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
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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.

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Proposed Evaluation for Section 1115 Demonstration Waiver

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

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

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

1. Background

Arkansas is a largely rural state with significant health care challenges including high health-risk burdens; low median family income; high rates of uninsured individuals; and limited provider capacity, particularly in non-urban areas of the state. Arkansas's Medicaid program currently has one of the most stringent eligibility thresholds in the nation, largely limiting coverage to the aged, disabled, and parents with extremely low incomes and limited assets.

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

Working closely with the Division of Medicaid Services within the Arkansas Department of Human Services, the Arkansas Insurance Department has issued guidance and directives to achieve plan offerings that conform to Centers for Medicaid and Medicare Services (CMS) and Center for

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

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

2. Section 1115 Waiver: The Health Care Independence Act

The U.S. Supreme Court's June 2012 ruling[2] allowed states to decide whether or not to extend Medicaid benefits to their citizens who qualify under PPACA expansion. Members of the Arkansas 89th General Assembly took a bipartisan approach to this prospect and crafted a unique proposal that will use federal Medicaid funding to provide health care benefits to individuals eligible under the PPACA expansion. These individuals will receive coverage via private insurance plans offered through the Marketplace. Commonly known as the "Private Option," the Health Care Independence Act[3] and its accompanying appropriation was passed by the required three-fourths majority vote in both the Arkansas House and Senate and signed into law by Governor Mike Beebe on April 23, 2013.

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

- maximize the available service options;
- promote accountability, personal responsibility, and transparency;
- encourage and reward healthy outcomes and responsible choices; and
- promote efficiencies that will deliver value to the taxpayers.

Arkansas DHS has secured approval of a waiver demonstration application submitted to the U.S. Department of Health and Human Services specifically designed to implement the act's requirements.[4]

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

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

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

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

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

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

In addition, if the traditional Medicaid program were expanded to include all individuals with incomes at or below 138 percent FPL, Arkansas would have increased its state Medicaid program population by nearly 40 percent. The state's existing network of participating fee-for-service Medicaid providers is already at capacity. As a result, Arkansas would have been faced with the challenge of increasing providers' capacity to serve Medicaid beneficiaries to ensure adequate access to care.

In short, absent the federal waiver to implement the act, a traditional Medicaid expansion would rely on the existing Medicaid delivery system and perpetuate an inadequately coordinated approach to patient care for those newly eligible under the PPACA. While reforms associated with the Arkansas Payment Improvement Initiative (www.paymentinitiative.org) are designed to address the quality and cost of care in Medicaid and the private market, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults who will enroll through the expansion.

A. HCIP Eligibility[4]

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

- Adults between the ages of 19 and 65 years.
- A U.S. citizen or qualified, documented alien.
- Those not otherwise eligible for Medicaid under current eligibility requirements, such as those who are disabled, children, dual eligible, or are parents earning less than 17 percent FPL.
- Those not enrolled in Medicare.
- Those not incarcerated.

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

B. HCIP Funding and Costs[3]

The act allows the program to continue in perpetuity during the period of the waiver that has been submitted by the Arkansas DHS but is contingent upon annual appropriations by the Arkansas General Assembly. The waiver has been approved by U.S. DHHS for 2014–2016. The costs of the program are shared by the federal government through provisions of the PPACA. In years 2014–2016 the federal share will be 100%, followed by 95%, 94%, 93%, and 90% in years 2017, 2018, 2019, and 2020 and beyond, respectively. The state will provide the additional funding beginning in 2017.

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

State budget:

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

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

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

Federal budget:

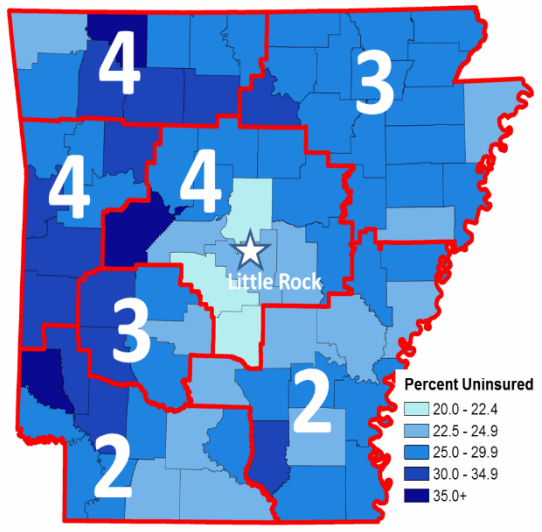
- The federal government will benefit from ~$1.1 billion per year in new taxes and Medicare payment reductions.[8]
- The increase in federal costs for expansion and ongoing Medicaid is projected at $1.59 billion in FY15 and $2.35 billion in FY20.[6]
- The net impact on the federal budget approaches neutrality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

C. Private Plans Available to Arkansans

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

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

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



Issuers:

- Arkansas Blue Cross Blue Shield of Little Rock
- National Blue Cross Blue Shield Multi-state Plan
- QCA Health Plan of Little Rock (QualChoice of Arkansas Inc.)
- Arkansas Health & Wellness Solutions (Ambetter)

[7] Optumas. *Newly Eligible Cost Model Intervention Comparison for Arkansas.* [Actuarial Analysis]. March 2013.
[8] Price C and Saltzman E. *The Economic Impact of the Affordable Care Act in Arkansas.* RAND Corporation, January 2013. Web March 31, 2013.
[9] Talk Business. *Only Four Insurance Carriers Could Qualify for Arkansas Exchange.* August 2013. Accessed at http://talkbusiness.net/2013/08/only-four-insurance-carriers-could-qualify-for-arkansas-exchange/ on September 24, 2013.
[10] Arkansas Insurance Department. *Bulletin No. 3B-2013.* June 2013. Accessed at http://www.insurance.arkansas.gov/Legal/Bulletins/3B-2013.pdf on September 24, 2013.

companies.[11]

D. Arkansas' HCIP Proposal[4]

The Private Option is crafted to address the provider capacity and care coordination issues noted above. By using premium assistance to purchase qualified health plans (QHPs) offered in the Health Insurance Marketplace, Arkansas will promote continuity of coverage and expand provider access, while improving efficiency and accelerating multi-payer cost-containment and quality-improvement efforts. Further, it is expected that by providing a source of payment to an estimated 250,000 currently uninsured citizens, an economic impetus will be created that will lead to an increase in the supply of health care services available, particularly in currently underserved areas counties. In fact, a recent study[8] sponsored by ACHI and conducted by the RAND Corporation indicated that full implementation of expanded coverage under the PPACA would result in a $550 million annual increase in Arkansas's gross domestic product and the creation of 6,200 jobs, with the majority of this impact accruing to rural Arkansas where the uninsured rates are relatively higher.

Continuity of Coverage

For households with members eligible for coverage under Title XIX or the Health Insurance Marketplace as well as those who have income fluctuations that cause their eligibility to change year to year, the act will create continuity of health plans and provider networks. Households can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, CHIP (after year one), or Advanced Payment Tax Credits.

Rational Provider Reimbursements and Improved Provider Access

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

Integration and Efficiency

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

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

"All Payer" Health Care Reform

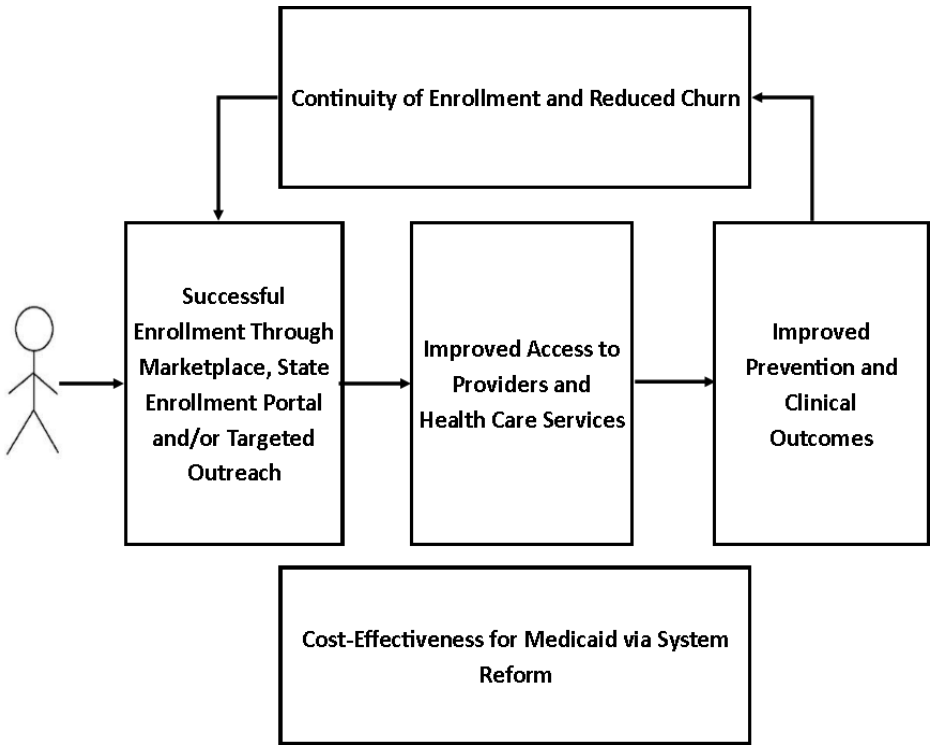
Arkansas is at the forefront of payment innovation and delivery system reform, and the Health Care Independence Act will accelerate and leverage the state's Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort, and the number of privately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

3. Evaluation Strategy

A. Goals and Objectives

The HCIP programmatic goals and objectives include successful enrollment, enhanced access, improved quality of care and clinical outcomes, and enhanced continuity of coverage and care at times of reenrollment and income fluctuation. These goals and objectives must be achieved within a cost-effective framework for the Medicaid program compared with what would have occurred if the state had provided coverage for the same expansion group in Arkansas Medicaid's traditional fee-for-service delivery system.

Figure 2: Arkansas Demonstration Waiver Evaluation Logic Model



New enrollees will successfully enroll through the Marketplace, state enrollment portal, and targeted outreach efforts (e.g., Supplemental Nutrition Assistance Program participant engagement). Compared with what would have been in a traditional Medicaid expansion, HCIP enrollees will receive coverage that improves access to providers and health care services by using carrier networks with provider reimbursements under deflationary pressure, thereby reducing payment differentials between Medicaid and privately insured individuals. Through this improved access, newly eligible HCIP individuals will receive more appropriate care including prevention, chronic disease management, and therapeutic interventions leading to better clinical outcomes. At times of reenrollment and/or changes in family income, individuals will have a greater ability to continue

coverage with the same carrier and clinical relationships with the same providers, which will lead to more seamless transitions and continuity of care. Finally, the enhancements to HCIP clients' experiences described above will be assessed to determine the cost effectiveness of the HCIP demonstration waiver for Medicaid and the broader impact on the health care system.

B. Hypotheses

Research questions of interest identified in the development and approval process for the HCIP waiver include those examining the goals of improving access, improving care and outcomes, reducing churning, and lowering costs. Appendix 1 provides a table that includes a description of each of the original 12 hypotheses outlined in STC #70 that have been re-organized into the following four categories:

1. **HCIP beneficiaries will have equal or better *access to health care* compared with what they would have otherwise had in the Medicaid fee-for-service system over time.** Access will be evaluated using the following measures:
    a. Use of primary care and specialty physician services, including analysis of provider networks
    b. Use of emergency room services (including emergent and non-emergent use)
    c. Potentially preventable emergency department and hospital admissions
    d. EPSDT benefit access for young, eligible adults
    e. Non-emergency transportation access

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

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

4. **Services provided to HCIP beneficiaries will prove to be *cost effective*.** Cost effectiveness will be evaluated using findings above in combination with the following costs determinations:
    a. Administrative costs for the HCIP beneficiaries, including those who become eligible for Marketplace coverage
    b. Overall premium costs in the Marketplace

c. Cost for covering HCIP beneficiaries compared with costs expected for covering the same expansion group in Arkansas fee-for-service Medicaid

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

C. Metrics and Data Available

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

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

Enrollment

We anticipate enrollment data to be available for HCIP, subsidized tax credit, and full-cost participants in the Marketplace. In addition to enrollment numbers, the method of enrollment—Federally Facilitated Marketplace (FFM), state-based portal, or outreach (e.g., SNAP enrollment)—and the geographic location of enrollees will provide information on the success of outreach and enrollment efforts across the state. Indicators considered for monitoring include the following:

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

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

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

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

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

Medicaid Adult Core Set

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

HEDIS

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

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

CAHPS

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

The Arkansas Foundation for Medical Care is the current contractor that collects CAHPS for the Arkansas Medicaid program every two years. They use the CAHPS 5.0H Medicaid Adult survey version. These surveys contain the following categories of metrics that could be used for the current evaluation (see Appendix 2C and 2D for background on CAHPS and Appendix 3 for the candidate list of CAHPS metrics and corresponding hypotheses):

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

For the purpose of this evaluation, CAHPS will be collected in the second quarter of demonstration year 2 (DY2) and DY3. A stratified sampling procedure will be used to ensure representative participants from each of the geographic regions of the state, as well as age and insurance groups (i.e., traditional Medicaid vs. HCIP).

D. Design Approaches

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

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

D1. Statewide Comparisons

This approach will compare all individuals in the HCIP to individuals enrolled in traditional Medicaid, controlling for region and individual demographics. Arkansas Medicaid identifies individuals as eligible for services in conjunction with the state's DHS county offices or District Social Security Offices.[12] The Social Security Administration automatically sends Supplemental Security Income (SSI) recipient information to DHS. The restricted eligibility for this program depends on age, income, and assets. Traditionally, the only adults who could qualify for Medicaid were the elderly, disabled, pregnant women, and parent/caretakers with incomes up to 17 percent FPL. Most people who qualify for Medicaid are typically in one or more of the following categories:

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

In comparison with the HCIP enrollees, individuals enrolled in the traditional Medicaid program will have much stricter income requirements and, in many cases, more complex health care needs. Statistical considerations will need to account for these differences.

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

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

Statistical Analysis

A series of multivariate regression models will be fitted for each metric (see Appendix 4). Each model will include a dummy variable "program type" to test the comparison between traditional Medicaid and HCIP. In quasi-experimental studies (i.e., non-randomized experiments) such as the current evaluation, it is important for research designs to control for important differences between the treatment and comparison groups that may affect the dependent variables but are confounding the observed effect of the independent variable of interest. One way to do this is through the use of covariates. Covariates will include, but are not limited to, age, gender, race and ethnicity (where available), known health conditions, income, and geographic region. We will also test the interaction between income and program type to examine moderation effects, particularly given the known differences in income level between the traditional Medicaid program and the newly enrolled beneficiaries in the HCIP. Another way to control for unmeasured variables is to incorporate an instrumental variable into models to account for unobserved variable bias. With this method it is often difficult to identify an appropriate instrumental variable, so this approach will have to be considered in light of available data. The contracted research team will explore the appropriate use of such instrumental variables to control for bias, if possible. To test the hypothesis of "equal or better than," for each metric the models will look for either a non-significant parameter estimate on program type (indicating equal outcomes) or a parameter estimate that favors the HCIP group based on a one-sided statistical test. All statistical tests will be performed with the probability of a Type I error of alpha=0.05.

D2. Subgroup Pre–Post Comparisons

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

For the EPSDT group we propose identifying a group of youth ages 17–18 during 2012 and 2013 who were enrolled in the traditional Medicaid program, and who upon turning 19 years of age will be eligible to enroll in HCIP. Estimates from 2011 suggest that across this two-year time frame approximately 12,000 youth will qualify for EPSDT services in this age group.

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

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

Statistical Analysis

Multiple regression models similar to those used for D1 (above) will be used with this group. In this case, however, models will include a dummy variable of "time" to test whether or not differences in outcomes can be attributed to the transition between the traditional Medicaid program and the HCIP, where Time 1 (omitted category) will include outcomes associated with enrollment in traditional Medicaid while Times 2, 3, and possibly 4 would be associated with HCIP enrollment. While we intend to use the same control covariates as D1 (above), considerations of sample size will need to be made particularly for the BreastCare program. In this case, a limited set of covariates including age and geographic region may be utilized to maximize power.

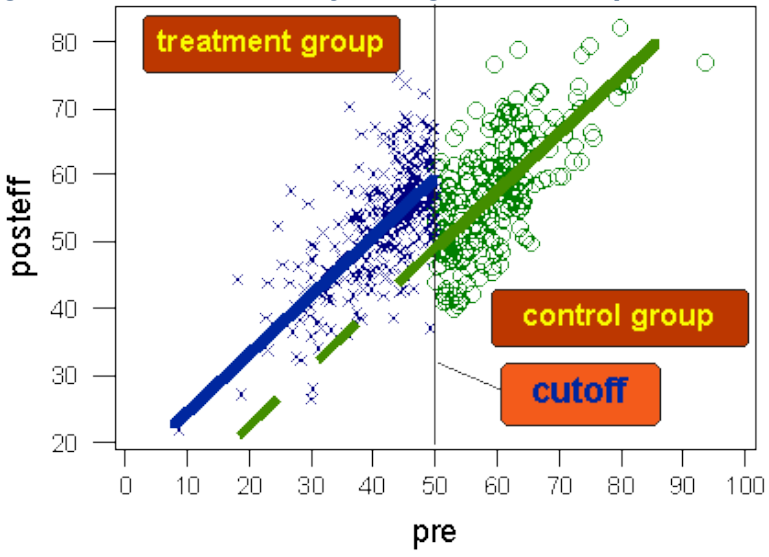
D3. Regression Discontinuity Analysis

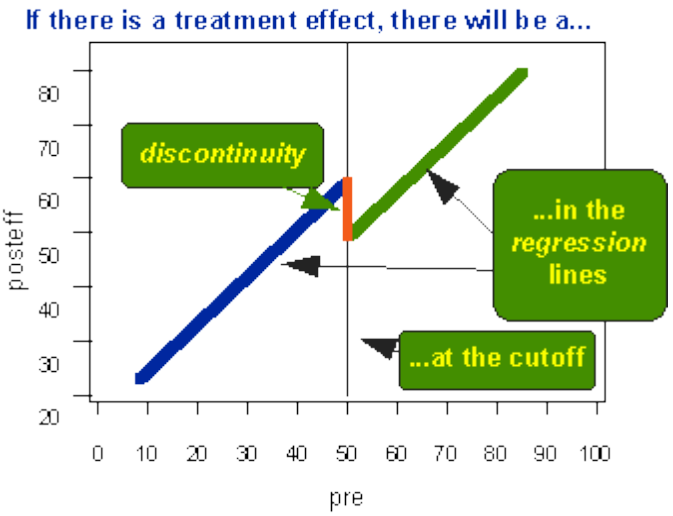
In cases where random assignment to treatment and control groups is not feasible, comparisons can be done by examining subgroups of individuals based on scores just above or below a cutoff value of a predetermined variable. The assumption is that such individuals with similar scores may not differ significantly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

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

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

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





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

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

In consultation with health status and exceptional needs measurement experts at the University of Michigan and the Agency for Healthcare Research and Quality, Arkansas has developed a screening process that seeks to identify the top 10 percent most medically needy to be included in this population—such as individuals who would benefit from long-term services and supports and targeted outreach and care coordination through the state's emerging health home program and Community First Choice state plan option. The final screener consists of 12 questions that will provide self-reported information; responses will be scored and calibrated to estimate the population who will be retained in the traditional Medicaid program. Downstream refinements to the screener algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

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

Statistical Analysis

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

D4. Provider Network Adequacy

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

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

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

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

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

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

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

To evaluate and compare the differences in access and availability by each of the provider types above for the networks of Medicaid demonstration participants compared with the traditional Medicaid network, geomapping efforts for adult patients in the traditional Medicaid would be replicated to enable comparisons of networks available through the Marketplace and those through traditional Medicaid provider panels. In addition serial examinations of primary care, specialists, and select providers within carrier networks will enable examinations of access continuity for primary care and specialists that compare the traditional Medicaid provider networks with the provider networks evidenced through the HCIP.

E. Approach for Test of Cost Effectiveness

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

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

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

The approaches represented recognize the expectation for Arkansas to undertake a robust evaluation to adequately test health outcomes and financial implications of Medicaid coverage expansion through premium assistance, as well as the need to accommodate certain limitations (e.g., comparison groups and data availability). We represent below the requirements, the current approach, challenges identified, anticipated uncertainties, and potential future policy implications. For the purpose of this Evaluation Plan, we have limited approaches to those for which the state can assure available data to the selected external contractor. Given the potential value of comparison with another state, the evaluation team will continue to explore this possibility with CMS guidance. Currently, CMS is exploring making available utilization data from another state to support secondary analyses. Should these data become available, the evaluation team will explore with CMS what analyses could reasonably be undertaken. Findings and key challenges will be shared in the summative evaluation report.

E1. Cost Effectiveness Requirement – STC #68

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

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

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

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

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

E2. Recommended Approach

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

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

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

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

Each issue is discussed briefly below.

Perspective and Length of Follow-up

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

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

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

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

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

Costs

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

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

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

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

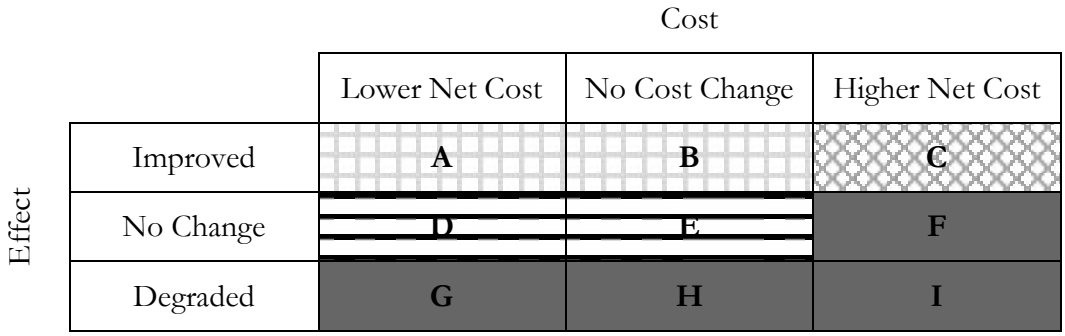
- Premiums set in advance for one year may be greater or less than actual experience; actual experience could lead to increases or decreases in premiums in future years.
- The state is entitled to repayment from carriers for premiums exceeding claims cost plus administration, subject to the minimum loss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

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

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

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

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



Effects (Health Outcomes)

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

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

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

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

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

For this hypothesis, candidate metrics include the following:

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

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

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

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

Hypothesis 4c: Overall costs for covering beneficiaries

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

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

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

Control Group Identification and Methods for Obtaining Estimates

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

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

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

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

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

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

Potential Statistical Methods

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

Accounting for Uncertainty in Estimates

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

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

4. Evaluation Implementation Strategy, Timeline, & Budget

A. Independent Evaluation

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

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

B. Data Availability

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

The Arkansas Insurance Department (AID) has issued guidance that carriers will be required to submit claims for the Marketplace experience inclusive of the demonstration participants—initially required reporting by the end of quarter 1 in DY2 for DY1 experience and on a quarterly basis thereafter. The submission process will utilize the X12 standards (www.X12.org) in eligibility files and medical claims, and the National Council for Prescription Drug Programs Standards in Pharmacy Claims files (see Appendix 6 for more information). These claims data will be the basis for development of access, utilization, and clinical quality indicators from established and accepted national metrics.

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

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

C. Timeline

Table 1 provides a proposed timeline for the work of this evaluation. It is anticipated that the hired contractor will use this general timeline to create a more thorough timeline and workplan once they are hired. Though the Demonstration is scheduled for 3 years, we have included a Year 4 in this evaluation proposal to encompass all the required reports that will be submitted subsequent to DY3. The three major pieces of work include the recruitment and hiring of an independent evaluation team, the collection and analysis of data, and the submission of reports.

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

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

The Interim Evaluation Report, Draft and Final Summative Evaluation Reports will follow the outline and included components in STC 70.

Table 1. Proposed Project Timeline

	DY 1 (2014)				DY 2 (2015)				DY 3 (2016)				DY 4 (2017)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Reports:																
Enrollment		U		U			U				U				U	
Reenrollment					U					U				U		
Retention					U					U				U		
Implementation Update					R											
Interim Report										R						
Final Draft Report															R	
Final Summary Report																R
Data Collection & Analysis:																
Enrollment	X X X X X X				X	X	X	X	X	X	X	X	X	X		
Geomapping				X	* * *			X	* * *			X	* * *			
CAHPS					X X X * * * *				X X X * * * *							
Carrier Claims					X * * X * * X * *				X * * X * * X * * X * *				X * * X * * X * * X * *			

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

D. Budget

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

5. Supplemental Hypotheses and Future Policy Implications

Additional questions of policy relevance are of interest; however, they are outside of the scope of STC #68 that requires examination of the Arkansas Demonstration in comparison with what would have happened under a traditional Medicaid expansion. These questions will be important completely frame the experience and understanding generated by the first major use of premium expansion through the new health insurance exchanges to cover low-income Americans. We anticipate framing these questions, securing supplemental funding, and conducting appropriate research to capture the experience and learning opportunities of the Arkansas Demonstration.

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

- By using premium assistance to purchase private health insurance on behalf of low-income Americans, how equitable was the access, outcomes, and experiences between Medicaid beneficiaries and their private-sector counterparts (regression discontinuity above and below 138% FPL)?
- Where differences exist in access, outcomes, and experiences of Medicaid beneficiaries and their private-sector counterparts, what are plausible causes and potential policy solutions?
- How did Arkansas expansion of health insurance affect a change on population health indicators compared with sister states with similar risk profiles who elected to delay implementation?
- If Arkansas' Demonstration proves to advantage the health insurance exchange and the Medicaid program through system improvements, actuary risk-pool stability, and/or deflationary pressure on premiums, what are the indirect long-term benefits of a more efficient market and stable risk pool to the federal treasury through lower expenditures on advanced premium tax credits?
- How did Arkansas' use of Supplemental Nutrition Assistance Program eligibility contribute to the stability of the risk pool compared with self-initiated enrollment of newly eligible beneficiaries?
- How did providers—both primary care and specialists—react to a major reduction in the numbers of the uninsured and receipt of equivalent payment rates for beneficiaries in the exchange marketplace? Did private-sector providers relocate over time or find alternative delivery strategies to highly concentrated areas of uncompensated care caused by the lack of insurance?
- How did safety-net providers—federally qualified health centers, rural health centers, critical access hospitals, educational institutions—fare under Medicaid expansion utilizing premium assistance through commercial carriers?

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

6. Appendices

Appendix 1: Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

Appendix 2: Proposed Measure Descriptions and Definitions

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

B. Selected Measures from Healthcare Effectiveness Data and Information Set (HEDIS) 2014

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

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

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

Appendix 4: Candidate Metrics by Approach

Appendix 5: Arkansas Insurance Department Network Adequacy Guidelines and Targets

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

Appendix 1

Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

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

ACHI
Arkansas Center for Health Improvement

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Appendix 1
Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

Arkansas Proposed Evaluation Hypotheses	Arkansas Original Terms and Conditions Hypotheses (Section 8, STC 70, #1)
1—Access	
a. Use of PCP/specialist	i. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
b. Non-emergent ER use	iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.
c. Preventable ER	vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
d. EPSDT	ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
e. Non-emergency transportation	x. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
2—Care/outcomes	
a. Preventive and health care services	ii. Premium Assistance beneficiaries will have equal or better access to preventive care services.
b. Experience	viii. Premium Assistance beneficiaries will report equal or better experience in the care provided.
c. Non-emergent ER use*	iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.
d. Preventable ER*	vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
3—Continuity	
a. Gaps in coverage	iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.
b. Continuous access to same health plans c. Continuous access to same providers	v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.

Arkansas Proposed Evaluation Hypotheses	Arkansas Original Terms and Conditions Hypotheses (Section 8, STC 70, #1)
4—Cost effectiveness	
a. Admin costs	vi. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.
b. Reduce premiums	xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.
c. Comparable costs	xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.

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

Appendix 2

Proposed Measure Descriptions and Definitions

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

Measure 1: Flu Shots for Adults Ages 50 to 64

National Committee for Quality Assurance

A. DESCRIPTION

A rolling average represents the percentage of Medicaid enrollees ages 50 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 5.0H adult survey was completed.

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C. QUESTIONS INCLUDED IN THE MEASURE

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

[a]YYYY = the measurement year (2012 for the survey fielded in 2013).

D. CALCULATION OF MEASURE

A rolling average is calculated using the following formula.

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

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

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

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

Measure 2: Breast Cancer Screening

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

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

Table 3.1. Codes to Identify Breast Cancer Screening

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

Table 3.2. Codes for Identifying Exclusions

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

D. ADDITIONAL NOTES

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

Measure 3: Cervical Cancer Screening

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

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

Table 4.1. Codes to Identify Cervical Cancer Screening

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

Table 4.2. Codes to Identify Exclusions

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

D. ADDITIONAL NOTES

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

Exclusions (optional)

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

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

Measure 4: Plan All-Cause Readmission Rate

National Committee for Quality Assurance

A. DESCRIPTION

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

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

Guidance for Reporting:

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

B. DEFINITIONS

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

C. ELIGIBLE POPULATION

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

D. Denominator: The eligible population.

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

E. ADDITIONAL NOTES

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

Measure 5: Diabetes Short-Term Complications Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

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

Include ICD-9-CM diagnosis codes:

25010 DM KETO T2, NT ST UNCNTRLD

25011 DM KETO T1, NT ST UNCNTRLD

25012 DM KETOACD UNCONTROLD

25013 DM KETOACD UNCONTROLD

25020 DMII HPRSM NT ST UNCNTRL

25021 DMI HPRSM NT ST UNCNTRLD

25022 DMII HPROSMLR UNCONTROLD

25023 DMI HPROSMLR UNCONTROLD

25030 DMII O CM NT ST UNCNTRLD

25031 DMI O CM NT UNCNTRLD

25032 DMII OTH COMA UNCONTROLD

25033 DMI OTH COMA UNCONTROLD

Exclusions

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

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

Agency for Healthcare Research and Quality

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

Numerator: All non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD. Select codes appearing in the primary diagnosis position must be accompanied by a secondary diagnosis of COPD.

Include ICD-9-CM COPD diagnosis codes:

4660 ACUTE BRONCHITIS*

490 BRONCHITIS NOS*

4910 SIMPLE CHR BRONCHITIS

4911 MUCOPURUL CHR BRONCHITIS

49120 OBST CHR BRONC W/O EXAC

49121 OBS CHR BRONC W(AC) EXAC

4918 CHRONIC BRONCHITIS NEC

4919 CHRONIC BRONCHITIS NOS

4920 EMPHYSEMATOUS BLEB

4928 EMPHYSEMA NEC

494 BRONCHIECTASIS

4940 BRONCHIECTAS W/O AC EXAC

4941 BRONCHIECTASIS W AC EXAC

496 CHR AIRWAY OBSTRUCT NEC

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

Exclusions

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

Measure 7: Congestive Heart Failure (CHF) Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

Numerator: All discharges with ICD-9-CM principal diagnosis code for CHF.

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

39891 RHEUMATIC HEART FAILURE

4280 CONGESTIVE HEART FAILURE

4281 LEFT HEART FAILURE

42820 SYSTOLIC HRT FAILURE NOS OCT02-

42821 AC SYSTOLIC HRT FAILURE OCT02-

42822 CHR SYSTOLIC HRT FAILURE OCT02-

42823 AC ON CHR SYST HRT FAIL OCT02-

42830 DIASTOLC HRT FAILURE NOS OCT02-

42831 AC DIASTOLIC HRT FAILURE OCT02-

42832 CHR DIASTOLIC HRT FAIL OCT02-

42833 AC ON CHR DIAST HRT FAIL OCT02-

42840 SYST/DIAST HRT FAIL NOS OCT02-

42841 AC SYST/DIASTOL HRT FAIL OCT02-

42842 CHR SYST/DIASTL HRT FAIL OCT02-

42843 AC/CHR SYST/DIA HRT FAIL OCT02-

4289 HEART FAILURE NOS

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

40201 MAL HYPERT HRT DIS W CHF

40211 BENIGN HYP HRT DIS W CHF

40291 HYPERTEN HEART DIS W CHF

40401 MAL HYPER HRT/REN W CHF

40403 MAL HYP HRT/REN W CHF/RF

40411 BEN HYPER HRT/REN W CHF

40413 BEN HYP HRT/REN W CHF/RF

40491 HYPER HRT/REN NOS W CHF

40493 HYP HT/REN NOS W CHF/RF

Exclusions

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

- MDC 14 (pregnancy, childbirth, and puerperium) With a cardiac procedure code

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

0050 IMPL CRT PACEMAKER SYS OCT02-

0051 IMPL CRT DEFIBRILLAT OCT02-

0052 IMP/REP LEAD LF VEN SYS OCT02-

0053 IMP/REP CRT PACEMKR GEN OCT02-

0054 IMP/REP CRT DEFIB GENAT OCT02-

0056 INS/REP IMPL SENSOR LEAD OCT06-

0057 IMP/REP SUBCUE CARD DEV OCT06-

0066 PTCA OCT06-

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

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

3500 CLOSED VALVOTOMY NOS

3501 CLOSED AORTIC VALVOTOMY

3502 CLOSED MITRAL VALVOTOMY

3503 CLOSED PULMON VALVOTOMY

3504 CLOSED TRICUSP VALVOTOMY

3510 OPEN VALVULOPLASTY NOS

3511 OPN AORTIC VALVULOPLASTY

3512 OPN MITRAL VALVULOPLASTY

3513 OPN PULMON VALVULOPLASTY

3514 OPN TRICUS VALVULOPLASTY

3520 REPLACE HEART VALVE NOS

3521 REPLACE AORT VALV-TISSUE

3522 REPLACE AORTIC VALVE NEC

3523 REPLACE MITR VALV-TISSUE

3524 REPLACE MITRAL VALVE NEC

3525 REPLACE PULM VALV-TISSUE

3526 REPLACE PULMON VALVE NEC

3527 REPLACE TRIC VALV-TISSUE

3528 REPLACE TRICUSP VALV NEC

3531 PAPILLARY MUSCLE OPS

3532 CHORDAE TENDINEAE OPS

3533 ANNULOPLASTY

3534 INFUNDIBULECTOMY

3535 TRABECUL CARNEAE CORD OP

3539 TISS ADJ TO VALV OPS NEC

3541 ENLARGE EXISTING SEP DEF

3542 CREATE SEPTAL DEFECT

3550 PROSTH REP HRT SEPTA NOS

3551 PROS REP ATRIAL DEF-OPN

3552 PROS REPAIR ATRIA DEF-CL

3553 PROST REPAIR VENTRIC DEF

3554 PROS REP ENDOCAR CUSHION

3555 PROS REP VENTRC DEF-CLOS OCT06-

3560 GRFT REPAIR HRT SEPT NOS

3561 GRAFT REPAIR ATRIAL DEF

3562 GRAFT REPAIR VENTRIC DEF

3563 GRFT REP ENDOCAR CUSHION

3570 HEART SEPTA REPAIR NOS

3571 ATRIA SEPTA DEF REP NEC

3572 VENTR SEPTA DEF REP NEC

3573 ENDOCAR CUSHION REP NEC

3581 TOT REPAIR TETRAL FALLOT

3582 TOTAL REPAIR OF TAPVC

3583 TOT REP TRUNCUS ARTERIOS

3584 TOT COR TRANSPOS GRT VES

3591 INTERAT VEN RETRN TRANSP

3592 CONDUIT RT VENT-PUL ART

3593 CONDUIT LEFT VENTR-AORTA

3594 CONDUIT ARTIUM-PULM ART

3595 HEART REPAIR REVISION

3596 PERC HEART VALVULOPLASTY

3598 OTHER HEART SEPTA OPS

3599 OTHER HEART VALVE OPS

3601 PTCA-1 VESSEL W/O AGENT

3602 PTCA-1 VESSEL WITH AGNT

3603 OPEN CORONRY ANGIOPLASTY

3604 INTRCORONRY THROMB INFUS

3605 PTCA-MULTIPLE VESSEL

3606 INSERT OF COR ART STENT OCT95-

3607 INS DRUG-ELUT CORONRY ST OCT02-

3609 REM OF COR ART OBSTR NEC

3610 AORTOCORONARY BYPASS NOS

3611 AORTOCOR BYPAS-1 COR ART

3612 AORTOCOR BYPAS-2 COR ART

3613 AORTOCOR BYPAS-3 COR ART

3614 AORTCOR BYPAS-4+ COR ART

3615 1 INT MAM-COR ART BYPASS

3616 2 INT MAM-COR ART BYPASS

3617 ABD-CORON ART BYPASS OCT96-

3619 HRT REVAS BYPS ANAS NEC

362 ARTERIAL IMPLANT REVASC

363 OTH HEART REVASCULAR

3631 OPEN CHEST TRANS REVASC

3632 OTH TRANSMYO REVASCULAR

3633 ENDO TRANSMYO REVASCULAR OCT06-

3634 PERC TRANSMYO REVASCULAR OCT06-

3639 OTH HEART REVASULAR

3691 CORON VESS ANEURYSM REP

3699 HEART VESSLE OP NEC

3731 PERICARDIECTOMY

3732 HEART ANEURYSM EXCISION

3733 EXC/DEST HRT LESION OPEN

3734 EXC/DEST HRT LES OTHER

3735 PARTIAL VENTRICULECTOMY

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

3741 IMPLANT PROSTH CARD SUPPORT DEV OCT06

375 HEART TRANSPLANTATION (NOT VALID AFTER OCT 03)

3751 HEART TRANPLANTATION OCT03-

3752 IMPLANT TOT REP HRT SYS OCT03-

3753 REPL/REP THORAC UNIT HRT OCT03-

3754 REPL/REP OTH TOT HRT SYS OCT03-

3755 REMOVAL OF INTERNAL BIVENTRICULAR HEART REPLACEMENT SYSTEM OCT08

3760 IMPLANTATION OR INSERTION OF BIVENTRICULAR EXTERNAL HEART ASSIST SYSTEM OCT08

3761 IMPLANT OF PULSATION BALLOON

3762 INSERTION OF NON-IMPLANTABLE HEART ASSIST SYSTEM

3763 REPAIR OF HEART ASSIST SYSTEM

3764 REMOVAL OF HEART ASSIST SYSTEM

3765 IMPLANT OF EXTERNAL HEART ASSIST SYSTEM

3766 INSERTION OF IMPLANTABLE HEART ASSIST SYSTEM

3770 INT INSERT PACEMAK LEAD

3771 INT INSERT LEAD IN VENT

3772 INT INSERT LEAD ATRI-VENT

3773 INT INSER LEAD IN ATRIUM

3774 INT OR REPL LEAD EPICAR

3775 REVISION OF LEAD

3776 REPL TV ATRI-VENT LEAD

3777 REMOVAL OF LEAD W/O REPL

3778 INSER TEAM PACEMAKER SYS

3779 REVIS OR RELOCATE POCKET

3780 INT OR REPL PERM PACEMKR

3781 INT INSERT 1-CHAM, NON

3782 INT INSERT 1-CHAM, RATE

3783 INT INSERT DUAL-CHAM DEV

3785 REPL PACEM W 1-CHAM, NON

3786 REPL PACEM 1-CHAM, RATE

3787 REPL PACEM W DUAL-CHAM

3789 REVISE OR REMOVE PACEMAK

3794 IMPLT/REPL CARDDEFIB TOT

3795 IMPLT CARDIODEFIB LEADS

3796 IMPLT CARDIODEFIB GENATR

3797 REPL CARDIODEFIB LEADS

3798 REPL CARDIODEFIB GENRATR

Measure 8: Adult Asthma Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator: Medicaid enrollees age 18 and older.

Numerator: All non-maternal discharges for enrollees age 18 and older with an ICD-9-CM principal diagnosis code of asthma.

Include ICD-9-CM diagnosis codes:

49300 EXT ASTHMA W/O STAT ASTH

49301 EXT ASTHMA W STATUS ASTH

49302 EXT ASTHMA W ACUTE EXAC OCT00-

49310 INT ASTHMA W/O STAT ASTH

49311 INT ASTHMA W STAT ASTH

49312 INT ASTHMA W ACUTE EXAC OCT00-

49320 CH OB ASTH W/O STAT ASTH

49321 CH OB ASTHMA W STAT ASTH

49322 CH OBS ASTH W ACUTE EXAC OCT00-

49381 EXERCSE IND BRONCHOSPASM OCT03-

49382 COUGH VARIANT ASTHMA OCT03-

49390 ASTHMA W/O STATUS ASTHM

49391 ASTHMA W STATUS ASTHMAT

49392 ASTHMA W ACUTE EXACERBTN OCT00-

Exclusions

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

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

27700 CYSTIC FIBROS W/O ILEUS

27701 CYSTIC FIBROSIS W ILEUS

27702 CYSTIC FIBROS W PUL MAN

27703 CYSTIC FIBROSIS W GI MAN

27709 CYSTIC FIBROSIS NEC

51661 NEUROEND CELL HYPRPL INF

51662 PULM INTERSTITL GLYCOGEN

51663 SURFACTANT MUTATION LUNG

51664 ALV CAP DYSP W VN MISALIGN

51669 OTH INTRST LUNG DIS CHLD

7421 ANOMALIES OF AORTIC ARCH

7483 LARYNGOTRACH ANOMALY NEC

7484 CONGENITAL CYSTIC LUNG

7485 AGENESIS OF LUNG

74860 LUNG ANOMALY NOS

74861 CONGEN BRONCHIECTASIS

74869 LUNG ANOMALY NEC

7488 RESPIRATORY ANOMALY NEC

7489 RESPIRATORY ANOMALY NOS

7503 CONG ESOPH FISTULA/ATRES

7593 SITUS INVERSUS

7707 PERINATAL CHR RESP DIS

Measure 9: Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance

A. DESCRIPTION

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

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

Guidance for Reporting:

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

B. DEFINITION

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

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

C. ELIGIBLE POPULATION

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

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

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

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

Table 13.2. Codes to Identify Inpatient Services MS—DRG

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

Table 13.3. Codes to Identify Nonacute Care

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

D. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerators:
30-Day Follow-Up

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

7-Day Follow-Up

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

Table 13.4. Codes to Identify Visits

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

E. ADDITIONAL NOTES

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

Measure 10: Annual HIV/AIDS Medical Visit

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. DEFINITION

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

C. ADMINISTRATIVE SPECIFICATION

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

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

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

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

Table 16.2. Codes to Identify Medical Visits

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

Measure 11: Comprehensive Diabetes Care: LDL-C Screening

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

Table 18.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

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

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

codes only.

Table 18.2. Codes to Identify Diabetes

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

Table 18.3. Codes to Identify Visit Type

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

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

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

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

Table 18.4. Codes to Identify LDL-C Screening

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

Table 18.5. Codes to Identify Exclusions

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

Measure 12: Comprehensive Diabetes Care: Hemoglobin A1c Testing

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

Table 19.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

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

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

Table 19.2. Codes to Identify Diabetes

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

Table 19.3. Codes to Identify Visit Type

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

C. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

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

Table 19.4. Codes to Identify HbA1c Tests

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

Table 19.5. Codes to Identify Exclusions

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

Measure 13: Antidepressant Medication Management

National Committee for Quality Assurance

A. DESCRIPTION

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

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

Guidance for Reporting:

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

B. DEFINITIONS

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

C. ELIGIBLE POPULATION

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

Table 20.1. Codes to Identify Major Depression

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

Table 20.2. Codes to Identify Visit Type

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

D. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator 1: Effective Acute Phase Treatment

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

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

Table 20.3. Antidepressant Medications

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

Numerator 2: Effective Continuation Phase Treatment

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

E. ADDITIONAL NOTES

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

Measure 15: Adherence to Antipsychotics for Individuals with Schizophrenia

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. DEFINITIONS

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

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

C. ELIGIBLE POPULATION

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

D. ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

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

Measure 16: Postpartum Care Rate

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. DEFINITIONS

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

C. ELIGIBLE POPULATION

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

D. ADMINISTRATIVE SPECIFICATION

Denominator:

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

Numerator:

Postpartum Care

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

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

Table 26.3. Codes to Identify Postpartum Visits

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

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

E. ADDITIONAL NOTES

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

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

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

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

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

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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 .

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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.

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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.

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Appendix 5
AID Network Adequacy Guidelines and Targets

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

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

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

Accreditation

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

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

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

Time and Distance Targets

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

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

GeoAccess Map Guidelines

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

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

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

Performance Metric Guidelines for Non-Accredited Carriers

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

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

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

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

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

Network Access Policies and Procedures for Non-Accredited Carriers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Standards for Essential Community Providers (ECPs)

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

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

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

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

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

Inclusion of School-Based Providers

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

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

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

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

Provider Directories

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

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

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

Specialty Services

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

Appendix 6

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

June 25, 2013

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

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Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

BULLETIN NO. 3B-2013

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

FROM: ARKANSAS INSURANCE DEPARTMENT

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

DATE: June 25, 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Accreditation	

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

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

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

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

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

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

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

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

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

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

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

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

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

[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

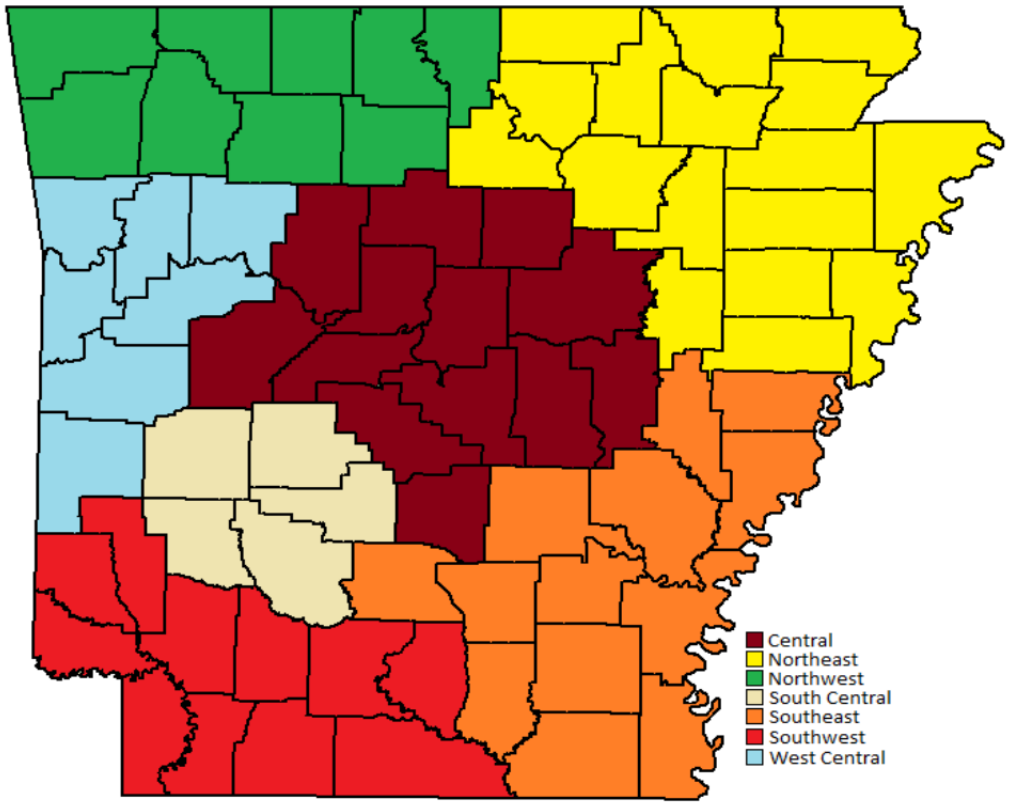
Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

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.