492.88	$ 494.15	$ 505.69	$ 498.71
Over/(Under) Cap PMPM	$ 15.25	$ (5.93)	$ (17.89)	$ (6.12)
Percent Difference from Cap	3.2%	-1.2%	-3.4%	-1.2%

Extension Figures

	Budget Neutrality Without Waiver						
	CY17	**CY18**	**CY19**	**CY20**	**CY21**	**Five Year Total**	**Eight Year Total**
Member Months	2,953,513	3,027,351	3,103,034	3,180,610	3,260,126	15,524,634	22,379,522
Medicaid Services PMPM	$ 557.62	$ 591.07	$ 623.58	$ 654.76	$ 685.54	$ 624.09	$ 587.56

	With Waiver						
	CY17	**CY18**	**CY19**	**CY20**	**CY21**	**Five Year Total**	**Eight Year Total**
Member Months	2,953,513	3,027,351	3,103,034	3,180,610	3,260,126	15,524,634	22,379,522
QHP Services PMPM	$ 534.51	$ 566.59	$ 597.75	$ 627.64	$ 657.13	$ 598.24	$ 566.41
Wrap Services PMPM	$ 4.05	$ 4.29	$ 4.53	$ 4.75	$ 4.97	$ 4.53	$ 4.48
Less Member Cost Share	$ 0.49	$ 0.49	$ 0.50	$ 0.51	$ 0.52	$ 0.50	$ 0.35
Total PMPM	$ 538.08	$ 570.38	$ 601.77	$ 631.88	$ 661.59	$ 602.26	$ 570.54
Over/(Under) Cap PMPM	$ (19.54)	$ (20.69)	$ (21.81)	$ (22.88)	$ (23.94)	$ (21.83)	$ (17.02)
Percent Difference from Cap	-3.5%	-3.5%	-3.5%	-3.5%	-3.5%	-3.5%	-2.9%

Assumptions						
CY	16 -> 17	17 -> 18	18 -> 19	19 -> 20	20 -> 21	Five Year Total
Without Waiver Trend	6.5%	6.0%	5.5%	5.0%	4.7%	5.54%
With Waiver Trend	6.5%	6.0%	5.5%	5.0%	4.7%	5.54%
Enrollment Growth	2.5%	2.5%	2.5%	2.5%	2.5%	2.50%
Member Cost Share Growth	1.5%	1.5%	1.5%	1.5%	1.5%	1.50%

Aggregate Waiver Calculations

	Without Waiver				
	Through CY17	**Through CY18**	**Through CY19**	**Through CY20**	**Through CY21**
	9,808,401	12,835,752	15,938,786	19,119,396	22,379,522
	$ 520.72	$ 537.32	$ 554.11	$ 570.85	$ 587.56

	With Waiver				
	Through CY17	**Through CY18**	**Through CY19**	**Through CY20**	**Through CY21**
	9,808,401	12,835,752	15,938,786	19,119,396	22,379,522
	$ 506.44	$ 520.62	$ 535.64	$ 550.94	$ 566.41
	$ 4.28	$ 4.28	$ 4.33	$ 4.40	$ 4.48
	$ 0.15	$ 0.23	$ 0.28	$ 0.32	$ 0.35
	$ 510.56	$ 524.67	$ 539.68	$ 555.02	$ 570.54
	$ (10.16)	$ (12.64)	$ (14.43)	$ (15.83)	$ (17.02)
	-2.0%	-2.4%	-2.6%	-2.8%	-2.9%

ARKANSAS 1115 WAIVER EXTENSION APPLICATION
APPENDIX A

	Trend Support				
	CY17	CY18	CY19	CY20	CY21
Service Type	Trend Rate	Trend Rate	Trend Rate	Trend Rate	Trend Rate
Pharmacy	11.00%	9.50%	7.75%	6.00%	5.00%
Medical	4.50%	4.50%	4.50%	4.50%	4.50%
Aggregate	6.50%	6.00%	5.50%	5.00%	4.70%

Pharmacy is weighted at 30% and Medical at 70% to calculate the Aggregate

APPENDIX B

RESPONSES TO PUBLIC COMMENTS ON ARKANSAS WORKS 1115 WAIVER EXTENSION APPLICATION

APPENDIX B
Responses to Public Comments on Arkansas Works 1115 Waiver Extension Application

Premium Assistance for Employer-Sponsored Insurance

Comment: Several commenters were supportive of the State's efforts to encourage employers to provide insurance for their employees through a premium assistance program for employer-sponsored insurance (ESI).

Response: The State appreciates commenters' support of its plans to implement a premium assistance program for ESI.

Comment: Several commenters were concerned that the State will have challenges administering a premium assistance program for ESI. Several commenters also expressed concerns about the fact that Arkansas Works beneficiaries receiving coverage through ESI would have two cards—one for their ESI and one for Medicaid—potentially leading to enrollee and provider confusion. One commenter specifically requested clarification that all providers in the ESI network, regardless of whether they participate in Medicaid, will charge enrollees only the Medicaid-level cost-sharing.

Response: The State is currently working closely with vendors and other state agencies to develop a plan to implement the ESI premium assistance program in a streamlined and seamless manner. The State intends to educate ESI premium assistance enrollees about the proper use of the two cards, and the State will, through its vendor, provide call center support for ESI premium assistance enrollees and providers with questions. Finally, the State will work closely with providers to ensure that ESI premium assistance enrollees have access to a broad number of providers, while remaining protected from cost-sharing above Medicaid levels.

Comment: One commenter urged the State to **not** expand the ESI premium assistance program to include dependents in the future; instead favoring retaining the current ARKids First program.

Response: The State appreciates this comment and will consider carefully any changes to coverage for children in the future.

Comment: One commenter expressed concerns about mid-year plan changes as employers begin participating in the ESI premium assistance program. The commenter suggested that the State allow QHP premium assistance enrollees who gain access to cost-effective ESI remain in their QHP until the annual re-enrollment period occurs.

Response: The State acknowledges that the launch of the ESI premium assistance program may require some QHP enrollees to change plans mid-year. The State will work closely with carriers, employers, and its vendor to ensure a smooth transition for these enrollees.

Comment: One commenter suggested that the State consider amending insurance rules to allow small group employers participating in Arkansas Works to waive any waiting period for individuals eligible for ESI premium assistance to minimize churn caused by the ESI premium assistance program. If waiving the waiting period is not possible, the commenter suggested providing coverage for enrollees through fee-for-service—rather than enroll them in a QHP only to shift them to ESI soon thereafter.

Response: The State will seek ways to minimize churn between QHPs and ESI. The State will take this suggestion under advisement.

Comment: One commenter requested clarification of whether an employer can begin participating in Arkansas Works at any time, or whether employers will be limited to a sign up period.

Response: The State anticipates allowing employers to begin participating in Arkansas Works at any time. The State may revise its policy in future years.

Comment: One commenter requested clarification of whether an employer can withdraw from participation in Arkansas Works at any time. Relatedly, the commenter asked how the State will address an employer that fails to make timely premium payments, leading to the cancellation of the small group policy.

Response: The State will require that all participating employers enter in to a Memorandum of Understanding, which will outline key requirements, such as the employer's withdrawal rights and penalties for failure to pay premiums.

Comment: One commenter suggested that the State develop an outreach and enrollment strategy specifically for small business owners, including involving insurance agents with expertise assisting small group consumers.

Response: The State agrees that effective communication with small employers about the Arkansas Works program will be important and will consider how agents' expertise may be best used in implementing this program.

Comment: One commenter made several suggestions related to the ESI premium assistance enrollment process, including engaging QHPs in identifying potential sources of third-party coverage.

Response: The State continues to develop its approach to implementing the ESI premium assistance program, including how it will confirm whether an individual has access to cost-effective ESI. As suggested, the State will evaluate how to use (and strengthen) its existing third-party liability processes to identify potential ESI premium assistance enrollees.

Comment: One commenter suggested that the State make the ESI premium assistance program mandatory for employers to maximize the State's ability to leverage ESI.

Response: The State does not intend to make the program mandatory for employers.

Premiums and Cost-Sharing

Comment: Four commenters expressed concerns about the State's proposal to require premiums for Arkansas Works enrollees with incomes above 100% FPL. The commenters indicated that the proposed premium amounts could place a significant financial burden on beneficiaries.

Response: By charging premiums, the State intends to promote personal responsibility and align with commercial coverage to the extent possible. The State acknowledges that some low-income individuals may have challenges paying monthly premiums, especially if they incur other unanticipated out-of-pocket expenses. Accordingly, the State will ensure that individuals remain eligible for coverage, even if they miss a premium payment. To reward those individuals who pay premiums (and complete certain healthy behaviors), the State will provide additional incentive benefits.

Comment: One commenter recommended against requiring deductibles or co-payments for services.

Response: No Arkansas Works beneficiaries will be subject to deductibles. The State believes that co-payments are a critical tool to promote personal responsibility and discourage inappropriate utilization and has required that individuals in the new adult group with incomes above 100% FPL pay co-payments since 2014.

Comment: One commenter noted that enrollees may misinterpret notices of past due premiums as meaning that they are no longer eligible for coverage under Arkansas Works, rather than that they may not be eligible for incentive benefits. The commenter underscored the need for clear enrollee communications to minimize potential confusion.

Response: The State agrees that clear enrollee communication will be critical.

Comment: One commenter asked the State to consider requiring co-payments for emergency room use while eliminating co-payments on primary care visits to encourage enrollees to receive care at appropriate settings.

Response: Federal Medicaid law will not permit the State to impose cost-sharing on emergency room use.[1] The State will explore ways to encourage enrollees to seek care in appropriate settings.

[1] Co-payments are only permitted on non-emergency use of the emergency room, which is not a covered benefit under Arkansas's Alternative Benefit Plan.

Benefits

Comment: One commenter asked for additional details on the "healthy behavior" required to earn incentive benefits.

Response: The State has tentatively determined to require one primary care provider visit during each calendar year. The State continues to refine its approach to incentive benefits.

Comment: Two commenters indicated support for providing dental coverage, and one commenter suggested that the State make dental coverage part of Medicaid benefit package for the new adult group—rather than an incentive benefit.

Response: The State agrees that oral health is important. The State is still evaluating which benefits to provide as incentive benefits.

Comment: Two commenters opposed the State's proposal to eliminate coverage for non-emergency medical transportation for individuals enrolled in ESI premium assistance, citing challenges of low-income individuals to travel to medical appointments and the risk of an additional financial burden on those without cars.

Response: The State expects that most individuals with access to ESI have sufficient transportation options, since most need transportation to get to and from work. As a result, the State expects that eliminating non-emergency medical transportation for individuals with access to ESI will not negatively impact beneficiary access to services.

Eligibility

Comment: Several commenters expressed concern with the State's proposal to eliminate retroactive eligibility. Commenters indicated that the State's systems challenges and inability to implement fully a presumptive eligibility program further underscore the need to maintain retroactive eligibility. Commenters also noted the potential negative financial impact on providers due to eliminating retroactive coverage.

Response: The State is in its third year of providing coverage to the new adult group and continues to improve its eligibility systems to ensure access to coverage and minimize gaps in coverage. The State believes that the need for retroactive eligibility is limited.

Comment: One commenter expressed concern that eligibility for coverage in Arkansas Works does **not** include an asset test. The commenter noted that individuals with high wealth but low income will not qualify for Arkansas Works, while individuals with low wealth but relatively higher income will not qualify.

Response: Asset tests are prohibited under federal Medicaid law for individuals in many eligibility categories, including those in the Arkansas Works population.

Comment: One commenter suggested that the State create a single redetermination period for a family, rather than have different redetermination periods for different family members depending on the program covering them. The commenter noted that some families could have children enrolled in ARKids First, one parent in QHP premium assistance, and one parent in ESI premium assistance, leading to three different renewal periods and processes.

Response: The State appreciates this comment and is working to reduce the administrative challenges facing families covered through multiple coverage programs. The State will consider the future feasibility of creating a single redetermination period for the entire family.

Comment: One commenter suggested that the State work with health plans, vendors, and insurance agents to improve eligibility and renewal processes to minimize churn. The commenter also suggested that the State measure the administrative costs associated with churn to inform process improvements.

Response: Reducing churn is a major objective of the Arkansas Works program, and the State will continue to work closely with stakeholders to develop strategies to minimize churn.

Comment: One commenter requested clarification of when eligibility would begin, if the State did not provide retroactive coverage.

Response: If the State were no longer required to offer retroactive coverage, coverage would begin as of the first day of the month in which the individual applies for coverage. For example, if an individual applies for coverage on September 20, they would have eligibility dating back to September 1, but no earlier.

General Comments

Comment: Nearly all commenters were very supportive of the Arkansas Works program. One commenter provided a personal anecdote about how coverage had improved his and his wife's lives. Another commenter noted the significant positive impact that expanded coverage had on providers throughout the State.

Response: The State appreciates the support for the State's Demonstration program. The State appreciates hearing from enrollees and provider about the positive impact of coverage, and the State looks forward to working with a broad range of stakeholders to make Arkansas Works a success.

Comment: One commenter provided support for offering life skills counseling to individuals seeking employment, rather than requiring them to participate in mandatory job search activities. Another commenter encouraged the State to collaborate with education and community organizations to support enrollees in gaining employment and developing careers.

Response: The State agrees that it is critical to support Arkansans in building the skills necessary to become employed. The State does not intend to link coverage under Title XIX with participation in any mandatory job search activities.

Comment: One commenter supported providing medically necessary case management to higher need individuals.

Response: The State agrees that it is important to ensure that Arkansas Works enrollees can navigate the complex healthcare system and will work with stakeholders to determine how best to provide appropriate support. Most individuals who are medically frail/have exceptional medical needs will be served through fee-for-service Medicaid.

Comment: One commenter encouraged the State to work with experts in health literacy to develop enrollee notices and educational materials.

Response: The State appreciates the suggestion and will consider working with experts to further refine notices.

Comment: One commenter indicated that the projected cost trend of 4.7% may not accurately reflect trends in healthcare costs for the new adult group. The commenter suggested a trend of between 6-7% annual growth.

Response: The State appreciates this feedback. After analyzing healthcare utilization among the new adult group, including the use of prescription drugs, the State has updated the budget neutrality trend in the final Demonstration application.

Comment: One commenter encouraged the State to enhance its program integrity efforts in Arkansas Works, especially in QHP premium assistance, to ensure that providers are billing appropriately.

Response: The State agrees that program integrity is essential to the success of Arkansas Works. The State will evaluate whether its program integrity policies require updating to reflect the unique features of the Arkansas Works program.

APPENDIX C

PUBLIC COMMENTS ON ARKANSAS WORKS 1115 WAIVER EXTENSION APPLICATION

From: Jacobson, David <HDJacobson@arkbluecross.com>
Sent: Friday, June 17, 2016 12:28 PM
To: DHS DMS HCIW
Cc: Parker, Kristin R
Subject: Arkansas Works Public Comment
Attachments: Arkansas Works Waiver Extension Public Comment - Arkansas BCBS - June 17 2016.pdf

Division of Medical Services:

We appreciate the opportunity to provide the attached comments and suggestions for the Arkansas Works Waiver Extension Application.

Best of luck with the approval process and we look forward to helping you and the state implement an innovative program to improve the health, workforce and economy of Arkansas.

David Jacobson
Vice President, Strategy & Business Development

Arkansas Blue Cross Blue Shield
601 S. Gaines Street
Little Rock, AR 72201
501-378-3011 (office)
hdjacobson@arkbluecross.com

Comments and Suggestions on
Arkansas Works 1115 Waiver Extension Application

Introduction

As a committed partner to the success of Arkansas Works, Arkansas Blue Cross Blue Shield (ABCBS) appreciates the continued national leadership and extraordinary effort by DHS to design Arkansas Works as described in the waiver extension application. We recognize that the extension application conforms to the CMS requirements for renewal and is not intended to address many of the operational details that will be important to a successful implementation. However, given the importance of this application document and CMS' consideration of this request, we have included several specific program comments and suggestions that we believe are relevant to both this immediate discussion and the long term program planning. We hope these comments will be helpful as you continue to develop Arkansas Works, and are happy to answer any questions you may have. ABCBS appreciates the opportunity to provide this input and we look forward to collaborating with you and other stakeholders in the coming months to continue the success of this important health care program for Arkansans.

As a Private Option/Arkansas Works participating QHP, a significant small employer health insurance plan and fellow Arkansans committed to the health, economy and citizens in our state, we offer the following comments and suggestions for your consideration.

Improve Enrollment Transitions and Participant Understanding

Challenges with churning are not unique to Arkansas; virtually every Medicaid program in the country has struggled with this problem, and we appreciate the efforts and interest DHS has demonstrated in identifying ways to minimize transitions between health plans, and the continued focus on this issue by including churning in the proposed Arkansas Works evaluation strategy. The success of the HCIP demonstrates how important these new health care options have been for improving access to health care, and we want to do everything possible to support continued success under Arkansas Works.

While we realize some level of churn is inevitable, we believe development of a comprehensive enrollee communication and education campaign and easy-to-understand enrollment materials will be critical to ensure a smooth transition. In addition to the assistance ABCBS and other QHPs can provide, Arkansas is fortunate to have many experienced insurance agents, advocacy representatives, and providers who work with the customers who will participate in Arkansas Works, and can provide valuable assistance with development and distribution of educational materials to ensure Arkansans have access to the information they need. ABCBS is eager to provide our help with this initiative, as well as several other suggestions provided below that we hope will be useful as DHS considers opportunities to minimize churning.

Comments

Like other public plans and as demonstrated in HCIP, Arkansas Works enrollees will continue to experience change that occurs due to income fluctuations as individuals change jobs, experience reductions or increases in hours and pay, seasonal shifts in work, changes in household arrangements and financial support, and other personal circumstances that lead to shifts in coverage, all of which contribute to the current churn between Medicaid, HCIP, and subsidized QHP coverage. With the Arkansas Works premium payment requirements and the new ESI premium subsidy program intially focused on the small group market, additional churn may occur as follows:

- Although we realize that individuals will not be dis-enrolled for non-payment of premiums, some individuals may be confused by the implications of non-payment or "past due notices" and may not complete the reapplication process based on the belief they are no longer eligible for the program. Others could discontinue using their plan if they think coverage is no longer effective. This could be particularly problematic in the small group ESI market as individuals with chronic conditions might not receive treatment they still have access to, resulting in more missed work due to health issues. An effective communication plan will be critical to ensure enrollees understand their coverage has not changed and continue to see their PCP and use their health benefits.
- Some families covered by Arkansas Works will have a mix of coverage types with inconsistent enrollment periods and varying re-determination dates. A family that shares identical qualifying income information could have children in traditional Medicaid, one adult in an Arkansas Works QHP and another in an ESI premium assistance plan. The complexity of navigating these programs and the renewal requirements will be challenging for many and is likely to contribute to temporary episodes of uninsurance as individuals do not understand the varying re-enrollment requirements or fail to meet deadlines for completing the process for three separate programs.

Suggestions

While churning between health plans cannot be entirely eliminated, minimizing the occurrence and the consequences of churning is important to maintain continued coverage and health care, and reduce costs for both the State and QHPs. While the initial structure of the program places specific boundaries around what is acceptable ESI coverage, this will become a more significant issue as Arkansas Works expands beyond the small group market into large group and self-funded group health plans. As both an Arkansas Works participating QHP and a small employer benefit plan for employers who are likely to choose to participate in the new ESI program, we offer the following suggestions for your consideration:

- Work with health plans, the Third Party Administrator (TPA), insurance agents and other stakeholders to develop the State's waiver evaluation strategy related to eligibility information, enrollment communications, and measuring the occurrence and impact of churn on enrollees, DHS, and QHPs and small employer health plans. Include an evaluation of the process, enrollee touchpoints, and administrative costs associated with premium and cost sharing processing, incentives reward tracking and reporting, reconciliation tracking and reporting, and other costs identified by the strategy team. Based on findings, develop targeted strategies to address contributing factors that can be controlled or minimized.
- For individuals enrolled in a QHP who subsequently have access to ESI, allow them to remain in the QHP until the annual re-enrollment period occurs. This will improve the continuity of care by

providing enrollees an adequate time period for the transition, and will reduce costs associated with enrollment changes.

- For families with members in multiple programs (including Medicaid, Arkansas Works and/or ESI premium subsidies), coordinate re-eligibility determinations to create one single renewal period for all family members. While this will require some additional effort by DHS, the long term benefits of improving the process for enrollees, reducing lapses of coverage, and reducing DHS and QHP administrative costs associated with multiple renewals and churn should be worth the effort. Agents can play a valuable role in the area.
- Ensure any premium past-due notifications sent by Arkansas Works or QHPs **clearly state** the individual will not lose coverage and should continue to use his/her health plan benefits. Studies have shown that consumer behavior is driven by people's perceptions of costs and penalties, whether accurate or not[1]. While we do not want to minimize the importance of premium payments and the personal responsibility it encourages, we also want to ensure individuals do not mistakenly believe they have lost coverage or fail to complete re-eligibility forms based on the perception they no longer qualify for coverage, which defeats the entire purpose of Arkansas Works.
- Work with QHPs, the TPA, small groups and agents to track administrative activity and costs associated with transitioning members between the various programs. Based on findings, consider continuous process improvements and enhanced administrative efficiencies to improve enrollment transitions between programs.
- Conduct periodic but regularly scheduled focus groups, stakeholder meetings and/or surveys of individuals who have experienced churn to identify contributing factors and potential solutions.
- Create a working group with QHPs, ESI health plans representatives, insurance agents, small employers and stakeholders to assist DHS in the development of a comprehensive Outreach and Education Program targeted to specific groups, such as employers, employees, agents, current HCIP enrollees and the general public. Use the work group to also identify opportunities to reduce churn and increase ESI uptake.
- Work with QHPs, small employer health insurers, providers and stakeholders to develop a policy to minimize disruptions of care and allow continuity of care for enrollees transitioning from one plan to another.

Eligibility and Enrollment Processes

Enrollment Requirements and Restrictions

Comments

As operational requirements are developed, we encourage DHS to address reconciliation of Arkansas Works enrollment periods and waiting periods under ESI with the requirement to effectuate coverage of new Arkansas Works enrollees beginning on the first day of the month in which a member applies for coverage. Include consideration that most small businesses have under ACA a a waiting period that cannot exceed 90 days from date of employment before an employee is eligible for enrollment. A typical small group employer will have a 60 day waiting period for full time new hires.

[1] Short PF, K Swartz, N Uberoi, and D Graefe. 2011. Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change. New York: The Commonwealth Fund.

Suggestions

- Consider if DHS will ask employers and small employer health insurers to disregard the waiting period for enrollment in the ESI for Arkansas Works enrollees. If so, applicable Arkansas Insurance Department regulations may need to be amended.
- If not, DHS could temporarily enroll individuals in fee-for-service Medicaid, or allow the individual to select a QHP. If this is the approach, we again note this practice would contribute to the enrollment transition process previously discussed.

Enrollment of New Small Employers in ESI Premium Assistance

Comments

On page 10, Section II 1. *Implementing a Premium Assistance Program for ESI*, the extension application explains that "In the first year of ESI premium assistance," eligible small employers interested in participating in the ESI premium assistance program will notify the State that their plan meets cost-effectiveness criteria (i.e., the employer covers at least 25% of the premiums) and opt in to participate in the ESI premium assistance program. The State then matches individuals who are eligible for Arkansas Works against a list of participating ESI employers. However, the extension application does not indicate if employers can apply at **any time** during the first year to become participating ESI employers, or if their enrollment is limited to a specific time frame prior to the beginning of the ESI program.

Suggestions

Depending on the answer to this question, the following may apply:

- If an employer is allowed to join at any time, we suggest DHS consider allowing employees who are already enrolled in an Arkansas Works QHP to remain in their QHP until their next re-enrollment date, rather than requiring the individual to switch to the newly available ESI plan immediately.

Employer Disenrollment or Cancellation of Coverage

Comments and Suggestions

We encourage DHS to consider the following plan administration scenarios; we will be happy to collaborate on decisions that are appropriate for an ESI market:

- Once enrolled in the ESI program, can an employer voluntarily withdraw from participation in the ESI premium assistance program? If so, are there any limitations or restrictions?
- If an **employer** fails to remit timely premiums to the insurance carrier, and the policy is cancelled, will the employees participating in ESI automatically be transitioned to the standard Arkansas Works, or with they have to re-apply for Arkansas Works? For purposes of the **incentive benefit**, will employees be penalized for failure of the **employer** to timely remit premium payments?

Enrollee and Employer Education

Comments

As discussed above, implementation of a comprehensive employee and employer education program will be critical to ensure the success of the ESI premium assistance program and minimize the potential for disruptions in benefits. Education materials will have to be developed that meet the needs of both current HCIP enrollees who must understand how their coverage is changing under ESI, as well as new enrollees who have no experience with HCIP or Arkansas Works and may have never had a health insurance plan. Employers and agents will expect a simple, easy and responsive open enrollment and ongoing benefit administration process.

Suggestions

We encourage DHS to consider the following plan administration scenarios and will be glad to work with you to provide additional information on options that are appropriate for an ESI market.

- Enrollees may not be aware of or understand the requirement to present two separate insurance cards when obtaining health services, which will create administrative challenges for providers, enrollees and health plans. In some cases (especially for new patients), providers may refuse to provide services without both cards, delaying enrollees' access to necessary care. In addition to a clear, simple communication program specifically targeted to ESI enrollees, also include a provider education and communications program that instructs them how to handle situations where an enrollee doesn't present both cards. For example, encourage providers to copy both cards during the patient's initial visit so the information is available if the enrollee forgets a card in the future. Provider education will be especially important since some providers in an employer health plan network may not be Medicaid providers.
- Enrollees and the provider community may not understand the concept of "wrap benefits" and may not be aware of services covered under the Arkansas Works ESI plan if they are relying solely on the summary of benefits provided by their employer health plan. Conveying this information in a simple, easy to understand explanation will be critical to ensuring members and providers are aware of the full scope of benefits available to them under Arkansas Works – ESI benefits.
- Enrollees who are transitioning from HCIP to ESI under Arkansas Works may have other family members who will continue to be covered under their current Arkansas Works QHP. These enrollees will need to understand that the change to ESI only impacts their health coverage; other family members will not be affected by the change, and should continue seeing their existing health care providers.
- To assist enrollees transitioning from HCIP to ESI, we recommend developing targeted information materials to help them understand the differences in their new coverage and provide a simple Q&A for questions they are likely to have. The materials should address such things as differences in provider networks, any differences in benefits, and the availability of wrap services. Enrollees will also need access to customer support services from both DHS and the ESI plan support staff who are trained to address the questions individuals will have. These changes can be challenging for individuals who have limited experience with the health care system, particularly those with chronic conditions or individuals who are currently involved in a care plan for a serious illness.
- New education materials and an outreach strategy should also be developed for small business owners. As a small employer health benefit plan provider in Arkansas, ABCBS has extensive

experience working with small businesses owners throughout the state. The majority of these owners wear many hats as small employers, and are usually overwhelmed by the complexities of purchasing a group health benefit plan. We have learned that those who offer insurance do so because they care about their employees and want to do "the right thing," but require a great deal of assistance when selecting a health plan. The added complexity of understanding the implications of the premium assistance plan will require additional time with each small employer, and development of financial proposals tailored to each individual business' individual circumstances. Additionally, we anticipate that most employers will want assistance with explaining the ESI premium assistance to employees they believe may be eligible.

Because of the relationship they have with small employers and their experience working with employee benefit plans, insurance agents bring a valuable perspective to this process and should be included as partners working with DHS, QHPs and the TPA to ensure a coordinated strategy for educating and working with employers and employees.

To facilitate employers' understanding of the program and ensure a consistent, uniform messaging strategy throughout the state, we offer our services to DHS to assist in the development of employer and employee educational materials to ensure the information is clear, written in easily understood terms, and comprehensive in the explanation of how the program works. We have a highly trained, experienced group of agents who specialize in working with small business owners and urge DHS to use our expertise to develop user-friendly materials that sufficiently address the many questions employers and employees will have. Doing so will significantly reduce the volume of questions posed to DHS staff during the roll-out of the new program, will smooth the transition process for enrollees, and will likely increase initial participation in the ESI program.

Additional Provisions/Comments

Cost-Sharing Reductions & Cost Sharing Wraps

Because of the complexities of the cost sharing reconciliation process, we suggest that DHS work with QHPs to discuss the implementation of this important process to identify any concerns or problems and minimize operational issues that may occur. While we understand the concept is very similar to the HCIP process, differences between the two programs may require some modification due to program variations.

Eliminating Retroactive Coverage

On page 14, the application indicates that "individuals will become eligible for Arkansas Works coverage at the point that they apply for coverage under Title XIX." Later, on page 15 under "Waivers", 6th bullet, you request an exemption from the requirement to provide coverage "any time prior to the first day of the month in which an individual applies." Similar information is included in the table on page 17, under the *Use for Waiver/Expenditure Authority for §1902(a)(34*). These two statements appear to conflict; in the first, it appears coverage is effective on the day a person applies; in the second and in the table, it appears the intent is to make coverage effective the first day of the month in which an individual applies. To ensure consistency and avoid any confusion, we suggestion you consider refining the language as appropriate based on your intent.

Improving Program Benefit Design

As the participation in Arkansas Works continues to grow, addressing existing benefit structure and plan design requirements that encourage inappropriate use of care or are not cost-effective becomes increasingly important. Based on recent Legislative discussions and the State's increasing focus on Medicaid reform, we strongly recommend that DHS work with participating QHPs to review existing program design provisions to ensure requirements incentivize and reward employees for appropriate, responsible behavior. While there are numerous specific changes that should be addressed, an example is the requirement for enrollees to make co-payments for PCP visits and **no** co-payment requirement for Emergency Room (ER) visits. While the co-payment requirements may seem minor, the message to enrollees is that ER visits are acceptable and encouraged by the absence of a co-pay requirement. We want to increase the use of primary and send the message to enrollees that an ER visit is not a substitute for a visit to your PCP and should only be used for emergency situations.

While we do not want to discourage enrollees from accessing ER services when appropriate, we suggest imposing a small ER co-payment requirement that should be at least equal to, if not more than, PCP co-payment requirements. Ideally, we suggest removing co-payment requirements for all PCP visits as a clear message to enrollees that their first choice for care should be the PCP when appropriate. We also suggest evaluating co-pays for urgent care centers or clinics with extended office hours to ensure co-payment costs are also lower than those for ER services. Along with these changes, we would also like to see an ongoing, collaborative effort between DHS, QHPs, and providers to improve education of enrollees regarding the appropriate utilization of health plan benefits, with a focus on the importance of visiting their PCP.

This is just one obvious benefit design change that is consistent with the Arkansas Works philosophy of improving patient responsibility. ABCBS welcomes the opportunity to provide recommendations for additional plan design changes that we believe will further encourage the appropriate utilization of health care, improve cost effectiveness, and further promote the Arkansas Works goals of emphasizing personal responsibility, promoting work, and enhancing program integrity.

Trend Assumptions

In Section V, you propose an annual cost growth rate of 4.7%, consistent with the current waiver and suggest considering a higher trend assumption based on claims and utilization experience. As the market has evolved, enrollees have become more knowledgeable about getting coverage and how to access care in the system after they are covered. This has increased utilization and among a higher prevalence of individuals with greater health care needs. Arkansas' experience with Medicaid Expansion and Exchanges is similar to most other states and, in fact, had less cost increases to-date.

A trend in the 6-7% range may be more reflective of the market for the next few years. We would be glad to provide additional data and analysis to support this recommendation. Based on our financial experience, MLR, cost trends, and our own future projections, we would welcome the opportunity to meet with DHS and Optumas to discuss this decision prior to submission of the application to CMS.

In addition to medical trend, there are other factors that will drive increases in rates during the proposed waiver period. First, the ACA health insurer fee is scheduled to resume in 2018 and then increase. Second, the period of the initial waiver, 2014-2016, was supported by the federal transitional reinsurance program, which expires in 2017. This suggests a specific change to the 2017 rate levels

would be appropriate. Third, when Medicaid begins to apply quarterly out-of-pocket maximums within this program, cost-sharing reduction payments will have to increase. This increase should be included in the overall budget targets, even though this will not affect Marketplace premiums. Lastly, the State has previously reported that the original demographic composition projected for the initial waiver period ended up understating the Budget Neutral costs. Corrected demographic assumptions should be applied to establish a better 2017 budget neutral calculation."

Workforce Development

While we understand that federal requirements limit the direct linkage of Medicaid programs to work requirements, we believe that there are appropriate ways to effectively align with the "works" part of Arkansas Works. This would include collaborating with state, education and community organizations to support members with employment and career development. We look forward to the opportunity to provide leadership in this area.

Conclusion

As previously stated, we are impressed with Arkansas' innovative leadership and know that DHS understands the challenges of launching such a new program and sincerely appreciate your ongoing engagement with ABCBS and other stakeholders. We realize much of the work on implementation is just beginning, and many important decisions will be made in the days ahead. As the largest health plan in Arkansas, the largest QHP in both the Private Option and the Arkansas Exchange, a leader in the small employer market, and a partner with the State's health care practice and payment transformation programs, Arkansas Blue Cross Blue Shield is committed to supporting the State through this transition period and continuing our partnership in the years ahead. As you continue to develop the operational and go-to-market plans for Arkansas Works, we look forward to working with you to build a successful program and provide critical services to improve the health, workforce and economy for all Arkansans.

Thank you for the opportunity to provide these comments. Please let us know if you have any questions or would like additional information on any of the suggestions or comments.

From: Giamfortone, Joseph <joseph.giamfortone@hms.com>
Sent: Friday, June 17, 2016 11:55 AM
To: DHS DMS HCIW
Subject: Arkansas Works Public Comments-RW-NW (003).docx
Attachments: Arkansas Works Public Comments-RW-NW (003).docx

HMS is pleased to have the opportunity to provide our comments on Arkansas Medicaid's 1115 Demonstration Waiver application. Please see our comments that are attached.

Thank you for this opportunity to provide our views on this important topic.

Sincerely,

Joseph E. Giamfortone
Government Relations Director
HMS

June 17, 2016

Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

RE: Comments on the Proposed Extension for and Potential Modification to the 1115 Demonstration Waiver for the Health Care Independence Program

Health Management Systems, Inc. (HMS), is pleased to submit comments to the Arkansas Division of Medical Services, for consideration as it gathers information on the proposed extension to the Section 1115 waiver for the Health Care Independence Program known as *Arkansas Works*.

In accordance with guiding principles detailed in the 2016 Arkansas Works Act, HMS recommends several ideas in order to further promote and maximize employer based insurance and enhance program integrity.

Promoting & Maximizing Employer Based Insurance

In the waiver application, the Division describes the enrollment process, which includes a step to identify whether a Title XIX eligible individual is employed by a participating employer for purposes of assessing that individual's eligibility for the mandatory Employer Sponsored Insurance (ESI) Premium Assistance Program. Indeed, this process will help to identify individuals who have access to ESI, but are not currently enrolled in that ESI. However, there is no detail on how to confirm ESI that is self-reported in the application; activity to search for undisclosed ESI at application and throughout the coverage period; or the role of the qualified health plans (QHPs) in ascertaining and maximizing ESI throughout an applicant's coverage period.

Nationally, on average, over 10% of Medicaid members have additional forms of health insurance coverage. While having other health insurance coverage and being on Medicaid is permissible, both federal and state law, §1902(a) (25) of the Social Security Act and Arkansas General Statutes § 20-77-306, respectively, require that Medicaid pay last.

As such, HMS recommends the following additional steps to further promote and maximize ESI throughout various intervals in the Arkansas Works program while ensuring that Medicaid pays last.

Recommendations

1. Electronically validate applicant self-reported health insurance information at the point of enrollment.
2. Electronically search for undisclosed health insurance coverage at the point of applicant enrollment.
3. Ensure ongoing checks for changes to a Medicaid members' other health insurance coverage.

4. Develop a process by which QHPs must routinely leverage ESI when known, and continue to search for unknown ESI throughout the beneficiary's enrollment in the QHP.
5. Make the ESI Premium Assistance Program mandatory for employers.

Each of the above listed recommendations are detailed as follows:

1. **Validate Self-Reported Applicant Health Insurance Information**
   Today, as part of the application process, applicants' self-report enrollment in other health insurance coverage, albeit an employer sponsored plan, a spouse's plan, Medicare, COBRA, etc. Self-attestation is routinely accepted by states for its face value. However, in order for the insurance to be meaningful, and it is maximized as early in the process as possible, **HMS recommends such disclosed health insurance information be electronically validated at the point of enrollment**. This will allow Medicaid to be the secondary payer immediately upon consumption of services.

2. **Search for Undisclosed Health Insurance Information at Enrollment**
   Sometimes applicants do not realize they have other health insurance coverage, or they choose not to disclose the other health insurance out of fear of being disqualified for Medicaid. Hence, states including Arkansas, already employ processes to search for undisclosed health insurance coverage on behalf of Medicaid beneficiaries. However, today, there is approximately a lag time between 45-90 days from when an applicant is determined Medicaid eligible before a search is conducted for other health insurance coverage. Consequently, due to this lag time, Medicaid is often forced to seek retrospective recoveries for the most significant and costly consumption period.

   Furthermore, the lag time from the point of enrollment to the identification of, and coordination with, other health insurance coverage does not become any less problematic in the Arkansas Works model. In its waiver application, Arkansas proposes that any Arkansas Works beneficiary who does not select a QHP within 42 days will be auto-assigned a QHP, providing up to 42 days of interim fee-for-service (FFS) coverage.

   For these reasons, **HMS recommends that Arkansas move the prospective identification of other health insurance coverage as close to the point of enrollment as possible**. As an added benefit, the state will be able to reduce the pay and chase activity by validating disclosed coverage at enrollment and searching for undisclosed coverage at enrollment. This is very important because, while highly effective, unfortunately pay and chase efforts do not result in the recovery of all claims that should have been the responsibility of another health insurer.

   In fact, a federal audit report issued in January, 2013 by the Department of Health and Human Services, Office of Inspector General, states that challenges remain in recovery of overpayments due to other health insurance coverage. According to the report, "As of June 30, 2011, 44 States cumulatively reported $4.1 billion that they believe is owed by third parties and is at risk of not being recovered."

3. **Ensure Ongoing Checks for Changes to Other Insurance Coverage**
   Medicaid applicants' access to other health insurance coverage is dynamic. As their economic and employment situations change, so does their access to health insurance coverage, particularly ESI. Therefore, identifying health insurance coverage solely at time of application does not account for a Medicaid member's movement in and out of other health insurance coverage over time. For these

reasons, **HMS encourages the Division to continue to routinely search for changes to a Medicaid members enrollment in other health insurance coverage.**

4. **QHPs Must Play an Active Role in Promoting and Maximizing ESI**
The current and proposed waiver is silent on the role that QHPs will play in identifying and coordinating with other health insurance coverage for their enrollees.

Over the past 15 years, states have increasingly relied upon Medicaid Managed Care Organizations (MCOs) to provide services to the Medicaid population. In these instances, Medicaid must still remain the payer of last resort. Arkansas Works role for QHPs can be likened to the usage of MCOs by other states and policies must be in pace to ensure the QHPs are searching for unknown and coordinating with known, other health insurance coverage.

There are numerous models that Arkansas could elect as detailed in an August, 1997 State Medicaid Director letter and referenced immediately below. All of these models are evident across states today and will be just as important for Arkansas to consider in its Arkansas Works program:

1. Exclude or dis-enroll individuals with known TPL from enrollment in MCOs (QHPs in Arkansas' case).
2. Allow individuals with TPL to receive coverage through MCOs (QHPs), with the state retaining TPL responsibility.
3. Require Medicaid MCOs (QHPs) to assume TPL responsibilities through a reduction in capitation payments reflecting the amount of projected TPL the plan should recover or has historically recovered.
4. Exclude or dis-enroll individuals with commercial managed care TPL coverage. Allow individuals with noncommercial (i.e., Medicare) managed care TPL coverage to receive Medicaid services through the MCO (QHP), with the MCO (QHP) assuming TPL responsibilities, but the state retaining responsibility for tort and estate recoveries.

HMS recommends that the Arkansas Division of Medical Services:

1. Select a model for TPL as described above.
2. Ensure that clear language identifying the QHP's TPL responsibilities is included in the waiver and MOU between the state and the QHP.
3. If delegating any TPL responsibilities to the QHPs:
   a. Account for TPL in the capitation rate setting process and ensure proper payment incentives are in place to reflect and maximize QHP TPL efforts.
   b. Require TPL results reporting from the QHPs and detail reporting requirements in the final MOU between the QHP and the state.
   c. Ensure proper oversight by the state through TPL safety net reviews, no sooner than one year from the date of service.

5. **Make the ESI Premium Assistance Program Mandatory for Employers**
HMS applauds the state of Arkansas for its proposal to include a mandatory ESI Premium Assistance Program as part of this waiver application. This requirement will help to ensure that Arkansas Medicaid will remain the payer of last resort and help to maximize ESI.

Medicaid agencies implement premium assistance programs to pay for Medicaid beneficiaries' commercial premium contributions when the beneficiaries' annual medical expenses outweigh the

cost of their annual premium contribution. Such programs save states millions each year by appropriately redirecting the health insurance costs to the responsible commercial insurer and maintains Medicaid's payer of last resort status. Beneficiaries frequently find these programs attractive because in many cases, the whole family can receive coverage under the commercial insurance policy, at no additional cost to them or to Medicaid. Additionally, beneficiaries generally have access to more providers because commercial insurers have historically enjoyed greater provider participation than experienced by Medicaid. At the same time, providers also find premium assistance programs attractive because reimbursement rates are generally higher under commercial insurance coverage as compared to Medicaid reimbursement rates.

The most successful premium assistance programs nationally mandate not only beneficiary participation, but also, employer participation. Without a mandate for both, success of the premium assistance program is significantly stymied. An employer mandate in the Arkansas ESI Premium Assistance Program is not a mandate to offer health insurance coverage to employees, rather it is a mandate requiring employers to share health insurance coverage information with the state in order to determine if Medicaid applicants and members have access to ESI, but are not enrolled.

Historical opposition to the employer mandate has been riddled with fallacies. Opponents have alleged that such programs increase costs to employers by shifting the coverage responsibility from Medicaid to the employer, particularly when such programs seek to identify the most costly Medicaid beneficiaries.

First, it's important to note that the employer is already offering health insurance coverage to the Medicaid applicant/beneficiary, but for whatever reason the Medicaid applicant/beneficiary is not enrolled in the ESI. Second, cost effectiveness tests often leverage historical utilization data to ensure it makes financial sense for Medicaid to pay the employee's premium share for the ESI. In the case of Arkansas Works, utilization will not be part of the cost effectiveness test. As a result, any argument of dumping high cost Medicaid beneficiaries back onto the employer is simply not accurate.

Lastly, concerns that by adding these otherwise eligible members onto their ESI will increase costs for the employer should also be rejected. The Affordable Care Act contained numerous rating rules that limit an insurer's ability to increase premium costs for employers and again, these employees, and dual Medicaid beneficiaries, were already entitled to participate in the ESI.

HMS highly recommends that Arkansas mandate employer participation in the ESI Premium Assistance Program. Additionally, should Arkansas maintain a phased in approach to the ESI Premium Assistance Program, **HMS recommends that the state start implementation of the ESI Premium Assistance Program with large employers, rather than small as currently proposed in the draft waiver.** This will help create a more sustainable program, and maximize the savings to the state in the most efficient way possible.

Enhancing Program Integrity

Program Integrity Roles and Responsibilities Given that QHPs are similar to MCOs, and QHP coverage is funded by state and federal taxpayer dollars, **HMS strongly recommends that Arkansas revisit what program integrity looks like in Arkansas Works - what efforts must be conducted to ensure taxpayer dollars are appropriately spent and by whom.**

States and MCOs have struggled with these questions for years and several state and national reports highlight the challenges with program integrity in a managed care environment, which is again directly pertinent and conveys to Arkansas Works use of QHPs. In a December 2011 report by the Department of Health and Human Services Office of Inspector General (OIG), *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards, it* noted the key vulnerability as services billed by providers, but never actually rendered. In this same report, the MCOs and States expressed concerns about provider and beneficiary fraud and abuse, including rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and pharmaceutical abuse by beneficiaries.

In June 2014, the Government Accountability Office (GAO) released a report, *Medicaid Program Integrity Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, highlighting significant gaps in state and federal efforts to ensure Medicaid managed care program integrity. The report did not detail how states or the federal government should specifically apply program integrity oversight, but rather focused more generally on areas that need more oversight, including a recommendation to require states to audit payments to and by MCOs. The report also recommended that CMS update guidance on MMC program integrity and provide audit tools and assistance to states for this purpose.

In May 2016, CMS released final rules, that in part, provide additional guidance on the roles and responsibilities for program integrity in a Medicaid managed care environment. *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability* proposes some basic program integrity roles by party. For example, MCOs have to report overpayments to the states within 60 days; states have to screen and enroll all MCO network providers, review the accuracy and completeness of encounter data, and validate medical loss ratio (MLR) annual reports, just to name a few. **HMS recommends that Arkansas leverage the new MCO rules to devise a principled, strategic approach for that includes**:

1. Seeking subject matter expertise to develop a compliant, comprehensive, transparent and collaborative program integrity approach in Arkansas Works.

Oversight in a managed care-like environment is distinctly different than oversight in FFS. Expertise is needed to understand and mitigate against pitfalls and leverage lessons learned from more mature managed care and managed care-like models.

2. Implementing wide-ranging, but coordinated program integrity strategies concurrently with the launch of Arkansas Works.

Many states focus on operations when rolling out Medicaid managed care and Medicaid managed care-like programs, but equal effort should be applied to the administration, including the application of program integrity initiatives. Doing so ensures that the inherent promises of managed care, and in Arkansas' case, QHP coverage, which includes better, more cost effective care, are in fact realized.

At the same time, many states take an initial, narrow approach to program integrity in a managed care environment which hinder these promises. For example, states sometimes hinge program integrity efforts on the timely reporting of encounter data, but do little, if any, analysis of the encounter data or review the analysis done by the MCOs. A broader approach to program integrity that includes substantive contract

compliance, quality measures and ongoing reviews of payments to QHPs and payments by QHPs is highly recommended.

3. Ensuring clear delineation of program integrity responsibilities between the QHPs and state staff and/or state contractors through MOUs and/or statutory and/or regulatory guidance.

There is an appropriate role for each of these entities, but it's imperative for ease of administration and efficiency that the roles and responsibilities be clearly defined, coordinated and results shared. Without this, duplication and provider and payer abrasion is likely. Care to beneficiaries may also be compromised. Furthermore, areas in need of additional oversight may go undetected without clear and transparent roles and responsibilities.

4. Providing adequate remuneration and incentives to all entities responsible for oversight.

Any worthwhile program integrity initiative drives significant return on investment; however, upfront and ongoing resources are required to maintain these efforts. It's important that states recognize these costs and account for them both in terms of ensuring the rightful assignment of these responsibilities, as well as properly remunerating the responsible entity for carrying out assigned responsibilities.

5. Imposing sanctions for noncompliance.

Like many compliance programs, application of both incentives and disincentives is necessary to ensure the assigned responsibilities are completed accurately, and if not, there are tools available to change behavior.

HMS applauds Arkansas for their vision in moving the Medicaid program forward through Arkansas Works. We appreciate the opportunity to submit these comments and look forward to providing any additional information that the Division may need to assist them in this process.

Sincerely,

Joseph E. Giamfortone
Director, State Government Relations

From: Marquita Little <mlittle@aradvocates.org>
Sent: Friday, June 17, 2016 10:14 AM
To: DHS DMS HCIW
Cc: Rich Huddleston; Dawn Stehle
Subject: 1115 Waiver Comments from AACF
Attachments: AR Works Comments_AACF 6.17.16.pdf

Attached please find comments from Arkansas Advocates for Children and Families on the 1115 demonstration waiver. Thank you for the opportunity to submit comments on the Arkansas Works plan. We look forward to continuing to work together to ensure all children and families in Arkansas can live healthy, productive lives.

Thanks,

Marquita Little

Marquita Little | Health Policy Director
Arkansas Advocates for Children and Families
Union Station, Suite 306, 1400 West Markham St.
Little Rock, Arkansas 72201
Office (501) 371-9678, Ext 119 |Mobile (501) 256-2796
mlittle@aradvocates.org

June 17, 2016

Dawn Stehle, Division of Medical Services Director
Arkansas Department of Human Services
P. O. Box 1437, Slot S295
Little Rock, Arkansas 72203-1437

Ms. Stehle:

Arkansas Advocates for Children and Families (AACF) applauds the work to continue the Medicaid expansion program in Arkansas. Because of the great success of the Private Option, Arkansas leads the nation in reducing the number of uninsured adults. Over 250,000 low-income Arkansans now have comprehensive health coverage, many for the first time. Moving forward, the transition to Arkansas Works will safeguard access to coverage for hundreds of thousands of hard-working families.

AACF also appreciates the thoughtful process that allowed stakeholders to have an active voice in shaping the program and offering Governor Hutchinson and legislators important feedback through the Health Reform Legislative Task Force. This demonstrates the commitment from leaders in our state to ensure all Arkansans, including the most vulnerable, have access to care regardless of their income and also a commitment to transparency and public engagement.

There are several concerns that we would like to highlight as the state moves forward with the implementation of Arkansas Works.

Employer Sponsored Insurance (ESI)

Our key concern regarding introducing subsidized ESI as a feature of the Arkansas Works program is the need for careful coordination to ensure the program is easy for enrollees to understand, navigate, and access their full benefits package. Many of the individuals enrolling in ESI have previously had to make contributions through an Independence Account. DHS should ensure these individuals are appropriately informed about changes to their coverage and counseled about how to pay the monthly premium, access doctors in the network, and other key changes. We learned a great deal about the importance of a simple and well-coordinated process from the complicated and costly implementation of the Independence Accounts. Both the necessary resources and time must be allocated to develop the needed IT platform and a coordinated system. For example, DHS should also explore solutions that will not require enrollees to carry two cards, both the ESI card and Arkansas Works

card, to avoid any confusion for providers and enrollees. This approach may be the best option today to ensure wraparound benefits are accessible, but DHS should consider the possibility of rolling out a single card with a special designation for Arkansas Works enrollees in the future.

We also are very concerned about the ability for beneficiaries to access benefits and cost-sharing protections provided as a wraparound to their ESI coverage. We appreciate the state's commitment to ensuring that benefit and cost-sharing protections are made available to beneficiaries. However, research has shown that there are reasons to be concerned about the implementation of premium assistance programs that wrap around employer-sponsored coverage. In particular we wish to clarify that all providers in the employer's network, regardless of whether they participate in the Medicaid program, will be required to charge Medicaid's lower cost-sharing levels and educated on the need to do so. This is important since Medicaid consistently offers enrollees more affordable coverage than ESI.

In addition, accessing services that may not be available under ESI may prove challenging for beneficiaries. Again, it is important to ensure that an ESI participant is not required to go to a Medicaid participating provider for a covered service and that providers who have not previously worked with Medicaid will understand that wraparound services are available and how to bill using a patient's client identification number.

DHS should also articulate how transitions will be managed if an enrollee becomes unemployed and is no longer qualified to be covered by ESI. This will require a seamless transition to a QHP to ensure there are no gaps in coverage.

The state should not seek a waiver to avoid providing non-emergency transportation to enrollees covered through ESI. Research shows that lack of transportation reduces utilization of health care services among low-income people. While many families may rely on alternative methods, like public transportation for their routine travel to and from work, their access to transportation to doctor's appointments may still be limited. In addition, in most parts of the state, public transit is not even available. Non-emergency transportation is a critical benefit that can help to prevent chronic conditions, such as diabetes and cardiovascular disease, from worsening.

The waiver indicates ESI sponsored coverage may be expanded to spouses or dependents of Medicaid-eligible individuals in the future. We strongly recommend DHS maintain the current ARKids First program because it's working for kids and families. The ARKids First program has been hugely successful in reducing rates of uninsured children in our state to under 5 percent and ensuring they receive comprehensive, affordable coverage. We have serious concerns about the likelihood of successfully providing the EPSDT benefit for kids through an ESI wraparound. There is no clear rationale for disrupting coverage for kids. Unless it can be demonstrated that this would be a cost-effective option that does not reduce access to coverage or care, the ARKids program should continue to function as it does today.

90 Day Retroactive Eligibility

Medical emergencies are unpredictable and costly. The 90-day retroactive eligibility policy helps safeguard low-income families from incurring medical debts that they are unable to pay. Health care providers and the state also benefit from retroactive eligibility. Doctors and clinics are not left with unpaid bills for treatment they've provided, and the state has been able to reduce uncompensated care spending. Though the proposal to eliminate retroactive eligibility would create similar enrollment processes for Arkansas Works and insurance carriers, the financial risk of removing retroactive coverage outweighs any potential benefit. It is even more critical because of significant delays families currently experience between the time they complete the application and are successfully enrolled in a health plan. Finally, 90-day retroactive eligibility is essential, since the state has not implemented presumptive eligibility, which would allow individuals in need of care to enroll quickly and avoid the administrative delays that plague our system today.

Premiums for Enrollees

Although the state currently requires some enrollees to make payments to an Independence Account, the proposal to establish fixed monthly contributions (up to $19) would function like premiums. Federal regulations prohibit premiums for individuals earning less than 150% FPL. Also, extensive research shows that even small fees can be a barrier to enrolling in coverage and accessing treatment. Furthermore, enrollees will incur a debt to the state if the premiums are not paid. While this is an improvement from more dangerous proposals to lock individuals out of coverage, it will still create a hardship for many low-income families and depress enrollment.

In addition to the concerns raised above, AACF is proud of the steps our state has taken to continue to improve the health of enrollees. Offering incentive benefits to encourage enrollees to receive preventative care is an important feature of Arkansas Works. With adequate coordination and consumer outreach and education, this is a promising policy to support the health and well-being of Arkansans. We would also strongly encourage the state to engage AACF and organizations with expertise in health literacy to assist with the development and review of enrollee notices and educational materials. Consumer education will be critical to the successful implementation of these policy changes.

AACF is proud of the progress in Arkansas to maintain affordable coverage for uninsured adults, and we think it is vitally important to support the successful implementation of Arkansas Works.

We look forward to continuing to work together to ensure all children and families in Arkansas can live healthy, productive lives. Thank you for the opportunity to submit comments on the Arkansas Works demonstration waiver.

Respectfully,

[redacted]

Rich Huddleston
Executive Director
Arkansas Advocates for Children and Families

[redacted]

Marquita Little
Health Care Policy Director
Arkansas Advocates for Children and Families

From: Stephanie Malone <smalone@chc-ar.org>
Sent: Thursday, June 16, 2016 12:29 PM
To: DHS DMS HCIW
Subject: AR Works Waiver 1115 Comments
Attachments: Arkansas Works Waiver - CHCA Response 06-2016.pdf

Please see the attachments for comments regarding the 1115 Waiver. Please feel free to contact me with any questions or concerns.
Thank you

Stephanie Malone
Policy/Advocacy Director
Community Health Centers of Arkansas
Arkansas Primary Care Association
119 South Izard
Little Rock, AR 72201
501-492-8388
www.chc-ar.org

Community Health Centers of Arkansas, Inc.
ARKANSAS PRIMARY CARE ASSOCIATION
Expanding Access to Affordable Quality Health Care

June 16, 2016

Ms. Dawn Stehle
Arkansas Department of Human Services
Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

Dear Ms. Stehle,

On May 18, 2016, the Arkansas Department of Human Services, (DHS), Division of Medical Services (DMS) issued public notice of its intent to submit to the Centers of Medicare and Medicaid Services (CMS) a written application to request approval from the Secretary of the Department of Health and Human Services of the Arkansas Works Waiver which is a Demonstration Waiver under Section 1115 of the Social Security Act.

On behalf of the Community Health Centers of Arkansas, Inc. (CHCA) and our 11 member community health centers (also known as FQHCs) and their over 70 locations, please accept the following comments on the Arkansas Works Proposed Section 1115 Waiver. As providers of primary and preventive care services to nearly 165,000 low income uninsured and underinsured Arkansans, CHCA and its members applaud the State of Arkansas for its passage of the Arkansas Works legislation during the 90th General Assembly.

Under Section II, Changes Requested to the Demonstration, Item 1 "Implementing a Premium Assistance Program for ESI" will require all individuals enrolled in coverage through Employer Sponsored Insured premium assistance to receive two insurance cards – an ESI plan card and an Arkansas Works card. While the concept is commendable, it is the details that taunt us. Since this program appears to be a voluntary based program there is concern as to exactly how this would all work, especially with the issuance of two separate insurance cards. We have found that simplicity works best with our patient population, and anything that reduces confusion is beneficial. DHS has recently struggled with the eligibility and verification system required under existing CMS requirements and we are concerned with adding another "voluntary" set of verifications scenarios to check against. Again, the details of exactly how a dual insurance card system would be implemented greatly concerns us.

Item 2 " Instituting Premiums for Arkansas Works Beneficiaries with Incomes above 100% FPL" contain some creativity in the offering of incentive benefits for those that pay timely premiums. We applaud the recognition of healthy behaviors, though for clarification, such should be clearly defined. Placing an additional financial burden on this patient population, even though minor in the eyes of you and I that make well in excess of the federal poverty level, can impact access to medical care to our most vulnerable in need of medical care. And, we feel strongly that dental care should be a standard medical care not an "incentive". Many overall health problems can be attributed to oral health and we are concerned that using dental care as an "incentive" is sending absolutely the wrong message about the importance of oral health. If you want to add an incentive, add teeth whitening, or membership to a fitness center.

Under Section III, Waiver 1902(a)(34) "to enable the State not to provide medical coverage to Arkansas Works, beneficiaries for any time prior to the first day of the month in which individual applies" puts an extra burden on the providers that we are sure is unintended. Many of the patients first come to see us without all the proper paperwork for enrollment in insurance coverage, though we work directly with each individual the first time we see them. Medicaid has worked very closely with us and many other providers as we worked through "presumptive eligibility" classification and eventually get proper documentation on our patients. Without such a window of time to get this paperwork done, Medicaid providers will not be able to take patients, and access to care for this patient population will be affected.

And, lastly, under Section III, Waiver 1902(a)(4) insofar as it incorporates 42 CFR 431.53: "To the extent necessary to relieve Arkansas of the requirement to assure transportation to and from medical providers for Arkansas Works beneficiaries enrolled in ESI premium assistance". FQHCs are extremely concerned about the removal of non-emergency transportation as many of our clients rely on this service, especially when it comes to receiving specialty care not available in rural Arkansas. This will create an out of pocket burden on the already struggling class, due to this burden many will stay home and avoid receiving proper care because they cannot afford a trip to the doctor, causing their health to deteriorate and in the long run will cost the state more money. We strongly request this language be removed all together.

Thank you for your attention to our comments. Should you need any clarification to any of our comments, please do not hesitate to contact Community Health Centers of Arkansas at 501.492-8384.

Sincerely,

[redacted]

Mary Leath
Chief Executive Officer

From: Shanna Hanson <shanson@humanarc.com>
Sent: Thursday, June 16, 2016 12:03 PM
To: DHS DMS HCIW
Subject: Waiver Comments
Attachments: Arkansas Works Waiver Comments-Human Arc.doc

Director Stehle,

Please accept the attached Comments on the Arkansas 1115 Waiver Extension Application.
We are available for consultation if we can be of any assistance in this process.

Respectfully Submitted,

Shanna Hanson, FHFMA
Manager, Business Knowledge
Human Arc
Phone: 800.278.5135, x7167 | Fax: 816.363.3535
1001 E 101st Terrace, Suite 210 | Kansas City, MO 64131
shanson@humanarc.com | www.humanarc.com

June 16, 2016

Dawn Stehle, Director
Division of Medical Services
Program Development and Quality Assurance
P.O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437
HCIW@Arkansas.gov

RE: ARKANSAS 1115 WAIVER EXTENSION APPLICATION

Dear Director Stehle:

Thank you for the opportunity to Comment on the Arkansas 1115 Waiver Extension Application (Arkansas Works), published for comment on May 18, 2016 at medicaid.state.ar.us.

I started Human Arc in 1984 with the sole purpose of bridging the gap between available government programs and their intended beneficiaries. Human Arc has expanded over the past 32 years to help hospitals and health plans connect their patients and members to governmental programs and community services. We have helped well over a million people in unfortunate circumstances enroll in Medicaid and have helped many millions find food, clothing, shelter, prescriptions and more. Human Arc has 550+ associates serving the low-income, disabled and elderly population for customers across 40 states. We are a for-profit organization financed by the value received by our customers. **We believe our long history of working with the low income population gives our voice credibility.**

We appreciate the intention of Arkansas Works to emphasize personal responsibility, promote work, and enhance program integrity. **Our greatest concern** with Arkansas Works is the elimination of retroactive eligibility for the expansion population.

RECOMMENDATION

- We propose that the application process be adjusted to allow for 90-days retroactive coverage from submission of application (as it is in current law - 42 U.S.C. §1396(a)(34)), allowing for provider reimbursement during the 90-day period prior to application if an applicant has medical bills during the current month or prior period. Below is a detailed explanation supporting our recommendation.

WAIVER OF RETROACTIVE COVERAGE

The ramifications of the Arkansas Works waiver, as written, will substantially impact the low-income expansion population of the state, particularly those that are uninsured, eligible for Medicaid and in need of health care services. It will also adversely impact the medical providers trying to serve them. Gaps of time without medical coverage for the low income population that are eligible and applying for Medicaid will be significant. Every day we experience situations where uninsured individuals present at a hospital requiring emergency medical treatment and many times are unable to manage an application process due to mental health issues, lack of capability, illness and a myriad of other reasons. In many cases they are unaware of their eligibility for a Medicaid program.

Retroactive eligibility was first enacted in 1972 to protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying. The provision was amended in 1973 to provide retroactive coverage for persons who died before eligibility could be claimed.[1] This is codified at 42 U.S.C. §1396(a)(34). The Social Security Program Operations Manual System (POMS) states that "Retroactivity is very important.[2]" Is it any less important for the Arkansas Works intended beneficiaries? We believe it is important, even critical, for **all** Medicaid applicants to have access to retroactive Medicaid coverage both for the reasons stated by Congress when it was legislated as well as those we have outlined below.

The following comments and rationale will illustrate that the Arkansas 1115 Waiver Extension Application **does not meet the following criteria** used by the Center for Medicare and Medicaid Services to determine whether Medicaid program objectives are met relative to providing retroactive coverage:

- Increase and strengthen overall coverage of low-income individuals in the state.
- Improve health outcomes for Medicaid and other low-income populations in the state.

Gap in coverage

- **Gap could be days to months or more:** The gap in coverage that will be created by the elimination of retroactive coverage could be devastating to those newly enrolled Arkansas Works recipients who received services prior to their start date. This gap could be substantial, particularly if an individual is denied, requests an appeal which is sustained and eventually overturned. The time frame for application processing could be days to weeks to months or more. Since there is not adequate coverage after a health care emergency, due to the delay from the application process the likelihood of following the intended continuum of care is reduced and health outcomes will be impacted.

Medical Debt

- **Collections, bankruptcies:** Lacking insurance coverage puts people at risk of medical debt. In 2014, according to the Kaiser Family Foundation analysis of 2014 Kaiser Survey of Low-Income Americans and the Affordable Care Act nearly a third (32 percent) of uninsured adults said they were carrying medical debt. Medical debts contribute to over half (52 percent) of debt collections actions that appear on consumer credit reports in the United States and contribute to almost half of all bankruptcies in the United States. Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.[3]

- **Stress:** Collection agencies will be pursuing more people; further stressing the financial, physical and mental health of uninsured and underinsured adults.

The following comments and rationale will illustrate that the Arkansas Works 1115 Demonstration Waiver **does not meet the following criterion** used by the Centers for Medicare and Medicaid Services to determine whether Medicaid program objectives are met:

- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state.

Financial

- **Lost reimbursement:** Millions of dollars annually could be lost in Medicaid reimbursement to hospitals alone, not including other medical providers. Lost Medicaid reimbursement de-stabilizes providers by shifting the cost of care back to the hospitals.

- **Increased expenses and write-offs:** Providers will experience an increase in charity care, and bad debt. The elimination of 90-day retroactive eligibility and reimbursement for serving Arkansas Works beneficiaries will add stress to self-pay collections. Providers must have a margin to continue providing care. Arkansas Works will not strengthen providers or their networks if they cannot pay their bills. No margin, no mission.

CONCLUSION

Human Arc believes the evidence shows that the bulk of the savings will come at the expense of the low income uninsured expansion group through the elimination (waiver) of retroactive Medicaid coverage. The estimated savings are really a shifting of costs to the low income uninsured and the medical providers that serve them.

To reiterate, our greatest concerns with the Arkansas Works Program 1115 Demonstration Waiver is the **Waiver of retroactive eligibility.**

We believe we have demonstrated that the waiver of retroactive coverage in the Arkansas Works program do **not meet the criteria used by the Centers for Medicare and Medicaid Services to determine whether Medicaid program objectives are met.**

We recommend that the application process be adjusted to allow for 90-days retroactive coverage from submission of application, allowing for provider reimbursement during this same time period.

We are available for consultation at your request. Thank you again for the opportunity to be heard in this Comment process.

Respectfully,

Michael J Baird
Chief Executive Officer
Human Arc
1457 E 40th Street
Cleveland, Ohio 44103
mb@humanarc.com
216.426.3510 direct
216.849.8493 mobile

References

[1] 99 Pa. Commonwealth Ct. 345 (1986), 514 A.2d 204, William Martin, Petitioner v. Commonwealth of Pennsylvania, Department of Public Welfare, Respondent. No. 2351 C.D. 1984. Commonwealth Court of Pennsylvania. Argued March 11, 1986. July 30, 1986. https://scholar.google.com/scholar_case?case=8264689460606004823&q=1396a(34)&hl=en&as_sdt=6,36 percent20-percent20r[13]#r[13]

[2] SI 01715.001 Medicaid and the Aged, Blind and Disabled C. 3., Program Operations Manual System (POMS), Social Security Administration, https://secure.ssa.gov/poms.nsf/lnx/0501715001

[3] *Ibid*

From: Bo Ryall <boryall@arkhospitals.org>
Sent: Monday, June 13, 2016 12:35 PM
To: DHS DMS HCIW
Subject: Comments on Arkansas Works Waiver
Attachments: 6-13-16 Arkansas Works Regulations Letter.pdf

Attached, please find comments on the Arkansas Works Waiver application submitted on behalf of the Arkansas Hospital Association.

Thanks,

Bo Ryall
Arkansas Hospital Association

ROBERT "BO" RYALL
President & CEO

June 13, 2016

Ms. Cindy Gillespie, Director
Arkansas Department of Human Services
P. O. Box 1437 (Slot S295)
Little Rock, Arkansas 72203-1437

Dear Ms. Gillespie:

The Arkansas Hospital Association (AHA), on behalf of its 100 member organizations and their combined 45,000-plus employees, expresses its appreciation for the opportunity to comment on the potential impact of proposed regulations that would implement the new Arkansas Works program.

As a membership organization with a mission to safeguard hospitals' operational effectiveness in advancing the health and well-being of their communities, the AHA is strongly supportive of the Arkansas Works program now being developed to continue Arkansas's unique and highly successful approach for providing affordable healthcare coverage for eligible low-income Arkansans. We are confident that Arkansas Works will continue to build and improve upon the successes of the Arkansas Private Option, which has helped Arkansas hospitals to retain their ability to serve patients throughout our state.

Specifically, the AHA applauds Governor Asa Hutchinson and the Arkansas Legislature for engineering Arkansas Works, which promises to maintain access to affordable healthcare for our poorest citizens and to strengthen the qualified health plan premium assistance model by emphasizing personal responsibility, promoting work, and enhancing program integrity. As Arkansas's healthcare system continues to improve and as the uncompensated care absorbed by hospitals is reduced, our hospitals stand a better chance to remain financially viable – even in the face of losing more than $2.5 billion in federal cuts related to Medicare payment cuts that have been implemented nationally through the Affordable Care Act (2010), the Budget Control Act of 2011 (sequestration), two separate Tax Acts in 2012, and various regulation changes.

However, the AHA has two major concerns with the Arkansas 1115 waiver extension application. First, and most importantly, the AHA would request to strike or modify §1902(a)(34) that would prohibit medical coverage to Arkansas Works beneficiaries for any time prior to the first day of the month in which the individual applies.

Unfortunately, the Arkansas Department of Human Services (DHS), Division of Medical Services, has been unable to implement the federal requirement for presumptive eligibility detailed in 42 CFR 435.1110. In practice, in place of presumptive eligibility, the department has allowed a 90-day period of retroactive coverage for beneficiaries who are deemed eligible for Private Option plans during the past two years. Should §1902(a)(34) be implemented, we are concerned that an otherwise-eligible beneficiary will be saddled with large amounts of healthcare debt that could have been avoided.

While the AHA encourages DHS to implement the already federally required provisions of "presumptive eligibility," an option would be to put in place an appropriate time-period of at least 60 days of retroactive

coverage. One of these solutions would not only be more beneficial to the patient, but would also more aptly enhance hospital discharge coordination options for patient care planning, which can reduce costly repeated hospital admissions. Retroactive coverage of at least 60 days or implementation of presumptive eligibility are far superior to the current proposal set forth in §1902(a)(34).

Also, while the AHA applauds the voluntary option for employers to be incentivized to offer insurance to their employees, the AHA has concerns that the current eligibility and enrollment systems within DHS are not able to efficiently perform the tasks that will be required to implement the details included in the proposed waivers. Specifically for the ESI population, the AHA is concerned that the patient experience will be less than ideal – due to cumbersome administrative processes – and will result in poor patient satisfaction scores. For example, it is anticipated that a patient who has selected to keep his employer-sponsored insurance with wrap-around benefits from Medicaid would need multiple healthcare identification cards in order for a healthcare provider to be able to receive appropriate payments for caring for that patient. Once the patient is seen, the provider would have the added burden to discern which bills go to the patient versus Medicaid versus the employer sponsored insurance.

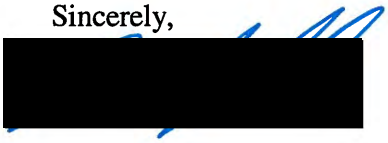
The rise of consumerism is having a major influence on healthcare delivery. As a result, patient satisfaction is becoming very important as a hospital quality measure and is more closely tied to reimbursements from public and private payer groups more than ever before. Because the hospital admissions process, which already is heavily laden with inefficiencies brought about by administrative burdens that actually harm the patient care experience, the AHA requests that DHS help to relieve patients and providers of these burdens at the point of care.

As noted by Secretary Burwell in her letter dated April 5, 2016, addressing the well-documented inadequacies with the existing eligibility determination and enrollment systems would be a step in that direction. Adding additional tasks and functionality to an existing system, as required under the waiver request, is counterproductive to creating a more efficient system, at best. Therefore, the AHA asks that DHS improve its enrollment and eligibility systems with the end-users in mind so that employers are truly incentivized to keep their employees insured.

Arkansas's hospitals, which employ about 45,000 Arkansans with a payroll of about $5 billion, go to great lengths to provide needed services to the people in our state in a high quality, cost effective manner. The AHA and its members look forward to continuing to work with Governor Hutchinson, the legislature, both the government and private sectors, and our patients to improve the health of people, leading to healthier families, healthier hospitals, and stronger communities in Arkansas.

Once again, thank you for this opportunity to make our concerns known.

Sincerely,



Bo Ryall
President/CEO

BR/ae

419 Natural Resources Drive • Little Rock, Arkansas 72205 • (501) 224-7878 • Facsimile (501) 224-0519

From: Skip Estes <skipestes@sbcglobal.net>
Sent: Thursday, June 09, 2016 8:12 PM
To: DHS DMS HCIW
Subject: Private Option

Why should anyone make any comments on the private option or changes to it? It is already a done deal, or that's how it appears. It is absolutely shameful that the option allows for people with a large amount of assets to qualify for Medicaid while others, in particular retired people, cannot qualify, simply because they may have monthly income slightly over the amount which automatically disqualifies them!!! Therefore, you can have a neighbor who has real estate worth several million dollars but who has a monthly income of below the $2,000/monthly qualifying limit alongside a retired person who may have monthly income slightly above the qualifying limit but not much in savings. Isn't it nice that retired people get to pay over $1,200/mo. for healthcare coverage and drugs that requires them to withdraw money from their IRAs just to pay for their health insurance and drugs. Meanwhile, Joe Blow with the real estate qualifies for Medicaid?!?! What about this situation makes it a good deal for people who have worked their entire lives and who finally get to retire, but who have to immediately use their savings to pay for health insurance and drug costs?????

From: Roland Robinson <rolandr47@yahoo.com>
Sent: Saturday, May 28, 2016 5:04 AM
To: DHS DMS HCIW
Subject: Medicaid Expansion

I fully support Expansion, I'm not in favor of requirements for deductibles or co-pays. I do support strenuous eligibility screening and life skills counseling availability as opposed to mandatory job seeking requirements or registration for employment.
I do favor case management from a strictly medical necessity standpoint.
Thanks

Sent from my iPad

From: Richard Bing <richbing@sbcglobal.net>
Sent: Friday, May 27, 2016 2:20 PM
To: DHS DMS HCIW
Subject: Private Option Changes Feedback

Amy

I read the article about you not receiving any feedback on the Private Option changes in the paper today. I think that's disappointing because I think the private option and the Affordable Care Act are truly a positive improvement for the country and Arkansas.

Prior to 2014 my wife and I had health insurance through her employment. She left her company in 2013 because of her extreme medical conditions. The high priced Cobra health insurance they made available ran out and we were left without medical insurance. Luckily, the ACA / PO kicked in and we were able to get affordable medical insurance through Healthcare.gov. She currently still obtains her Medical insurance through healthcare.gov. I have turned 65 and I am now on Medicare. She is not 65 yet and will need to be on the Private Option medical insurance for 2+ more years.

I have worked full time since I was 22 years old, after graduating from college. I contributed significantly in taxes and social security for 43 years. She graduated in '84 from Nursing School with a RN degree. She worked as an RN or RN Manager for almost 30 years, again contributing significantly. Unfortunately she had to leave the profession due to arthritis and Crohn's. She is not illegible for SS or retirement yet, but I hope we can survive financially until she turns 65 / 66. We do have income and probably not be legible for a much assistance this year.

- **Paying an additional $19 per month is not appreciated. It's just another "gotcha" for people that truly need assistance paying for medical insurance. Most people have contributed substantially and this seemed like an insult.**
- **Yes, let's ensure that all employers provide medical insurance. I think this was for the smaller employers and they need to realize that if you have a business you've got to plan for this. Take some ownership.**
- **Have we gotten Wal-Mart and other big companies to belly up to the bar yet and provide medical insurance for all ee's if they want it and quit playing the PT game.**
- **Dental insurance is a great option. To purchase it your self is expensive too.**

My wife and I are truly grateful the Affordable Care Act is up and running. There are changes that need to be done but the overall structure is good. Now, if we could get "all" politicians to earnestly make the changes that need to be made. We are happy too that the state of Arkansas realized the Private Option needed continuing. There would have been a lot of unhappy voters if they had trashed it.

Overall all insurance price will lower if everyone has insurance. The more in the better. Yes, we do need to address the games that individuals, medical providers, insurance companies, hospitals and state governments play. Better things take time.

Thanks for soliciting feedback

Richard Bingenheimer

501.851.6801

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Administrator
Washington, D.C. 20201

December 8, 2016

Ms. Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Dear Ms. Gillespie:

The Centers for Medicare & Medicaid Services (CMS) is approving an extension of Arkansas' Medicaid section 1115 demonstration project entitled, "Arkansas Works" (Project Number 11-W-00298/1), originally entitled, "Arkansas Health Care Independence Program." The demonstration is approved on December 7, 2016 in accordance with section 1115(a) of the Social Security Act (the Act). The demonstration is effective on January 1, 2017 and is approved through December 31, 2021, assuming the state fulfills the requirements outlined within the special terms and conditions (STCs).

Under the Arkansas Works demonstration, the state will continue using premium assistance to purchase qualified health plans (QHPs) offered through the individual market in the Marketplace for those eligible for expanded coverage under Title XIX. In addition, the demonstration will establish a mandatory cost-effective small group employer sponsored insurance (ESI) program for the new adult group that has an offer of coverage from a qualified small group employer. Both the QHP premium assistance and ESI program will comply with federal requirements regarding cost sharing, benefits, and cost effectiveness.

Arkansas Works beneficiaries with incomes at or below 100 percent of the federal poverty level (FPL) will not be subject to premiums or cost sharing. Arkansas Works enrollees with incomes above 100 percent of the FPL will be required to pay monthly premiums of up to 2 percent of household income, regardless of whether they obtain coverage through ESI premium assistance or through QHPs. This premium contribution is in lieu of monthly contributions to Independence Accounts previously authorized under the demonstration. The Independence Account program is formally terminated with the approval of this renewal. Individuals who do not pay their premiums in a timely manner will incur a debt to the state. Individuals with incomes above 100 percent of the FPL will continue to be subject to point-of-service cost sharing consistent with Medicaid limits (no more than 5 percent of quarterly household income), regardless of whether they obtain coverage through ESI premium assistance or through QHPs.

The demonstration includes a conditional waiver of retroactive coverage, with implementation of the waiver conditioned upon the state coming into compliance with statutory and regulatory requirements related to the determination of eligibility. The demonstration provides authority for

the state to not offer non-emergency medical transportation for individuals covered through ESI premium assistance who have not demonstrated a need for such services.

The authority to deviate from Medicaid requirements is limited to the specific waivers and expenditure authorities described in the enclosed lists, and to the purposes indicated for each of those waivers and expenditure authorities. The enclosed STCs further define the nature, character, and extent of anticipated federal involvement in the project, and the state's implementation of the waivers and expenditure authorities, and the state's responsibilities to CMS during the demonstration period. Our approval of the demonstration is conditioned upon the state's compliance with these STCs. Our approval is further subject to CMS 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 these demonstrations is Ms. Jessica Woodard. She is available to answer any questions concerning your section 1115 demonstration Ms. Woodard'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
E-mail: Jessica.woodard@cms.hhs.gov

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

Mr. Bill Brooks
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
1301 Young Street, Suite 833
Dallas, TX 75202

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

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

Sincerely,

/s/

Andrew M. Slavitt
Acting Administrator

Enclosure

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: **Arkansas Works 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 Works Section 1115 demonstration.

The expenditure authorities listed below promote the objectives of title XIX by: increasing overall coverage of low-income individuals in the state, improving health outcomes for Medicaid and other low-income populations in the state, and increasing access to, stabilizing, and strengthening the availability of provider and provider networks to serve Medicaid and low-income individuals in the state.

The following expenditure authorities shall enable Arkansas to implement the Arkansas Works section 1115 demonstration:

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

2. **Premium Assistance Payments for Employer-Sponsored Insurance** Expenditures for the employee share of cost-effective small group employer-sponsored insurance when the employer contributes at least 25 percent of the overall cost of the coverage for individuals enrolled in the new adult group described in section 1905(a)(10)(A)(i)(VIII) of the Act, that would not meet the requirements for premium assistance under the state plan.

3. **Employer Incentives for New Or Expanded Employer-Sponsored Insurance.** Expenditures for the employer share of cost-effective small group employer-sponsored insurance attributable to individuals receiving premium assistance under demonstration expenditure authority #2, to the extent that the remaining employer contribution is no less than 25 percent of the overall cost of the coverage, limited to a three year period per employer and only for employers who either (1) offer coverage effective on or after January 1, 2017 and had not offered coverage in calendar year 2016 or (2) offer non-grandfathered small group coverage effective on or after January 1, 2017 and had previously offered only grandfathered coverage.

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, with respect to individuals covered under this demonstration through qualified health plans, 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 & MEDICAID SERVICES
WAIVER LIST

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

TITLE: **Arkansas Works 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 January 1, 2017 through December 31, 2021. 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 Arkansas Works beneficiary's Qualified Health Plan or Employer Sponsored Insurance. No waiver of freedom of choice is authorized for family planning providers.

2. Payment to Providers **Section 1902(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 or Employer Sponsored Insurance participating under Arkansas Works.

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, and for expedited review in exigent circumstances within 24 hours, rather than 24 hours for all circumstances 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. Premiums **Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A**

To the extent necessary to enable the state to collect monthly premiums for individuals with incomes above 100 up to and including 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.

6. Non-Emergency Medical Transportation **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to relieve the state of its obligation to provide non-emergency medical transportation to and from providers for individuals who are enrolled in employer-sponsored insurance and have not demonstrated a need for such transportation.

7. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to not provide retroactive eligibility for the affected populations. This provision will become effective 30 days after the later of CMS receiving written assurance from the state that it complies with the reasonable opportunity provisions in Section 1137(d) of the Social Security Act and CMS receiving written assurance from the state that the state has successfully completed the Arkansas MAGI Backlog Mitigation Plan as provided for in STC 20. The state shall also implement the Affordable Care Act provision on presumptive eligibility determinations by qualified hospitals as provided for in STC 20.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Arkansas Works**

AWARDEE: **Arkansas Department of Human Services**

I. PREFACE

The following are the amended Special Terms and Conditions (STCs) for the Arkansas Works section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Arkansas Department of Human Services (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. Enrollment into the demonstration will be statewide and is approved through December 31, 2021.

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. Arkansas Works Premium Assistance Enrollment
VI. Premium Assistance Delivery System
VII. Benefits
VIII. Premiums & Cost Sharing
IX. Appeals
X. General Reporting Requirements
XI. General Financial Requirements
XII. Monitoring Budget Neutrality
XIII. Evaluation
XIV. Monitoring

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Arkansas Works 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 Enrollment activities for the new adult population began on October 1, 2013 for the qualified health plan (QHP) with eligibility effective January 1, 2014. In Arkansas, individuals eligible for coverage under the new adult group are as described at Section 1902(a)(10)(A)(i)(VIII) of the Social

Security Act (collectively Arkansas Works beneficiaries). Arkansas expected approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.

With this amendment and extension, the state will test innovative approaches to promoting individual financial responsibility for care and to minimizing churn through strengthening employer sponsored insurance (ESI). All Arkansas Works beneficiaries with incomes above 100 percent of the FPL will be charged monthly premium payments. Additionally, all Arkansas Works beneficiaries age 21 and over who receive the alternative benefit plan (ABP) and who have access to cost-effective ESI through participating Arkansas Works employers will be required to participate in ESI.

Arkansas Works beneficiaries will receive a state plan ABP. Services will be delivered primarily through the service delivery network of the QHP that they select (or of the ESI plan, if applicable) and the QHP (or ESI, if applicable) 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,
- Improving continuity of care across the continuum of coverage,
- Furthering quality improvement and delivery system reform initiatives, and
- Leveraging employer contributions for insurance coverage to enhance Medicaid coverage.

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 Arkansas Works 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, as well as expanding use of ESI.

The state proposes to demonstrate the 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). Similarly, individuals with access to ESI will be able to maintain coverage through their ESI, regardless of whether their income fluctuates above or below Medicaid levels.

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.

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

Strengthening the state's employer sponsored insurance market – The state will strengthen its employer-sponsored insurance market by expanding the number of potential individuals covered through employer-sponsored insurance and by reducing changes in coverage due to fluctuations in income for individuals covered through employer-sponsored insurance.

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 provide the state with additional notice of the changes.

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 Section 431.412.
b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 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. Pre-Approved Transition and Phase Out Plan. The state may elect to submit a draft transition and phase-out plan for review and approval at any time, including prior to when a date of termination has been identified. Once the transition and phase-out plan has been approved, implementation of the plan may be delayed indefinitely at the option of the state.

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 Demonstration Authority. CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.

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

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the State's approved state plan, when any program changes to the demonstration are proposed by the State.

a. In States with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

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

IV. POPULATIONS AFFECTED

The State will use this demonstration to ensure coverage for Arkansas Works eligible beneficiaries provided primarily through QHPs offered in the individual market or through ESI 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 or ESI for Arkansas Works beneficiaries.

17. Populations Affected by the Arkansas Works Demonstration. Except as described in STCs 18 and 19, the Arkansas Works 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 adults up to and including 133 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act	Title XIX	MEG – 1

18. Medically Frail Individuals. Arkansas will institute a process to determine whether an individual is medically frail. The process is described in the Alternative Benefit state plan. Medically frail individuals will be excluded from the demonstration with the following exception for individuals who have access to and chose to enroll in ESI. Specifically, for the purposes of these STCs, the terms "medically frail" or "medically frail individuals" shall exclude any individuals identified as medically frail by the state, consistent with the process described in the Alternative Benefit state plan, if that individual is age 21 or over and has elected to receive the Alternative Benefit Plan, and has access to cost-effective ESI through an employer participating in Arkansas Works. All such individuals will be covered through the demonstration and will be required to enroll in ESI. For the purposes of these STCs, these individuals will be included in the term "Arkansas Works beneficiaries," unless expressly noted otherwise.

a. Medically frail individuals will only be subject to cost sharing under the terms of this demonstration if they are age 21 or over, have elected to receive the Alternative Benefit Plan, and are enrolled in cost-effective ESI through an employer participating in Arkansas Works.
b. Individuals excluded from enrolling in QHPs through the Arkansas Works 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 or ESI in this demonstration, but can choose to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted into the Arkansas Works 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.

20. Retroactive Coverage. Upon completion of the Arkansas MAGI Backlog Mitigation Plan, the state shall submit written assurance with supporting documentation that the backlog has been eliminated and that eligibility determinations and redeterminations are completed on a timely basis. The state shall submit data on a quarterly basis to CMS to demonstrate continued compliance with timely determinations of eligibility.

The state shall submit written assurance with supporting documentation that it provides benefits during a reasonable opportunity period to individuals who are otherwise eligible for Medicaid and who attest to eligible immigration status, consistent with Section 1137(d) of the Social Security Act.

The state will also implement the Affordable Care Act requirement that allows qualified hospitals to make presumptive eligibility (PE) determinations for certain Medicaid populations and have an approved State Plan Amendment for hospitals to make presumptive eligibility (PE) determinations by April 1, 2017. Any Medicaid-enrolled hospital that agrees to the PE determination process established by the state will be considered a qualified hospital.

V. ARKANSAS WORKS PREMIUM ASSISTANCE ENROLLMENT

21. Arkansas Works. For Arkansas Works beneficiaries, enrollment in either a QHP or ESI will be a condition of receiving benefits. All Arkansas Works beneficiaries ages 21 and over with access to cost-effective ESI through an employer participating in the Arkansas Works program will be required to enroll in ESI; all other Arkansas Works beneficiaries will be required to enroll in a QHP, unless they have been determined to be medically frail.

22. Notices. Arkansas Works beneficiaries will receive a notice or notices from Arkansas Medicaid or its designee advising them of the following:

a. Requirement to Enroll in ESI or QHP. The notice will inform Arkansas Works beneficiaries whether they are required to enroll in ESI or QHPs to receive coverage.
b. QHP Plan Selection. If applicable, the notice will include information regarding how Arkansas Works beneficiaries who are required to enroll in QHPs can select a QHP and information on the State's auto- assignment process in the event that the beneficiary does not select a plan.
c. ESI Enrollment. If applicable, the notice will include information regarding how Arkansas Works beneficiaries who are required to enroll in ESI should enroll in ESI and how the beneficiary will access services before ESI begins.
d. State Premiums and Cost-Sharing. The notice will include information about the individuals premium and cost-sharing obligations, if any, as well as the quarterly cap on premiums and cost-sharing.
e. Access to Services until QHP/ESI 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 or ESI enrollment is effective. In addition to a CIN number, Arkansas Works beneficiaries who are required to enroll in ESI will receive an Arkansas Works card to access services prior to ESI enrollment and any wrapped benefits after ESI enrollment.
f. Wrapped Benefits. The notice will also include information on how beneficiaries can 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.
g. Appeals. The notice will also include information regarding the grievance and appeals process.

h. Identification of Medically Frail. The notice will include information describing how Arkansas Works beneficiaries who believe they may be exempt from the Arkansas Works ABP, and individuals who are medically frail, can request a determination of whether they are exempt from the ABP. The notice will also include alternative benefit plans options.

23. QHP Selection. The QHP in which Arkansas Works 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.

24. Enrollment Process. In accordance with the state established timeframes established in the Enrollment Protocols, individuals will enroll through the process described in operational protocols developed by the state and approved by CMS.

25. Auto-assignment. In the event that an individual is determined eligible for coverage through the Arkansas Works QHP premium assistance program, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's rating area. 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.

26. Distribution of Members Auto-assigned. Arkansas Works QHP 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 Arkansas Works 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 Arkansas Works enrollees in that region.
Three QHP issuers: 25 percent of Arkansas Works enrollees in that region.
Four QHP issuers: 20 percent of Arkansas Works enrollees in that region.
More than four QHP issuers: 10 percent of Arkansas Works enrollees in that region.

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

28. Disenrollment. Enrollees in the Arkansas Works QHP Premium Assistance Program may be disenrolled if they are determined to be medically frail after they were previously determined eligible. Enrollees in the Arkansas Works ESI Premium Assistance Program may be disenrolled if they are determined to be medically frail and select to receive the standard benefit package at any time.

29. Operational Protocols. By April 30, 2017, the state will submit for CMS approval operational protocols further describing, among other things the enrollment/disenrollment process for all Arkansas Works beneficiaries. The protocol must include, at a minimum, a description of the following items:

a. The process for identifying participating employers;
b. The process for demonstrating cost effectiveness in ESI;
c. The process for assisting beneficiaries in enrolling in ESI;
d. The process for ensuring beneficiaries have access to services before ESI coverage become effective;
e. The methodology for determining employer incentives for new or expanded ESI;
f. The beneficiary incentive benefit structure and design;
g. The process for qualifying for the beneficiary incentive benefit; and
h. Information on how beneficiaries can access wrapped services and cost sharing, including services from a non-Medicaid provider.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

30. Memorandum of Understanding for QHP Premium Assistance. 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, including the process for collecting and tracking beneficiary premiums;
c. Reporting and data requirements necessary to monitor and evaluate the Arkansas Works including those referenced in STC 71, ensuring enrollee access to EPSDT and other covered benefits through the QHP;
d. Requirement for QHPs to provide, consistent with federal and state laws, claims and other data as requested to support state and federal evaluations, including any corresponding state arrangements needed to disclose and share data, as required by 42 CFR 431.420(f)(2), to CMS or CMS' evaluation contractors.
e. Noticing requirements; and,
f. Audit rights.

31. Qualified Health Plans. The State will use premium assistance to support the purchase of coverage for Arkansas Works beneficiaries through Marketplace QHPs.

32. Choice of QHPs. Each Arkansas Works beneficiary required to enroll in a QHP 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. Arkansas Works 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. Arkansas Works beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area and that meet the purchasing guidelines established by the State in that year, and thus all Arkansas Works 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. Arkansas Works beneficiaries will have access to the same networks as other individuals enrolling in silver level QHPs through the individual Marketplace.

33. Memorandum of Understanding for ESI Premium Assistance. The Arkansas Department of Human Services will require that its vendor enter into a memorandum of understanding with all employers participating in the ESI Premium Assistance Program.

34. Coverage Prior to Enrollment in a QHP or ESI. 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 or ESI becomes effective.

a. For individuals who enroll in a QHP (whether by selecting the QHP or through auto-assignment) or ESI between the first and fifteenth day of a month, QHP/ESI coverage will become effective as of the first day of the month following QHP/ESI enrollment.
b. For individuals who enroll in a QHP (whether by selecting the QHP or through auto-assignment) or ESI between the sixteenth and last day of a month, QHP/ESI coverage will become effective as of the first day of the second month following QHP/ESI selection (or auto-assignment).

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

36. NEMT. Non-emergency medical transport services will be provided through the State's fee- for-service Medicaid program. See STC 43 for further discussion of non-emergency medical transport services.

VII. BENEFITS

37. Arkansas Works 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.

38. Alternative Benefit Plan. The benefits provided under an alternative benefit plan for the new adult group are reflected in the State ABP state plan.

39. 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 or ESI. 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.

40. Access to Wrap Around Benefits. In addition to receiving an insurance card from the applicable QHP or ESI issuer, Arkansas Works beneficiaries will have a Medicaid CIN or

Arkansas Works card (for ESI enrolled beneficiaries) through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN or card will include information about which services Arkansas Works 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 or through the call center for ESI enrollees established by the state or its vendor.

41. 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).

42. Access to Federally Qualified Health Centers and Rural Health Centers. Arkansas Works enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC and RHC. Arkansas Works beneficiaries receiving coverage through ESI will have access to at least one FQHC and RHC through their ESI. If their ESI does not contract with an FQHC and RHC, they may access an FQHC and RHC through fee-for-service Medicaid.

43. 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. Individuals served by IHS or Tribal facilities, and medically frail individuals will be exempt from such requirements. The state will have no obligation to provide NEMT to individuals covered through ESI premium assistance to individuals who have not demonstrated a need for such services.

44. Incentive Benefits. To the extent an amendment is approved by CMS and also described in operational protocols developed by the state, Arkansas will offer an additional benefit not otherwise provided under the Alternative Benefit Plan for Arkansas Works enrollees who make timely premium payments (if above 100 percent FPL) and engage with a primary care provider (PCP). Arkansas Works enrollees with incomes at or below 100 percent FPL and others who are exempt from premiums, will be eligible for an incentive benefit at the time the amendment is approved.

VIII. PREMIUMS & COST SHARING

45. Premiums & Cost sharing. Cost sharing for Arkansas Works 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 447.56(a).

46. Premiums & Cost Sharing Parameters for the Arkansas Works program. With the approval of this Demonstration:

a. Enrollees up to and including 100 percent of the FPL will have no cost sharing.
b. Enrollees above 100 percent of the FPL will have cost sharing consistent with Medicaid requirements.

c. Enrollees above 100 percent of the FPL will be required to pay monthly premiums of up to 2 percent of household income.
d. Premiums and cost-sharing will be subject to an aggregate cap of no more than 5 percent of family monthly or quarterly income.
e. Cost sharing limitations described in 42 CFR 447.56(a) will be applied to all program enrollees.
f. Copayment and coinsurance amounts will be consistent with federal requirements regarding Medicaid cost sharing and with the state's approved state plan; premium, copayment, and coinsurance amounts are listed in Attachment B.

47. 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 Arkansas Works 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.

48. Grace Period/Debt Collection. Arkansas Works members will have two months from the date of the payment invoice to make the required monthly premium contribution. Arkansas and/or its vendor may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The state and/or its vendor may not "sell" the debt for collection by a third party.

49. Process for Cost-Sharing for ESI. The state will pay cost sharing in excess of levels specified in Attachment B for all Arkansas Works beneficiaries enrolled in ESI whose ESI imposes cost-sharing. The state will pay such excess cost-sharing directly to providers, provided that such providers are enrolled in the Medicaid program.

a. Tracking. The state will create a process for individuals enrolled in the ESI premium assistance program to submit receipts of their cost sharing, if it reaches an aggregate cap of no more than 5 percent of family monthly or quarterly income. Once the state verified that the limit had been reached, the state will shut off the individual's cost sharing for the remainder of that quarter. This interim tracking of beneficiary cost sharing will only be allowed until March 31, 2018. At such time, the state will track beneficiary's cost sharing through its MMIS system. The state will provide quarterly updates to CMS on its progress in implementing the new MMIS system for purposes of tracking.

b. Appeals. The state will create a process for individuals enrolled in ESI premium assistance to have access to the state fair hearing system for denial or reduction of benefits or services similar to the one already used for the QHP premium

assistance programs. If the procedure for accessing state fair hearings for individuals enrolled in ESI premium assistance differs from the one used in QHP premium assistance programs, the state will submit a new single state agency SPA to document such changes.

IX. 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 has submitted a state plan amendment delegating certain responsibilities to the Arkansas Insurance Department.

X. GENERAL REPORTING REQUIREMENTS

50. Deferral for Failure to Submit Timely Demonstration Deliverables. The state agrees that CMS may issue deferrals in the amount of $5,000,000 when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
b. For each deliverable, the state may submit a written request for an extension in which to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.
c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.
d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.
e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.
f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

51. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall 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. Pursuant to 42 CFR 431.420(c),the state must include a summary of the

comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

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

53. Compliance with Federal Systems Innovation. As federal systems continue to evolve and incorporate 1115 demonstration 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. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

XI. 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.

54. 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.

55. 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
Demonstration Year 4 (DY4)	January 1, 2017	12 months
Demonstration Year 5 (DY5)	January 1, 2018	12 months
Demonstration Year 6 (DY6)	January 1, 2019	12 months
Demonstration Year 7 (DY7)	January 1, 2020	12 months
Demonstration Year 8 (DY8)	January 1, 2021	12 months

56. 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").

57. 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.

58. 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 83, 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.

59. 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.

60. 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 63:

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.

61. 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.

62. 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.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

63. 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 66, 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.

64. 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.

65. 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 STC 66 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 67 below.

66. 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 4 - PMPM	DY 5 – PMPM	DY 6 – PMPM	DY 7 – PMPM	DY 8 – PMPM
New Adult Group	4.7%	$570.50	$597.32	$625.39	$654.79	$685.56

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 1 of 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.

67. 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 9), 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.

68. 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.

69. 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 4	Cumulative budget neutrality limit plus:	0%
DY 5	Cumulative budget neutrality limit plus:	0%
DY 6	Cumulative budget neutrality limit plus:	0%
DY 7	Cumulative budget neutrality limit plus:	0%
DY 8	Cumulative budget neutrality limit plus:	0%

70. 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.

XIII. EVALUATION

71. Evaluation Design and Implementation. The State shall submit a draft evaluation design for Arkansas Works to CMS no later than 60 days after the award of the Demonstration extension. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the Health Care Independence Program. The state must submit a final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval.

72. 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.

73. 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 Works 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 Arkansas Works 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 Arkansas Works 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 Arkansas Works. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Arkansas will be determined and compared to improvement efforts undertaken in other delivery systems.

74. Evaluation Requirements. 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.

75. 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. QHP Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
x. QHP Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
xi. QHP 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.
xiii. The use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance.
xiv. ESI premium assistance will increase the number of employers offering ESI coverage.

xv. Continuity of coverage under ESI premium assistance will be improved compared to QHP premium assistance for individuals with access to ESI.
xvi. Incentive benefits offered to Arkansas Works beneficiaries will increase participation rates for premium contributions compared to historical experience with Independence Accounts and increase primary care utilization.

These hypotheses should be addressed in the demonstration reporting described in STC 83 and 84 with regard to progress towards the expected outcomes.

b. Data: This discussion shall include:

i. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;

ii. Method of data collection

iii. Frequency and timing 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

c. Study Design: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies 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. To the extent possible, the former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. 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

d. 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.

e. 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.

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, and the deliverables outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.

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.

j. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

76. Interim Evaluation Report. The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending December 31, 2021. The Interim Evaluation Report shall include the same core components as identified in STC 77 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

77. Summative Evaluation Reports.

a. The state shall provide the summative evaluation reports described below to capture the different demonstration periods.

i. The state shall provide a Summative Evaluation Report for the Arkansas Private Option demonstration period September 27, 2013 through December 31, 2016. This Summative Evaluation Report is due July 1, 2018, i.e., eighteen months following the date by which the demonstration would have ended except for this extension.

ii. The state shall provide two Summative Evaluation Reports for the Arkansas Works demonstration period starting January 1, 2017 through December 31, 2021.

a. The first of these is due within 210 days of the end of this demonstration period, i.e., July 28, 2022. This report shall include documentation of outstanding assessments due to data lags to complete the summative evaluation.

b. The second of these is due within 500 days of the end of this demonstration period, i.e., May 15, 2023. The State should respond to comments and submit the final Summative Evaluation Report within 30 days after receipt of CMS' comments.

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

i. 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.

ii. Demonstration Description. This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

iii. 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.

iv. 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.

v. 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.

vi. 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.

78. 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 76. The State will present on its summative evaluation in conjunction with STC 77.

79. 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.

80. Cooperation with Federal Evaluators. Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate timely and 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. Failure to cooperate with federal evaluators in a timely manner, including but not limited to entering into data use agreements covering data that the state is legally permitted to share, providing a technical point of contact, providing data dictionaries and record layouts of any data under control of the state that the state is legally permitted to share, and/or disclosing data may result in CMS requiring the state to cease drawing down federal funds until satisfactory cooperation, until the amount of federal funds not drawn down would exceed $5,000,000.

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

XIV. MONITORING

82. 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. 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. Quality of care;
g. Beneficiary access,

h. Benefit package and wrap around benefits;
i. Audits;
j. Lawsuits;
k. Financial reporting and budget neutrality issues;
l. Progress on evaluation activities and contracts;
m. Related legislative developments in the state; and
n. Any demonstration changes or amendments the state is considering.

83. Quarterly Reports. The state must submit three Quarterly Reports and one compiled Annual Report each DY.

a. The state will submit the reports following the format established by CMS. All Quarterly Reports and associated data must be submitted through the designated electronic system(s). The Quarterly Reports are due no later than 60 days following the end of each demonstration quarter, and the compiled Annual Report is due no later than 90 days following the end of the DY.
b. 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.
c. 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.
d. The Quarterly Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section. The reports shall provide sufficient information for CMS to understand implementation progress and operational issues associated with the demonstration and whether there has been progress toward the goals of the demonstration.
    i. Operational Updates - The reports shall provide sufficient information to document 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. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.
    ii. Performance Metrics – Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.
    iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly

expenditures associated with the populations affected by this demonstration on the Form CMS-64.

iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, 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 for monitoring and evaluation of the demonstration.

e. The Annual Report must include all items included in the preceding three quarterly reports, which must be summarized to reflect the operation/activities throughout the whole DY. All items included in the quarterly report pursuant to STC 83 must be summarized to reflect the operation/activities throughout the DY. In addition, the annual report must, at should include the requirements outlined below.

i. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;
ii. Total contributions, withdrawals, balances, and credits; and,
iii. Yearly unduplicated 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.

84. 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.

ATTACHMENT B

Copayment Amounts[1]

General Service Description	Cost Sharing for Enrollees with Incomes >100% FPL
Behavioral Health – Inpatient	$140/day
Behavioral Health – Outpatient	$4
Behavioral Health – Professional	$4
Durable Medical Equipment	$4
Emergency Room Services	-
FQHC	$8
Inpatient	$140/day
Lab and Radiology	-
Skilled Nursing Facility	$20/day
Other	$4
Other Medical Professionals	$4
Outpatient Facility	-
Primary Care Physician	$8
Specialty Physician	$10
Pharmacy – Generics	$4
Pharmacy – Preferred Brand Drugs	$4
Pharmacy – Non-Preferred Brand Drugs, including specialty drugs	$8

No copayments for individual at or below 100% FPL.

[1] Enrollees with incomes above 100% FPL will also be required to pay monthly premiums of up to 2 percent of household income.

STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

June 30, 2017

The Honorable Thomas E. Price, M.D.
Secretary
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Mr. Secretary:

On behalf of the citizens of Arkansas, I am pleased to submit an amendment to the Special Terms and Conditions for the Arkansas Works Section 1115 Medicaid demonstration. The changes proposed in this amendment were authorized by the Arkansas General Assembly during the First Extraordinary Session of 2017. In December 2016, the Centers for Medicare & Medicaid Services (CMS) approved the Arkansas Works demonstration, which implemented a new approach to health coverage for Arkansans. To date, the demonstration and its predecessor have been successful in providing continuity of coverage, smoothing the "seams" across the continuum of coverage, improving access to providers, and furthering quality improvement and delivery system reform initiatives. The changes we are seeking will build on these successes and increase the sustainability of the Arkansas Works program.

This amendment proposes four substantive changes to the Arkansas Works demonstration: (1) modify income eligibility for expansion adults to less than or equal to 100 percent of the federal poverty level (FPL) as of January 1, 2018; (2) institute work requirements as a condition of Arkansas Works eligibility as of January 1, 2018; (3) eliminate the Arkansas Works employer-sponsored insurance (ESI) premium assistance program on December 31, 2017; and (4) implement the state's waiver of retroactive eligibility on or after July 1, 2017. Together, these amendments to the demonstration seek to test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions from Arkansas Works to employer-sponsored insurance and Marketplace coverage. The state is not requesting any changes related to budget neutrality.

I appreciate your ongoing partnership with our state and look forward to your continued support of Arkansas Works. Please do not hesitate to contact me if you have questions or need additional information.

Sincerely,

Asa Hutchinson

500 WOODLANE STREET, SUITE 250 • LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345
www.governor.arkansas.gov

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: **Arkansas Works 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 Works Section 1115 demonstration.

The expenditure authorities listed below promote the objectives of title XIX by: increasing overall coverage of low-income individuals in the state, improving health outcomes for Medicaid and other low-income populations in the state, and increasing access to, stabilizing, and strengthening the availability of providers and provider networks to serve Medicaid and low-income individuals in the state.

The following expenditure authorities shall enable Arkansas to implement the Arkansas Works section 1115 demonstration:

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

~~2. **Premium Assistance Payments for Employer-Sponsored Insurance** Expenditures for the employee share of cost-effective small group employer-sponsored insurance when the employer contributes at least 25 percent of the overall cost of the coverage for individuals enrolled in the new adult group described in section 1905(a)(10)(A)(i)(VIII) of the Act, that would not meet the requirements for premium assistance under the state plan.~~

~~3. **Employer Incentives for New Or Expanded Employer-Sponsored Insurance.** Expenditures for the employer share of cost-effective small group employer-sponsored insurance attributable to individuals receiving premium assistance under demonstration expenditure authority #2, to the extent that the remaining employer contribution is no less than 25 percent of the overall cost of the coverage, limited to a three year period per employer and only for employers who either (1) offer coverage effective on or after January 1, 2017 and had not offered coverage in calendar year 2016 or (2) offer non-grandfathered small group coverage effective on or after January 1, 2017 and had previously offered only grandfathered coverage.~~

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, with respect to individuals covered under this demonstration through qualified health plans, 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 & MEDICAID SERVICES WAIVER LIST

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

TITLE: **Arkansas Works 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 January 1, 2017 through December 31, 2021. In addition, these waivers may only be implemented consistent with the approved amended 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 Arkansas Works beneficiary's Qualified Health Plan ~~or Employer Sponsored Insurance.~~ No waiver of freedom of choice is authorized for family planning providers.

2. Payment to Providers — Section 1902(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 ~~or Employer Sponsored Insurance participating under Arkansas Works~~.

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, and for expedited review in exigent circumstances within 24 hours, rather than 24 hours for all circumstances 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. Premiums — Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A

To the extent necessary to enable the state to collect monthly premiums for individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act with incomes above 100 ~~up to and including 133~~ percent of the federal poverty level (FPL~~).~~) as described in STC 17.

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)(~~VnI~~VIII) of the Act~~.~~ with incomes above 100 percent of the FPL as described in STC 17.

To the extent necessary to enable the state to phase out demonstration eligibility for individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Act with incomes above 100 percent of the FPL as described in STC 17.

~~6. Non-Emergency Medical Transportation — Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53~~

~~To the extent necessary to relieve the state of its obligation to provide non-emergency medical transportation to and from providers for individuals who are enrolled in employer-sponsored insurance and have not demonstrated a need for such transportation.~~

~~7~~6. Retroactive Eligibility — Section 1902(a)(34)

To enable the state to not provide retroactive eligibility for the affected populations on or after July 1, 2017. ~~This provision will become effective 30 days after the later of CMS receiving written assurance from the state that it complies with the reasonable opportunity provisions in Section 1137(d) of the Social Security Act and CMS receiving written assurance from the state that the state has successfully completed the Arkansas MAGI Backlog Mitigation Plan as provided for in STC 20. The state shall also implement the Affordable Care Act provision on presumptive eligibility determinations by qualified hospitals as provided for in STC 20.~~

7. Reasonable Promptness — Section 1902(a)(3)

To enable the state to prohibit re-enrollment for the remainder of the calendar year for individuals disenrolled from coverage for failing to meet work requirements.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Arkansas Works**

AWARDEE: **Arkansas Department of Human Services**

I. PREFACE

The following are the amended Special Terms and Conditions (STCs) for the Arkansas Works section 1115(a) Medicaid demonstration (hereinafter demonstration) to enable the Arkansas Department of Human Services (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. Enrollment into the demonstration ~~will be~~is statewide and is approved through December 31, 2021.

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. Arkansas Works Premium Assistance Enrollment
VI. Premium Assistance Delivery System
VII. Benefits
VIII. Premiums & Cost Sharing
IX. Work Requirements
X. Appeals
~~X~~XI. General Reporting Requirements
~~XI~~XII. General Financial Requirements
~~XII~~XIII. Monitoring Budget Neutrality
~~XIII~~XIV. Evaluation
~~XIV~~XV. Monitoring

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the Arkansas Works 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 qualified health plans (QHPs) offered in the individual market through the Marketplace. Enrollment activities for the new adult population began on October 1, 2013 for ~~the qualified health plan (QHP)~~QHPs with eligibility effective January 1, 2014. ~~In~~

~~Arkansas~~Beginning in 2014, individuals eligible for coverage under the new adult group are ~~as~~individuals described at Section 1902(a)(10)(A)(i)(~~VnI~~VIII) of the Social Security Act and is further specified in the state plan (collectively Arkansas Works beneficiaries). ~~Arkansas expected approximately 200,000 beneficiaries to be enrolled into the Marketplace through this demonstration program.~~

~~With this amendment and extension, the state will test innovative approaches to promoting individual financial responsibility for care and to minimizing churn through strengthening employer sponsored insurance (ESI). All Arkansas Works beneficiaries with incomes above 100 percent of the FPL will be charged monthly premium payments. Additionally,~~Through the approved December 2016 extension and amendment to the demonstration, the state required that all Arkansas Works beneficiaries age 21 and over who receive the alternative benefit plan (ABP) and who have access to cost-effective employer sponsored insurance (ESI) through participating Arkansas Works employers ~~will be required to~~ participate in ESI. (as described below, the Arkansas Works ESI premium assistance program will terminate on December 31, 2017).

With this amendment, the state will test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions between and among Arkansas Works, ESI, and the Marketplace for Arkansas Works enrollees. On January 1, 2018, the state will limit Arkansas Works income eligibility to 100 percent of the federal poverty level (FPL), including the 5 percent income disregard required for the purposes of determining income eligibility based on modified adjusted gross income (MAGI) standards. When enrollees have their first eligibility redetermination or submit a change in circumstances on or after January 1, 2018, those determined to have an income above 100 percent of the FPL will no longer be eligible for Arkansas Works. Individuals may enroll in QHPs supported by federal tax credits or, for those individuals with access to ESI, may enroll in ESI.

Beginning on January 1, 2018, the state will also institute work requirements as a condition of Arkansas Works eligibility. Once work requirements are fully implemented, Arkansas Works beneficiaries ~~will~~ who are ages 19-49 must work or engage in specified educational, job training, or job search activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who are subject to work requirements will be required to demonstrate that they are meeting the work requirements on a monthly basis. Arkansas Works beneficiaries who fail to meet the work requirements for any three months during a plan year will be disenrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year.

Finally, the state will eliminate its ESI premium assistance program under the demonstration. As of January 1, 2018, all Arkansas Works beneficiaries who were enrolled in ESI premium assistance and who remain eligible for Arkansas Works will transition to QHP coverage.

Arkansas Works beneficiaries receive a state plan ABP. Services ~~will be~~are delivered primarily through the service delivery network of the QHP that they select ~~(or of the ESI plan, if applicable)~~ and the QHP ~~(or ESI, if applicable) will be~~is 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~~Providing continuity of coverage for individuals,
- Improving access to providers,
- Improving continuity of care across the continuum of coverage,
- Furthering quality improvement and delivery system reform initiatives that are successful across population groups, and
- ~~Leveraging employer contributions for insurance coverage to enhance Medicaid coverage.~~
- Promoting independence through employment.

Arkansas proposes that the demonstration will provide integrated coverage for low-income Arkansans, leveraging the efficiencies and experience of the private market to improve continuity, access, and quality for Arkansas Works beneficiaries that should ultimately result in lowering the rate of growth in premiums across population groups. 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 at least doubling the size of the population enrolling in QHPs offered through the Marketplace~~, as well as expanding use of ESI~~.

The state proposes to demonstrate the 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~~Premium Tax Credits/Cost Sharing Reductions (APTC/CSRs). ~~Similarly, individuals with access to ESI will be able to maintain coverage through their ESI, regardless of whether their income fluctuates above or below Medicaid levels.~~

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.

Integration ~~and~~, efficiency, quality improvement and delivery system reform - Arkansas is proposing taking an integrated and market-based approach to covering uninsured Arkansans. It is anticipated that QHPs will bring the experience of successful private sector models that can improve access to high quality services and lead delivery system reform. One of the benefits of this demonstration should be to gain a better understanding of how the private sector uses incentives to engage individuals in healthy behaviors.

~~***Strengthening the state's employer sponsored insurance market*** - The state will strengthen its employer-sponsored insurance market by expanding the number of potential individuals covered through employer-sponsored insurance and by reducing changes in coverage due to fluctuations in income for individuals covered through employer-sponsored insurance.~~

Promoting employment - By instituting work requirements as a condition of eligibility, the demonstration will incentivize employment and increase the number of employed Arkansas Works beneficiaries.

III. GENERAL PROGRAM REQUIREMENTS

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

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

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 Section 431.412.

b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 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. **Pre-Approved Transition and Phase Out Plan.** The state may elect to submit a draft transition and phase-out plan for review and approval at any time, including prior to when a date of termination has been identified. Once the transition and phase-out plan has been approved, implementation of the plan may be delayed indefinitely at the option of the state.

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 Demonstration Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.

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

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements contained in the State's approved state plan, when any program changes to the demonstration are proposed by the State.

a. In States with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).

b. In States with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).

c. The State must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.

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

IV. POPULATIONS AFFECTED

The State will use this demonstration to ensure coverage for Arkansas Works eligible beneficiaries provided primarily through QHPs offered in the individual market ~~or through ESI~~ instead of the fee-for-service delivery system that serves the traditional Medicaid population. The State will provide premium assistance to aid ~~individuals~~Arkansas Works beneficiaries in enrolling in coverage through QHPs in the Marketplace ~~or ESI for Arkansas Works beneficiaries~~.

17. **Populations Affected by the Arkansas Works Demonstration.** Except as described in STCs 18 and 19, the Arkansas Works 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~~who have incomes up to and including 100 percent of the FPL, including the 5 percent income disregard required for the purposes of determining income eligibility based on MAGI standards, eligible under the state plan under 1902(a)(10)(A)(i)(VIII) of the Act, 42 CFR Section 435.119. During calendar year 2018, the Arkansas Works Demonstration will also affect 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 who have incomes above 100 percent of the FPL, including the 5 percent income disregard required for the purposes of determining income eligibility based on MAGI standards, eligible under the state plan under 1902(a)(10)(A)(i)(VIII) of the Act, 42 CFR Section 435.119 to the extent they were enrolled in 2017 and remain enrolled (hereinafter transitional enrollees). Beginning in 2018, when the state assesses at eligibility redetermination or upon a change in circumstances submission that an Arkansas Works beneficiary has an income above 100 percent of the FPL, he or she will no longer be eligible for the demonstration.

Eligibility and coverage for Arkansas Works beneficiaries 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 adults~~Adults up to and including ~~133~~100 percent of the FPL who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIlI) of the Social Security Act In 2018 only, adults above 100 percent of the FPL to the extent they were enrolled in Arkansas Works in 2017 and remain enrolled who meet the other criteria specified in Section 1902(a)(10)(A)(i)(VIlI) of the Social Security Act (transitional enrollees)	Title XIX	MEG - 1

~~17.~~18. **Medically Frail Individuals.** Arkansas ~~will institute~~has instituted a process to determine whether an individual is medically frail. The process is described in the Alternative Benefit state plan. Medically frail individuals ~~will be~~are excluded from the demonstration, except for the purposes of STC 20. ~~with the following exception for individuals who have access to and chose to enroll in ESI. Specifically, these STCs, the terms "medically frail" or "medically frail individuals" shall exclude any individuals identified as medically frail by the state, consistent with the process described in the Alternative Benefit state plan, if that individual is age 21 or over and has elected to receive the Alternative Benefit Plan, and has access to cost-effective ESI through an employer participating in Arkansas Works. All such individuals will be covered through the demonstration and will be required to enroll in ESI.For the purposes of these STCs, these individuals will be included in the term "Arkansas Works beneficiaries," unless~~

~~expressly noted otherwise. Medically frail individuals will only be subject to cost sharing under the terms of this demonstration if they are age 21 or over, have elected to receive the Alternative Benefit Plan, and are enrolled in cost-effective ESI through an employer participating in Arkansas Works.~~

a. Individuals excluded from enrolling in QHPs through the Arkansas Works 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.

~~18.~~19. **American Indian/Alaska Native Individuals.** Individuals identified as American Indian or Alaskan Native (AI/AN) will not be required to enroll in QHPs ~~or ESI~~ in this demonstration, but can choose to opt into the demonstration and access coverage pursuant to all the terms and conditions of this demonstration. Individuals who are AI/AN and who have not opted into the Arkansas Works 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.

~~19.~~20. **Retroactive Coverage.** Beginning on or after July 1, 2017, the State will provide coverage effective as of the first day of the month in which an individual eligible under the demonstration applies for coverage. ~~Upon completion of the Arkansas MAGI Backlog Mitigation Plan, the state shall submit written assurance with supporting documentation that the backlog has been eliminated and that eligibility determinations and redeterminations are completed on a timely basis. The state shall submit data on a quarterly basis to CMS to demonstrate continued compliance with timely determinations of eligibility.~~

~~The state shall submit written assurance with supporting documentation that it provides benefits during a reasonable opportunity period to individuals who are otherwise eligible for Medicaid and who attest to eligible immigration status, consistent with Section 1137(d) of the Social Security Act.~~

~~The state will also implement the Affordable Care Act requirement that allows qualified hospitals to make presumptive eligibility (PE) determinations for certain Medicaid populations and have an approved State Plan Amendment for hospitals to make presumptive eligibility (PE) determinations by April 1, 2017. Any Medicaid-enrolled hospital that agrees to the PE determination process established by the state will be considered a qualified hospital.~~

21. **Work Requirements.** Arkansas Works beneficiaries ages 19 to 49 will be subject to work requirements as a condition of eligibility, unless they are deemed exempt. See STCs 47 through 51 for further discussion of work requirements.

V. ARKANSAS WORKS PREMIUM ASSISTANCE ENROLLMENT

~~20.~~22. **Arkansas Works.** For Arkansas Works beneficiaries, enrollment in ~~either~~ a QHP ~~or ESI will be~~is a condition of receiving benefits. ~~All Arkansas Works beneficiaries ages 21 and over with access to cost-effective ESI through an employer participating in the Arkansas Works program will be required to enroll in ESI; all other Arkansas Works beneficiaries will be required to enroll in a QHP, unless they have been determined to be medically frail.~~

~~21.~~23. **Notices.** Arkansas Works beneficiaries will receive a notice or notices from Arkansas Medicaid or its designee advising them of the following:

~~a. Requirement to Enroll in ESI or QHP. The notice will inform Arkansas Works beneficiaries whether they are required to enroll in ESI or QHPs to receive coverage.~~

~~b.~~a. QHP Plan Selection. ~~If applicable, the~~The notice will include information regarding how Arkansas Works beneficiaries ~~who are required to enroll in QHPs~~ can select a QHP and information on the State's auto-assignment process in the event that the beneficiary does not select a plan.

~~c. ESI Enrollment. If applicable, the notice will include information regarding how Arkansas Works beneficiaries who are required to enroll in ESI should enroll in ESI and how the beneficiary will access services before ESI begins.~~

~~d.~~b. State Premiums and Cost-Sharing. The notice will include information about the ~~individuals~~individual's premium and cost-sharing obligations, if any, as well as the quarterly cap on premiums and cost-sharing.

~~e.~~c. Access to Services until QHP~~/ESI~~ 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 ~~or ESI enrollment is effective. In addition to a CIN number, Arkansas Works beneficiaries who are required to enroll in ESI will receive an Arkansas Works card to access services prior to ESI enrollment and any wrapped benefits after ESI enrollment.~~enrollment is effective.

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

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

h.f. Identification of Medically Frail. The notice will include information describing how Arkansas Works beneficiaries who believe they ~~may be exempt from the Arkansas Works ABP, and individuals who~~ are medically frail~~,~~ can request a determination of whether they are exempt from the ABP. The notice will also include alternative benefit ~~plans~~plan options.

g. Change in Arkansas Works Eligibility Limit. The notice will include information about the change in the Arkansas Works eligibility limit to 100 percent of the FPL.

h. Work Requirements. The notice will include information describing the Arkansas Works work requirements. The notice will describe the population subject to and exempt from work requirements; the process for enrollees to demonstrate that they are meeting the work requirements; the activities that count towards meeting the work requirements; and the penalties for failing to meet the work requirements.

~~22.~~24. **QHP Selection.** The ~~QHP~~QHPs in which Arkansas Works beneficiaries ~~will~~ enroll ~~will be~~are certified through the Arkansas Insurance Department's QHP certification process. The QHPs available for selection by the beneficiary ~~will be~~are determined by the Medicaid agency.

~~23. **Enrollment Process.** In accordance with the state established timeframes established in the Enrollment Protocols, individuals will enroll through the process described in operational protocols developed by the state and approved by CMS.~~

~~24.~~25. **Auto-assignment.** In the event that an individual is determined eligible for coverage through the Arkansas Works QHP premium assistance program, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's rating area. 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.~~26. **Distribution of Members Auto-assigned.** Arkansas Works QHP 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 Arkansas Works 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 Arkansas Works enrollees in that region.~~
~~Three QHP issuers: 25 percent of Arkansas Works enrollees in that region.~~
~~Four QHP issuers: 20 percent of Arkansas Works enrollees in that region.~~

~~More than four QHP issuers: 10 percent of Arkansas Works enrollees in that region.~~

~~26.~~27. **Changes to Auto-assignment Methodology.** The state will advise CMS ~~60 days~~ prior to implementing a change to the auto-assignment methodology.

~~27.~~28. **Disenrollment.** Enrollees ~~in the Arkansas Works QHP Premium Assistance Program~~ may be disenrolled from the demonstration if they are determined to be medically frail after they were previously determined eligible. ~~Enrollees in the Arkansas Works ESI Premium Assistance Program may be disenrolled if they are determined to be medically frail and select to receive the standard benefit package at any time.~~

~~28. **Operational Protocols.** By April 30, 2017, the state will submit for CMS approval operational protocols further describing, among other things the enrollment/disenrollment process for all Arkansas Works beneficiaries. The protocol must include, at a minimum, a description of the following items:~~

~~a. The process for identifying participating employers;~~

~~b. The process for demonstrating cost effectiveness in ESI;~~

~~c. The process for assisting beneficiaries in enrolling in ESI;~~

~~d. The process for ensuring beneficiaries have access to services before ESI coverage become effective;~~

~~e. The methodology for determining employer incentives for new or expanded ESI;~~

~~f. The beneficiary incentive benefit structure and design;~~

~~g. The process for qualifying for the beneficiary incentive benefit; and~~

~~h. Information on how beneficiaries can access wrapped services and cost sharing, including services from a non-Medicaid provider.~~

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

29. **Memorandum of Understanding for QHP Premium Assistance.** 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~~enrolls individuals covered under the ~~Demonstration~~demonstration. Areas to be addressed in the MOU include, but are not limited to:

a. Enrollment of individuals in populations covered by the ~~Demonstration~~demonstration;

b. Payment of premiums and cost-sharing reductions, including the process for collecting and tracking beneficiary premiums for transitional enrollees;

c. Reporting and data requirements necessary to monitor and evaluate the Arkansas Works including those referenced in STC ~~7177~~, ensuring enrollee access to EPSDT and other covered benefits through the QHP;

d. Requirement for QHPs to provide, consistent with federal and state laws, claims and other data as requested to support state and federal evaluations, including any corresponding state arrangements needed to disclose and share data, as required by 42 CFR 431.420(f)(2), to CMS or CMS' evaluation contractors.

e. Noticing requirements; and,

f. Audit rights.

30. **Qualified Health Plans.** The State will use premium assistance to support the purchase of coverage for Arkansas Works beneficiaries through Marketplace QHPs.

31. **Choice of QHPs.** Each Arkansas Works beneficiary required to enroll in a QHP 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. Arkansas Works 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. Arkansas Works beneficiaries will be permitted to choose among all silver plans covering only Essential Health Benefits that are offered in their geographic area and that meet the purchasing guidelines established by the State in that year, and thus all Arkansas Works beneficiaries will have a choice of at least two ~~qualified health plans~~QHPs.

c. The State will comply with Essential Community Provider network requirements, as part of the ~~Qualified Health Plan~~QHP certification process.

d. Arkansas Works beneficiaries will have access to the same networks as other individuals enrolling in silver level QHPs through the individual Marketplace.

~~32. **Memorandum of Understanding for ESI Premium Assistance.** The Arkansas Department of Human Services will require that its vendor enter into a memorandum of understanding with all employers participating in the ESI Premium Assistance Program.~~

~~33.~~32. **Coverage Prior to Enrollment in a QHP ~~or ESI~~.** 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 ~~or ESI~~ becomes effective.

a. For individuals who enroll in a QHP (whether by selecting the QHP or through auto-assignment) ~~or ESI~~ between the first and fifteenth day of a month, QHP~~/ESI~~

coverage will become effective as of the first day of the month following QHP~~/ESI~~ enrollment.

b. For individuals who enroll in a QHP (whether by selecting the QHP or through auto-assignment) ~~or ESI~~ between the sixteenth and last day of a month, QHP~~/ESI~~ coverage will become effective as of the first day of the second month following QHP~~/ESI~~ selection (or auto-assignment).

~~34.~~33. **Family Planning.** If family planning services are accessed at a facility that the QHP~~/ESIconsiders~~ considers to be an out-of-network provider, the State's fee-for-service Medicaid program will cover those services.

~~35.~~34. **NEMT.** Non-emergency medical transport services will be provided through the State's fee-~~-~~for-service Medicaid program. See STC ~~43~~41 for further discussion of non-emergency medical transport services.

VII. BENEFITS

~~36.~~35. **Arkansas Works 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.

~~37.~~36. **Alternative Benefit Plan.** The benefits provided under an alternative benefit plan for the new adult group are reflected in the State ABP state plan.

~~38.~~37. **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 or ESI.~~QHPs. 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.

~~39.~~38. **Access to Wrap Around Benefits.** In addition to receiving an insurance card from the applicable QHP ~~or ESI~~ issuer, Arkansas Works beneficiaries will have a Medicaid CIN ~~or Arkansas Works card (for ESI enrolled beneficiaries)~~ through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN ~~or card~~ will include information about which services Arkansas Works beneficiaries may receive through fee-for-service Medicaid and how to access those services. This information ~~will~~is also ~~be~~ posted on Arkansas Department of Human Service's Medicaid website and will be provided through information at the Department of Human Service's call centers and through QHP issuers ~~or through the call center for ESI enrollees established by the state or its vendor~~.

~~40.~~39. **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).

41.40. **Access to Federally Qualified Health Centers and Rural Health Centers.** Arkansas Works enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC and RHC. ~~Arkansas Works beneficiaries receiving coverage through ESI will have access to at least one FQHC and RHC through their ESI. If their ESI does not contract with an FQHC and RHC, they may access an FQHC and RHC through fee-for-service Medicaid.~~

42.41. **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. Individuals served by IHS or Tribal facilities~~,~~ and medically frail individuals will be exempt from such requirements. ~~The state will have no obligation to provide NEMT to individuals covered through ESI premium assistance to individuals who have not demonstrated a need for such services.~~

43.42. **Incentive Benefits.** To the extent an amendment is approved by CMS ~~and also described in operational protocols developed by the state~~, Arkansas will offer an additional benefit not otherwise provided under the Alternative Benefit Plan for transitional Arkansas Works enrollees who make timely premium payments (if above 100 percent FPL) and engage with a primary care provider (PCP). Arkansas Works enrollees with incomes at or below 100 percent FPL and others who are exempt from premiums~~,~~ will be eligible for an incentive benefit at the time the amendment is approved.

VIII. PREMIUMS & COST SHARING

44.43. **Premiums & Cost ~~sharing~~Sharing.** Cost sharing for Arkansas Works 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 447.56(a).

45.44. **Premiums & Cost Sharing Parameters for the Arkansas Works ~~program~~Program.** With the approval of this ~~Demonstration~~demonstration:

a. Enrollees up to and including 100 percent of the FPL will have no cost sharing.

b. ~~Enrollees~~Transitional enrollees above 100 percent of the FPL will have cost sharing consistent with Medicaid requirements.

c. ~~Enrollees~~Transitional enrollees above 100 percent of the FPL will be required to pay monthly premiums of up to 2 percent of household income.

d. Premiums and cost-sharing will be subject to an aggregate cap of no more than 5 percent of family monthly or quarterly income.

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

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

~~46.~~45. **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 Arkansas Works 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.

~~47.~~ **Grace Period/Debt Collection.** Transitional Arkansas Works ~~members~~ enrollees will have two months from the date of the payment invoice to make the required monthly premium contribution. Arkansas and/or its vendor may attempt to collect unpaid premiums and the related debt from beneficiaries, but may not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of the individual's earnings for enrollees at any income level. The state and/or its vendor may not "sell" the debt for collection by a third party.

~~**Process for Cost-Sharing for ESI.** The state will pay cost sharing in excess of levels specified in Attachment B for all Arkansas Works beneficiaries enrolled in ESI whose ESI imposes cost-sharing. The state will pay such excess cost-sharing directly to providers, provided that such providers are enrolled in the Medicaid program.~~

~~48. Tracking. The state will create a process for individuals enrolled in the ESI premium assistance program to submit receipts of their cost sharing, if it reaches an aggregate cap of no more than 5 percent of family monthly or quarterly income. Once the state verified that the limit had been reached, the state will shut off the individual's cost sharing for the remainder of that quarter. This interim tracking of beneficiary cost sharing will only be allowed until March 31, 2018. At such time, the state will track beneficiary's cost sharing through its MMIS system. The state will provide quarterly updates to CMS on its progress in implementing the new MMIS system for purposes of tracking.~~

~~49.~~16. ~~Appeals. The state will create a process for individuals enrolled in ESI premium assistance to have access to the state fair hearing system for denial or reduction of benefits or services similar to the one already used for the QHP premium assistance programs. If the procedure for accessing state fair hearings for individuals enrolled in ESI premium assistance differs from the one used in QHP premium assistance programs, the state will submit a new single state agency SPA to document such changes.~~

IX. WORK REQUIREMENTS

47. **Population Subject to Work Requirements.** Beginning on January 1, 2018, the state will phase in work requirements by age group. Once work requirements are fully implemented, Arkansas Works beneficiaries ages 19 to 49 who do not meet established exemption criteria described in STC 48 will be required to meet work requirements as a condition of Arkansas Works eligibility. Work requirements will not apply to Arkansas Works beneficiaries ages 50 and older. Medically frail individuals are not covered under the demonstration, and therefore, are not subject to work requirements.

48. **Exemption from Work Requirements.** Arkansas Works beneficiaries meeting one of the criteria below will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. Exemptions will be valid for the duration specified below. When a beneficiary's exemption expires, he or she may be required to demonstrate that the exemption is still valid.

Exemption Criteria	**Duration of Exemption**
Beneficiary's income is consistent with being employed or self-employed at least 80 hours per month	Exemption valid until a change in circumstances or renewal
Beneficiary attends high school, an institution of higher education, vocational training, or job training on a full-time basis	Exemption valid for six months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is exempt from Supplemental Nutrition Assistance Program (SNAP) work requirements	Exemption valid for duration of SNAP exemption
Beneficiary is receiving TEA Cash Assistance	Exemption valid for duration that individual is receiving TEA Cash Assistance
Beneficiary is incapacitated in the short-term or is medically certified as physically or mentally unfit for unemployment	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is caring for an incapacitated person or a dependent child under age 6	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary lives in a home with a minor dependent child age 17 or younger	Exemption valid until a change in circumstances
Beneficiary is receiving unemployment	Exemption valid for six months before

Exemption Criteria	Duration of Exemption
benefits	beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is currently participating in a treatment program for alcoholism or drug addiction	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is pregnant	Exemption valid until end of post-partum care

49. **Work Requirements.** Arkansas Works beneficiaries who are subject to the work requirements will be required to demonstrate electronically on a monthly basis that they are meeting them. Arkansas Works beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of the following activities as deemed appropriate by the state.

a. Employed or self-employed

b. Enrollment in an educational program, including high school, higher education, or GED classes

c. Participating in on-the-job training

d. Participating in vocational training

e. Volunteering

f. Participating in independent job search (up to 40 hours per month)

g. Participating in job search training (up to 40 hours per month)

h. Participating in a class on health insurance, using the health system, or healthy living (up to 20 hours per year)

i. Participating in activities or programs available through the Arkansas Department of Workforce Services

50. **Disenrollment for Failure to Meet Work Requirements.** Enrollees who are subject to work requirements will lose eligibility for Arkansas Works if they fail to meet work requirements for any three months during the coverage year, either consecutive or non-consecutive months. Effective the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage

after proper notice and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to reenroll in Arkansas Works.

51. **Catastrophic Events.** Enrollees who have experienced a catastrophic event will be exempt from work requirements.

~~IX.~~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 has submitted a state plan amendment delegating certain responsibilities to the Arkansas Insurance Department.

~~X.~~XI. GENERAL REPORTING REQUIREMENTS

~~50.~~52. **Deferral for Failure to Submit Timely Demonstration Deliverables.** The state agrees that CMS may issue deferrals in the amount of $5,000,000 when deliverables are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS.

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension in which to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

51.53. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state shall 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. Pursuant to 42 CFR 431.420(c),the state must include a summary of the comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

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

53.55. **Compliance with Federal Systems Innovation.** As federal systems continue to evolve and incorporate 1115 demonstration 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. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

XI.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.

54.56. **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.

55.57. **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~~65.

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
Demonstration	January 1, 2017	12 months

Year 4 (DY4)		
Demonstration Year 5 (DY5)	January 1, 2018	12 months
Demonstration Year 6 (DY6)	January 1, 2019	12 months
Demonstration Year 7 (DY7)	January 1, 2020	12 months
Demonstration Year 8 (DY8)	January 1, 2021	12 months

56.58. **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").

57.59. **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.

58.60. **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 8385, 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.

59.61. **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.

60.62. **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 6365:

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.

61.63. **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.

62.64. **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.

~~XII.~~XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

~~63.~~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 ~~66~~68, 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.

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 6368, 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.

65.67. **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 STC 6668 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 6769 below.

66.68. **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 6671. 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 4 - PMPM	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM
New Adult Group	4.7%	$570.50	$597.32	$625.39	$654.79	$685.56

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 1 of 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.

67.69. **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 9), 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.

68.70. **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.

69.71. **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 4	Cumulative budget neutrality limit plus:	0%
DY 5	Cumulative budget neutrality limit plus:	0%
DY 6	Cumulative budget neutrality limit plus:	0%
DY 7	Cumulative budget neutrality limit plus:	0%
DY 8	Cumulative budget neutrality limit plus:	0%

70.72. **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.

XIII.XIV. EVALUATION

71.73. **Evaluation Design and Implementation.** The State shall submit a draft evaluation design for Arkansas Works to CMS no later than 60 days after the award of the ~~Demonstration~~demonstration extension. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the Health Care Independence Program. The state must submit a final evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as an attachment to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within 30 days of CMS approval.

72.74. **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.

73.75. **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 Works 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 Arkansas Works 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 Arkansas Works 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 Arkansas Works. To the extent possible, component contributions to changes in access and quality and their associated levels of investment in Arkansas will be determined and compared to improvement efforts undertaken in other delivery systems.

~~74.~~76. **Evaluation Requirements.** 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.

~~75.~~77. **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. ~~QHP~~ Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.

x. ~~QHP~~ Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.

xi. ~~QHP~~ 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~~75 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.

~~xiii. The use of ESI premium assistance will result in reduced costs to Medicaid compared to costs through QHP premium assistance.~~

~~xiv.~~xiii. ~~ESI premium assistance~~Work requirements will increase the number of ~~employers offering ESI coverage.~~Arkansas Works beneficiaries who are employed.

~~xv. Continuity of coverage under ESI premium assistance will be improved compared to QHP premium assistance for individuals with access to ESI.~~

~~xvi.~~xiv. Incentive benefits offered to Arkansas Works beneficiaries will ~~increase participation rates for premium contributions compared to historical experience with Independence Accounts and~~ increase primary care utilization.

These hypotheses should be addressed in the demonstration reporting described in STC ~~83~~85 and ~~84~~86 with regard to progress towards the expected outcomes.

b. Data: This discussion shall include:

i. A description of the data, including a definition/description of the sources and the baseline values for metrics/measures;

ii. Method of data collection;

iii. Frequency and timing 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

c. Study Design: The design will include a description of the quantitative and qualitative study design, including a rationale for the methodologies 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. To the extent possible, the former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. 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

d. 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.

e. 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.~~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.

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~~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, and the deliverables outlined in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due.

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.

j. ~~j.~~ State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

~~76.~~78. **Interim Evaluation Report.** The state must submit a draft Interim Evaluation Report one year prior to this renewal period ending December 31, 2021. The Interim Evaluation Report shall include the same core components as identified in STC ~~77~~79 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The State shall submit the final Interim Evaluation Report within 30 days after receipt of CMS' comments.

~~77.~~79. **Summative Evaluation Reports.**

a. The state shall provide the summative evaluation reports described below to capture the different demonstration periods.

i. The state shall provide a Summative Evaluation Report for the Arkansas Private Option demonstration period September 27, 2013 through December 31, 2016. This Summative Evaluation Report is due July 1, 2018, i.e., eighteen months following the date by which the demonstration would have ended except for this extension.

ii. The state shall provide two Summative Evaluation Reports for the Arkansas Works demonstration period starting January 1, 2017 through December 31, 2021.

a. The first of these is due within 210 days of the end of this demonstration period, i.e., July 28, 2022. This report shall include documentation of outstanding assessments due to data lags to complete the summative evaluation.

b. The second of these is due within 500 days of the end of this demonstration period, i.e., May 15, 2023. The State should respond to comments and submit the final Summative Evaluation Report within 30 days after receipt of CMS' comments.

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

i. Executive Summary. This includes a concise summary of the goals of the ~~Demonstration~~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.

ii. Demonstration Description. This includes a description of the ~~Demonstration~~demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.

iii. 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.

iv. 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.

v. Policy Implications. This includes an interpretation of the conclusions; the impact of the ~~Demonstration~~demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful ~~Demonstration~~demonstration strategies to be replicated in other State Medicaid programs.

vi. 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.

~~78.~~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~~73. The State will present on its interim evaluation in conjunction with STC ~~76~~78. The State will present on its summative evaluation in conjunction with STC ~~77~~79.

~~79.~~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.

~~80.~~82. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, the state shall cooperate timely and 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. Failure to cooperate with federal evaluators in a timely manner, including but not limited to entering into data use agreements covering data that the state is legally permitted to share, providing a technical point of contact, providing data dictionaries and record layouts of any data under control of the state that the state is legally permitted to share, and/or disclosing data may result in CMS requiring the state to cease drawing down federal funds until satisfactory cooperation, until the amount of federal funds not drawn down would exceed $5,000,000.

~~81.~~83. **Cooperation with Federal Learning Collaboration Efforts.** The State will cooperate with improvement and learning collaboration efforts by CMS.

~~XIV.~~XV. MONITORING

~~82.~~84. **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. 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. Quality of care;

g. Beneficiary access,

h. Benefit package and wrap around benefits;

i. Audits;

j. Lawsuits;

k. Financial reporting and budget neutrality issues;

l. Progress on evaluation activities and contracts;

m. Related legislative developments in the state; and

n. Any demonstration changes or amendments the state is considering.

~~83.~~85. **Quarterly Reports.** The state must submit three Quarterly Reports and one compiled Annual Report each DY.

a. The state will submit the reports following the format established by CMS. All Quarterly Reports and associated data must be submitted through the designated electronic system(s). The Quarterly Reports are due no later than 60 days

following the end of each demonstration quarter, and the compiled Annual Report is due no later than 90 days following the end of the DY.

b. 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.

c. 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.

d. The Quarterly Report must include all required elements and should not direct readers to links outside the report, except if listed in a Reference/Bibliography section. The reports shall provide sufficient information for CMS to understand implementation progress and operational issues associated with the demonstration and whether there has been progress toward the goals of the demonstration.

    i. Operational Updates - The reports shall provide sufficient information to document 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. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.

    ii. Performance Metrics - Progress on any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports. Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

    iii. Budget Neutrality and Financial Reporting Requirements - The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

    iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and

how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, 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 for monitoring and evaluation of the demonstration.

e. The Annual Report must include all items included in the preceding three quarterly reports, which must be summarized to reflect the operation/activities throughout the whole DY. All items included in the quarterly report pursuant to STC ~~83~~85 must be summarized to reflect the operation/activities throughout the DY. In addition, the annual report must, at should include the requirements outlined below.

i. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

ii. Total contributions, withdrawals, balances, and credits; and,

iii. Yearly unduplicated 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.

~~84.~~86. **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.

ATTACHMENT B

Copayment Amounts[1]

General Service Description	Cost Sharing for Transitional Enrollees with Incomes >100% FPL
Behavioral Health - Inpatient	$~~140/day~~60
Behavioral Health - Outpatient	$4
Behavioral Health - Professional	$4
Durable Medical Equipment	$4
Emergency Room Services	-
FQHC	$8
Inpatient	$~~140/day~~60
Lab and Radiology	-
Skilled Nursing Facility	$20~~/day~~
Other	$4
Other Medical Professionals	$4
Outpatient Facility	-
Primary Care Physician	$8
Specialty Physician	$10
Pharmacy - Generics	$4
Pharmacy - Preferred Brand Drugs	$4
Pharmacy - Non-Preferred Brand Drugs, including specialty drugs	$8

No copayments for individuals at or below 100% FPL.

[1] ~~Enrollees~~ Transitional enrollees with incomes above 100% FPL will also be required to pay monthly premiums of up to 2 percent of household income.

APPENDIX A
Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers of Medicare and Medicaid Services (CMS) a written request to amend the Arkansas Works 1115 Demonstration waiver and to hold public hearings to receive comments on the amendments to the Demonstration.

The State will request amendments to the Arkansas Works 1115 Demonstration waiver to: (1) limit income eligibility for individuals in the eligibility group found at Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (hereinafter "the new adult group") to less than or equal to 100 percent of the federal poverty level (FPL) as of January 1, 2018; (2) institute work requirements as a condition of Arkansas Works eligibility as of January 1, 2018; (3) eliminate the Arkansas Works employer-sponsored insurance (ESI) premium assistance program on December 31, 2017; and (4) implement its waiver of retroactive eligibility on or after July 1, 2017.

With this amendment, on January 1, 2018, the State will limit income eligibility for individuals in the new adult group to less than or equal to 100 percent of the FPL, including the 5 percent income disregard required for the purposes of determining income eligibility based on modified adjusted gross income (MAGI) standards. The change in the eligibility limit will apply to both Arkansas Works enrollees and medically frail individuals covered under the State's fee-for-service Medicaid program. When members of the new adult group have their first eligibility redetermination or submit a change in circumstances after January 1, 2018, those determined to have an income above 100 percent of the FPL will no longer be eligible for Arkansas Works or Medicaid fee-for-service coverage. Individuals may enroll in qualified health plans (QHPs) supported by federal tax credits, or, for those individuals with access to ESI, may enroll in ESI.

Beginning on January 1, 2018, the State will institute work requirements as a condition of Arkansas Works eligibility. Once work requirements are fully implemented, all Arkansas Works enrollees who are ages 19-49 must work or engage in specified educational, job training, or job search activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the State. Arkansas Works enrollees who are subject to work requirements will be required to demonstrate that they are meeting the work requirements on a monthly basis. Arkansas Works enrollees who fail to meet the work requirements for any three months during a plan year will be disenrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year. Individuals who experience a catastrophic event will be exempt from work requirements.

Under this amendment, the State will also eliminate its ESI premium assistance program under the Demonstration on December 31, 2017. As of January 1, 2018, all Arkansas Works beneficiaries who were enrolled in ESI premium assistance and who remain eligible for Arkansas Works will transition to QHP coverage.

Finally, as part of this amendment, the State will modify the terms and conditions associated with implementing its waiver of retroactive eligibility. Beginning on or after July 1, 2017, the State will no longer provide retroactive coverage to the new adult group, including both Arkansas Works enrollees and medically frail individuals covered through the State's fee-for-service Medicaid program. Coverage will be effective as of the first day of the month that an individual applies for coverage.

The State will request the following waivers to implement the changes to the Demonstration:

- § 1902(a)(10)(B): To enable the State to phase out demonstration eligibility for individuals with incomes above 100 percent of the FPL.
- § 1902(a)(3): To enable the State to prohibit re-enrollment for the remainder of the calendar year for individuals disenrolled from coverage for failing to meet work requirements.

In addition, the State will request to modify its existing waivers to reflect that it: will no longer operate an ESI premium assistance program under the Demonstration; will limit income eligibility for the new adult group to 100 percent of the FPL; and plans to implement its waiver of retroactive eligibility by modifying the current terms and conditions to remove language on the enrollment backlog, reasonable opportunity, and hospital presumptive eligibility. Specifically, the State will request the following changes:

- § 1902(a)(23)(A): To enable Arkansas to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Arkansas Works beneficiary's QHP. No waiver of freedom of choice is authorized for family planning providers.
- § 1902(a)(13) and § 1902(a)(30): To permit Arkansas to provide for payment to providers equal to the market-based rates determined by the QHP.
- § 1902(a)(14) insofar as it incorporates § 1916 and § 1916A: To enable the State to collect monthly premiums for individuals with incomes above 100 percent of the FPL who remain enrolled in the Demonstration.
- § 1902(a)(10)(B): To enable the State to impose targeted cost sharing on individuals in the eligibility group found at § 1902(a)(10)(A)(i)(VIII) of the Act with incomes above 100 percent of the FPL who remain enrolled in the Demonstration.
- § 1902(a)(34): To enable the state to not provide retroactive eligibility for the affected populations; current conditions related to the enrollment backlog, reasonable opportunity, and hospital presumptive eligibility will no longer apply.

The State will seek to eliminate the following waiver and expenditure authorities related to its ESI premium assistance program:

Waiver

- § 1902(a)(4) insofar as it incorporates 42 CFR 431.53: To relieve the State of its obligation to provide non-emergency medical transportation to and from providers for individuals who are enrolled in employer-sponsored insurance and have not demonstrated a need for such transportation.

Expenditure Authorities

- Premium Assistance Payments for Employer-Sponsored Insurance. Expenditures for the employee share of cost-effective small group employer-sponsored insurance when the employer contributes at least 25 percent of the overall cost of the coverage for individuals enrolled in the new adult group described in Section 1902(a)(10)(A)(i)(VIII) of the Act, that would not meet the requirements for premium assistance under the state plan.
- Employer Incentives for New Or Expanded Employer-Sponsored Insurance: Expenditures for the employer share of cost-effective small group employer-sponsored insurance attributable to individuals receiving premium assistance under Demonstration expenditure authority #2 [Premium Assistance Payments for Employer-Sponsored Insurance], to the extent that the

remaining employer contribution is no less than 25 percent of the overall cost of the coverage, limited to a three year period per employer and only for employers who either (1) offer coverage effective on or after January 1, 2017 and had not offered coverage in calendar year 2016 or (2) offer non-grandfathered small group coverage effective on or after January 1, 2017 and had previously offered only grandfathered coverage.

The State continues to evaluate whether it will request other waivers or expenditure authorities.

The amendments to the Demonstration will further the objectives of Title XIX by providing continuity and smoothing the "seams" across the continuum of coverage, improving provider access, and promoting independence through employment.

These amendments will be statewide and will operate from calendar years 2018 through 2021, with the exception of the waiver of retroactive eligibility that will be implemented on or after July 1, 2017. The State anticipates that this amendment will affect most of the approximately 280,000 individuals covered under the Demonstration.

The Demonstration, including the proposed amendments, will test hypotheses related to access to care, quality of care, churning, cost-comparability, the elimination of retroactive coverage, and the impact of work requirements. The State expects that, over the life of the Demonstration, covering Arkansas Works enrollees will be comparable to what the costs would have been for covering the same group of Arkansas adults using traditional Medicaid. The State does not anticipate that the amendments to the Demonstration will affect its current waiver trend rate or per capita cost estimates, which can be found below.

Mandatory Enrollment Group	Trend	Demonstration Year (DY) 4 (2017) - Per Member Per Month (PMPM)	DY 5 (2018) - PMPM	DY 6 (2019) - PMPM	DY 7 (2020) - PMPM	DY 8 (2021) - PMPM
New Adult Group	4.7%	$570.50	$597.32	$625.39	$654.79	$685.56

The complete version of the current draft of the Demonstration application will be available for public review as of Friday, May 19, at https://www.medicaid.state.ar.us/General/comment/demowaivers.aspx. The Demonstration application may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

Public comments may be submitted until midnight on Sunday, June 18, 2017. Comments may be submitted by email to hciw@arkansas.gov or by regular mail to PO Box 1437, S-295, Little Rock, AR 72203-1437.

To view comments that others have submitted, please visit
https://www.medicaid.state.ar.us/general/comment/comment.aspx.
Comments may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contact: Becky Murphy

The State will host two public hearings during the public comment period.

1. Arkansas Works Waiver Amendment Public Hearing
   Date: May 25, 2017
   Time: 5:30 pm – 7:30 pm CDT
   Location: Central Arkansas Main Library in Little Rock, Darragh Center Auditorium
   Address: 100 S. Rock St, Little Rock, AR 72201

   You may also join by webinar on May 25, 2017 at 5:30 pm CDT.
   https://attendee.gotowebinar.com/register/4749300322783175 69

   After registering, you will receive a confirmation email containing information about joining the webinar.

2. Arkansas Works Waiver Amendment Public Hearing
   Date: June 06, 2017
   Time: 5:30 pm – 7:30 pm CDT
   Location: Arkansas State University in Jonesboro, Cooper Alumni Center
   Address: 2600 Alumni Blvd., Jonesboro, AR 72401

   You may also join by webinar on June 6, 2017 at 5:30 pm CDT.
   https://attendee.gotowebinar.com/register/3155727397286233858

   After registering, you will receive a confirmation email containing information about joining the webinar.

APPENDIX B
Overview of Public Notice Process for Arkansas Works Waiver Amendment

1) Start and end dates of the state's public comment period.

The State's comment period was from May 19, 2017 to June 18, 2017.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Arkansas certifies that it provided public notice of the application on the State's Medicaid website (https://www.medicaid.state.ar.us/) beginning on May 19, 2017. Arkansas also certifies that it provided notice of the proposed amendment to the Demonstration in the *Arkansas Democrat- Gazette*—the newspaper of widest circulation in Arkansas—on May 19, 20, and 21. A copy of the notice that appeared in the newspaper is included here as Appendix A.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Arkansas certifies that it convened two public hearings at least twenty days prior to submitting the Demonstration amendment application to CMS. Specifically, Arkansas held the following hearings:

- *Little Rock – May 25, 2017, from 5:30 – 7:30 pm.* Mary Franklin, Director of the Arkansas Division of County Operations, provided an overview of the amendment to the Demonstration. Individuals could also access this public hearing by teleconference and webinar.
- *Jonesboro – June 6, 2017 from 5:30 pm – 7:30 pm*. Mary Franklin, Director of the Arkansas Division of County Operations, provided an overview of the amendment to the Demonstration. Individuals could also access this public hearing by teleconference and webinar.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

Arkansas certifies that it used an electronic mailing list to provide notice of the proposed amendment to the Demonstration to the public. Specifically, Arkansas Medicaid provided notice through email lists of key stakeholders, including payers, providers, and advocates.

5) Comments received by the state during the 30-day public notice period.

Arkansas received 58 comments during the public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

We attach here at Appendix C a document summarizing and responding to the comments received. In addition, we have included all public comments received in Appendix D.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Arkansas contains no federally recognized tribes or Indian health programs. As a result, tribal consultation was not required.

APPENDIX C
Responses to Public Comments on Arkansas Works Waiver Amendment

General Comments

Comment: Several commenters expressed robust support for the Arkansas Works demonstration and its success in reducing the uninsurance rate. Commenters noted that the coverage provided through Arkansas Works has been crucial to improving the health of Arkansans and increasing access to and quality of care. Commenters also indicated that Arkansas Works has had a positive impact on the State budget and providers' financial stability.

Response: The State appreciates commenters' support for Arkansas Works and is proud that the demonstration has played a key role in improving Arkansans' health. Arkansas looks forward to continuing implementation of the demonstration, while tailoring the program to better meet the needs of all Arkansans. The Department of Human Services (DHS) will continue its work with stakeholders across the State to ensure the demonstration's ongoing success and sustainability.

Comment: Two commenters recommended that Arkansas conduct in-depth outreach and education to ensure that enrollees understand the changes to Arkansas Works. One commenter noted that historically, the State has not conducted sufficient outreach related to demonstration modifications and suggested that the State develop a detailed outreach and education plan for the proposed waiver amendment. Furthermore, the commenter noted the importance of education materials being written at an appropriate reading level.

Response: Arkansas agrees that enrollee outreach and education will be critical to ensuring the success of the proposed waiver amendment. Arkansas is currently working with carriers, providers, and other key stakeholders to develop strategies to inform enrollees about upcoming changes to Arkansas Works. These efforts have focused on proposals to implement work requirements and modify income eligibility for expansion adults in Arkansas to 100% of the federal poverty level (FPL). Together with carriers, providers, and other stakeholders, the State will launch a multi-pronged outreach strategy in the months before any changes are implemented, including extensive direct outreach to enrollees through notices. The State will ensure that all direct-to-enrollee communications are at an appropriate readability level.

Comment: Three commenters expressed concern that the State is seeking to amend the Arkansas Works demonstration while Congress is contemplating significant changes to the federal health care landscape. Two commenters noted that in particular, it is unclear whether advance premium tax credits (APTCs) and cost-sharing reduction (CSR) payments will continue to be available on the Marketplace in the future, and if these subsidies cease to exist, it will be difficult for current Arkansas Works enrollees with incomes above 100% FPL to afford coverage on the Marketplace.

Response: The State agrees that changes in federal support for health insurance could affect options available to individuals transitioning off Arkansas Works. Accordingly, Arkansas is closely monitoring legislation being considered by Congress. Depending on what, if any, changes to federal health care programs are enacted by Congress, the State may consider modifying Arkansas Works.

Comment: Several commenters indicated that they believe that the proposed Arkansas Works waiver amendment does not align with the goals of the Medicaid program.

Response: The proposed changes to Arkansas Works are intended to strengthen Arkansas's Medicaid program and ensure that it remains sustainable. Although enrollees with incomes above 100% FPL will transition out of Arkansas Works, these individuals will be able to maintain coverage and access to providers through Marketplace and employer-sponsored insurance (ESI) coverage—plans they can remain in as they continue to climb the income ladder. Further, with these changes, Arkansas Works will be better positioned to focus on continuing to improve health outcomes and the quality of care for the most vulnerable enrollees.

Comment: Several commenters opposed the waiver amendment request, expressing concern that proposed features such as changing the income eligibility limit to 100% FPL and the implementation of work requirements will increase the number of uninsured Arkansans.

Response: The State notes that all individuals currently enrolled in Arkansas Works will continue to have access to coverage when the waiver amendment is implemented. Individuals with incomes above 100% FPL will be able to enroll in qualified health plans (QHPs) on the Marketplace with financial support from APTCs and CSRs or employer-sponsored coverage. Individuals with incomes at or below 100% FPL will remain covered through the demonstration and may be subject to work requirements as a condition of eligibility. The proposed waiver amendment emphasizes the importance of personal responsibility in maintaining coverage, and as described above, DHS will conduct extensive education and outreach to promote continuity of coverage. Over the length of the demonstration, the State will monitor Arkansas's uninsurance rate.

Comment: Two commenters flagged that they believe that features of the proposed waiver amendment, including the reduction in the income eligibility to 100% FPL, the implementation of work requirements, and the elimination of retroactive eligibility, will negatively impact access to and continuity of care.

Response: The State agrees that access to and continuity of care are critical to improving health outcomes in Arkansas. Arkansas's QHP premium assistance model is designed to promote continuity of care as individuals move between Medicaid and Marketplace coverage. Many individuals with incomes above 100% FPL will be able to remain in the same QHP when they transition to Marketplace coverage. Individuals with incomes at or below 100% FPL who comply with or are exempt from work requirements will retain their current coverage.

Comment: Several commenters noted that individuals who become uninsured may forego necessary medical treatment, worsening the State's health outcomes, or that they may rely on the emergency room as their primary source of care.

Response: As discussed above, the State anticipates that most enrollees transitioning off of Arkansas Works will enroll in other coverage that enables them to continue receiving all medically necessary care. In addition to the State's efforts to work with carriers and brokers to promote seamless coverage, Arkansas is also working closely with providers to ensure that providers are equipped to assist their patients in obtaining and maintaining coverage. This multi-pronged outreach and engagement strategy will promote continued coverage and access to care.

Comment: Several commenters expressed concern that proposed features of the waiver amendment, including adjusting the income eligibility limit to 100% FPL, implementing work requirements, and eliminating retroactive eligibility, will decrease financial stability for providers serving low-income

populations. In particular, commenters noted that the State's proposal may increase uncompensated care costs and bad debt.

Response: The State is committed to ensuring the financial stability of Arkansas's providers. In the coming months, DHS will collaborate with the provider community to develop strategies to achieve this objective. Arkansas will also monitor any changes in uncompensated care over the course of the demonstration.

Comment: Several commenters flagged that proposed changes to Arkansas Works will be administratively complex and costly for the State to implement. Commenters expressed particular concerns about how the State will operationalize the work requirement, noting that the State will need to build new technology and hire new staff to monitor compliance with the requirement.

Response. The State appreciates these comments and is in the midst of a year-long planning process to ensure the smooth implementation of this waiver amendment. Arkansas is working with its vendors to enact in the most cost-effective way possible the systems changes necessary to operationalize features of the waiver amendment, including the adjustment in income eligibility for expansion adults, implementation of work requirements, and the elimination of retroactive eligibility.

Comment: One commenter noted that the proposed waiver amendment will result in more frequent changes to individuals' Arkansas Works eligibility. The commenter noted that frequent eligibility changes will be onerous for insurance carriers covering Arkansas Works enrollees.

Response: The State is grateful for its continued partnership with carriers throughout implementation of Arkansas Works and seeks to minimize carriers' administrative burden to the extent possible. As described above, DHS is collaborating with carriers to develop strategies promoting continuity of coverage as the State implements the Arkansas Works waiver amendment.

Income Eligibility for Expansion Adults

Comment: Several commenters expressed concern that individuals with incomes above 100% FPL transitioning from Arkansas Works to the Marketplace will be subject to higher maximum out-of-pocket spending than they would have paid under Arkansas Works. Commenters flagged that higher cost sharing on the Marketplace may deter individuals from seeking medically necessary care.

Response: Arkansas agrees that it is essential for low-income individuals to have access to affordable coverage. Under current law, individuals with incomes above 100% FPL who are transitioning to the Marketplace will have access to APTCs and CSRs, which will ensure that premiums and cost-sharing remain at levels similar to those in Arkansas Works. Specifically, the State has evaluated premiums charged by silver plans on the Arkansas Marketplace and believes that enrollees transitioning to the Marketplace will only experience minimal premium increases after accounting for the APTCs. Finally, Arkansas requires all carriers in its Marketplace to offer a 94% AV silver plan that complies with a standardized cost-sharing design meeting Medicaid cost-sharing requirements. Individuals transitioning from Arkansas Works to the Marketplace will have the option of remaining in the same QHP, meaning that if they remain in their current plan, their cost sharing will remain the largely the same with the exception of a deductible.

Comment: Three commenters indicated that affordability of coverage will be a particular concern for individuals with incomes above 100% FPL transitioning out of Arkansas Works who have access to ESI.

They noted that ESI is considered affordable if an employee's premiums are less than 9.69% of household income.

Response: The State considers affordable ESI a priority for Arkansans at all income levels. While ESI affordability standards are established by the federal government, analyses by the State have found that Arkansas employers contribute generously to ESI premiums. Over the course of the demonstration, the State will monitor whether ESI premiums present a barrier to coverage for low-income employees in Arkansas.

Commenter: One commenter noted that by decreasing the Arkansas Works income eligibility limit to 100% FPL, the State will increase the number of families subject to the Affordable Care Act's "family glitch." Under the "family glitch," ESI affordability for a household is determined based on the cost of employee-only coverage instead of the cost of a family plan.

Response: The State agrees that the "family glitch" is problematic and notes that the federal government establishes ESI affordability standards. Further, children will continue to be eligible for Medicaid coverage up to 138% FPL.

Comment: One commenter requested that Arkansas consider permitting medically frail expansion adults with incomes above 100% FPL, including individuals in active cancer treatment and recent cancer survivors, to remain covered by Arkansas Medicaid until they no longer meet medical frailty criteria. In addition, the commenter recommended that if the State does not permit medically frail expansion adults with incomes above 100% FPL to remain enrolled in Medicaid, that it establish continuity of care policies to ensure that individuals undergoing cancer treatment can retain their providers and course of treatment.

Response: Arkansas appreciates these recommendations and agrees that continuity of care is a priority for medically frail individuals. The vast majority of medically frail individuals have incomes below 100% FPL, and as a result, will remain enrolled in Arkansas Medicaid in 2018. DHS believes that it is important that all current expansion adults with incomes above 100% FPL are treated comparably by the State and intends to transition all individuals with incomes above 100% to the Marketplace or ESI. The State will work with carriers to develop strategies promoting continuity of coverage for medically frail individuals with incomes above 100% FPL.

Comment: Two commenters expressed concern that modifying the expansion adult income eligibility limit to 100% FPL will increase the amount of churn between Medicaid, the Marketplace, and being uninsured.

Response: Arkansas recognizes that regardless of the Medicaid eligibility limit, enrollees may churn between Medicaid and the Marketplace. The State created Arkansas Works, and its predecessor, the Private Option, to smooth the "seams" between Medicaid and Marketplace coverage and permit individuals to remain in the same health plan as their income changes. As a result, when Arkansas modifies the expansion adult eligibility limit to 100% FPL and transitions this population to the Marketplace, these enrollees will have the opportunity to remain in their current plan unless they have access to affordable ESI. As noted above, the State intends to work with carriers, agents, brokers, and other stakeholders to promote continuity of coverage.

Comment: Three commenters asked whether the State will continue to receive the enhanced federal medical assistance percentage (FMAP) for expansion adults with its proposal to limit Arkansas Works income eligibility to 100% FPL.

Response: Arkansas will continue to receive enhanced FMAP for expansion adults who remain covered under the demonstration and is working with the Centers for Medicare and Medicaid Services (CMS) to confirm this understanding.

Comment: One commenter expressed concern about the State's projection that modifying the Arkansas Works income eligibility level to 100% FPL will increase premiums in the individual market by 0.8% to 1.7%. In addition, the commenter was unsure whether the State will approve adequate carrier rate increases to reflect the change in the Arkansas Works income eligibility.

Response: DHS is working closely with carriers to promote a smooth transition for individuals with incomes above 100% FPL from Arkansas Works to the Marketplace and projects that adjusting the Arkansas Works income eligibility limit will only result in minimal changes to the cost of insurance premiums on the individual market. Since Arkansas Works employs a QHP premium assistance model, Arkansas Works enrollees are currently in the same risk pool as Marketplace enrollees and will remain in the same risk pool in the future. Accordingly, the State expects that the individual market risk pool will remain largely the same with changes to the demonstration. When reviewing carriers' proposed rate increases, the Arkansas Insurance Department will ensure that the rates are sufficient to ensure access and provider stability, while avoiding excessive increases that would be unaffordable for consumers.

Other Eligibility Provisions

Comment: Several commenters opposed the State's proposal to implement its waiver of retroactive eligibility for reasons including concerns regarding medical debt, gaps in coverage, and increased uncompensated care costs.

Response: Arkansas agrees that it is important to promote affordable coverage, minimize gaps in coverage, and promote timely enrollment in Medicaid. Arkansas believes that the need for retroactive coverage is limited and that waiving this provision will not have a large impact on uncompensated care costs.

Comment: Several commenters encouraged Arkansas to institute hospital presumptive eligibility, particularly in light of the State's request to implement its waiver of retroactive eligibility.

Response: As noted above, the State agrees that timely access to Medicaid coverage is crucial and has developed multiple pathways to provide individuals with such timely access to coverage.

Comment: Two commenters noted that with the requested changes to Arkansas Works, it will be critical for the State to conduct administrative reviews to evaluate whether individuals with incomes above 100% FPL may be eligible for another Medicaid eligibility category or subsidies in the Marketplace. Another commenter requested clarification around Arkansas's administrative review process.

Response: Arkansas agrees that it is essential to assist enrollees with transitions between insurance affordability programs and that renewals should be as seamless as possible. The Arkansas Division of County Operations will leverage the account transfer service to transfer files for individuals who are no longer eligible for Arkansas Works to the Marketplace. The State is also working with carriers, agents,

and brokers, among other stakeholders, to promote smooth transitions between Arkansas Works and the Marketplace.

Premium Assistance for Employer-Sponsored Insurance

Comment: Several commenters opposed the State's proposal to eliminate the Arkansas Works ESI premium assistance program, citing that this change will make it more difficult for individuals to obtain coverage.

Response: While Arkansas believes that encouraging employer and employee adoption of ESI is an important priority, the State has determined that it is more efficient to deliver Arkansas Works coverage through QHPs. Currently, there is limited enrollment in the Arkansas Works ESI premium assistance program, meaning that the elimination of this program will cause minimal disruption to enrollees while streamlining the program's administration.

Work Requirements

Comment: Two commenters supported Arkansas's interest promoting employment, creating household independence, promoting financial stability, and increasing opportunities for economic advancement.

Response: The State thanks commenters for their support of these important objectives. The Arkansas Works work requirements aim to encourage individuals to climb the economic ladder.

Comment: One commenter appreciated that enrollees will be able to meet the work requirement through a range of activities, including employment, job training, education, and volunteerism.

Response: The State recognizes that there are many pathways to economic advancement, including employment, on-the-job training, vocational training, and education, among other activities. In designing the Arkansas Works work requirement, the State felt that it was important to give individuals multiple options for obtaining skills necessary for success in the workplace.

Comment: Several commenters requested clarification of Arkansas's goals for work requirements. They noted that many Arkansas Works enrollees are already employed, and that many unemployed enrollees experience significant barriers to employment, such as a chronic illness or family caregiving responsibilities.

Response: In proposing work requirements, Arkansas is seeking to promote independence through employment. The State believes that work requirements are a critical vehicle for incentivizing individuals to engage in work. Many individuals who experience barriers to working, such as individuals who are medically frail or care for an incapacitated person or dependent under age six, will either not be subject to or exempt from work requirements.

Comment: Several commenters opposed Arkansas's proposed work requirements approach. Specifically, they were concerned that individuals who fail to meet requirements for three months will be disenrolled from Arkansas Works and locked out of coverage until the next plan year.

Response: To incentivize enrollees to work and encourage personal responsibility, Arkansas believes that it is crucial that compliance with work requirements be a condition of Medicaid eligibility. All individuals subject to the work requirement will have the opportunity to remain enrolled in Arkansas Works, and

the State has identified a wide range of activities that enrollees can participate in to meet the requirement.

Comment: One commenter requested assurance that federally mandated appeals rights, including the right to a fair hearing on eligibility determinations and coverage issues, will apply when Arkansas implements work requirements. Another commenter asked for details about the process through which enrollees can appeal decisions related to work requirements.

Response: The State is committed to ensuring that Arkansas Works enrollees will retain all federally mandated appeals rights. With the implementation of work requirements, the State will ensure that enrollees maintain their appeals rights, including the right to a fair hearing. Through notices, the State will provide enrollees with information about how they can appeal decisions related to work requirements.

Comment: One commenter requested clarification about whether the State will provide employment services to individuals subject to work requirements.

Response: The State is committed to providing employment services to individuals subject to the work requirement. DHS is working with the Arkansas Department of Workforce Services (DWS) to ensure the availability of employment services for enrollees subject to work requirements.

Comment: Two commenters suggested that the State reallocate funds designated for implementation of work requirements and instead fund voluntary employment and education programs.

Response: The State thanks commenters for this recommendation. Arkansas believes that a mandatory work requirement is important to achieving maximum gains in employment among the Arkansas Works population and will be investing in employment and education programs to support enrollees.

Comment: Several commenters expressed concern that it may be challenging for enrollees to report their compliance with or exemption from work requirements. Commenters flagged that individuals who are in compliance with the work requirement may lose coverage if they misunderstand processes for reporting.

Response: The State is planning to conduct a robust outreach and education campaign around work requirements to ensure that enrollees understand the reporting process. Arkansas Works call center staff will be available to assist enrollees who have difficulties reporting their compliance with the work requirement. In addition, as Arkansas continues to develop its electronic portal for reporting on work requirements, it will strive for the tool to be as user friendly as possible.

Comment: Three commenters stated that some Arkansas Works enrollees may not have reliable internet access, meaning that they will have difficulty accessing the electronic work requirements portal.

Response: If enrollees do not have home or mobile internet access, they will be able to access the portal at Division of County Operations offices.

Comment: Two commenters expressed concern that the process for obtaining exemptions from work requirements will be onerous for enrollees. One commenter noted that it may be confusing that the duration of exemptions differs across exemptions.

Response: Arkansas agrees that it is important that the exemption process is consumer friendly. As noted above, the State will undertake an extensive enrollee education and outreach campaign related to work requirements and will strive to make the work requirements portal easy for enrollees to use.

Comment: Commenters requested additional information about the State's intended process for assessing compliance with work requirements.

Response: Arkansas is building an electronic work requirements portal, which will be the primary mechanism for assessing compliance with the work requirement. Enrollees who are subject to work requirements will be required to login to the State's electronic work requirements portal on a monthly basis and attest compliance for the previous month no later than the fifth day of the month. If an enrollee does not attest by the fifth day of the month, DHS will send a notice informing the enrollee that he/she has accrued a month of non-compliance. If an enrollee is in the third month of non-compliance, the State will send a notice informing the enrollee that he/she will be disenrolled from coverage at the end of the month unless he/she attests to compliance by the fifth day of the next month.

Comment: Several commenters expressed concern that the proposed work requirements will be costly and complex for Arkansas to administer and noted that the State will need to establish systems to track compliance with the work requirement and send notices to enrollees.

Response: The State agrees that administering work requirements will require changes to State systems and the creation of a new work requirements portal. Over the past six months, Arkansas has conducted extensive planning on systems changes and other administrative issues to facilitate the smooth and cost-effective rollout and implementation of work requirements.

Comment: One commenter appreciated that the State exempted certain populations from the work requirement.

Response: Arkansas thanks the commenter for this support and understands that certain enrollees, such as those who are medically frail, caring for an incapacitated person, or participating in a drug or alcohol treatment program, may experience barriers that prevent them from meeting the work requirement.

Comment: One commenter requested that the State clarify the definition of a "catastrophic event" that would exempt an enrollee from work requirements.

Response: Arkansas will establish a process to identify a "catastrophic event" that would exempt an enrollee from work requirements. This exemption is intended to prevent the disenrollment of enrollees who experience an unexpected hardship that prevents them from meeting work requirements.

Comment: Several commenters indicated concern about the potential for medically frail individuals to be disenrolled from coverage for failure to meet the work requirement.

Response: The State agrees that medically frail individuals should not be subject to the work requirement. Medically frail individuals are covered through Arkansas's Medicaid fee-for-service program, which is outside of the Arkansas Works demonstration. As a result, they will not be subject to work requirements.

Comment: One commenter suggested that Arkansas should expand its definition of medically frail individuals to include cancer patients and recent cancer survivors since these populations will have difficulty meeting work requirements.

Response: The State thanks the commenter for this recommendation and agrees that cancer patients and recent cancer survivors may have difficulty meeting work requirement. The State expects that cancer patients and many recent cancer survivors will either be exempt from the work requirement on the basis of having a short-term incapacitation or will not be subject to the work requirement on the basis of being medically frail.

Comment: One commenter expressed concern about 19- and 20-year old Arkansas Works enrollees being subject to the work requirement. The commenter noted that 19- and 20-year olds are assuming many new responsibilities as they transition from school to work, and they may have particular difficulty reporting compliance with the work requirement.

Response: Arkansas agrees that 19- and 20-year olds face many new responsibilities as they transition into adulthood. Accordingly, this transition is a pivotal time to incentivize work. The State notes that 19- and 20-year olds will not be subject to the work requirement in the first year of implementation, and during that year, the State will consider outreach strategies targeted towards this age group.

Comment: One commenter requested that Arkansas provide further clarification on the State's definition of "incapacitated," noting that individuals with a short-term incapacitation and individuals who are caring for an incapacitated person are exempt from the work requirement.

Response: The State is in the process of refining its definition of "incapacitated" and will provide more detailed specification for the exemption criteria as part of the educational materials on work requirements.

Comment: One commenter expressed concern that when the work requirement is implemented, individuals with disabilities will have difficulty obtaining an exemption because of physical or mental challenges that they face, such as difficulty understanding the exemption process or traveling to a medical appointment necessary to validate an exemption.

Response: The State agrees that individuals with disabilities should not be subject to work requirements. Medicaid enrollees who receive Supplemental Security Income (SSI) or who are medically frail are not eligible for the Arkansas Works demonstration, and therefore will not be subject to work requirements. As part of education and outreach efforts, Arkansas will provide Arkansas Works enrollees with detailed information about how to notify DHS if they believe that they should not be subject to the work requirement on the basis of being medically frail or should be exempt from the work requirement on the basis of having a short-term incapacitation, participating in an alcohol or drug treatment program, or any other specified exemption criteria.

Comment: One commenter suggested that the State develop a medical or hardship exemption from work requirements to ensure that individuals managing complex medical conditions are not subject to disenrollment if they do not comply with requirements.

Response: The State appreciates this comment and anticipates that many enrollees managing complex medical conditions will either not be subject to or will be exempt from work requirements on the basis

of being medically frail or having a short-term incapacitation. Enrollees will have the ability to attest to having short-term incapacitation or being medically frail throughout the coverage year.

Comment: One commenter requested that Arkansas exempt enrollees with mental illness from work requirements.

Response: Arkansas agrees that if an individual is mentally unable to work, he or she should be exempt from the work requirement. The State will treat inability to work because of a physical or mental issue comparably. Arkansas anticipates that many individuals who are unable to work because of mental illness will either be not subject to or will be exempt from work requirements on the basis of being medically frail or having a short-term incapacitation. As noted above, enrollees will have the ability to attest to a short-term incapacitation or medical frailty throughout year.

Comment: Two commenters flagged that Arkansas Works enrollees residing in rural areas of the State may face significant barriers to meeting work requirements. The commenters noted that rural areas have higher rates of unemployment and poverty than other areas of Arkansas and experience transportation challenges.

Response: DHS is working closely with DWS to ensure that Arkansas Works enrollees in all regions of the State have sufficient opportunities to meet work requirements.

Comment: One commenter questioned whether work requirements are permissible under federal law.

Response: Arkansas appreciates that the Trump Administration has indicated a willingness to grant states increased flexibility to tailor their Medicaid programs to their populations. At the federal level, the Department of Health and Human Services has signaled strong interest in testing innovative programs that promote employment. The State believes that the proposed Arkansas Works work requirements are in line with this federal priority.

Benefits

Comment: One commenter expressed concern about the demonstration eliminating the non-emergency medical transportation (NEMT) benefit for Arkansas Works enrollees.

Response: The State wishes to clarify that it is not seeking to eliminate the NEMT benefit in Arkansas Works and that enrollees will continue to have access to this benefit. Arkansas recognizes that lack of transportation is a barrier to seeking appropriate medical care, particularly in rural areas of the State.

Comment: One commenter recommended that the State consider implementing a healthy behavior incentive program targeted towards prevention and management of chronic conditions.

Response: The State appreciates this recommendation and is currently considering strategies to promote healthy behaviors through Arkansas Works.

Evaluation

Comment: To reflect new program features proposed through the waiver amendment, two commenters suggested that the State incorporate additional hypotheses into its evaluation design. Commenters recommended the inclusion of hypotheses related to the impact of modifying the expansion adult

income eligibility limit to 100% FPL, eliminating retroactive eligibility, and implementing work requirements as a condition of Arkansas Works eligibility.

Response: The State agrees that it is important to evaluate the impact of new Arkansas Works features. In response to commenters' recommendations, the State will be adding new hypotheses to the waiver amendment evaluation.

Appendix D

Arkansas Works Waiver Phase-Out and Transition Plan
June 30, 2017
DRAFT

The Arkansas Works Act of 2016 requires that "Within thirty (30) days of a reduction in federal medical assistance percentages...the Department of Human Services shall present to the Centers [for] Medicare and Medicaid Services a plan to terminate the Arkansas Works Program and transition eligible individuals out of the Arkansas Works Program within one hundred twenty (120) days of a reduction in any of the following federal medical assistance percentages:

(A) Ninety-five percent (95%) in the year 2017;
(B) Ninety-four percent (94%) in the year 2018;
(C) Ninety-three percent (93%) in the year 2019; and
(D) Ninety percent (90%) in the year 2020 or any year after the year 2020."

To meet the requirements of this Act and enable the State to have the flexibility to expeditiously terminate coverage for the adult expansion group in the case of a reduction in the federal medical assistance percentage (FMAP), Arkansas is holding a 30-day public comment period beginning on [INSERT DATE] on its waiver phase-out and transition plan. After the 30-day public comment period, on [INSERT DATE], Arkansas will submit the plan to the Centers for Medicare and Medicaid Services (CMS). Once approved, this plan will "sit on the shelf" at CMS unless and until a reduction in FMAP causes the State to terminate the Arkansas Works demonstration and coverage for the adult expansion group. The State will notify CMS of its intent to activate the phase-out and transition plan within 30 days of a reduction in FMAP for the adult expansion group. The basis for this notification will be the effective date of the FMAP reduction thereby triggering the termination procedures as outlined in this plan.

Introduction

The United States Congress passed legislation reducing the FMAP for the adult expansion group to [INSERT PERCENTAGE] beginning on [INSERT DATE], thereby triggering termination procedures for the Arkansas Works Section 1115 waiver and coverage for the adult expansion group in Arkansas. This document describes Arkansas's waiver phase-out and transition plan that will be implemented, beginning [INSERT DATE], to meet State statutory requirements. Coverage for the adult expansion group in Arkansas will terminate on [INSERT DATE].

Summary of Arkansas Works Eligibility

Under the Arkansas Works demonstration, Arkansas has provided premium assistance to support individuals in the adult expansion group to purchase qualified health plans (QHPs) offered on the Marketplace and cost-effective employer-sponsored insurance (ESI) coverage offered through their participating employers. Medically frail individuals are only eligible for coverage under the demonstration if they have access to cost-effective ESI and they elect to receive the alternative benefit plan.

Since the State is terminating coverage for the entire adult expansion group, the provisions of this waiver phase-out and transition plan apply to medically frail adults receiving coverage outside of the

demonstration, in addition to all members of the adult expansion group covered under Arkansas Works. The remainder of this document applies to all members of the adult expansion group in Arkansas, regardless of whether they are covered under the Arkansas Works demonstration.

Adult Expansion Group Coverage Phase-Out and Noticing Process

Beginning on [

DATE], Arkansas's Division of County Operations (DCO) will begin the coverage termination process for all members of the adult expansion group. The process will be completed as follows:
DCO will send members of the adult expansion group notices regarding the termination of Arkansas Works and coverage for the adult expansion group, including information regarding appeal and hearing rights. The State will comply with all appeal and fair hearing requirements.

Initial Notices Regarding Termination of Coverage for the Adult Expansion Group

The State will send all adults in the adult expansion group notices regarding the termination of Arkansas Works. This notice will include the effective date that adult expansion coverage will end. This notice will inform individuals who are pregnant or disabled how to apply for continued coverage through other Medicaid eligibility categories. The notice will also provide information on the right and process to appeal.

Individuals Found Eligible for Another Eligibility Category

DCO will send notices to members of the adult expansion group who apply for and are found eligible for coverage under a different Medicaid eligibility category. The notice will also provide information on the right and process to appeal.

Notices Informing Individuals of the Outcome of Appeals

Individuals who have been found ineligible for another Medicaid eligibility category or who have failed to submit their application for an eligibility determination in another Medicaid category can appeal their eligibility determination and the termination of coverage.

DCO will send members of the adult expansion group who are found eligible for coverage under a different Medicaid eligibility category on the basis of an appeal a notice informing them that they will be disenrolled from their current coverage and immediately enrolled in Medicaid under another eligibility category. DCO will send individuals found ineligible for coverage under a different Medicaid eligibility category on the basis of an appeal a notice informing them that their Arkansas Works coverage will be terminated and their eligibility information will be sent to the FFM.

Arkansas will leverage its existing notice and eligibility processes to complete this phase-out and transition.

Eligibility for Other Insurance Affordability Programs.

At the time that notices are generated to the adult expansion group informing them of the end of the program and the effective date their coverage will end, the State will transfer their files to the federally-facilitated Marketplace (FFM) through the Account Transfer service for determination of advanced premium tax credit eligibility.

Community Outreach

Arkansas will conduct community outreach to ensure that stakeholders are informed about the termination of Arkansas Works and coverage for the adult expansion group. Outreach will include:

Arkansas State Websites. Arkansas will post beneficiary-facing information about the phase-out of Arkansas Works and coverage for the adult expansion group on the Arkansas Medicaid website (https://www.medicaid.state.ar.us/) and the Arkansas Works ESI premium assistance program website. In addition, Arkansas will post beneficiary-facing information on the Access Arkansas website (https://access.arkansas.gov/), where Arkansans apply for Medicaid and other publicly-funded social service programs, and the Insure Ark website (https://www.insureark.org/), the beneficiary portal for QHP selection.

Carriers. Arkansas will hold a meeting for QHP carriers to discuss the Arkansas Works phase-out process. In addition, Arkansas will send carriers written information regarding the termination process and will ask carriers to notify their enrollees about the termination of coverage.

Providers. Arkansas will develop informational materials for carriers to distribute to their provider networks regarding the termination of Arkansas Works.

Employers. Arkansas will notify employers participating in its ESI premium assistance program about the termination of Arkansas Works.

Call Centers. Arkansas will train its Medicaid and ESI premium assistance program call center staff on the specifics of the termination of coverage for the adult expansion group. This training will include information on other coverage options such as HealthCare.gov.

Other Community Stakeholders. Arkansas maintains an email list of key Arkansas Works and Medicaid stakeholders. The State will provide these stakeholders with information about the process for terminating coverage for the adult expansion group and will notify them when the Arkansas Medicaid website has been updated with new information.

Systems Changes

Arkansas will update its eligibility system and the Access Arkansas website to reflect the termination of the adult expansion group. To terminate Medicaid eligibility for the adult expansion group, on [INSERT DATE], Arkansas will submit the Eligibility State Plan Amendment (SPA): "Mandatory Eligibility Groups-Mandatory Coverage: Adult Group" to CMS. Arkansas will also update its eligibility rules in HealthCare.gov using the required CMS form.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-06
Baltimore, Maryland 21244-1850

State Demonstrations Group

MAY 3 1 2018

Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Dear Ms. Gillespie:

The State of Arkansas submitted its community engagement eligibility and enrollment monitoring plan as required by special term and condition (STC) 54 of the state's section 1115 demonstration, Arkansas Works (Project No. 11-W-00287/6). The Centers for Medicare & Medicaid Services (CMS) has reviewed the monitoring plan and determined that it is consistent with the requirements outlined in the STCs; therefore, with this letter, CMS is approving the monitoring plan for completeness and the state may continue implementation of its community engagement program under the terms of its demonstration.

The monitoring plan has been incorporated in the STCs as Attachment A; we have included a copy of the revised STCs with the updated Attachment A. As outlined in STC 54, the state will provide status updates on the implementation of the eligibility and enrollment monitoring plan as part of the state's quarterly and annual monitoring reports. Should the state wish to make additional changes to the monitoring plan, the state should submit revisions to the plan for CMS review and approval. As you know, CMS is developing additional community engagement monitoring metrics and templates for reporting these metrics and related qualitative information about the state's implementation. We look forward to receiving input from Arkansas as we finalize these metrics. Once finalized, they will be incorporated into the state's monitoring plan. This effort is important to CMS' commitment to accountability. It also allows us to observe trends over time and across states, to support learning and identification and diffusion of best practices in community engagement strategies.

If you have any questions, please contact your project officer, Ms. Jessica Woodard, at 410-786-9249 or by email at Jessica.Woodard@cms.hhs.gov. We appreciate your cooperation throughout the review process.

Sincerely,

[redacted]

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Bill Brooks, Associate Regional Administrator, CMS Dallas Regional Office

Eligibility and Enrollment Monitoring Plan

Arkansas Works – Work and Community Engagement Amendment

Strategic Approach

Overview

Arkansas plans to test innovative and administratively efficient approaches to promoting personal responsibility, encouraging improved health and well-being and movement up the economic ladder by requiring work and community engagement as a condition of continued eligibility in the Arkansas Works program. Based on enrollment as of March 2, 2018, approximately 69,000 out of 278,734 individuals currently enrolled in Arkansas Works will be expected to participate in monthly approved work activities. Arkansas has designed the work and community engagement requirement for Arkansas works to closely align with requirements in the Supplemental Nutrition Assistance Program (SNAP). SNAP work requirements can be reviewed in online policy through the following link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Once work requirements are fully implemented, Arkansas Works beneficiaries who are ages 19-49 must work or engage in specified educational, job training, job search or community service activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who are subject to work requirements will be required to demonstrate that they are meeting the work requirements on a monthly basis. Arkansas Works beneficiaries who fail to meet the work requirements for any three months during a plan year will be dis-enrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year.

External Partnering for Success

Arkansas plans to build on the innovation of the premium assistance model by partnering with insurance carriers who provide qualified health plans for Arkansas Works beneficiaries. The carriers will leverage their current care coordination and outreach activities to encourage work and assist Arkansas Works beneficiaries to engage in activities that satisfy the work and community engagement requirement as one of the steps to promoting overall healthy living. The relationship between DHS and carriers is outlined in a Memorandum of Understanding.

The Arkansas Department of Human Services (DHS) has had a long-standing partnership with the Arkansas Department of Workforce Services (DWS). Together, we have jointly administered the Temporary Assistance for Needy Families (TANF) program in Arkansas for more than a decade. Act 1705 of the 85th Arkansas General Assembly transferred the TANF block grant from DHS to DWS. Responsibilities of each agency in the operation of the program are documented through a Memorandum of Understanding that is updated annually. As part of the agreement, Arkansas DHS provides eligibility and enrollment services for the Transitional Employment Assistance (TEA) program while Arkansas DWS provides case management services to help move beneficiaries toward self-sufficiency. Arkansas DHS staff conducts eligibility interviews, explain program requirements, and

authorize TEA coverage in the DHS legacy system called ANSWER. The ANSWER system automatically creates an electronic referral to Arkansas DWS staff that also has access to the ANSWER eligibility system. Arkansas DWS staff communicates with Arkansas DHS staff when changes in eligibility are needed. Act 1 of the 90th Arkansas General Assembly Second Extraordinary Session required Arkansas DHS to refer all Arkansas Works beneficiaries with income at or below 50% of the federal poverty level to Arkansas DWS for free job search and job training assistance. In compliance with this law, we expanded that partnership in January 2017 to include a referral to obtain job search assistance and training opportunities available at the Arkansas DWS for all Arkansas Works beneficiaries. Arkansas DWS has physical locations in thirty-two out of seventy-five counties and statewide services available online by accessing the following link: www.arjoblink.arkansas.gov or www.dws.arkansas.gov. Arkansas DHS and DWS exceeded the requirement of the law by referring all recipients approved or renewed in the Arkansas Works program each month to DWS. The referral language was added to the approval and renewal notices. To track and monitor the effectiveness of the referral process, Arkansas DHS and DWS began exchanging monthly files to identify those who were referred that actually accessed services at DWS. In addition to identifying those who accessed DWS services, we also identified whether or not they were reported by employers to DWS as newly hired individuals. We obtained data through this process that demonstrates that Arkansas Works beneficiaries who had accessed services at Arkansas DWS were more likely to find work. Over the last 12 months, 347,949 Arkansas Works enrollees have received a referral to DWS. Of that number, 16,900 have accessed services at DWS. Additionally, 27% of those who accessed services at DWS have been reported by employers as new hires compared to 12% of those who did not access services at DWS. See Attachment 1 for the most recent rolling 12 month Arkansas Works – DWS referral report. We will further expand this partnership to serve Arkansas Works beneficiaries with a work or community engagement requirement. Arkansas DHS will continue to provide referrals and information about services available through the Arkansas DWS in all of our notices related to the Arkansas Works program. Attachment 2 is a sample Arkansas Works notice that contains the DWS referral language that is included in all Arkansas Works notices. Arkansas DWS will also send follow-up letters to Arkansas Works beneficiaries who have a work and community engagement requirement. A sample copy of the DWS follow up letter that is sent to Arkansas Works beneficiaries with work and community engagement requirements will be provided once finalized. Arkansas DWS will provide career assessment, job-search assistance, and referrals for training as appropriate. The Workforce Opportunities and Innovation Act of 2014 (WIOA) placed heightened emphasis on coordination and collaboration at the Federal, State, local, and tribal levels to ensure a streamlined and coordinated service delivery system for job seekers, (from low income families including those with disabilities), and employers.

Job seekers can also explore training programs offered through the extensive Eligible Training Provider List. They can discuss education, training, and apprenticeship programs through Arkansas DWS-WIOA, their partners, and determine if they would qualify to participate in any of those opportunities. Since Arkansas Works participants are considered low income, they could be eligible for those services (Funding and slots availability, and additional requirements may apply). Arkansas Works recipients will also have access to attain Career Readiness Certifications (CRCs), create professional resumes, and other

universal job services to help be effective in their job-search activities. The following screenings and assessments available in the Arkansas Workforce Integrated Network System (ARWINS) for Arkansas Works recipients:

- A basic screener to determine if the client could be eligible for UI, targeted WIOA programs, computer literacy
- Assessments that will help determine job-seeker Characteristics like Abilities, Occupational Interests, Work Values, Skills, Knowledge, and high demand occupation matches based on current education and experience levels
- Assessments that will help determine if the job-seeker has any barriers as related to Transportation, Child Care, Legal, Domestic Violence, and Homelessness

The assessments are voluntary and there is a prescribed path. The job-seeker is encouraged to take the path, but the individual will not be forced to take those assessments.

Arkansas DHS has also leveraged our current contract for Medicaid beneficiary relations with the Arkansas Foundation for Medical Care (AFMC) to provide outreach and education about the work and community engagement requirement. AFMC will do active outreach to educate Arkansas Works beneficiaries who need to complete work and community engagement activities to make sure they understand the requirements. AFMC will also provide education and assistance to beneficiaries on how to properly and timely report their activities and to direct them to the Arkansas Department of Workforce Services, Supplemental Nutrition Assistance Program (SNAP) Employment and Training providers, or other resources as appropriate to help them comply with work requirements. Contractual requirements for work and community engagement include an outreach period 30 days prior to the beginning of work and community engagement requirements for existing Arkansas Works beneficiaries. Outreach and education methods will include outbound phone contact as well as an inbound integrated voice response system where beneficiaries can receive education about work and community engagement requirements. All scripts and materials used by AFMC will be approved by DHS. AFMC will also spend the first 12 days conducting outreach and education after an Arkansas Works beneficiary is approved with work and community engagement requirements. AFMC must successfully contact and educate 30% of existing Arkansas Works beneficiaries and 40% of newly approved Arkansas Works beneficiaries. To facilitate the successful outreach and education, AFMC staff has received training and access to our Curam eligibility system and will be receiving a daily and monthly file containing Arkansas Works beneficiaries with work and community engagement requirements and their current status related to these activities. AFMC is required to make a minimum of two attempts by a live agent to contact beneficiaries by phone when a phone number is available. Additional attempts and methods used by AFMC to reach their contractual obligations are not specified. AFMC will be required to provide DHS with results of outreach efforts through various reports.

Arkansas implemented the requirement to work in the Supplemental Nutrition Assistance Program (SNAP) statewide in January 2016. The Arkansas Department of Human Services has partnered with the

United States Department of Agriculture Food and Nutrition Services since that time to expand the SNAP Employment and Training Program in Arkansas. Participation in SNAP Employment and Training is one option available to SNAP recipients as a means to comply with SNAP work requirements. SNAP recipients may also comply on their own through work, education, training, or community service and volunteerism activities Arkansas has expanded the availability of SNAP Employment and Training from thirteen to fifty out of seventy-five counties since January 2016. In each of these counties DHS has either a contract or sub grant agreement in place with at least one SNAP Employment and Training provider with a physical location to provide employment and training services. DHS is currently in negotiations with additional providers to add an additional fifteen counties by the end of 2018. DHS has commitments from the providers who will cover these additional counties and we are awaiting approval from the USDA Food and Nutrition Services to implement this additional expansion. Point in time data comparison in March 2018 between the SNAP program and Arkansas Works has shown that approximately twenty-two to twenty-five percent of Arkansas Works beneficiaries also receive SNAP. We plan to leverage the expanded SNAP Employment and Training program to assist individuals who are dually eligible for SNAP and Arkansas Works to meet work and community engagement requirements by referring them to SNAP Employment and Training providers as appropriate for assistance with job search and training. SNAP Employment and Training providers already attempt to reach and engage SNAP recipients. SNAP recipients who are also enrolled in Arkansas Works may satisfy work and community engagement requirements in both programs by participating in SNAP Employment and Training. A list of our current SNAP Employment and Training providers is provided as Attachment 3. A map showing the current SNAP E & T coverage is provided as Attachment 4. Proposed expanded SNAP E & T coverage by the end of 2018 is provided as Attachment 5. Dual SNAP and Arkansas Works beneficiaries will be allowed to satisfy the work and community engagement requirement for both programs by participating in and reporting in either the SNAP or the Arkansas Works program. They will not be required to comply with or report separately to both programs to maintain continued eligibility. The Arkansas Works program, SNAP, and the Transitional Employment Assistance programs reside in separate eligibility systems operated by Arkansas DHS. Working with contracted developers for both systems, Arkansas DHS has developed a process whereby data files will be exchanged between these systems daily to update exemption and compliance information in both programs without manual intervention by the beneficiaries or DHS staff. User acceptance testing to validate this process is underway.

Online Reporting

Arkansas has enhanced the innovation and administrative efficiency of the work and community engagement requirement by planning and designing an online portal for beneficiaries to report their work activities, exemptions, and other household changes. This portal is actually an enhancement of the Curam eligibility system that has already passed CMS readiness review standards. DHS required through contract with Curam developers that the portal is mobile device friendly and ADA compliant. The access.arkansas.gov online portal complies with 42 CFR 435.1200 f (2). Beneficiaries will use an email address and password to access the online portal. Rather than providing verification of exempt or compliant status with paper documentation, beneficiaries will enter and attest to the information submitted through the online portal. These attestations will be evaluated through a robust quality

assurance process (See Quality Assurance and Fraud Process). Use of the portal promotes work and community engagement goals by reinforcing basic computer skills, internet navigation, and communication via email. This approach is administratively efficient to implement. The eligibility system processes information submitted via the online portal automatically without worker intervention. This allows Arkansas to implement the work and community engagement requirement without additional resources. Individuals, who are disabled, including mental and physical disability, will be exempt from work and community engagement requirements and will not be at risk for losing coverage. Arkansas DHS will provide reasonable accommodations to assist individuals with the online reporting requirement. Beneficiaries may receive in-person assistance through the local DHS county offices. All notices provide instructions to contact the Access Arkansas Call Center or a county office for help regarding work and community engagement requirements.

Arkansas DHS has also developed a "Registered Reporter" process to assist individuals with their online reporting requirements. Individuals may become a registered reporter by reviewing specified online training material, signing a Registered Reporter Acknowledgement Form and emailing that form to Arkansas DHS. The beneficiary must also authorize the reporter to serve in that role. To promote this as an additional reporting support for Arkansas Works beneficiaries, Arkansas DHS will announce this process through a press release and schedule meetings and webinars with stakeholder agencies. Information on the process and training is available on our public SharePoint site at the following link: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Outcome Monitoring

Arkansas DHS will develop reports that track the following information related to the Arkansas Works program:

- Number and percentage of individuals required to report each month
- Number and percentage of beneficiaries who are exempt from the community engagement requirement
- Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements
- Number and percentage of beneficiaries granted good cause exemption from reporting requirements
- Number and percentage of beneficiaries who requested reasonable accommodations
- Number and percentage and type of reasonable accommodations provided to beneficiaries
- Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements
- Number and percentage of beneficiaries disenrolled for failing to report
- Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements
- Number and percentage of community engagement appeal requests from beneficiaries
- Number, percentage and type of community engagement good cause exemptions requested
- Number, percentage and type of community engagement good cause exemptions granted
- Number, percentage and type of reporting good cause exemptions requested

- Number, percentage and type of reporting good cause exemptions granted
- Number of appeals of dis-enrollments for non-compliance with community engagement
- Number of appeals for dis-enrollments for failure to comply with the reporting requirements
- Number and percentage of applications made in-person, via phone, via mail and electronically.

All of the data required to produce these reports is owned by Arkansas DHS, with the exception of the good cause exemption reports and the work and community engagement appeal requests; these reports will be system-generated from the eligibility system data warehouse. Requirements, design, and delivery of these reports are covered by the Arkansas DHS contractual agreement with the eligibility system developer. A database outside of the eligibility system is being developed by DHS to track and report all good cause exemption metrics. Appeal metrics will be tracked and provided by the DHS Office of Chief Counsel Appeals and Hearings section. These reports will be compiled monthly and will be reported to CMS quarterly. Documentation on design requirements for each report will be available at a later date when report development is complete.

Implementation Plan and Timeline

Planning, policy and system development, partner and stakeholder engagement, and resource availability assessment (See Community Resource and Supports Availability Mapping) began in January 2017 and have been ongoing.

Upon approval of the work and community engagement amendment, Arkansas began finalizing plans and testing of the process to implement the requirement on June 1, 2018. Based on data as of March 2, 2018, there were 171,449 Arkansas Works beneficiaries ages 19 – 49. Approximately 69,000 have no initial exemption identified through system data. Due to the number of beneficiaries impacted, Arkansas will phase in work requirements by age group. Beginning June through September 2018, beneficiaries ages 30 – 49 at or below federal poverty level will be phased in to the work requirement. 19 – 29 year olds at or below federal poverty level will be phased in during 2019 between January and April.

Based on the same data, there were 125,242 Arkansas Works beneficiaries ages 30 – 49. Of those, 38,321 have no exemption identified through system data. Arkansas has chosen to phase in this group over four months based on when their cases are due for renewal. The chart below depicts the month the work requirement begins, the renewal months and number of beneficiaries affected.

Month Work Requirement Begins	**Renewal Months**	**Approximate #of beneficiaries required to report work activities**
June 2018	Jan, Feb, Mar	9,152
July 2018	April, May, June	9,341
August 2018	July, August, September	8,682
September 2018	Oct, Nov, Dec	11,146
Data date: 3/2/2018	TOTAL	38,321

The planning, testing, implementation, and monitoring timeline is provided below:

- **March 15, 2018** – Mass notice will be issued to all Arkansas Works beneficiaries informing them of the change in the program and upcoming implementation of work and community engagement requirements. The notice will instruct them that no additional action is required at

that time and will encourage them to provide an email address to Arkansas DHS if they have not already.

- **March 30, 2018** – The Arkansas Works online portal will go live. Beneficiaries will be able to begin linking their secure online accounts and reporting exemptions.
- **April 1, 2018** – New Arkansas Works beneficiaries ages 30 – 49 approved beginning April 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **April 1 – 8, 2018** – Work requirement begin months will be set for beneficiaries 30 – 49 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- **April 13, 2018** –The first data file of Arkansas Works beneficiaries containing specific information regarding work and community engagement details will be provided to Arkansas DWS, the Medicaid Beneficiary Relations provider, and QHP carriers. Outreach and education will begin. Updated files will be provided weekly thereafter.
- **May 8, 2018** – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in June 2018 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of June 2018. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
- **June 1, 2018** – Implementation of mandatory work requirements begins for individuals ages 30 - 49.
- **June 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in July 2018 will be mailed individually tailored notices.
- **June 26, 2018** – The Post Award Forum will be held at 10:00 AM at the Hillary Rodham Clinton Children's Library and Learning Center, 4800 W. 10th Street, Little Rock, AR 72204.
- **July 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in August will be mailed individually tailored notices.
- **August 8, 2018** - Arkansas Works beneficiaries ages 30 - 49 who are scheduled to begin the work and community engagement requirement in September 2018 will be mailed individually tailored notices.
- **August 30, 2018** – Monitoring phase begins and first quarterly report will be posted to the Arkansas DHS website.
- **November 1, 2018** - New Arkansas Works beneficiaries ages 19 - 29 approved beginning November 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **November 1 – 8, 2018** - Work requirement phase in will be set based on renewal months for beneficiaries 19 - 29 years of age and notices will be mailed to each individual with specific

details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.

- **November 30, 2018** – Second quarterly monitoring report will be submitted to CMS.
- **December 8, 2018** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in January 2019 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of January 2019. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
- **January 1, 2019** – Implementation of mandatory work requirements begins for individuals ages 19 - 29.
- **January 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in February 2019 will be mailed individually tailored notices.
- **January 30, 2019** – Third quarterly monitoring report will be submitted to CMS.
- **February 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in March 2019 will be mailed individually tailored notices.
- **March 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in April 2019 will be mailed individually tailored notices.
- **April 30, 2019** – Fourth quarterly monitoring report will be submitted to CMS.

Arkansas Works Application and Renewal Overview

Applications for healthcare coverage are accepted through multi-channels including online, by phone, in person, and by mail. Application assistance is provided by Arkansas DHS staff both in person and by phone. No changes are needed to the current process for applications related to the addition of the work and community engagement requirement. Assistance is provided in local offices to those who need assistance completing applications. Arkansas DHS also maintains a contract with a vendor who provides interpretation and translation services. This service is accessible statewide and each county office can access the vendor as needed to assist individuals. Arkansas DHS also accepts applications from incarcerated individuals up to forty-five days prior to release. The Arkansas Department of Corrections has contracted with a vendor to assist exiting inmates with the application process for Medicaid prior to release. Applications received from beneficiaries who lost eligibility due to non-compliance with work and community engagement requirements will be denied if received prior to the yearly open enrollment period. Applications received during open enrollment will be processed with coverage beginning on January 1 of the following year for beneficiaries that are otherwise eligible. The State's reasonable accommodation process will be available in a procedural desk guide developed for Medicaid eligibility caseworkers and administrative staff and will be posted online once complete.

Renewals are conducted monthly through an ex-parte process. Beneficiaries whose renewals cannot be completed ex-parte are sent specific notices to provide information that is needed to complete the renewal. Beneficiaries are not required to complete forms that require information that has been previously provided or is available to DHS. Arkansas Works beneficiaries who are subject to work and community engagement requirements will have their renewals completed by the same method as beneficiaries who are not subject to work and community engagement activities. Work activity reporting continues through the online portal with no interruption or change to the reporting process during renewal. Being non-compliant in the month a beneficiary's case is due for renewal does not prevent the ex-parte renewal process from occurring.

Arkansas monitors Medicaid timeliness with data and conducts a weekly Medicaid Eligibility Operations meeting to review progress and develop strategies to address any issues that arise. Weekly management reports are reviewed by the team during each meeting. Timeliness reports can be provided along with other quarterly reports. Additional information is also reported to CMS monthly through Performance Indicators.

Arkansas DHS completes daily electronic account transfers to the federally facilitated marketplace for individuals determined to be ineligible for Medicaid. No changes to this process are necessitated by the addition of the work and community engagement process.

Work and Community Engagement Overview and Operational Approach

Population Subject to Work Requirements

Once work requirements are implemented in June of 2018, on a rolling, phased in basis, Arkansas Works beneficiaries ages 19 to 49 who do not meet established exemption criteria will be required to meet work requirements as a condition of continued Arkansas Works eligibility. Work requirements will not apply to Arkansas Works beneficiaries ages 50 and older. Work and Community Engagement Requirements will be promulgated according to the State's Administrative Procedures Act in Medicaid eligibility rules. Link to the promulgated Medicaid eligibility manual: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Exemption from Work Requirements

Arkansas Works beneficiaries meeting one of the criteria described in the STCs will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including employment and self-employment of at least 80 hours a month, medical frailty, exemption from the SNAP work requirement, receipt of TEA Cash Assistance, and receipt of unemployment benefits. Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval. Detailed information about exemptions from work and community engagement requirements can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Allowed Work Activities and Work Activity Hour Calculations

Arkansas Works beneficiaries ages 19 – 49 who are not exempt must engage in 80 hours of monthly work and community engagement activities. Arkansas Works beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of activities as deemed appropriate by the state. Arkansas Works beneficiaries must demonstrate electronically on a monthly basis that they are meeting the work requirement. Detailed information about allowed work and community engagement activities can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Disenrollment for Failure to Meet Work Requirement

Beneficiaries who are subject to work requirements will lose eligibility for Arkansas Works if they fail to meet work requirements for any three consecutive or non-consecutive months during the coverage year. Effective the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage, following proper notice and due process, and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to re-enroll in Arkansas Works. Arkansas Works beneficiaries whose coverage has been terminated due to non-compliance may apply for and receive coverage in other Medicaid categories if eligible during the lockout period. Notices of denial and closure due to non-compliance with work and community engagement requirements will contain information about how to access primary and preventive care services at low or no cost at free health clinics and community health centers (See Community Resource and Supports Mapping). Closure of the Arkansas Works case will be transmitted to the InterChange Medicaid Management Information System. Termination of the QHP premium payment is automated in the InterChange system.

Beneficiary Work and Community Engagement Online Reporting Requirements

Beneficiaries must use the online portal to report exemptions and completion of work and community engagement activities. The work and community engagement portal is part of the existing eligibility system. Information entered into the portal is seamlessly processed by the eligibility system with no additional beneficiary or DHS staff requirement to re-key or transfer the information into the system. Exemptions must only be re-attested to at the required intervals specified above. Completion of work activities must be entered and attested to monthly. Individuals will have until the 5th day of the following month to attest for the previous month. The online portal is secure, mobile device friendly, and compliant with the ADA. The portal requires an email address and password to access. To assist beneficiaries prepare for this requirement, Arkansas DHS and our Access Arkansas Call Center have conducted a campaign over the last several months where we encourage beneficiaries to provide an email address. We have also offered information about how to obtain free email addresses and assistance with setting up email addresses. We have been able to collect several thousand email addresses during this effort. The portal allows beneficiaries to reset passwords through self-service. Technical assistance will also be available through our Access Arkansas Call Center for website and password issues. Beneficiaries who require assistance using the portal can receive assistance from

several sources, including Arkansas DHS staff, Call Center Agents, Arkansas DWS staff, or their QHP carrier. Arkansas DHS worked with the University of Arkansas for Medical Sciences Health Literacy team to help develop language for work and community engagement notices and fliers. Similar verbiage was used on the portal for consistency and understanding at lower literacy levels. Arkansas DHS maintains a contract for language interpretation and translation. Beneficiaries who need assistance with languages other than English will be assisted in the local DHS county offices. Each notice and flier regarding work and community engagement direct beneficiaries who need help to contact our toll free call center or local DHS County office. The portal will be available daily between 7 AM and 9 PM except for times when it is necessary to take the portal offline for system upgrades. Those outages when necessary are scheduled over weekends for minimal disruption. The website displays a notice each time the portal is offline for maintenance. The State will make every effort not to schedule maintenance during the first through the fifth of each month for beneficiaries who need to report the previous month's activities before the reporting deadline.

Upon logging into the portal, beneficiaries will be able to see their work and community engagement status for the current reporting month as well as history for the year to date. They will be able to update and confirm their contact information and household composition. Beneficiaries will know immediately upon submission if they have entered enough information to be considered compliant or exempt for the reporting month. If they have not yet completed 80 hours, the portal will display the number of hours needed to become compliant. Each portal screen includes information about the method for calculating completed hours for that activity.

Good Cause Exemptions / Catastrophic Events

Beneficiaries who have experienced a catastrophic event during a month they were required to complete work activities will be exempt from work requirements or reporting by requesting and being granted a good cause exemption. Circumstances that may lead to an approved good cause exemption are outline in the STCs and include but are not limited to a natural disaster, hospitalization or serious illness, birth or death of a family member living in the home and domestic violence. Beneficiaries who have lost coverage due to non-compliance with the work and community engagement requirement will have their cases reinstated without a new application if they are granted a good cause exemption and are otherwise eligible. Information about good cause exemptions and how to request these is provided in all work and community engagement notices. Verification of the catastrophic event which caused the beneficiary not to complete and/or report required activities will be required as part of the good cause approval process. DHS staff may use discretion to waive the verification in cases such as natural disaster when the event is known to the general public.

Interim Period Prior to Work and Community Engagement Requirement – Outreach and Education

Newly approved Arkansas Works beneficiaries who are subject to the work and community engagement requirement will have an interim period of up to 59 days prior to beginning work activities. The work requirement will begin on the first of the second month after the month of approval. For example, a non-exempt beneficiary approved in the Arkansas Works program on any day during the month of April

will be required to begin completing work activities on June 1st. Through our implementation plan, existing beneficiaries will also have an interim period after notification before they are required to begin completing and reporting work activities. The interim period will be used to conduct outreach to beneficiaries to educate them on all aspects of the work requirement including using the online portal, connecting with the Arkansas Department of Workforce Services and other resources to assist them with compliance with work activities. The outreach will be done through a multi-media and multi-partner approach that includes Arkansas DHS, Arkansas DWS, our Medicaid Beneficiary Relations provider, and QHP carriers. This outreach effort also involves social media including Facebook and Twitter. Over the last several months, Arkansas DHS has developed several educational tools regarding work and community engagement requirements that are intended to assist beneficiaries and partners alike. These tools include a computer-based training on the Arkansas Works program and the work and community engagement requirement. Tutorials on linking their secure account on the portal, entering work activity and exemption information on the portal have also been developed. This Arkansas Works toolkit will be available online to the public so that partners and beneficiaries can access the information as needed. Link to Arkansas Works education and Outreach information: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Work and Community Engagement Notices

In addition to traditional postal mail, Arkansas DHS will communicate with Arkansas Works beneficiaries who have provided email addresses through an electronic message to a secure inbox. Notices content will meet all requirements in the standards, terms, and conditions reflected in the approved 1115 waiver amendment. With the exception of good cause exemption denials, all notices related to the work and community engagement requirement are automated and system-generated in real time. This automation ensures that timely and adequate notice requirements are met. Specific notices related to work and community engagement requirements have been developed and contain detailed information for beneficiaries.

Until good cause exemption functionality can be developed in our eligibility system, notices of either approval or denial of a good cause exemption will be manually generated and uploaded to the electronic case record. A separate tracking website will be developed and maintained for Arkansas DHS staff to use to track good cause exemption requests for noncompliance with work activities or reporting requirements until this capability is achieved in the eligibility system to meet CMS monitoring and reporting requirements included in the approved waiver amendment.

Community Resource and Supports Availability and Mapping

Arkansas DHS has been working with a team of partners and stakeholders for several months to identify community engagement resources throughout the state. This team includes Arkansas DHS, Arkansas DWS, Arkansas Center for Health Improvement, representatives from each Arkansas Works qualified health plan carrier, the Arkansas Hospital Association, the University of Arkansas for Medical Sciences, and the Arkansas Department of Career Education. Input and participation is open to interested stakeholder organizations. As a result of this effort, an Arkansas Works Interactive Resource Map has

been developed for users to click county by county for specific information on local resource availability. The resource map contains information on work and employment services, education and training opportunities, and volunteerism opportunities. The resource map also contains information on locations with public access to computers and free Wi-Fi and other supportive resources such as public transportation, substance abuse treatment, housing, and more. Public access to computers is being provided by Arkansas DHS, Arkansas DWS, Arkansas libraries and other community organizations. We are also actively engaging other state agencies and non-profit agencies to assess their willingness and capacity to provide support to Arkansas Works beneficiaries in this and other ways. Arkansas DHS has lead on this project. Locations where beneficiaries and former beneficiaries can access free and reduced cost health care have also been collected and made available in this map. DHS will include information in notices for individuals who lose coverage due to non-compliance in addition to sharing this information through social media. This resource map will be available to the public online in the Arkansas Works information SharePoint site and will be updated quarterly and as new information becomes available. Link to Arkansas Works Information: https://ardhs.sharepointsite.net/ARWorks/default.aspx

Quality Assurance and Fraud Process

Arkansas DHS will conduct a monthly quality assurance process to validate exemptions and work activities that have been attested to by beneficiaries as a special effort in addition to normal PERM and MEQC requirements. The quality assurance process will include reviewing a statistically valid random sample to achieve a 95% (+ / - 3% variance) level of confidence. In addition to these quality assurance reviews, Arkansas DHS will review data on attestations monthly and quarterly from the universe of Arkansas Works beneficiaries who are subject to work and community engagement requirements to identify trends and potential anomalies that should also be reviewed for accuracy. Based on the outcomes of these reviews, the quality assurance process will be enhanced with additional reviews in error prone areas. The quality assurance component will be promulgated in Medicaid eligibility rules. Specific quality assurance processes will be outlined in a procedural desk guide for DHS staff. If inaccuracies are discovered during the quality assurance process, appropriate action will be taken to remove months of exemption or compliance. If this results in three months of non-compliance for the calendar year, the Arkansas Works case will be closed and referred for investigation as potential fraud and overpayment.

Appeal Process

Beneficiaries will be provided full appeal rights with regard to work and community engagement requirements just as they have for other Medicaid eligibility determinations. The process will be the same regardless for the reason for appeal. Each notice contains information about beneficiaries' rights to appeal and how to request an appeal. Requests for appeal that are received in county offices are forwarded to the DHS Office of Chief Counsel Appeals and Hearings Unit who schedule and conduct appeal hearings and render decisions.

Data Exchange between Programs and Partners

To ensure that dual Arkansas Works and SNAP beneficiaries have no additional compliance or reporting requirements, Arkansas DHS will use data exchanges between systems to record compliance and exemption information. This data exchange is currently in the final stages of testing. SNAP and Arkansas Works beneficiaries may choose to comply through either program.

To ensure a robust outreach and education process, a weekly data file will be shared with Arkansas DWS, our Medicaid Beneficiary Relations provider, and each QHP carrier. Information provided to carriers will be limited to Arkansas Works beneficiaries that are members of their individual plans. The file will contain information on each beneficiary that includes contact information, work and community engagement exemption and compliance information, type of exemption, number of months of cumulative non-compliance, compliance status for the current month, and renewal month. This level of detail will allow our partners to conduct specific outreach and education encouraging beneficiaries to participate and complete work activities.

Summary

Arkansas appreciates the opportunity to help our fellow Arkansans begin to move up the economic ladder through the Arkansas Works program with work and community engagement requirements. We have put a great amount of thought and effort into the policy and operational design of this program to make it as successful as possible. We have developed a strong team of partners ready to help these beneficiaries take the steps toward self-sufficiency. We appreciate the continued support and partnership from the Centers for Medicare and Medicaid Services to help us implement this program and look forward to reporting our progress as implementation continues.

Eligibility and Enrollment Monitoring Plan

Arkansas Works – Work and Community Engagement Amendment

Strategic Approach

Overview

Arkansas plans to test innovative and administratively efficient approaches to promoting personal responsibility, encouraging improved health and well-being and movement up the economic ladder by requiring work and community engagement as a condition of continued eligibility in the Arkansas Works program. Based on enrollment as of March 2, 2018, approximately 69,000 out of 278,734 individuals currently enrolled in Arkansas Works will be expected to participate in monthly approved work activities. Arkansas has designed the work and community engagement requirement for Arkansas works to closely align with requirements in the Supplemental Nutrition Assistance Program (SNAP). SNAP work requirements can be reviewed in online policy through the following link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Once work requirements are fully implemented, Arkansas Works beneficiaries who are ages 19-49 must work or engage in specified educational, job training, job search or community service activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who are subject to work requirements will be required to demonstrate that they are meeting the work requirements on a monthly basis. Arkansas Works beneficiaries who fail to meet the work requirements for any three months during a plan year will be dis-enrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year.

External Partnering for Success

Arkansas plans to build on the innovation of the premium assistance model by partnering with insurance carriers who provide qualified health plans for Arkansas Works beneficiaries. The carriers will leverage their current care coordination and outreach activities to encourage work and assist Arkansas Works beneficiaries to engage in activities that satisfy the work and community engagement requirement as one of the steps to promoting overall healthy living. The relationship between DHS and carriers is outlined in a Memorandum of Understanding.

The Arkansas Department of Human Services (DHS) has had a long-standing partnership with the Arkansas Department of Workforce Services (DWS). Together, we have jointly administered the Temporary Assistance for Needy Families (TANF) program in Arkansas for more than a decade. Act 1705 of the 85th Arkansas General Assembly transferred the TANF block grant from DHS to DWS. Responsibilities of each agency in the operation of the program are documented through a Memorandum of Understanding that is updated annually. As part of the agreement, Arkansas DHS provides eligibility and enrollment services for the Transitional Employment Assistance (TEA) program while Arkansas DWS provides case management services to help move beneficiaries toward self-sufficiency. Arkansas DHS staff conducts eligibility interviews, explain program requirements, and

authorize TEA coverage in the DHS legacy system called ANSWER. The ANSWER system automatically creates an electronic referral to Arkansas DWS staff that also has access to the ANSWER eligibility system. Arkansas DWS staff communicates with Arkansas DHS staff when changes in eligibility are needed. Act 1 of the 90th Arkansas General Assembly Second Extraordinary Session required Arkansas DHS to refer all Arkansas Works beneficiaries with income at or below 50% of the federal poverty level to Arkansas DWS for free job search and job training assistance. In compliance with this law, we expanded that partnership in January 2017 to include a referral to obtain job search assistance and training opportunities available at the Arkansas DWS for all Arkansas Works beneficiaries. Arkansas DWS has physical locations in thirty-two out of seventy-five counties and statewide services available online by accessing the following link: www.arjoblink.arkansas.gov or www.dws.arkansas.gov. Arkansas DHS and DWS exceeded the requirement of the law by referring all recipients approved or renewed in the Arkansas Works program each month to DWS. The referral language was added to the approval and renewal notices. To track and monitor the effectiveness of the referral process, Arkansas DHS and DWS began exchanging monthly files to identify those who were referred that actually accessed services at DWS. In addition to identifying those who accessed DWS services, we also identified whether or not they were reported by employers to DWS as newly hired individuals. We obtained data through this process that demonstrates that Arkansas Works beneficiaries who had accessed services at Arkansas DWS were more likely to find work. Over the last 12 months, 347,949 Arkansas Works enrollees have received a referral to DWS. Of that number, 16,900 have accessed services at DWS. Additionally, 27% of those who accessed services at DWS have been reported by employers as new hires compared to 12% of those who did not access services at DWS. See Attachment 1 for the most recent rolling 12 month Arkansas Works – DWS referral report. We will further expand this partnership to serve Arkansas Works beneficiaries with a work or community engagement requirement. Arkansas DHS will continue to provide referrals and information about services available through the Arkansas DWS in all of our notices related to the Arkansas Works program. Attachment 2 is a sample Arkansas Works notice that contains the DWS referral language that is included in all Arkansas Works notices. Arkansas DWS will also send follow-up letters to Arkansas Works beneficiaries who have a work and community engagement requirement. A sample copy of the DWS follow up letter that is sent to Arkansas Works beneficiaries with work and community engagement requirements will be provided once finalized. Arkansas DWS will provide career assessment, job-search assistance, and referrals for training as appropriate. The Workforce Opportunities and Innovation Act of 2014 (WIOA) placed heightened emphasis on coordination and collaboration at the Federal, State, local, and tribal levels to ensure a streamlined and coordinated service delivery system for job seekers, (from low income families including those with disabilities), and employers.

Job seekers can also explore training programs offered through the extensive Eligible Training Provider List. They can discuss education, training, and apprenticeship programs through Arkansas DWS-WIOA, their partners, and determine if they would qualify to participate in any of those opportunities. Since Arkansas Works participants are considered low income, they could be eligible for those services (Funding and slots availability, and additional requirements may apply). Arkansas Works recipients will also have access to attain Career Readiness Certifications (CRCs), create professional resumes, and other

universal job services to help be effective in their job-search activities. The following screenings and assessments available in the Arkansas Workforce Integrated Network System (ARWINS) for Arkansas Works recipients:

- A basic screener to determine if the client could be eligible for UI, targeted WIOA programs, computer literacy
- Assessments that will help determine job-seeker Characteristics like Abilities, Occupational Interests, Work Values, Skills, Knowledge, and high demand occupation matches based on current education and experience levels
- Assessments that will help determine if the job-seeker has any barriers as related to Transportation, Child Care, Legal, Domestic Violence, and Homelessness

The assessments are voluntary and there is a prescribed path. The job-seeker is encouraged to take the path, but the individual will not be forced to take those assessments.

Arkansas DHS has also leveraged our current contract for Medicaid beneficiary relations with the Arkansas Foundation for Medical Care (AFMC) to provide outreach and education about the work and community engagement requirement. AFMC will do active outreach to educate Arkansas Works beneficiaries who need to complete work and community engagement activities to make sure they understand the requirements. AFMC will also provide education and assistance to beneficiaries on how to properly and timely report their activities and to direct them to the Arkansas Department of Workforce Services, Supplemental Nutrition Assistance Program (SNAP) Employment and Training providers, or other resources as appropriate to help them comply with work requirements. Contractual requirements for work and community engagement include an outreach period 30 days prior to the beginning of work and community engagement requirements for existing Arkansas Works beneficiaries. Outreach and education methods will include outbound phone contact as well as an inbound integrated voice response system where beneficiaries can receive education about work and community engagement requirements. All scripts and materials used by AFMC will be approved by DHS. AFMC will also spend the first 12 days conducting outreach and education after an Arkansas Works beneficiary is approved with work and community engagement requirements. AFMC must successfully contact and educate 30% of existing Arkansas Works beneficiaries and 40% of newly approved Arkansas Works beneficiaries. To facilitate the successful outreach and education, AFMC staff has received training and access to our Curam eligibility system and will be receiving a daily and monthly file containing Arkansas Works beneficiaries with work and community engagement requirements and their current status related to these activities. AFMC is required to make a minimum of two attempts by a live agent to contact beneficiaries by phone when a phone number is available. Additional attempts and methods used by AFMC to reach their contractual obligations are not specified. AFMC will be required to provide DHS with results of outreach efforts through various reports.

Arkansas implemented the requirement to work in the Supplemental Nutrition Assistance Program (SNAP) statewide in January 2016. The Arkansas Department of Human Services has partnered with the

United States Department of Agriculture Food and Nutrition Services since that time to expand the SNAP Employment and Training Program in Arkansas. Participation in SNAP Employment and Training is one option available to SNAP recipients as a means to comply with SNAP work requirements. SNAP recipients may also comply on their own through work, education, training, or community service and volunteerism activities Arkansas has expanded the availability of SNAP Employment and Training from thirteen to fifty out of seventy-five counties since January 2016. In each of these counties DHS has either a contract or sub grant agreement in place with at least one SNAP Employment and Training provider with a physical location to provide employment and training services. DHS is currently in negotiations with additional providers to add an additional fifteen counties by the end of 2018. DHS has commitments from the providers who will cover these additional counties and we are awaiting approval from the USDA Food and Nutrition Services to implement this additional expansion. Point in time data comparison in March 2018 between the SNAP program and Arkansas Works has shown that approximately twenty-two to twenty-five percent of Arkansas Works beneficiaries also receive SNAP. We plan to leverage the expanded SNAP Employment and Training program to assist individuals who are dually eligible for SNAP and Arkansas Works to meet work and community engagement requirements by referring them to SNAP Employment and Training providers as appropriate for assistance with job search and training. SNAP Employment and Training providers already attempt to reach and engage SNAP recipients. SNAP recipients who are also enrolled in Arkansas Works may satisfy work and community engagement requirements in both programs by participating in SNAP Employment and Training. A list of our current SNAP Employment and Training providers is provided as Attachment 3. A map showing the current SNAP E & T coverage is provided as Attachment 4. Proposed expanded SNAP E & T coverage by the end of 2018 is provided as Attachment 5. Dual SNAP and Arkansas Works beneficiaries will be allowed to satisfy the work and community engagement requirement for both programs by participating in and reporting in either the SNAP or the Arkansas Works program. They will not be required to comply with or report separately to both programs to maintain continued eligibility. The Arkansas Works program, SNAP, and the Transitional Employment Assistance programs reside in separate eligibility systems operated by Arkansas DHS. Working with contracted developers for both systems, Arkansas DHS has developed a process whereby data files will be exchanged between these systems daily to update exemption and compliance information in both programs without manual intervention by the beneficiaries or DHS staff. User acceptance testing to validate this process is underway.

Online Reporting

Arkansas has enhanced the innovation and administrative efficiency of the work and community engagement requirement by planning and designing an online portal for beneficiaries to report their work activities, exemptions, and other household changes. This portal is actually an enhancement of the Curam eligibility system that has already passed CMS readiness review standards. DHS required through contract with Curam developers that the portal is mobile device friendly and ADA compliant. The access.arkansas.gov online portal complies with 42 CFR 435.1200 f (2). Beneficiaries will use an email address and password to access the online portal. Rather than providing verification of exempt or compliant status with paper documentation, beneficiaries will enter and attest to the information submitted through the online portal. These attestations will be evaluated through a robust quality

assurance process (See Quality Assurance and Fraud Process). Use of the portal promotes work and community engagement goals by reinforcing basic computer skills, internet navigation, and communication via email. This approach is administratively efficient to implement. The eligibility system processes information submitted via the online portal automatically without worker intervention. This allows Arkansas to implement the work and community engagement requirement without additional resources. Individuals, who are disabled, including mental and physical disability, will be exempt from work and community engagement requirements and will not be at risk for losing coverage. Arkansas DHS will provide reasonable accommodations to assist individuals with the online reporting requirement. Beneficiaries may receive in-person assistance through the local DHS county offices. All notices provide instructions to contact the Access Arkansas Call Center or a county office for help regarding work and community engagement requirements.

Arkansas DHS has also developed a "Registered Reporter" process to assist individuals with their online reporting requirements. Individuals may become a registered reporter by reviewing specified online training material, signing a Registered Reporter Acknowledgement Form and emailing that form to Arkansas DHS. The beneficiary must also authorize the reporter to serve in that role. To promote this as an additional reporting support for Arkansas Works beneficiaries, Arkansas DHS will announce this process through a press release and schedule meetings and webinars with stakeholder agencies. Information on the process and training is available on our public SharePoint site at the following link: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Outcome Monitoring

Arkansas DHS will develop reports that track the following information related to the Arkansas Works program:

- Number and percentage of individuals required to report each month
- Number and percentage of beneficiaries who are exempt from the community engagement requirement
- Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements
- Number and percentage of beneficiaries granted good cause exemption from reporting requirements
- Number and percentage of beneficiaries who requested reasonable accommodations
- Number and percentage and type of reasonable accommodations provided to beneficiaries
- Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements
- Number and percentage of beneficiaries disenrolled for failing to report
- Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements
- Number and percentage of community engagement appeal requests from beneficiaries
- Number, percentage and type of community engagement good cause exemptions requested
- Number, percentage and type of community engagement good cause exemptions granted
- Number, percentage and type of reporting good cause exemptions requested

- Number, percentage and type of reporting good cause exemptions granted
- Number of appeals of dis-enrollments for non-compliance with community engagement
- Number of appeals for dis-enrollments for failure to comply with the reporting requirements
- Number and percentage of applications made in-person, via phone, via mail and electronically.

All of the data required to produce these reports is owned by Arkansas DHS, with the exception of the good cause exemption reports and the work and community engagement appeal requests; these reports will be system-generated from the eligibility system data warehouse. Requirements, design, and delivery of these reports are covered by the Arkansas DHS contractual agreement with the eligibility system developer. A database outside of the eligibility system is being developed by DHS to track and report all good cause exemption metrics. Appeal metrics will be tracked and provided by the DHS Office of Chief Counsel Appeals and Hearings section. These reports will be compiled monthly and will be reported to CMS quarterly. Documentation on design requirements for each report will be available at a later date when report development is complete.

Implementation Plan and Timeline

Planning, policy and system development, partner and stakeholder engagement, and resource availability assessment (See Community Resource and Supports Availability Mapping) began in January 2017 and have been ongoing.

Upon approval of the work and community engagement amendment, Arkansas began finalizing plans and testing of the process to implement the requirement on June 1, 2018. Based on data as of March 2, 2018, there were 171,449 Arkansas Works beneficiaries ages 19 – 49. Approximately 69,000 have no initial exemption identified through system data. Due to the number of beneficiaries impacted, Arkansas will phase in work requirements by age group. Beginning June through September 2018, beneficiaries ages 30 – 49 at or below federal poverty level will be phased in to the work requirement. 19 – 29 year olds at or below federal poverty level will be phased in during 2019 between January and April.

Based on the same data, there were 125,242 Arkansas Works beneficiaries ages 30 – 49. Of those, 38,321 have no exemption identified through system data. Arkansas has chosen to phase in this group over four months based on when their cases are due for renewal. The chart below depicts the month the work requirement begins, the renewal months and number of beneficiaries affected.

Month Work Requirement Begins	**Renewal Months**	**Approximate #of beneficiaries required to report work activities**
June 2018	Jan, Feb, Mar	9,152
July 2018	April, May, June	9,341
August 2018	July, August, September	8,682
September 2018	Oct, Nov, Dec	11,146
Data date: 3/2/2018	TOTAL	38,321

The planning, testing, implementation, and monitoring timeline is provided below:

- **March 15, 2018** – Mass notice will be issued to all Arkansas Works beneficiaries informing them of the change in the program and upcoming implementation of work and community engagement requirements. The notice will instruct them that no additional action is required at

that time and will encourage them to provide an email address to Arkansas DHS if they have not already.

- **March 30, 2018** – The Arkansas Works online portal will go live. Beneficiaries will be able to begin linking their secure online accounts and reporting exemptions.
- **April 1, 2018** – New Arkansas Works beneficiaries ages 30 – 49 approved beginning April 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **April 1 – 8, 2018** – Work requirement begin months will be set for beneficiaries 30 – 49 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- **April 13, 2018** –The first data file of Arkansas Works beneficiaries containing specific information regarding work and community engagement details will be provided to Arkansas DWS, the Medicaid Beneficiary Relations provider, and QHP carriers. Outreach and education will begin. Updated files will be provided weekly thereafter.
- **May 8, 2018** – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in June 2018 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of June 2018. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
- **June 1, 2018** – Implementation of mandatory work requirements begins for individuals ages 30 - 49.
- **June 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in July 2018 will be mailed individually tailored notices.
- **June 26, 2018** – The Post Award Forum will be held at 10:00 AM at the Hillary Rodham Clinton Children's Library and Learning Center, 4800 W. 10th Street, Little Rock, AR 72204.
- **July 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in August will be mailed individually tailored notices.
- **August 8, 2018** - Arkansas Works beneficiaries ages 30 - 49 who are scheduled to begin the work and community engagement requirement in September 2018 will be mailed individually tailored notices.
- **August 30, 2018** – Monitoring phase begins and first quarterly report will be posted to the Arkansas DHS website.
- **November 1, 2018** - New Arkansas Works beneficiaries ages 19 - 29 approved beginning November 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **November 1 – 8, 2018** - Work requirement phase in will be set based on renewal months for beneficiaries 19 - 29 years of age and notices will be mailed to each individual with specific

details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.

- **November 30, 2018** – Second quarterly monitoring report will be submitted to CMS.
- **December 8, 2018** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in January 2019 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of January 2019. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
- **January 1, 2019** – Implementation of mandatory work requirements begins for individuals ages 19 - 29.
- **January 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in February 2019 will be mailed individually tailored notices.
- **January 30, 2019** – Third quarterly monitoring report will be submitted to CMS.
- **February 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in March 2019 will be mailed individually tailored notices.
- **March 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in April 2019 will be mailed individually tailored notices.
- **April 30, 2019** – Fourth quarterly monitoring report will be submitted to CMS.

Arkansas Works Application and Renewal Overview

Applications for healthcare coverage are accepted through multi-channels including online, by phone, in person, and by mail. Application assistance is provided by Arkansas DHS staff both in person and by phone. No changes are needed to the current process for applications related to the addition of the work and community engagement requirement. Assistance is provided in local offices to those who need assistance completing applications. Arkansas DHS also maintains a contract with a vendor who provides interpretation and translation services. This service is accessible statewide and each county office can access the vendor as needed to assist individuals. Arkansas DHS also accepts applications from incarcerated individuals up to forty-five days prior to release. The Arkansas Department of Corrections has contracted with a vendor to assist exiting inmates with the application process for Medicaid prior to release. Applications received from beneficiaries who lost eligibility due to non-compliance with work and community engagement requirements will be denied if received prior to the yearly open enrollment period. Applications received during open enrollment will be processed with coverage beginning on January 1 of the following year for beneficiaries that are otherwise eligible. The State's reasonable accommodation process will be available in a procedural desk guide developed for Medicaid eligibility caseworkers and administrative staff and will be posted online once complete.

Renewals are conducted monthly through an ex-parte process. Beneficiaries whose renewals cannot be completed ex-parte are sent specific notices to provide information that is needed to complete the renewal. Beneficiaries are not required to complete forms that require information that has been previously provided or is available to DHS. Arkansas Works beneficiaries who are subject to work and community engagement requirements will have their renewals completed by the same method as beneficiaries who are not subject to work and community engagement activities. Work activity reporting continues through the online portal with no interruption or change to the reporting process during renewal. Being non-compliant in the month a beneficiary's case is due for renewal does not prevent the ex-parte renewal process from occurring.

Arkansas monitors Medicaid timeliness with data and conducts a weekly Medicaid Eligibility Operations meeting to review progress and develop strategies to address any issues that arise. Weekly management reports are reviewed by the team during each meeting. Timeliness reports can be provided along with other quarterly reports. Additional information is also reported to CMS monthly through Performance Indicators.

Arkansas DHS completes daily electronic account transfers to the federally facilitated marketplace for individuals determined to be ineligible for Medicaid. No changes to this process are necessitated by the addition of the work and community engagement process.

Work and Community Engagement Overview and Operational Approach

Population Subject to Work Requirements

Once work requirements are implemented in June of 2018, on a rolling, phased in basis, Arkansas Works beneficiaries ages 19 to 49 who do not meet established exemption criteria will be required to meet work requirements as a condition of continued Arkansas Works eligibility. Work requirements will not apply to Arkansas Works beneficiaries ages 50 and older. Work and Community Engagement Requirements will be promulgated according to the State's Administrative Procedures Act in Medicaid eligibility rules. Link to the promulgated Medicaid eligibility manual: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Exemption from Work Requirements

Arkansas Works beneficiaries meeting one of the criteria described in the STCs will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including employment and self-employment of at least 80 hours a month, medical frailty, exemption from the SNAP work requirement, receipt of TEA Cash Assistance, and receipt of unemployment benefits. Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval. Detailed information about exemptions from work and community engagement requirements can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Allowed Work Activities and Work Activity Hour Calculations

Arkansas Works beneficiaries ages 19 – 49 who are not exempt must engage in 80 hours of monthly work and community engagement activities. Arkansas Works beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of activities as deemed appropriate by the state. Arkansas Works beneficiaries must demonstrate electronically on a monthly basis that they are meeting the work requirement. Detailed information about allowed work and community engagement activities can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Disenrollment for Failure to Meet Work Requirement

Beneficiaries who are subject to work requirements will lose eligibility for Arkansas Works if they fail to meet work requirements for any three consecutive or non-consecutive months during the coverage year. Effective the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage, following proper notice and due process, and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to re-enroll in Arkansas Works. Arkansas Works beneficiaries whose coverage has been terminated due to non-compliance may apply for and receive coverage in other Medicaid categories if eligible during the lockout period. Notices of denial and closure due to non-compliance with work and community engagement requirements will contain information about how to access primary and preventive care services at low or no cost at free health clinics and community health centers (See Community Resource and Supports Mapping). Closure of the Arkansas Works case will be transmitted to the InterChange Medicaid Management Information System. Termination of the QHP premium payment is automated in the InterChange system.

Beneficiary Work and Community Engagement Online Reporting Requirements

Beneficiaries must use the online portal to report exemptions and completion of work and community engagement activities. The work and community engagement portal is part of the existing eligibility system. Information entered into the portal is seamlessly processed by the eligibility system with no additional beneficiary or DHS staff requirement to re-key or transfer the information into the system. Exemptions must only be re-attested to at the required intervals specified above. Completion of work activities must be entered and attested to monthly. Individuals will have until the 5th day of the following month to attest for the previous month. The online portal is secure, mobile device friendly, and compliant with the ADA. The portal requires an email address and password to access. To assist beneficiaries prepare for this requirement, Arkansas DHS and our Access Arkansas Call Center have conducted a campaign over the last several months where we encourage beneficiaries to provide an email address. We have also offered information about how to obtain free email addresses and assistance with setting up email addresses. We have been able to collect several thousand email addresses during this effort. The portal allows beneficiaries to reset passwords through self-service. Technical assistance will also be available through our Access Arkansas Call Center for website and password issues. Beneficiaries who require assistance using the portal can receive assistance from

several sources, including Arkansas DHS staff, Call Center Agents, Arkansas DWS staff, or their QHP carrier. Arkansas DHS worked with the University of Arkansas for Medical Sciences Health Literacy team to help develop language for work and community engagement notices and fliers. Similar verbiage was used on the portal for consistency and understanding at lower literacy levels. Arkansas DHS maintains a contract for language interpretation and translation. Beneficiaries who need assistance with languages other than English will be assisted in the local DHS county offices. Each notice and flier regarding work and community engagement direct beneficiaries who need help to contact our toll free call center or local DHS County office. The portal will be available daily between 7 AM and 9 PM except for times when it is necessary to take the portal offline for system upgrades. Those outages when necessary are scheduled over weekends for minimal disruption. The website displays a notice each time the portal is offline for maintenance. The State will make every effort not to schedule maintenance during the first through the fifth of each month for beneficiaries who need to report the previous month's activities before the reporting deadline.

Upon logging into the portal, beneficiaries will be able to see their work and community engagement status for the current reporting month as well as history for the year to date. They will be able to update and confirm their contact information and household composition. Beneficiaries will know immediately upon submission if they have entered enough information to be considered compliant or exempt for the reporting month. If they have not yet completed 80 hours, the portal will display the number of hours needed to become compliant. Each portal screen includes information about the method for calculating completed hours for that activity.

Good Cause Exemptions / Catastrophic Events

Beneficiaries who have experienced a catastrophic event during a month they were required to complete work activities will be exempt from work requirements or reporting by requesting and being granted a good cause exemption. Circumstances that may lead to an approved good cause exemption are outline in the STCs and include but are not limited to a natural disaster, hospitalization or serious illness, birth or death of a family member living in the home and domestic violence. Beneficiaries who have lost coverage due to non-compliance with the work and community engagement requirement will have their cases reinstated without a new application if they are granted a good cause exemption and are otherwise eligible. Information about good cause exemptions and how to request these is provided in all work and community engagement notices. Verification of the catastrophic event which caused the beneficiary not to complete and/or report required activities will be required as part of the good cause approval process. DHS staff may use discretion to waive the verification in cases such as natural disaster when the event is known to the general public.

Interim Period Prior to Work and Community Engagement Requirement – Outreach and Education

Newly approved Arkansas Works beneficiaries who are subject to the work and community engagement requirement will have an interim period of up to 59 days prior to beginning work activities. The work requirement will begin on the first of the second month after the month of approval. For example, a non-exempt beneficiary approved in the Arkansas Works program on any day during the month of April

will be required to begin completing work activities on June 1st. Through our implementation plan, existing beneficiaries will also have an interim period after notification before they are required to begin completing and reporting work activities. The interim period will be used to conduct outreach to beneficiaries to educate them on all aspects of the work requirement including using the online portal, connecting with the Arkansas Department of Workforce Services and other resources to assist them with compliance with work activities. The outreach will be done through a multi-media and multi-partner approach that includes Arkansas DHS, Arkansas DWS, our Medicaid Beneficiary Relations provider, and QHP carriers. This outreach effort also involves social media including Facebook and Twitter. Over the last several months, Arkansas DHS has developed several educational tools regarding work and community engagement requirements that are intended to assist beneficiaries and partners alike. These tools include a computer-based training on the Arkansas Works program and the work and community engagement requirement. Tutorials on linking their secure account on the portal, entering work activity and exemption information on the portal have also been developed. This Arkansas Works toolkit will be available online to the public so that partners and beneficiaries can access the information as needed. Link to Arkansas Works education and Outreach information: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Work and Community Engagement Notices

In addition to traditional postal mail, Arkansas DHS will communicate with Arkansas Works beneficiaries who have provided email addresses through an electronic message to a secure inbox. Notices content will meet all requirements in the standards, terms, and conditions reflected in the approved 1115 waiver amendment. With the exception of good cause exemption denials, all notices related to the work and community engagement requirement are automated and system-generated in real time. This automation ensures that timely and adequate notice requirements are met. Specific notices related to work and community engagement requirements have been developed and contain detailed information for beneficiaries.

Until good cause exemption functionality can be developed in our eligibility system, notices of either approval or denial of a good cause exemption will be manually generated and uploaded to the electronic case record. A separate tracking website will be developed and maintained for Arkansas DHS staff to use to track good cause exemption requests for noncompliance with work activities or reporting requirements until this capability is achieved in the eligibility system to meet CMS monitoring and reporting requirements included in the approved waiver amendment.

Community Resource and Supports Availability and Mapping

Arkansas DHS has been working with a team of partners and stakeholders for several months to identify community engagement resources throughout the state. This team includes Arkansas DHS, Arkansas DWS, Arkansas Center for Health Improvement, representatives from each Arkansas Works qualified health plan carrier, the Arkansas Hospital Association, the University of Arkansas for Medical Sciences, and the Arkansas Department of Career Education. Input and participation is open to interested stakeholder organizations. As a result of this effort, an Arkansas Works Interactive Resource Map has

been developed for users to click county by county for specific information on local resource availability. The resource map contains information on work and employment services, education and training opportunities, and volunteerism opportunities. The resource map also contains information on locations with public access to computers and free Wi-Fi and other supportive resources such as public transportation, substance abuse treatment, housing, and more. Public access to computers is being provided by Arkansas DHS, Arkansas DWS, Arkansas libraries and other community organizations. We are also actively engaging other state agencies and non-profit agencies to assess their willingness and capacity to provide support to Arkansas Works beneficiaries in this and other ways. Arkansas DHS has lead on this project. Locations where beneficiaries and former beneficiaries can access free and reduced cost health care have also been collected and made available in this map. DHS will include information in notices for individuals who lose coverage due to non-compliance in addition to sharing this information through social media. This resource map will be available to the public online in the Arkansas Works information SharePoint site and will be updated quarterly and as new information becomes available. Link to Arkansas Works Information:
https://ardhs.sharepointsite.net/ARWorks/default.aspx

Quality Assurance and Fraud Process

Arkansas DHS will conduct a monthly quality assurance process to validate exemptions and work activities that have been attested to by beneficiaries as a special effort in addition to normal PERM and MEQC requirements. The quality assurance process will include reviewing a statistically valid random sample to achieve a 95% (+ / - 3% variance) level of confidence. In addition to these quality assurance reviews, Arkansas DHS will review data on attestations monthly and quarterly from the universe of Arkansas Works beneficiaries who are subject to work and community engagement requirements to identify trends and potential anomalies that should also be reviewed for accuracy. Based on the outcomes of these reviews, the quality assurance process will be enhanced with additional reviews in error prone areas. The quality assurance component will be promulgated in Medicaid eligibility rules. Specific quality assurance processes will be outlined in a procedural desk guide for DHS staff. If inaccuracies are discovered during the quality assurance process, appropriate action will be taken to remove months of exemption or compliance. If this results in three months of non-compliance for the calendar year, the Arkansas Works case will be closed and referred for investigation as potential fraud and overpayment.

Appeal Process

Beneficiaries will be provided full appeal rights with regard to work and community engagement requirements just as they have for other Medicaid eligibility determinations. The process will be the same regardless for the reason for appeal. Each notice contains information about beneficiaries' rights to appeal and how to request an appeal. Requests for appeal that are received in county offices are forwarded to the DHS Office of Chief Counsel Appeals and Hearings Unit who schedule and conduct appeal hearings and render decisions.

Data Exchange between Programs and Partners

To ensure that dual Arkansas Works and SNAP beneficiaries have no additional compliance or reporting requirements, Arkansas DHS will use data exchanges between systems to record compliance and exemption information. This data exchange is currently in the final stages of testing. SNAP and Arkansas Works beneficiaries may choose to comply through either program.

To ensure a robust outreach and education process, a weekly data file will be shared with Arkansas DWS, our Medicaid Beneficiary Relations provider, and each QHP carrier. Information provided to carriers will be limited to Arkansas Works beneficiaries that are members of their individual plans. The file will contain information on each beneficiary that includes contact information, work and community engagement exemption and compliance information, type of exemption, number of months of cumulative non-compliance, compliance status for the current month, and renewal month. This level of detail will allow our partners to conduct specific outreach and education encouraging beneficiaries to participate and complete work activities.

Summary

Arkansas appreciates the opportunity to help our fellow Arkansans begin to move up the economic ladder through the Arkansas Works program with work and community engagement requirements. We have put a great amount of thought and effort into the policy and operational design of this program to make it as successful as possible. We have developed a strong team of partners ready to help these beneficiaries take the steps toward self-sufficiency. We appreciate the continued support and partnership from the Centers for Medicare and Medicaid Services to help us implement this program and look forward to reporting our progress as implementation continues.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-06
Baltimore, Maryland 21244-1850

State Demonstrations Group

February 19, 2019

Cindy Gillespie
Director
Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Dear Ms. Gillespie:

The State of Arkansas submitted its revised community engagement eligibility and enrollment monitoring plan as required by special term and condition (STC) 54 of the state's section 1115 demonstration, Arkansas Works (Project No. 11-W-00287/6). The Centers for Medicare & Medicaid Services (CMS) has reviewed the monitoring plan and determined that it is consistent with the requirements outlined in the STCs; therefore, with this letter, CMS is approving the monitoring plan for completeness and the state may continue implementation of its community engagement program under the terms of its demonstration.

The revised monitoring plan has been incorporated in the STCs as Attachment A; we have included a copy of the revised STCs with the updated Attachment A. As outlined in STC 54, the state will provide status updates on the implementation of the eligibility and enrollment monitoring plan as part of the state's quarterly and annual monitoring reports. Should the state wish to make additional changes to the monitoring plan, the state should submit revisions to the plan for CMS review and approval.

If you have any questions, please contact your project officer, Ms. Rachel Nichols, at 410-786-6269 or by email at Rachel.Nichols@cms.hhs.gov. We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Bill Brooks, Associate Regional Administrator, CMS Dallas Regional Office

ATTACHMENT A

Eligibility and Enrollment Monitoring Plan

Arkansas Works – Work and Community Engagement Amendment

Strategic Approach

Overview

Arkansas plans to test innovative and administratively efficient approaches to promoting personal responsibility, encouraging improved health and well-being and movement up the economic ladder by requiring work and community engagement as a condition of continued eligibility in the Arkansas Works program. Based on enrollment as of March 2, 2018, approximately 69,000 out of 278,734 individuals currently enrolled in Arkansas Works will be expected to participate in monthly approved work activities. Arkansas has designed the work and community engagement requirement for Arkansas works to closely align with requirements in the Supplemental Nutrition Assistance Program (SNAP). SNAP work requirements can be reviewed in online policy through the following link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Once work requirements are fully implemented, Arkansas Works beneficiaries who are ages 19-49 must work or engage in specified educational, job training, job search or community service activities for at least 80 hours per month to remain covered through Arkansas Works, unless they meet exemption criteria established by the state. Arkansas Works beneficiaries who are subject to work requirements will be required to demonstrate that they are meeting the work requirements on a monthly basis. Arkansas Works beneficiaries who fail to meet the work requirements for any three months during a plan year will be dis-enrolled from Arkansas Works and will not be permitted to re-enroll until the following plan year.

External Partnering for Success

Arkansas plans to build on the innovation of the premium assistance model by partnering with insurance carriers who provide qualified health plans for Arkansas Works beneficiaries. The carriers will leverage their current care coordination and outreach activities to encourage work and assist Arkansas Works beneficiaries to engage in activities that satisfy the work and community engagement requirement as one of the steps to promoting overall healthy living. The relationship between DHS and carriers is outlined in a Memorandum of Understanding.

The Arkansas Department of Human Services (DHS) has had a long-standing partnership with the Arkansas Department of Workforce Services (DWS). Together, we have jointly administered the Temporary Assistance for Needy Families (TANF) program in Arkansas for more than a decade. Act 1705 of the 85th Arkansas General Assembly transferred the TANF block grant from DHS to DWS. Responsibilities of each agency in the operation of the program are documented through a Memorandum of Understanding that is updated annually. As part of the agreement, Arkansas DHS provides eligibility and enrollment services for the Transitional Employment Assistance (TEA) program

while Arkansas DWS provides case management services to help move beneficiaries toward self-sufficiency. Arkansas DHS staff conducts eligibility interviews, explain program requirements, and authorize TEA coverage in the DHS legacy system called ANSWER. The ANSWER system automatically creates an electronic referral to Arkansas DWS staff that also has access to the ANSWER eligibility system. Arkansas DWS staff communicates with Arkansas DHS staff when changes in eligibility are needed. Act 1 of the 90th Arkansas General Assembly Second Extraordinary Session required Arkansas DHS to refer all Arkansas Works beneficiaries with income at or below 50% of the federal poverty level to Arkansas DWS for free job search and job training assistance. In compliance with this law, we expanded that partnership in January 2017 to include a referral to obtain job search assistance and training opportunities available at the Arkansas DWS for all Arkansas Works beneficiaries. Arkansas DWS has physical locations in thirty-two out of seventy-five counties and statewide services available online by accessing the following link: www.arjoblink.arkansas.gov or www.dws.arkansas.gov. Arkansas DHS and DWS exceeded the requirement of the law by referring all recipients approved or renewed in the Arkansas Works program each month to DWS. The referral language was added to the approval and renewal notices. To track and monitor the effectiveness of the referral process, Arkansas DHS and DWS began exchanging monthly files to identify those who were referred that actually accessed services at DWS. In addition to identifying those who accessed DWS services, we also identified whether or not they were reported by employers to DWS as newly hired individuals. We obtained data through this process that demonstrates that Arkansas Works beneficiaries who had accessed services at Arkansas DWS were more likely to find work. Over the last 12 months, 347,949 Arkansas Works enrollees have received a referral to DWS. Of that number, 16,900 have accessed services at DWS. Additionally, 27% of those who accessed services at DWS have been reported by employers as new hires compared to 12% of those who did not access services at DWS. See Attachment 1 for the most recent rolling 12 month Arkansas Works – DWS referral report. We will further expand this partnership to serve Arkansas Works beneficiaries with a work or community engagement requirement. Arkansas DHS will continue to provide referrals and information about services available through the Arkansas DWS in all of our notices related to the Arkansas Works program. Attachment 2 is a sample Arkansas Works notice that contains the DWS referral language that is included in all Arkansas Works notices. Arkansas DWS will also send follow-up letters to Arkansas Works beneficiaries who have a work and community engagement requirement. A sample copy of the DWS follow up letter that is sent to Arkansas Works beneficiaries with work and community engagement requirements will be provided once finalized. Arkansas DWS will provide career assessment, job-search assistance, and referrals for training as appropriate. The Workforce Opportunities and Innovation Act of 2014 (WIOA) placed heightened emphasis on coordination and collaboration at the Federal, State, local, and tribal levels to ensure a streamlined and coordinated service delivery system for job seekers, (from low income families including those with disabilities), and employers.

Job seekers can also explore training programs offered through the extensive Eligible Training Provider List. They can discuss education, training, and apprenticeship programs through Arkansas DWS-WIOA, their partners, and determine if they would qualify to participate in any of those opportunities. Since Arkansas Works participants are considered low income, they could be eligible for those services

(Funding and slots availability, and additional requirements may apply). Arkansas Works recipients will also have access to attain Career Readiness Certifications (CRCs), create professional resumes, and other universal job services to help be effective in their job-search activities. The following screenings and assessments available in the Arkansas Workforce Integrated Network System (ARWINS) for Arkansas Works recipients:

- A basic screener to determine if the client could be eligible for UI, targeted WIOA programs, computer literacy
- Assessments that will help determine job-seeker Characteristics like Abilities, Occupational Interests, Work Values, Skills, Knowledge, and high demand occupation matches based on current education and experience levels
- Assessments that will help determine if the job-seeker has any barriers as related to Transportation, Child Care, Legal, Domestic Violence, and Homelessness

The assessments are voluntary and there is a prescribed path. The job-seeker is encouraged to take the path, but the individual will not be forced to take those assessments.

Arkansas DHS has also leveraged our current contract for Medicaid beneficiary relations with the Arkansas Foundation for Medical Care (AFMC) to provide outreach and education about the work and community engagement requirement. AFMC will do active outreach to educate Arkansas Works beneficiaries who need to complete work and community engagement activities to make sure they understand the requirements. AFMC will also provide education and assistance to beneficiaries on how to properly and timely report their activities and to direct them to the Arkansas Department of Workforce Services, Supplemental Nutrition Assistance Program (SNAP) Employment and Training providers, or other resources as appropriate to help them comply with work requirements. Contractual requirements for work and community engagement include an outreach period 30 days prior to the beginning of work and community engagement requirements for existing Arkansas Works beneficiaries. Outreach and education methods will include outbound phone contact as well as an inbound integrated voice response system where beneficiaries can receive education about work and community engagement requirements. All scripts and materials used by AFMC will be approved by DHS. AFMC will also spend the first 12 days conducting outreach and education after an Arkansas Works beneficiary is approved with work and community engagement requirements. AFMC must successfully contact and educate 30% of existing Arkansas Works beneficiaries and 40% of newly approved Arkansas Works beneficiaries. To facilitate the successful outreach and education, AFMC staff has received training and access to our Curam eligibility system and will be receiving a daily and monthly file containing Arkansas Works beneficiaries with work and community engagement requirements and their current status related to these activities. AFMC is required to make a minimum of two attempts by a live agent to contact beneficiaries by phone when a phone number is available. Additional attempts and methods used by AFMC to reach their contractual obligations are not specified. AFMC will be required to provide DHS with results of outreach efforts through various reports.

Arkansas implemented the requirement to work in the Supplemental Nutrition Assistance Program (SNAP) statewide in January 2016. The Arkansas Department of Human Services has partnered with the United States Department of Agriculture Food and Nutrition Services since that time to expand the SNAP Employment and Training Program in Arkansas. Participation in SNAP Employment and Training is one option available to SNAP recipients as a means to comply with SNAP work requirements. SNAP recipients may also comply on their own through work, education, training, or community service and volunteerism activities. Arkansas has expanded the availability of SNAP Employment and Training from thirteen to fifty out of seventy-five counties since January 2016. In each of these counties DHS has either a contract or sub grant agreement in place with at least one SNAP Employment and Training provider with a physical location to provide employment and training services. DHS is currently in negotiations with additional providers to add an additional fifteen counties by the end of 2018. DHS has commitments from the providers who will cover these additional counties and we are awaiting approval from the USDA Food and Nutrition Services to implement this additional expansion. Point in time data comparison in March 2018 between the SNAP program and Arkansas Works has shown that approximately twenty-two to twenty-five percent of Arkansas Works beneficiaries also receive SNAP. We plan to leverage the expanded SNAP Employment and Training program to assist individuals who are dually eligible for SNAP and Arkansas Works to meet work and community engagement requirements by referring them to SNAP Employment and Training providers as appropriate for assistance with job search and training. SNAP Employment and Training providers already attempt to reach and engage SNAP recipients. SNAP recipients who are also enrolled in Arkansas Works may satisfy work and community engagement requirements in both programs by participating in SNAP Employment and Training. A list of our current SNAP Employment and Training providers is provided as Attachment 3. A map showing the current SNAP E & T coverage is provided as Attachment 4. Proposed expanded SNAP E & T coverage by the end of 2018 is provided as Attachment 5. Dual SNAP and Arkansas Works beneficiaries will be allowed to satisfy the work and community engagement requirement for both programs by participating in and reporting in either the SNAP or the Arkansas Works program. They will not be required to comply with or report separately to both programs to maintain continued eligibility. The Arkansas Works program, SNAP, and the Transitional Employment Assistance programs reside in separate eligibility systems operated by Arkansas DHS. Working with contracted developers for both systems, Arkansas DHS has developed a process whereby data files will be exchanged between these systems daily to update exemption and compliance information in both programs without manual intervention by the beneficiaries or DHS staff. User acceptance testing to validate this process is underway.

Online Reporting

Arkansas has enhanced the innovation and administrative efficiency of the work and community engagement requirement by planning and designing an online portal for beneficiaries to report their work activities, exemptions, and other household changes. This portal is actually an enhancement of the Curam eligibility system that has already passed CMS readiness review standards. DHS required through contract with Curam developers that the portal is mobile device friendly and ADA compliant. The access.arkansas.gov online portal complies with 42 CFR 435.1200 f (2). Beneficiaries will use an email address and password to access the online portal. Rather than providing verification of exempt or

compliant status with paper documentation, beneficiaries will enter and attest to the information submitted through the online portal. These attestations will be evaluated through a robust quality assurance process (See Quality Assurance and Fraud Process). Use of the portal promotes work and community engagement goals by reinforcing basic computer skills, internet navigation, and communication via email. This approach is administratively efficient to implement. The eligibility system processes information submitted via the online portal automatically without worker intervention. This allows Arkansas to implement the work and community engagement requirement without additional resources. Individuals, who are disabled, including mental and physical disability, will be exempt from work and community engagement requirements and will not be at risk for losing coverage. Arkansas DHS will provide reasonable accommodations to assist individuals with the online reporting requirement. Beneficiaries may receive in-person assistance through the local DHS county offices. All notices provide instructions to contact the Access Arkansas Call Center or a county office for help regarding work and community engagement requirements.

Arkansas DHS has also developed a "Registered Reporter" process to assist individuals with their online reporting requirements. Individuals may become a registered reporter by reviewing specified online training material, signing a Registered Reporter Acknowledgement Form and emailing that form to Arkansas DHS. The beneficiary must also authorize the reporter to serve in that role. To promote this as an additional reporting support for Arkansas Works beneficiaries, Arkansas DHS will announce this process through a press release and schedule meetings and webinars with stakeholder agencies. Information on the process and training is available on our public SharePoint site at the following link: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Operational update: In December 2018, Arkansas DHS launched an Arkansas Works Helpline to further assist individuals with their online reporting requirements. As of December 19, 2018, individuals may contact our county offices or call our toll-free number 855-372-1084 to report directly to Arkansas DHS by phone. Beneficiaries may now report the types and hours of work and community engagement activities that they participate in, report changes in exemption status, and renew existing exemptions by phone directly to DHS staff who will key the information into the system. This is in addition to receiving in-person assistance in the DHS county offices, from registered reporters, or through self-service using the online portal.

Outcome Monitoring

Arkansas DHS will develop reports that track the following information related to the Arkansas Works program:

- Number and percentage of individuals required to report each month
- Number and percentage of beneficiaries who are exempt from the community engagement requirement
- Number and percentage of beneficiaries requesting good cause exemptions from reporting requirements

- Number and percentage of beneficiaries granted good cause exemption from reporting requirements
- Number and percentage of beneficiaries who requested reasonable accommodations
- Number and percentage and type of reasonable accommodations provided to beneficiaries
- Number and percentage of beneficiaries disenrolled for failing to comply with community engagement requirements
- Number and percentage of beneficiaries disenrolled for failing to report
- Number and percentage of beneficiaries disenrolled for not meeting community engagement and reporting requirements
- Number and percentage of community engagement appeal requests from beneficiaries
- Number, percentage and type of community engagement good cause exemptions requested
- Number, percentage and type of community engagement good cause exemptions granted
- Number, percentage and type of reporting good cause exemptions requested
- Number, percentage and type of reporting good cause exemptions granted
- Number of appeals of dis-enrollments for non-compliance with community engagement
- Number of appeals for dis-enrollments for failure to comply with the reporting requirements
- Number and percentage of applications made in-person, via phone, via mail and electronically.

All of the data required to produce these reports is owned by Arkansas DHS, with the exception of the good cause exemption reports and the work and community engagement appeal requests; these reports will be system-generated from the eligibility system data warehouse. Requirements, design, and delivery of these reports are covered by the Arkansas DHS contractual agreement with the eligibility system developer. A database outside of the eligibility system is being developed by DHS to track and report all good cause exemption metrics. Appeal metrics will be tracked and provided by the DHS Office of Chief Counsel Appeals and Hearings section. These reports will be compiled monthly and will be reported to CMS quarterly. Documentation on design requirements for each report will be available at a later date when report development is complete.

Implementation Plan and Timeline

Planning, policy and system development, partner and stakeholder engagement, and resource availability assessment (See Community Resource and Supports Availability Mapping) began in January 2017 and have been ongoing.

Upon approval of the work and community engagement amendment, Arkansas began finalizing plans and testing of the process to implement the requirement on June 1, 2018. Based on data as of March 2, 2018, there were 171,449 Arkansas Works beneficiaries ages 19 – 49. Approximately 69,000 have no initial exemption identified through system data. Due to the number of beneficiaries impacted, Arkansas will phase in work requirements by age group. Beginning June through September 2018, beneficiaries ages 30 – 49 at or below federal poverty level will be phased in to the work requirement. 19 – 29 year olds at or below federal poverty level will be phased in during 2019 between January and April.

Operational update: The phase in plan for 2019 was adjusted to include implementing beneficiaries ages 30 – 49 in households with income above 100% FPL as well as all beneficiaries ages 19 – 29.

Additionally, beneficiaries ages 19 – 29 will be phased in over six months between January and June 2019 rather than four months.

Based on the same data, there were 125,242 Arkansas Works beneficiaries ages 30 – 49. Of those, 38,321 have no exemption identified through system data. Arkansas has chosen to phase in this group over four months based on when their cases are due for renewal. The chart below depicts the month the work requirement begins, the renewal months and number of beneficiaries affected.

Month Work Requirement Begins	**Renewal Months**	**Approximate #of beneficiaries required to report work activities**
June 2018	Jan, Feb, Mar	9,152
July 2018	April, May, June	9,341
August 2018	July, August, September	8,682
September 2018	Oct, Nov, Dec	11,146
Data date: 3/2/2018	TOTAL	38,321

The planning, testing, implementation, and monitoring timeline is provided below:

- **March 15, 2018** – Mass notice will be issued to all Arkansas Works beneficiaries informing them of the change in the program and upcoming implementation of work and community engagement requirements. The notice will instruct them that no additional action is required at that time and will encourage them to provide an email address to Arkansas DHS if they have not already.
- **March 30, 2018** – The Arkansas Works online portal will go live. Beneficiaries will be able to begin linking their secure online accounts and reporting exemptions.
- **April 1, 2018** – New Arkansas Works beneficiaries ages 30 – 49 approved beginning April 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **April 1 – 8, 2018** – Work requirement begin months will be set for beneficiaries 30 – 49 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- **April 13, 2018** –The first data file of Arkansas Works beneficiaries containing specific information regarding work and community engagement details will be provided to Arkansas DWS, the Medicaid Beneficiary Relations provider, and QHP carriers. Outreach and education will begin. Updated files will be provided weekly thereafter.
- **May 8, 2018** – Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in June 2018 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of June 2018. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.

- **June 1, 2018** – Implementation of mandatory work requirements begins for individuals ages 30 - 49.
- **June 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in July 2018 will be mailed individually tailored notices.
- **June 26, 2018** – The Post Award Forum will be held at 10:00 AM at the Hillary Rodham Clinton Children's Library and Learning Center, 4800 W. 10th Street, Little Rock, AR 72204.
- **July 8, 2018** - Arkansas Works beneficiaries ages 30 – 49 who are scheduled to begin the work and community engagement requirement in August will be mailed individually tailored notices.
- **August 8, 2018** - Arkansas Works beneficiaries ages 30 - 49 who are scheduled to begin the work and community engagement requirement in September 2018 will be mailed individually tailored notices.
- **August 30, 2018** – Monitoring phase begins and first quarterly report will be posted to the Arkansas DHS website.
- **November 1, 2018** - New Arkansas Works beneficiaries ages 19 - 29 approved beginning November 1, 2018, or later will become subject to the work and community engagement and have their begin dates for completing and reporting work activities set to begin the second month after approval.
- **November 1 – 8, 2018** - Work requirement phase in will be set based on renewal months for beneficiaries 19 - 29 years of age and notices will be mailed to each individual with specific details about the work and community engagement requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
- **November 30, 2018** – Second quarterly monitoring report will be submitted to CMS.
- **December 8, 2018** - Arkansas Works beneficiaries ages 19 – 29 and beneficiaries ages 30 – 49 with household income above 100% FPL who are scheduled to begin the work and community engagement requirement in January 2019 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of January 2019. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
- **January 1, 2019** – Implementation of mandatory work requirements begins for individuals ages 19 – 29 and individuals ages 30 – 49 with household income above 100% FPL.
- **January 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in February 2019 will be mailed individually tailored notices.
- **February 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in March 2019 will be mailed individually tailored notices.
- **February 28, 2019** – Third quarterly monitoring report will be submitted to CMS.
- **March 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in April 2019 will be mailed individually tailored notices.

- **April 8, 2019** - Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in May 2019 will be mailed individually tailored notices.
- **April 30, 2019** – Fourth quarterly monitoring report will be submitted to CMS.
- **May 8, 2019** – The final group of Arkansas Works beneficiaries ages 19 - 29 who are scheduled to begin the work and community engagement requirement in June 2019 will be mailed individually tailored notices.

Arkansas Works Application and Renewal Overview

Applications for healthcare coverage are accepted through multi-channels including online, by phone, in person, and by mail. Application assistance is provided by Arkansas DHS staff both in person and by phone. No changes are needed to the current process for applications related to the addition of the work and community engagement requirement. Assistance is provided in local offices to those who need assistance completing applications. Arkansas DHS also maintains a contract with a vendor who provides interpretation and translation services. This service is accessible statewide and each county office can access the vendor as needed to assist individuals. Arkansas DHS also accepts applications from incarcerated individuals up to forty-five days prior to release. The Arkansas Department of Corrections has contracted with a vendor to assist exiting inmates with the application process for Medicaid prior to release. Applications received from beneficiaries who lost eligibility due to non-compliance with work and community engagement requirements will be denied if received prior to the yearly open enrollment period. Applications received during open enrollment will be processed with coverage beginning on January 1 of the following year for beneficiaries that are otherwise eligible. The State's reasonable accommodation process will be available in a procedural desk guide developed for Medicaid eligibility caseworkers and administrative staff and will be posted online once complete.

Renewals are conducted monthly through an ex-parte process. Beneficiaries whose renewals cannot be completed ex-parte are sent specific notices to provide information that is needed to complete the renewal. Beneficiaries are not required to complete forms that require information that has been previously provided or is available to DHS. Arkansas Works beneficiaries who are subject to work and community engagement requirements will have their renewals completed by the same method as beneficiaries who are not subject to work and community engagement activities. Work activity reporting continues through the online portal with no interruption or change to the reporting process during renewal. Being non-compliant in the month a beneficiary's case is due for renewal does not prevent the ex-parte renewal process from occurring.

Arkansas monitors Medicaid timeliness with data and conducts a weekly Medicaid Eligibility Operations meeting to review progress and develop strategies to address any issues that arise. Weekly management reports are reviewed by the team during each meeting. Timeliness reports can be provided along with other quarterly reports. Additional information is also reported to CMS monthly through Performance Indicators.

Arkansas DHS completes daily electronic account transfers to the federally facilitated marketplace for individuals determined to be ineligible for Medicaid. No changes to this process are necessitated by the addition of the work and community engagement process.

Work and Community Engagement Overview and Operational Approach

Population Subject to Work Requirements
Once work requirements are implemented in June of 2018, on a rolling, phased in basis, Arkansas Works beneficiaries ages 19 to 49 who do not meet established exemption criteria will be required to meet work requirements as a condition of continued Arkansas Works eligibility. Work requirements will not apply to Arkansas Works beneficiaries ages 50 and older. Work and Community Engagement Requirements will be promulgated according to the State's Administrative Procedures Act in Medicaid eligibility rules. Link to the promulgated Medicaid eligibility manual: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx.

Exemption from Work Requirements
Arkansas Works beneficiaries meeting one of the criteria described in the STCs will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including employment and self-employment of at least 80 hours a month, medical frailty, exemption from the SNAP work requirement, receipt of TEA Cash Assistance, and receipt of unemployment benefits. Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval. Detailed information about exemptions from work and community engagement requirements can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Allowed Work Activities and Work Activity Hour Calculations
Arkansas Works beneficiaries ages 19 – 49 who are not exempt must engage in 80 hours of monthly work and community engagement activities. Arkansas Works beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of activities as deemed appropriate by the state. Arkansas Works beneficiaries must demonstrate electronically on a monthly basis that they are meeting the work requirement. Detailed information about allowed work and community engagement activities can be found online at the following link. Link: https://ardhs.sharepointsite.net/DHSPolicy/Pages/dcohome.aspx

Disenrollment for Failure to Meet Work Requirement
Beneficiaries who are subject to work requirements will lose eligibility for Arkansas Works if they fail to meet work requirements for any three consecutive or non-consecutive months during the coverage year. Effective the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage, following proper notice and due process, and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to re-enroll in Arkansas Works. Arkansas Works beneficiaries whose coverage has been terminated due to non-compliance may apply for and receive coverage in other Medicaid categories if eligible during the lockout period. Notices of denial and closure due to non-compliance with work and community engagement requirements will contain information about how to access primary and

preventive care services at low or no cost at free health clinics and community health centers (See Community Resource and Supports Mapping). Closure of the Arkansas Works case will be transmitted to the InterChange Medicaid Management Information System. Termination of the QHP premium payment is automated in the InterChange system.

Beneficiary Work and Community Engagement Online Reporting Requirements

Beneficiaries must use the online portal to report exemptions and completion of work and community engagement activities. The work and community engagement portal is part of the existing eligibility system. Information entered into the portal is seamlessly processed by the eligibility system with no additional beneficiary or DHS staff requirement to re-key or transfer the information into the system. Exemptions must only be re-attested to at the required intervals specified above. Completion of work activities must be entered and attested to monthly. Individuals will have until the 5th day of the following month to attest for the previous month. The online portal is secure, mobile device friendly, and compliant with the ADA. The portal requires an email address and password to access. To assist beneficiaries prepare for this requirement, Arkansas DHS and our Access Arkansas Call Center have conducted a campaign over the last several months where we encourage beneficiaries to provide an email address. We have also offered information about how to obtain free email addresses and assistance with setting up email addresses. We have been able to collect several thousand email addresses during this effort. The portal allows beneficiaries to reset passwords through self-service. Technical assistance will also be available through our Access Arkansas Call Center for website and password issues. Beneficiaries who require assistance using the portal can receive assistance from several sources, including Arkansas DHS staff, Call Center Agents, Arkansas DWS staff, or their QHP carrier. Arkansas DHS worked with the University of Arkansas for Medical Sciences Health Literacy team to help develop language for work and community engagement notices and fliers. Similar verbiage was used on the portal for consistency and understanding at lower literacy levels. Arkansas DHS maintains a contract for language interpretation and translation. Beneficiaries who need assistance with languages other than English will be assisted in the local DHS county offices. Each notice and flier regarding work and community engagement direct beneficiaries who need help to contact our toll-free call center or local DHS County office. The portal will be available daily between 7 AM and 9 PM except for times when it is necessary to take the portal offline for system upgrades. Those outages when necessary are scheduled over weekends for minimal disruption. The website displays a notice each time the portal is offline for maintenance. The State will make every effort not to schedule maintenance during the first through the fifth of each month for beneficiaries who need to report the previous month's activities before the reporting deadline.

Upon logging into the portal, beneficiaries will be able to see their work and community engagement status for the current reporting month as well as history for the year to date. They will be able to update and confirm their contact information and household composition. Beneficiaries will know immediately upon submission if they have entered enough information to be considered compliant or exempt for the reporting month. If they have not yet completed 80 hours, the portal will display the

number of hours needed to become compliant. Each portal screen includes information about the method for calculating completed hours for that activity.

Good Cause Exemptions / Catastrophic Events

Beneficiaries who have experienced a catastrophic event during a month they were required to complete work activities will be exempt from work requirements or reporting by requesting and being granted a good cause exemption. Circumstances that may lead to an approved good cause exemption are outline in the STCs and include but are not limited to a natural disaster, hospitalization or serious illness, birth or death of a family member living in the home and domestic violence. Beneficiaries who have lost coverage due to non-compliance with the work and community engagement requirement will have their cases reinstated without a new application if they are granted a good cause exemption and are otherwise eligible. Information about good cause exemptions and how to request these is provided in all work and community engagement notices. Verification of the catastrophic event which caused the beneficiary not to complete and/or report required activities will be required as part of the good cause approval process. DHS staff may use discretion to waive the verification in cases such as natural disaster when the event is known to the general public.

Interim Period Prior to Work and Community Engagement Requirement – Outreach and Education

Newly approved Arkansas Works beneficiaries who are subject to the work and community engagement requirement will have an interim period of up to 59 days prior to beginning work activities. The work requirement will begin on the first of the second month after the month of approval. For example, a non-exempt beneficiary approved in the Arkansas Works program on any day during the month of April will be required to begin completing work activities on June 1st. Through our implementation plan, existing beneficiaries will also have an interim period after notification before they are required to begin completing and reporting work activities. The interim period will be used to conduct outreach to beneficiaries to educate them on all aspects of the work requirement including using the online portal, connecting with the Arkansas Department of Workforce Services and other resources to assist them with compliance with work activities. The outreach will be done through a multi-media and multi-partner approach that includes Arkansas DHS, Arkansas DWS, our Medicaid Beneficiary Relations provider, and QHP carriers. This outreach effort also involves social media including Facebook and Twitter. Over the last several months, Arkansas DHS has developed several educational tools regarding work and community engagement requirements that are intended to assist beneficiaries and partners alike. These tools include a computer-based training on the Arkansas Works program and the work and community engagement requirement. Tutorials on linking their secure account on the portal, entering work activity and exemption information on the portal have also been developed. This Arkansas Works toolkit will be available online to the public so that partners and beneficiaries can access the information as needed. Link to Arkansas Works education and Outreach information: https://ardhs.sharepointsite.net/ARWorks/default.aspx.

Operational Update: Enhanced Outreach and Education

In our ongoing efforts to monitor this program and adjust our operational approach to help beneficiaries successfully engage in the work and community engagement requirement, Arkansas DHS launched and Arkansas Works Helpline to assist individuals with their online reporting requirement by phone directly to DHS through our toll-free phone number in December 2018. Beneficiaries may now report the types and hours of work and community engagement activities that they participate in, report changes in exemption status, and renew existing exemptions by phone directly to DHS staff who will key the information into the system. In addition to helping inbound callers, this team is also conducting proactive outreach to beneficiaries identified through various monitoring reports to offer them additional assistance. This team makes proactive calls to beneficiaries who have reported some activities, but not enough to meet the 80-hour requirement as well as beneficiaries who have exemptions that ended and have not been renewed. This team provides education to connect beneficiaries with additional options for meeting the requirement and uses the Resource Dashboard to help guide the discussion.

Work and Community Engagement Notices

In addition to traditional postal mail, Arkansas DHS will communicate with Arkansas Works beneficiaries who have provided email addresses through an electronic message to a secure inbox. Notices content will meet all requirements in the standards, terms, and conditions reflected in the approved 1115 waiver amendment. With the exception of good cause exemption denials, all notices related to the work and community engagement requirement are automated and system-generated in real time. This automation ensures that timely and adequate notice requirements are met. Specific notices related to work and community engagement requirements have been developed and contain detailed information for beneficiaries.

Until good cause exemption functionality can be developed in our eligibility system, notices of either approval or denial of a good cause exemption will be manually generated and uploaded to the electronic case record. A separate tracking website will be developed and maintained for Arkansas DHS staff to use to track good cause exemption requests for noncompliance with work activities or reporting requirements until this capability is achieved in the eligibility system to meet CMS monitoring and reporting requirements included in the approved waiver amendment.

Community Resource and Supports Availability and Mapping

Arkansas DHS has been working with a team of partners and stakeholders for several months to identify community engagement resources throughout the state. This team includes Arkansas DHS, Arkansas DWS, Arkansas Center for Health Improvement, representatives from each Arkansas Works qualified health plan carrier, the Arkansas Hospital Association, the University of Arkansas for Medical Sciences, and the Arkansas Department of Career Education. Input and participation is open to interested stakeholder organizations. As a result of this effort, an Arkansas Works Interactive Resource Map has been developed for users to click county by county for specific information on local resource availability. The resource map contains information on work and employment services, education and training opportunities, and volunteerism opportunities. The resource map also contains information on

locations with public access to computers and free Wi-Fi and other supportive resources such as public transportation, substance abuse treatment, housing, and more. Public access to computers is being provided by Arkansas DHS, Arkansas DWS, Arkansas libraries and other community organizations. We are also actively engaging other state agencies and non-profit agencies to assess their willingness and capacity to provide support to Arkansas Works beneficiaries in this and other ways. Arkansas DHS has lead on this project. Locations where beneficiaries and former beneficiaries can access free and reduced cost health care have also been collected and made available in this map. DHS will include information in notices for individuals who lose coverage due to non-compliance in addition to sharing this information through social media. This resource map will be available to the public online in the Arkansas Works information SharePoint site and will be updated quarterly and as new information becomes available. Link to Arkansas Works Information: https://ardhs.sharepointsite.net/ARWorks/default.aspx

Quality Assurance and Fraud Process

Arkansas DHS will conduct a monthly quality assurance process to validate exemptions and work activities that have been attested to by beneficiaries as a special effort in addition to normal PERM and MEQC requirements. The quality assurance process will include reviewing a statistically valid random sample to achieve a 95% (+ / - 3% variance) level of confidence. In addition to these quality assurance reviews, Arkansas DHS will review data on attestations monthly and quarterly from the universe of Arkansas Works beneficiaries who are subject to work and community engagement requirements to identify trends and potential anomalies that should also be reviewed for accuracy. Based on the outcomes of these reviews, the quality assurance process will be enhanced with additional reviews in error prone areas. The quality assurance component will be promulgated in Medicaid eligibility rules. Specific quality assurance processes will be outlined in a procedural desk guide for DHS staff. If inaccuracies are discovered during the quality assurance process, appropriate action will be taken to remove months of exemption or compliance. If this results in three months of non-compliance for the calendar year, the Arkansas Works case will be closed and referred for investigation as potential fraud and overpayment.

Appeal Process

Beneficiaries will be provided full appeal rights with regard to work and community engagement requirements just as they have for other Medicaid eligibility determinations. The process will be the same regardless for the reason for appeal. Each notice contains information about beneficiaries' rights to appeal and how to request an appeal. Requests for appeal that are received in county offices are forwarded to the DHS Office of Chief Counsel Appeals and Hearings Unit who schedule and conduct appeal hearings and render decisions.

Data Exchange between Programs and Partners

To ensure that dual Arkansas Works and SNAP beneficiaries have no additional compliance or reporting requirements, Arkansas DHS will use data exchanges between systems to record compliance and exemption information. This data exchange is currently in the final stages of testing. SNAP and Arkansas Works beneficiaries may choose to comply through either program.

To ensure a robust outreach and education process, a weekly data file will be shared with Arkansas DWS, our Medicaid Beneficiary Relations provider, and each QHP carrier. Information provided to carriers will be limited to Arkansas Works beneficiaries that are members of their individual plans. The file will contain information on each beneficiary that includes contact information, work and community engagement exemption and compliance information, type of exemption, number of months of cumulative non-compliance, compliance status for the current month, and renewal month. This level of detail will allow our partners to conduct specific outreach and education encouraging beneficiaries to participate and complete work activities.

Summary

Arkansas appreciates the opportunity to help our fellow Arkansans begin to move up the economic ladder through the Arkansas Works program with work and community engagement requirements. We have put a great amount of thought and effort into the policy and operational design of this program to make it as successful as possible. We have developed a strong team of partners ready to help these beneficiaries take the steps toward self-sufficiency. We appreciate the continued support and partnership from the Centers for Medicare and Medicaid Services to help us implement this program and look forward to reporting our progress as implementation continues.