



Arkansas Health Care Independence
Program ("Private Option")
Proposed Evaluation for
Section 1115 Demonstration Waiver

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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 ruling² 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 Act³ and its accompanying appropriation was passed by the required three-fourths majority vote in both the Arkansas House and Senate and signed into law by Governor Mike Beebe on April 23, 2013.

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

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

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

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

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

² 567 U.S. ____ (2012).

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

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

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

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

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

A. HCIP Eligibility⁴

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 Costs³

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:

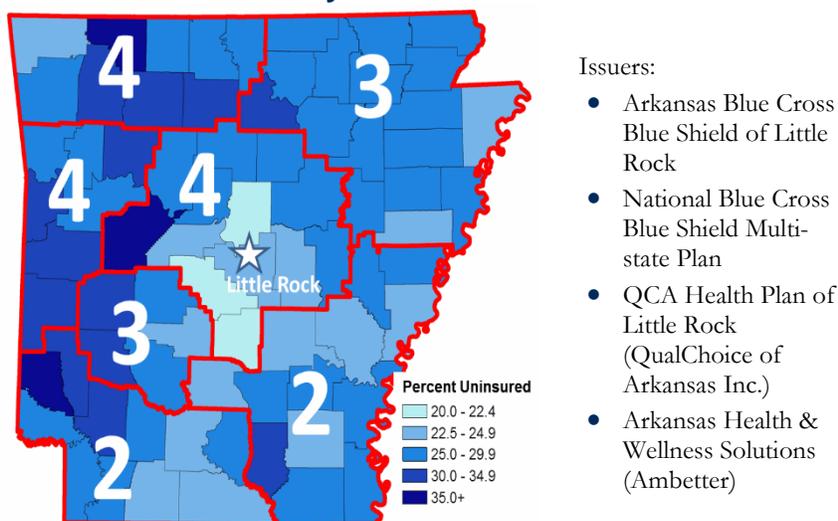
- The federal government will benefit from ~\$1.1 billion per year in new taxes and Medicare payment reductions.⁸
- The increase in federal costs for expansion and ongoing Medicaid is projected at \$1.59 billion in FY15 and \$2.35 billion in FY20.⁶
- The net impact on the federal budget approaches neutrality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



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 Proposal⁴

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 study⁸ sponsored by ACHI and conducted by the RAND Corporation indicated that full implementation of expanded coverage under the PPACA would result in a \$550 million annual increase in Arkansas’s gross domestic product and the creation of 6,200 jobs, with the majority of this impact accruing to rural Arkansas where the uninsured rates are relatively higher.

Continuity of Coverage

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

Rational Provider Reimbursements and Improved Provider Access

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

Integration and Efficiency

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

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

"All Payer" Health Care Reform

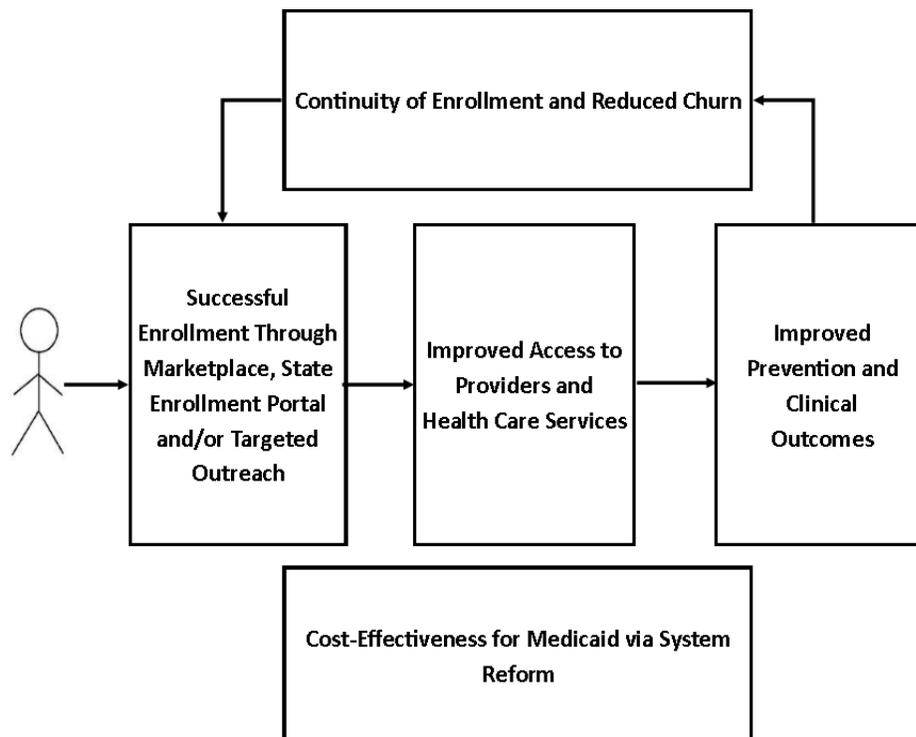
Arkansas is at the forefront of payment innovation and delivery system reform, and the Health Care Independence Act will accelerate and leverage the state’s Arkansas Health Care Payment Improvement Initiative by increasing the number of carriers participating in the effort, and the number of privately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

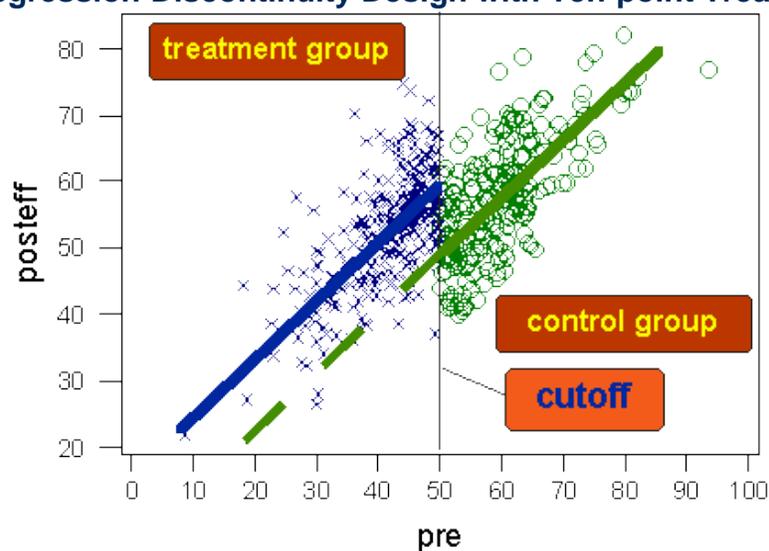
D3. Regression Discontinuity Analysis

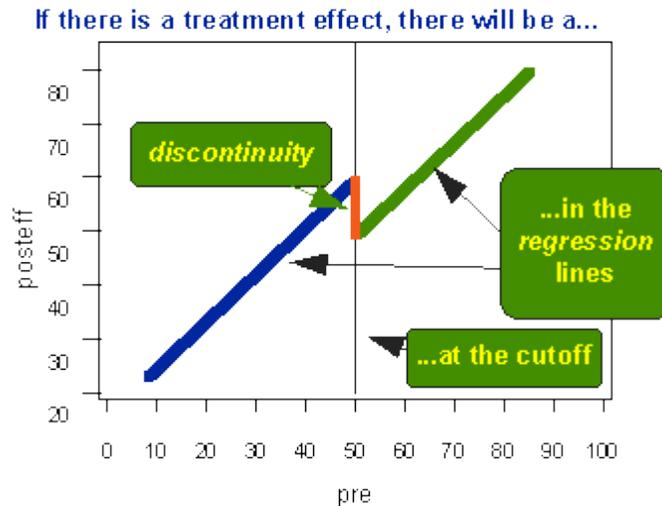
In cases where random assignment to treatment and control groups is not feasible, comparisons can be done by examining subgroups of individuals based on scores just above or below a cutoff value of a predetermined variable. The assumption is that such individuals with similar scores may not differ significantly 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 $\leq 138\%$ 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:

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

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:

$$[\text{Eq. 2}] \quad \text{COST}_{\text{HCIP}} - \text{COST}_{\text{Control}} = \text{Premium}_{\text{HCIP}} - (\text{Medicaid Admin Costs} + \text{Medicaid FFS Claim Payments})_{\text{Control}}$$

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

		Cost		
		Lower Net Cost	No Cost Change	Higher Net Cost
Effect	Improved	A	B	C
	No Change	D	E	F
	Degraded	G	H	I

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 threshold (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 be 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 probability that HCIP is cost effective at different levels of willingness to pay for an avoidable hospitalization averted.

¹⁸ Guo S. and Fraser M. Propensity score analysis: statistical methods and applications. Thousand Oaks, CA. 2010.

¹⁹ Rosenbaum PR. and Rubin DB. The Central Role of the Propensity Score in Observational Studies for Causal Effects. *Biometrika*. 1983;70(1): 41-55.

²⁰ Briggs AH, O'Brien BJ, and Blackhouse G. Thinking outside the box: Recent advances in the analysis and presentation of uncertainty in cost-effectiveness studies. *Annual Review of Public Health*. 2002;23: 377-401.

²¹ Chaudhary MA and Stearns SC. Estimating confidence intervals for cost-effectiveness ratios: An example from a randomized trial. *Statistics in Medicine*. 1996;15(13):1447-58.

4. Evaluation Implementation Strategy, Timeline, & Budget

A. Independent Evaluation

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

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

B. Data Availability

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

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

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

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

C. Timeline

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

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

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

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

Table 1. Proposed Project Timeline

	DY 1 (2014)				DY 2 (2015)				DY 3 (2016)				DY 4 (2017)				
	Q1	Q2	Q3	Q4													
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			
Geomapping					X	*	*	*					X	*	*	*	
CAHPS						X	X	X	*	*	*	*					
Carrier Claims						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 Waiver 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
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Appendix 3: HCIP Waiver Evaluation Planning: State’s Medicaid Reporting Measures

Appendix 4: Candidate Metrics by Approach

Appendix 5: Arkansas Insurance Department Network Adequacy Guidelines and Targets

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

Appendix 1

Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

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



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Appendix 1

Arkansas Evaluation Hypotheses: Proposed & Original Crosswalk

Arkansas Proposed Evaluation Hypotheses	Arkansas Original Terms and Conditions Hypotheses (Section 8, STC 70, #1)
<p>1—Access</p> <ul style="list-style-type: none"> a. Use of PCP/specialist b. Non-emergent ER use c. Preventable ER d. EPSDT e. Non-emergency transportation 	<ul style="list-style-type: none"> i. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services. iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services. vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions. ix. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits. x. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.
<p>2—Care/outcomes</p> <ul style="list-style-type: none"> a. Preventive and health care services b. Experience c. Non-emergent ER use* d. Preventable ER* 	<ul style="list-style-type: none"> ii. Premium Assistance beneficiaries will have equal or better access to preventive care services. viii. Premium Assistance beneficiaries will report equal or better experience in the care provided. iii. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services. vii. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
<p>3—Continuity</p> <ul style="list-style-type: none"> a. Gaps in coverage b. Continuous access to same health plans c. Continuous access to same providers 	<ul style="list-style-type: none"> iv. Premium Assistance beneficiaries will have fewer gaps in insurance coverage. v. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.

Arkansas Proposed Evaluation Hypotheses	Arkansas Original Terms and Conditions Hypotheses (Section 8, STC 70, #1)
<p>4—Cost effectiveness</p> <ul style="list-style-type: none"> a. Admin costs b. Reduce premiums c. Comparable costs 	<ul style="list-style-type: none"> 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. xi. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care. xii. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.

** 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

^aYYYY = the measurement year (2012 for the survey fielded in 2013).

D. CALCULATION OF MEASURE

A rolling average is calculated using the following formula.

$$\text{Rate} = (\text{Year 1 Numerator} + \text{Year 2 Numerator}) / (\text{Year 1 Denominator} + \text{Year 2 Denominator})$$

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 30 th 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 30 th 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 30 th 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 INTRACORONRY 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 INSEK 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 INSEK 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 30 th 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 EXERCISE 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	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
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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	HCCPS	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).
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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	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	<p>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.</p> <p>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).</p> <p>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.</p>

Table 18.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
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 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	<p>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.</p> <p>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).</p> <p>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.</p>

Table 19.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
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.

<p>Calculating Number of Days Covered for Oral Medications</p>	<p>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.</p> <p>If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator .</p> <p>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).</p> <p>Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.</p>
<p>Calculating Number of Days Covered for Long-Acting Injections</p>	<p>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.</p>

C. ELIGIBLE POPULATION

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

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 test 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.



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Suite 300, Victory Building
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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>).



File name: 2151a_engadultcom_50.docx

Last updated: April 1, 2012

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 health 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.



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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 you 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?

- Same day
- 1 day
- 2 to 3 days
- 4 to 7 days
- 8 to 14 days
- 15 to 30 days
- 31 to 60 days
- 61 to 90 days
- 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?

- Never
- Sometimes
- Usually
- 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?

- Never
- Sometimes
- Usually
- 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?

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

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?

- | | <u>Yes</u> | <u>No</u> |
|---|---------------------------------------|---------------------------------------|
| a) You did not know where to go for after hours care | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| 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 <input type="checkbox"/> | ² <input type="checkbox"/> |
| c) The doctor's office or clinic that had after hours care was too far away | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| d) Office or clinic hours for after hours care did not meet your needs | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| e) Some other reason | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |

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?

- | | <u>Yes</u> | <u>No</u> |
|---|---------------------------------------|---------------------------------------|
| a) You did not know what number to call | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| b) You left a message but no one returned your call | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| c) You could not leave a message at the number you phoned | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| d) Another doctor was covering for your personal doctor | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| e) Some other reason | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |

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?

- | | <u>Yes</u> | <u>No</u> |
|--|---------------------------------------|---------------------------------------|
| a) You had to call several times before you could speak with someone | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| b) The information customer service gave you was not correct | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| c) Customer service did not have the information you needed | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| d) You waited too long for someone to call you back | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| e) No one called you back | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| f) Some other reason | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |

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?

- | | <u>Yes</u> | <u>No</u> |
|--|----------------------------|----------------------------|
| a) Benefits and coverage for doctor or specialist visits | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b) Benefits and coverage for pharmacy | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c) Getting a referral to a specialist | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d) After hours or urgent care | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| e) Choosing a health provider | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| f) Getting care outside your network | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| g) Something else | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

Please specify: _____

PW5. Where did you get that information? Mark one or more.

- | | <u>Yes</u> | <u>No</u> |
|------------------------------|----------------------------|----------------------------|
| a) From your health plan | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b) From your employer | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c) From your doctor's office | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d) From some other source | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| e) Not sure where you got it | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

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

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HCIP Waiver Evaluation Planning: State's Medicaid Reporting Measures

Hypotheses

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 Coronary 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 measurement year. For each product line, report each of the four rates separately and as a total rate. <ul style="list-style-type: none"> • 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	Utilization 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 populations--proportion of enrollees with primary care accessible 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

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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

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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 GeoAccess 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 GeoAccess 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
 - Ophthalmologists
 - 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 CCHIO 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 <i>School-Based Providers</i>

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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Suite 300, Victory Building
Little Rock, Arkansas 72201
www.achi.net

Arkansas Insurance Department

Mike Beebe
Governor



Jay Bradford
Commissioner

BULLETIN NO. 3B-2013

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

FROM: ARKANSAS INSURANCE DEPARTMENT

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

DATE: June 25, 2013

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

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

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

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

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

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

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

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

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

- **Eligible Individuals with Incomes from 0-100% of the Federal Poverty Level:** Zero Cost Sharing Silver Plan Variation (100% actuarial value) for year one. In year two, AID will implement cost sharing for this income group where actuarial value can be attained (e.g. 50-100% FPL).
- **Eligible Individuals with Incomes from 101-138% FPL:** High-Value Silver Plan Variation (94% +/- 1% actuarial value). To facilitate implementation of a consistent approach to cost sharing across all High-Value Silver Plan enrollees, AID will require that all QHP Issuers’ High-Value Silver Plan variations conform with prescribed cost sharing amounts as defined

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

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

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

General Requirements	
<p>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</p>	<p>A QHP Issuer must—</p> <ol style="list-style-type: none"> (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

	<p>plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice;</p> <p>(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;</p> <p>(15) Meet all readability and accessibility standards;</p> <p>(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;</p> <p>(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;</p> <p>(18) Participate in the reinsurance program, including making reinsurance contributions and receiving reinsurance payments; and</p> <p>(19) Participate in risk adjustment.</p>
<p>State Standard</p>	<p>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.</p> <p>AID will review the pricing of QHPs, to ensure that all QHPs are adequately and appropriately priced for the Arkansas Marketplace.</p> <p>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.</p> <p>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.</p> <p>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.</p>

Licensure and Solvency	
Federal Requirements 45 CFR 156.200	A QHP Issuer must be licensed and in good standing with the State.
State Requirements	<p>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.</p> <p>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.</p> <p>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.</p>
Network Adequacy	
Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702(c)	<p>A QHP Issuer must ensure that the provider network of each of its QHPs is available to all enrollees and:</p> <p>(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.</p> <p>This must be done by demonstrating one of the following during the first year of the Marketplace:</p> <ul style="list-style-type: none"> • 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. <p style="text-align: center;"><u>OR</u></p> <p>(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:</p> <ul style="list-style-type: none"> • That the issuer has at least the same number of providers located in designated low income areas as the

	<p>equivalent of at least 20% of available ECPs in the service area;</p> <ul style="list-style-type: none"> • 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. <p>(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</p> <p>(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.</p>
State Standard	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>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-Providers-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.</p>

Accreditation	
<p>Federal Standard 45 CFR 156.275 45 CFR 155.1045</p>	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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.
<p>State Standard</p>	<p>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</p>

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	<p>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:</p> <ul style="list-style-type: none"> • 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

	<p>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;</p> <ul style="list-style-type: none"> • 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.
<p>State Standard</p>	<p>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.</p> <p>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.</p> <p><i>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.</i></p> <p>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.</p>
<p>General Offering Requirements</p>	

<p>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</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>For plans issued in the small group market, the deductible under the plan shall not exceed either:</p> <ul style="list-style-type: none"> • \$2,000 in the case of a plan covering a single individual; and • \$4,000 in the case of any other plan. <p>However, an issuer may propose a higher deductible in order to meet</p>
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	<p>the actuarial value of the plan that is proposed.</p> <p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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. <p>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.</p>
<p>State Standard</p>	<p>Specific state rate and form filing requirements may be found in Appendix A, attached.</p> <p>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:</p> <ul style="list-style-type: none"> • Providing a link to a plan brochure that describes the

	<p>mandatory offering benefits and how to purchase; and</p> <ul style="list-style-type: none"> • Including an application and description of mandatory offering benefits in the mailing with the consumer's plan identification card. <p>Information regarding Arkansas mandatory offerings can be found at: http://www.insurance.arkansas.gov/LH/Mandates.html.</p>
Essential Health Benefit Standards	
<p>Federal Standards</p> <p>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</p>	<p>The QHP Issuer must offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<p>State Standards</p>	<p>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.</p> <p>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.</p> <p>AID will require an attestation from the QHP Issuer that states the issuer is in compliance with all EHB standards.</p>

Essential Health Benefit Formulary Review	
Federal Standards 45 CFR 156.120 45 CFR §156.295	<p>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.</p> <p>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.</p>
State Standards	<p>AID will require an attestation of compliance with EHB Formulary Standards.</p> <p>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.</p>
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	<p>(1) A QHP Issuer must:</p> <ul style="list-style-type: none"> • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: <ul style="list-style-type: none"> ○ Adjusting premiums based on genetic information; ○ 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; ○ Utilizing any preexisting condition exclusions; ○ Requesting/requiring genetic testing; or ○ Collecting genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

	<p>(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.</p> <p>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.</p>
State Standard	<p>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.</p> <p>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.</p> <p>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.</p>
Actuarial Value Standards	
Federal Standards 45 CFR 156.135	<p>Plans being offered at the various metal tiers within the Marketplace must meet the specified levels of AV (or fall within the allowable variation):</p> <p>Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%)</p> <p>SAD plans must offer plans at either a 70% or 85% AV level.</p>
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	<p>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.</p> <p>QHP Issuers must also provide plain language information/data on claims payment policies and practices, periodic financial disclosures,</p>

	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	<p>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.</p> <ul style="list-style-type: none"> • 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) <p>All rates filed for individual QHPs will be set for an entire benefit/plan year.</p> <p>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.</p> <p>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.</p> <p>QHP Issuers, but not SAD Issuers, are required to submit the Unified Rate Review Template for rate increase.</p>
State Standard	<p>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 <i>any</i> rate increase on its Web site.</p> <p>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.</p>

Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR §155.1030 45 CFR §156.420	<p>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.</p> <p>This will be completed via rate and benefit templates.</p>
State Standard	<p>AID will require an attestation of compliance with Plan Variation Standards.</p> <p>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.</p>
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)	<p>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.</p> <p>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.</p>
State Standard	<p>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.</p>


 JAY BRADFORD, COMMISSIONER
 ARKANSAS INSURANCE DEPARTMENT

June 25' 2013
 DATE

APPENDIX A

✓	Category	Statute Section
QHP Issuer Application Receipt		
<input type="checkbox"/>	Marketplace application data is complete	
<input type="checkbox"/>	Received Final QHP Issuer Application Submission Attestations, including: <ul style="list-style-type: none"> • 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		
<i>Accreditation and Quality Standards</i>		45 CFR 156.275
<input type="checkbox"/>	Applicant has <i>Marketplace</i> accreditation through NCQA and/or URAC, or: Year 1- Applicant has applied for <i>Marketplace</i> accreditation through NCQA and/or URAC Year 2- Issuer procedures and policies are accredited	
<input type="checkbox"/>	Attestations and supporting documentation are accurate and complete or accreditation is verified in SERFF	
<input type="checkbox"/>	Issuer has authorized release of accreditation data	State Partnership Guidance 1/2013
<i>Complaint and Compliance</i>		
<input type="checkbox"/>	Requested complaint and compliance information (from consumer services division) received and reviewed	
<i>Cost-Sharing Reductions</i>		42 CFR 18022(c); 45 CFR 156.130(a); PPACA Section 1302(c) 45 CFR §155.1030 45 CFR §156.420
<input type="checkbox"/>	Three silver plan cost-sharing variations are submitted for each silver-level QHP.	PPACA 1402(a)-(c)
<input type="checkbox"/>	High-Value Silver Plan Variation (94% +/- 1% actuarial value) meets AHIP requirements.	
<input type="checkbox"/>	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.	

<input type="checkbox"/>	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: <ul style="list-style-type: none"> 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)
<input type="checkbox"/>	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
<input type="checkbox"/>	Actuarial Value <i>Issuer has separately offered at least one QHP at each of the following Actuarial Values:</i> <i>Gold: 80% (78 to 82%)</i> <i>Silver: 70% (68 to 72%)</i>	45 CFR 156.200
<input type="checkbox"/>	<i>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.</i>	PPACA 1302(f)
<input type="checkbox"/>	Actuarial Memorandum and Certification Received	
<input type="checkbox"/>	<i>Verify that plan is substantially equal to benchmark plan</i>	
<input type="checkbox"/>	<i>If the issuer is substituting benefits, confirm that the issuer has demonstrated actuarial equivalence of substituted benefits</i>	45 CFR 156.115
<input type="checkbox"/>	<i>Compliance with premium rating factors including:</i> <i>Self-only or family enrollment,</i> <i>geographic rating areas (7 areas)</i> <i>Age (3:1 for adults)</i> <i>Tobacco use (1.2:1)</i>	PPACA 1201 SEC. 2701(a) PHSA 2701
<input type="checkbox"/>	<i>Justification information received for rate increase, if applicable</i>	
<input type="checkbox"/>	Confirm Benefit Substitution A/V	
<input type="checkbox"/>	Confirm Actuarial Metal Level Submitted <i>Bronze (60%)</i> <i>Silver (70%)</i> <i>Gold (80%)</i> <i>Platinum (90%)</i> <i>Catastrophic (<58%)</i> <i>(Allowable variance: +/- 2%)</i> <i>For Stand Alone Dental:</i> <i>Low (70%)</i> <i>High (85)</i> <i>(Allowable variance +/- 2%)</i>	
<input type="checkbox"/>	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.	
<input type="checkbox"/>	Inclusion of all 10 Essential Health Benefits that meet or exceed benchmark plan, including:	
<input type="checkbox"/>	Ambulatory patient services	

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

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

	Polishing services Vision Therapy Developmental Testing	
<input type="checkbox"/>	Miscellaneous Complications from Smallpox vaccine	
<input type="checkbox"/>	State Mandated Benefits Autism Spectrum Disorders Breast Reconstruction/Mastectomy Children's Preventive Health Care Colorectal Cancer Screening Dental Anesthesia Diabetic Supplies/Education Diabetes Management Services Equity in Prescription Insurance & Contraceptive Coverage Formula PKU/Medical Foods & Low Protein Modified Food Medical Foods and Low Protein Modified Foods Gastric Pacemakers In-Vitro Fertilization (insurance companies only) Loss or Impairment of Speech or Hearing Maternity & Newborn Coverage Mental Health parity Off-Label Drug Use Prostate Cancer Screening Orthotic & Prosthetic Devices or Services	23-99-418 23-99-405 23-79-141 et al. & Rule 45 23-79-1201 et al 23-86-121 23-79-601 et al & Rule 70 23-79-1101 et al 23-79-701 et al 23-99-419 23-85-137, 23- 86-118 & Rule 1 23-79-130 23-99-404; 23-79-129 23-99-501 et al 23-79-147 23-79-1301 23-99-417
<input type="checkbox"/>	Mandated Persons Covered, including:	
<input type="checkbox"/>	Adopted Children	
<input type="checkbox"/>	Handicapped Dependents	
<input type="checkbox"/>	Mandated Providers Ambulatory Surgery Center, Audiologists, Chiropractors, Dentists, Emergency Services, Nurse Anesthetists, Optometrists, Podiatrists, Psychologists, Physician Assistant	
<input type="checkbox"/>	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.	
<input type="checkbox"/>	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)
<input type="checkbox"/>	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)

<input type="checkbox"/>	Benefits not designed in a way that discriminates against individuals because of age, disability, or expected length of life	PPACA §1302(b)(4)(B)
<input type="checkbox"/>	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
<i>Pre-existing conditions</i>		42 USC 300gg-3
<input type="checkbox"/>	Plan must contain no preexisting condition exclusions	
<i>State licensure, solvency, and good standing</i>		45 CFR 156.200(b)(4)
<input type="checkbox"/>	Issuer properly licensed	
<input type="checkbox"/>	Company financially solvent and in good standing	
<i>Marketing Standards</i>		45 CFR 156.220
<input type="checkbox"/>	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.
<input type="checkbox"/>	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
<input type="checkbox"/>	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
<input type="checkbox"/>	Received Attestation of compliance with marketing/discriminatory benefit design regulations	
<i>Market Reform Rules</i>		PHS 2701; PHS 2702; PHS 2703; PPACA 1302(e); PPACA 1312(c);PPACA 1402; 42 CFR 156; 42 CFR 147
<input type="checkbox"/>	QHP compliance with market reform rules in accordance with state and federal requirements	
<input type="checkbox"/>	Received QHP Market Reform Attestation of QHP compliance with market reform rules in accordance with state and federal requirements.	
<input type="checkbox"/>	Guaranteed Availability of Coverage	45 CFR § 147.104
<input type="checkbox"/>	Guaranteed Renewability of Coverage	45 CFR §

		147.106
<input type="checkbox"/>	Single Risk Pool	45 CFR § 156.80
<input type="checkbox"/>	Catastrophic Plan Requirements, including but not limited to: <ul style="list-style-type: none"> 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
<i>Network Adequacy</i>		45 CFR 156.230; 45 CFR 156.235; PHS SEC.2702(c) ; PPACA 156.230
<input type="checkbox"/>	Submission of provider-enrollee ratios for each QHP network	45 CFR 156.230
<input type="checkbox"/>	Submission of time/distance measures for each QHP network	45 CFR 156.230
<input type="checkbox"/>	Essential community providers listed	45 CFR 156.235
<input type="checkbox"/>	Accredited policies and procedures that includes network adequacy	PHS SEC.2702(c)
<input type="checkbox"/>	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
<input type="checkbox"/>	Provider directory is available for online publication with indication of providers no longer accepting new patients	PPACA 156.230
<input type="checkbox"/>	Provider directory available to individuals in English and Spanish	PPACA 156.230
<i>Rating Areas and Actuarial Value</i>		
<input type="checkbox"/>	Rate-setting practices are consistent with the approved metrics	PHS SEC.2701(a)
<input type="checkbox"/>	Attestation of compliance with state rating areas (7 rating areas)	PHS SEC.2701(b)
<i>Service Areas</i>		
<input type="checkbox"/>	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)
<input type="checkbox"/>	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		
<input type="checkbox"/>	Plan data and supporting documentation complete	
<input type="checkbox"/>	Issuer submission of data completed before end of open enrollment period	
<input type="checkbox"/>	QHP rate and benefit data and information approved	
QHP Certification Agreement		
<input type="checkbox"/>	Issuer application and plan data approved	
<input type="checkbox"/>	Submit issuer and plan data to CMS	

<input type="checkbox"/>	CMS Certification Received	
Issuer or Plan Non Certification		
<input type="checkbox"/>	Notify issuer of non-certification of QHP(s) or Issuer	
<input type="checkbox"/>	Update QHP(s) and Issuer Account Information	

APPENDIX BDEFINITION OF HABILITATIVE SERVICES

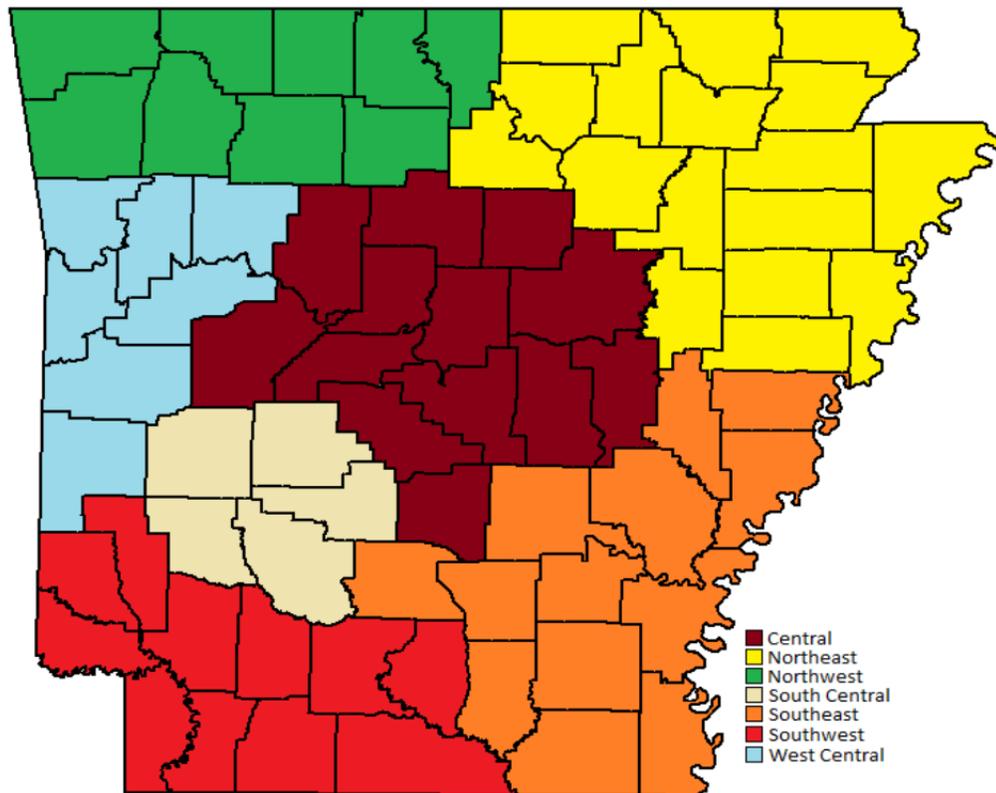
Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

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 in 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.

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 24 2014

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

Dear Mr. Allison:

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

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

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

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

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

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

Page 2 – Andy Allison

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

Sincerely,

A handwritten signature in black ink, appearing to read "Diane T. Gerrits". The signature is fluid and cursive, with the first name being the most prominent.

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



STATE OF ARKANSAS
MIKE BEEBE
GOVERNOR

August 2, 2013

The Honorable Kathleen Sebelius
Secretary of the U.S. Department of Health and Human Services
330 Independence Avenue, S.W., Room 4257
Washington, DC 20201

Dear Madam Secretary:

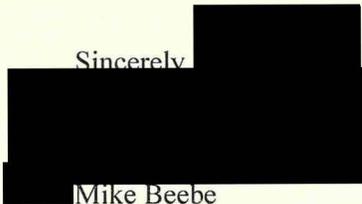
On behalf of the citizens of Arkansas, I am pleased to submit to the U.S. Department of Health and Human Services (DHHS) the enclosed Section 1115 Demonstration Waiver application. Authorized by provisions in the Arkansas Health Care Independence Act of 2013, the demonstration will allow the use of premium assistance to purchase qualified health plan (QHP) coverage through the Health Insurance Marketplace.

The waiver application aligns with and builds upon the concept proposed in our February 2013 meeting and in the memo sent in March of 2013. The waiver application also reflects additional input from state legislators, public comments, and cooperative consultation with federal officials over the last several months. In conjunction with this waiver, we will be submitting State Plan Amendments to secure federal funding for the expansion group, including those individuals who have complex medical conditions and/or are medically frail and who will receive coverage through our traditional program.

In addition to improving provider access, reducing disruption across the continuum of coverage upon income fluctuation, and furthering quality improvement, our vision is to provide truly integrated coverage for low-income Arkansans. The demonstration will leverage the efficiencies of the private market to enhance continuity, access, and quality for beneficiaries and is expected to drive more competitive premium pricing for all individuals purchasing through the Marketplace by adding approximately 225,000 eligible individuals. Most important, the demonstration incorporates delivery-system improvement initiatives that have already received federal support, thereby augmenting the ability to achieve desired outcomes.

We appreciate the assistance your department has offered and look forward to your continued support as we implement the premium assistance model and other innovative approaches outlined in the Arkansas Health Care Independence Act.

Sincerely,


Mike Beebe

Ccs: Marilyn Tavenner, Administrator for the Center for Medicare & Medicaid Services
Cindy Mann, Director of the Center for Medicaid and CHIP Services

STATE CAPITOL, SUITE 250 • LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345 • FAX (501) 682-1382
INTERNET WEB SITE • www.governor.arkansas.gov

Section I - Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Under the Demonstration, the State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or incarcerated¹ or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare or incarcerated (collectively “Private Option beneficiaries”). Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace. The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals (and in the longer run, families), improving access to providers, smoothing the “seams” across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives. Ultimately, the Demonstration will provide truly integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Private Option beneficiaries. Additionally, by nearly doubling the size of the population enrolling in QHPs offered through the Marketplace, the Demonstration is expected to drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace.

In future years, the State anticipates revising the waiver to include parents with incomes below 17% FPL and children. In addition, the State anticipates developing a pilot project to create health savings accounts to promote cost-effective use of the health care system.

2) Include the rationale for the Demonstration

This 1115 Demonstration waiver request supports implementation of Arkansas’s Health Care Independence Act of 2013, which was signed into law by Governor Beebe on April 23, 2013. The Act clearly articulates the context, goals, and objectives for the Demonstration.

Arkansas is uniquely situated to serve as a laboratory of comprehensive and innovative healthcare reform that can reduce the state and federal obligations to entitlement spending. Arkansas has historically addressed state-specific needs to achieve personal responsibility and affordable health care for its citizens through initiatives such as the ARHealthNetworks partnership between the state and small businesses. The State has also initiated nationally recognized and transformative changes in the healthcare delivery system through alignment of

¹ The term “incarcerated” means “any individual who is an inmate of a public institution (except as a patient in a medical institution).”

ARKANSAS 1115 WAIVER APPLICATION

payment incentives, health care delivery system improvements, enhanced rural health care access, initiatives to reduce waste, fraud and abuse, policies and plan structures to encourage the proper utilization of the healthcare system, and policies to advance disease prevention and health promotion.

The Health Care Independence Act calls on the Arkansas Department of Human Services to explore design options that reform the Medicaid Program so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:

- (1) Maximize the available service options;
- (2) Promote accountability, personal responsibility, and transparency;
- (3) Encourage and reward healthy outcomes and responsible choices; and
- (4) Promote efficiencies that will deliver value to the taxpayers.

The Act determines that the State of Arkansas shall take an integrated and market-based approach to covering low-income Arkansans through offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program. The specific purposes of the novel approach to coverage established in the Health Care Independent Act are to:

- (1) Improve access to quality health care;
- (2) Attract insurance carriers and enhance competition in the Arkansas insurance Marketplace;
- (3) Promote individually-owned health insurance;
- (4) Strengthen personal responsibility through cost-sharing;
- (5) Improve continuity of coverage;
- (6) Reduce the size of the state-administered Medicaid program;
- (7) Encourage appropriate care, including early intervention, prevention, and wellness;
- (8) Increase quality and delivery system efficiencies;
- (9) Facilitate Arkansas's continued payment innovation, delivery system reform, and market-driven improvements;
- (10) Discourage over-utilization; and
- (11) Reduce waste, fraud, and abuse.

The Demonstration program described below in this 1115 waiver application is specifically designed to meet the requirements of the Health Care Independence Act of 2013.

Expanding Medicaid to nearly all individuals with incomes at or below 138% FPL, as set out in the Affordable Care Act, would present several challenges for Arkansas. First, the new adults are likely to have frequent income fluctuations that lead to changes in eligibility. In fact, studies indicate that more than 35% of adults will experience a change in eligibility within six months of

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their eligibility determination.² Without carefully crafted policy and operational interventions, these frequent changes in eligibility could lead to (1) 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 (2) disruptive changes in benefits, provider networks, premiums, and cost-sharing as individuals transition from one IAP to another. In addition, by expanding Medicaid to include all individuals with incomes at or below 138% FPL, Arkansas would be increasing its Medicaid program by nearly 40%. The State’s existing network of fee-for-service Medicaid providers is at capacity; as a result, Arkansas would be faced with the challenge of increasing providers’ capacity to serve Medicaid beneficiaries to ensure adequate access to care. In short, absent the Demonstration, Arkansas’s Medicaid expansion would rely on the existing Medicaid delivery system and perpetuate an inefficient, underfunded and inadequately coordinated approach to patient care. While reforms associated with Arkansas’ Payment Improvement Initiative are designed to address the quality and cost of care, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults that will enroll through the expansion.

The Demonstration is crafted to address these problems. By using premium assistance to purchase QHPs offered in the Marketplace, Arkansas will promote continuity of coverage and expand provider access, while improving efficiency and accelerating multi-payer cost-containment and quality improvement efforts.

- **Continuity of coverage** – For households with members eligible for coverage under Title XIX and Marketplace coverage as well as those who have income fluctuations that cause their eligibility to change year-to-year, the Demonstration 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 reimbursement and improved provider access** – Arkansas Medicaid provides rates of reimbursement lower than Medicare or commercial payers, causing some providers to forego participation in the program and others to “cross subsidize” their Medicaid patients by charging more to private insurers. The Demonstration will rationalize provider reimbursement across payers, expanding provider access and eliminating the need for providers to cross-subsidize.
- **Integration and efficiency** – Arkansas is taking an integrated and market-based approach to covering uninsured Arkansans, rather than relying on a system for insuring lower income families that is separate and duplicative. This transition to private markets is a more efficient way of covering Arkansans.

² Health Affairs, “Frequent Churning Predicted Between Medicaid and Exchanges,” February 2011.

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- **“All payer” health care reform** – Arkansas is at the forefront of payment innovation and delivery system reform, and the Demonstration will accelerate and leverage its 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) Describe the hypotheses that will be tested/evaluated during the Demonstration’s approval period and the plan by which the State will use to test them.

The Demonstration will authorize the delivery of health insurance benefits to a new group of low-income adults through a novel alternative to traditional Medicaid programs and will test the following hypotheses during the approval period:

Hypothesis	Evaluation Approach	Data Sources ³
Access		
(1) Private Option beneficiaries will have appropriate access to care and will have equal or greater provider access than newly eligible adults would otherwise have in a traditional fee-for-service Medicaid system.	<p>Compare differences in measured outcomes for A and B, while controlling for relevant factors, with the assumption that differences in B will be greater than differences in A:</p> <ul style="list-style-type: none"> • A: Extent to which primary care and specialist access and consumer satisfaction varies between the Health Insurance Marketplace (HIM) and Private Option enrollees. • B: Extent to which primary care and specialist access and consumer satisfaction varies between the HIM and existing Medicaid Fee-for-Service for low-income adults. <p>Access (e.g., wait times, drive times) and consumer</p>	<p>Arkansas Health Data Initiative physician masterfile</p> <p>State claims databases</p> <p>Hospital Discharge Data</p> <p>Medical Expenditure Panel Survey from AHRQ (MEPS)</p> <p>NCQA HEDIS</p> <p>CAHPS</p> <p>CDC- Behavioral Risk Factor Surveillance System</p>

³ Subject to availability.

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Hypothesis	Evaluation Approach	Data Sources ³
	satisfaction measurements will be based on available state and national level survey information and empirical data.	
(2) Private Option beneficiaries will have access to preventive care services at least as consistently as or more consistently than newly eligible adults would otherwise have in a traditional fee-for-service Medicaid system and beneficiaries in non-Premium Assistance expansions nationally.	<p>Compare differences in measured outcomes for A and B, while controlling for relevant factors, with the assumption that differences in B will be greater than differences in A:</p> <ul style="list-style-type: none"> • A: The extent to which the percentage of enrollees with an ambulatory or preventive care visit in the past year varies between the HIM and Private Option enrollees. • B: The extent to which the percentage of enrollees with an ambulatory or preventive care visit in the past year varies between the HIM and existing Medicaid Fee-for-Service for low-income adults. 	<p>State claims databases</p> <p>Medical Expenditure Panel Survey from AHRQ (MEPS)</p> <p>CAHPS</p> <p>CDC- Behavioral Risk Factor Surveillance System</p>
(3) Private Option beneficiaries will have lower non-emergent use of emergency room services as compared to Medicaid beneficiaries in non-Premium Assistance expansions nationally.	To the extent that data is available from other states, compare the extent of non-emergent emergency department use to data from expansion states with similar program characteristics, or, alternatively, compare existing Medicaid versus Private Option utilization patterns.	Medicaid/QHP claims databases and available data from other states
(4) Churning—Private Option Beneficiaries will have fewer gaps	Compare churn rates between Private Option and evidence in	Enrollment data from

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Hypothesis	Evaluation Approach	Data Sources³
<p>in insurance coverage than Medicaid beneficiaries in non-Premium Assistance expansions nationally.</p>	<p>literature/other states experiences with traditional expansion</p> <p>Compare the extent to which the percentage of individuals with any period of uninsurance during the year varies between Private Option and HIM/traditional Arkansas Medicaid populations</p>	<p>Arkansas and other states MEPS</p>
<p>(5) <i>Churning</i>: Private Option beneficiaries will maintain continuous access to the same health plans and/or providers at higher rates than under a traditional Medicaid expansion.</p>	<p>Compare differences in measured outcomes for A and B, while controlling for relevant factors, with the assumption that differences in B will be greater than differences in A:</p> <p>A: Identify the extent to which individuals have access to the same plans and providers in the HIM and Private Option when income fluctuates and causes a change in paying source.</p> <p>B: Identify the extent to which individuals have access to the same plans and providers in the HIM and the existing Medicaid for low-income adults when income fluctuates and causes a change in paying source</p>	<p>HIM/Private Option enrollment data</p>
<p>Cost</p>		
<p>(1) <i>Churning</i>: Reduction in churning for Private Option Beneficiaries will lead to reduced</p>	<p>Comparison of administrative costs per capita expended for Private Option enrollees at</p>	<p>Enrollment/Administrative costs data from Arkansas and other states if data is</p>

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Hypothesis	Evaluation Approach	Data Sources³
administrative costs.	churn points versus administrative costs under traditional Medicaid expansion in Arkansas	available
(2) <i>Comparability</i> : Over the life of the demonstration, the cost for covering Private Option beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service, assuming adjustments to fee-for-service reimbursement to achieve access in the fee-for-service model.	TBD	
(3) <i>Medicaid Uncompensated Care</i> : Uncompensated care costs will go down as a result of higher levels of provider reimbursement and lower numbers of uninsured.	Analysis of Disproportionate Share Hospital Payments Comparison of take-up rate between Private Option and traditional fee-for service Medicaid expansions in other states	CMS data Private Option/other state enrollment data
(4) <i>Cost in the Arkansas Marketplace</i> : The Private Option will drive down overall premium costs in the Marketplace and will result in better quality than would otherwise have occurred absent the Private Option.	Actuarial analysis of the impact of increased volume and competitive pricing requirements for plans offered to Private Option beneficiaries	Claims data
Quality		
(1) <i>Quality Improvement</i> : Private Option enrollees will have lower rates of potentially preventable admissions than enrollees in Arkansas’s Medicaid fee for	Analysis of hospital discharge data	Arkansas Department of Health data Arkansas Health Data Initiative

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Hypothesis	Evaluation Approach	Data Sources ³
service program.		
(2) <i>Quality in the Arkansas Marketplace</i> : The Private Option, inclusive of its requirement to participate in the Arkansas Payment Improvement Initiative (APII), will produce improved quality over time than would otherwise have occurred absent the Private Option	Analysis of Arkansas Payment Improvement Initiative PCMH quality metrics for preventive care and chronic disease management	Claims and clinical information

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration

The Demonstration will operate during calendar years 2014, 2015, and 2016.

6) Describe whether the Demonstration will affect and/or modify other components of the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

No. The demonstration will not modify the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing or delivery systems.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

Please refer to Medicaid Eligibility Groups: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

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The Demonstration will not affect any of the eligibility categories or criteria that are set forth in the State Plan.

Participation in the Demonstration, however, will be mandatory for Private Option-eligible individuals. Individuals who qualify for the Private Option will be required to receive coverage through QHPs, and those who decline coverage through QHPs will not be permitted to receive benefits through the State Plan.

Eligibility Chart

Mandatory State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Expansion Populations

Eligibility Group Name	N/A	Income Level

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible for the Private Option, Arkansas will apply the same eligibility standards and methodologies as those articulated in the State Plan.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no caps on enrollment in the Demonstration. To be eligible to participate in the Demonstration an individual must: (1) be a childless adult between 19 and 65 years of age, with an income at or below 138% of the federal poverty level who is not enrolled in Medicare and not incarcerated **or** be a parent between 19 and 65 years of age, with an income between 17-

ARKANSAS 1115 WAIVER APPLICATION

138% FPL who is not enrolled in Medicare and not incarcerated and (2) be a United States citizen or a documented, qualified alien. However, individuals determined to be medically frail/ have exceptional medical needs for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care will not be eligible for the Demonstration.

Description	Income	Age	Exceptions
Adults in Section VIII Group	<i>Childless Adults: 0-138% FPL</i> <i>Parents: 17-138% FPL</i>	19-65	<ul style="list-style-type: none"> ▪ Dual Eligibles ▪ Individuals who are medically frail/have exceptional medical needs. ▪ Incarcerated individuals

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Approximately 225,000 individuals will be eligible for the Demonstration. Currently, the State estimates that approximately 250,000 individuals will be newly eligible for or newly enrolled in Medicaid in Arkansas beginning in 2014. It is projected that 90% of newly eligible Medicaid beneficiaries will also be eligible for the Demonstration, with the remaining 10% of the newly eligibles receiving ABP or standard coverage under the State Plan.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State)

N/A. Long-term services and supports will not be provided through the Demonstration, since the ABP, as set forth in the State Plan, does not cover long-term services and supports.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

N/A. The State will not institute continuous eligibility or express lane eligibility.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or

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standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

___ Yes X No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

___ Yes X No (if no, please skip questions 8 - 11)

Cost-sharing requirements for ABP will be the same regardless of whether the benefits are delivered under the State Plan or the Demonstration.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Table with 2 columns: Eligibility Group, Benefit Package. It contains three empty rows for data entry.

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

- ___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
 X Secretary Approved

Since individuals in the new adult group are required to receive coverage through the Alternative Benefit Plan ("ABP"), the State is not electing ABP-equivalent coverage for a

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population; instead, the State is providing the statutorily required benefit package. Arkansas’s State Plan Amendment will outline its selection of a Secretary-approved ABP.

5) In addition to the Benefit Specifications and Qualifications form: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

N/A. Benefits are the same under the Demonstration and the State Plan.

Benefit Chart

Benefit	Description of Amount, Duration, and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration, and Scope	Reference

Although the benefits in the ABP will be identical across the State Plan and the Demonstration, the appeals process relating to coverage determinations will differ. Under the Demonstration, Private Option beneficiaries will use their QHP appeals process to appeal denials of benefits covered under the QHP. (Private Option beneficiaries will continue to use the Medicaid appeals process for denials of wrapped benefits.) All QHPs must comply with federal standards governing internal insurance coverage appeals. Additionally, all QHPs must comply with state standards governing external review of insurance coverage appeals, which in turn are approved as meeting the requirements imposed under the Affordable Care Act. Private Option beneficiaries will have access to the following two levels of appeals:

Internal Review

Each QHP must provide all enrollees with:

- 1) Notice identifying the claim or claims being denied;
- 2) A description of the reason for the denial;
- 3) Copies of the guidelines used to deny the claim; and
- 4) Notice that the recipient may request more explanation of the reason for the denial.

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Any enrollee whose claim for health care is denied or is not acted upon with reasonable promptness may:

- 1) Appeal to the QHP; and
- 2) Present evidence and testimony to support the claim.

The QHP must render a decision regarding an internal appeal within:

- 1) 72 hours for denial of a claim for urgent care;
- 2) 30 days for non-urgent care that has not yet been delivered; and
- 3) 60 days for denials of services already delivered.

External Review

If the QHP does not render a decision within the timeframe specified above, or affirms the denial in whole or in part, the enrollee may request review, and in some cases expedited review, by a Qualified Independent Review Organization that has been selected by the Arkansas Insurance Department (AID). Each QIRO must use qualified and impartial clinical reviewers who are experts in the treatment of the enrollee's medical condition and have recent or current actual clinical experience treating patients similar to the enrollee. Additionally, the enrollee is permitted to submit a statement in writing to support its claim. The QIRO will render its decision in 45 days, or within 72 hours in the case of an expedited review.

In addition to, and separate from, the safeguards provided above, Arkansas enrollees may sue the QHP directly in state court for breach of contract. QHP enrollees may also file coverage complaints with AID. If AID determines that a claim for coverage was denied improperly, AID may bring an enforcement action against the issuer to require it to provide coverage. During that enforcement action, AID has the right to engage in discovery, conduct depositions, and cross-examine witnesses. AID may also permit the enrollee to engage in discovery, conduct depositions, and cross-examine witnesses.

6) Indicate whether Long Term Services and Supports will be provided.

Yes (if yes, please check the services that are being offered) No

In addition, please complete the: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and the: <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>.)

- Homemaker
- Case Management
- Adult Day Health Services
- Habilitation – Supported Employment
- Habilitation – Day Habilitation

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- Habilitation – Other Habilitative**
- Respite**
- Psychosocial Rehabilitation**
- Environmental Modifications (Home Accessibility Adaptations)**
- Non-Medical Transportation**
- Home Delivered Meals Personal**
- Emergency Response**
- Community Transition Services**
- Day Supports (non-habilitative)**
- Supported Living Arrangements**
- Assisted Living**
- Home Health Aide**
- Personal Care Services**
- Habilitation – Residential Habilitation**
- Habilitation – Pre-Vocational**
- Habilitation – Education (non-IDEA Services)**
- Day Treatment (mental health service)**
- Clinic Services**
- Vehicle Modifications**
- Special Medical Equipment (minor assistive devices)**
- Assistive Technology**
- Nursing Services**
- Adult Foster Care**
- Supported Employment**
- Private Duty Nursing**
- Adult Companion Services**
- Supports for Consumer Direction/Participant Directed Goods and Services**
- Other (please describe)**

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

Yes (if yes, please address the questions below)

No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

N/A

b) Include the minimum employer contribution amount.

N/A

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c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

N/A

d) Indicate how the cost-effectiveness test will be met.

N/A

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

There are no premiums under the Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

Consumer cost-sharing obligations under the Demonstration will be identical to those under the State Plan for all individuals receiving the ABP. The SPA describing the ABP will include the cost-sharing design for all individuals receiving the ABP. As will be described in the SPA, Private Option beneficiaries with incomes below 100% FPL will not have cost-sharing obligations in year one of the Demonstration; Arkansas plans to submit amendments to the waiver to implement cost-sharing for Demonstration participants with incomes from 50-100% FPL to be effective in years two and three of the Demonstration. Individuals with incomes of 100-138% FPL will be responsible for cost-sharing in amounts consistent with Medicaid cost-sharing rules. For individuals with income between 100-138% FPL, aggregate annual cost-sharing will be capped at 5% of 100% FPL (\$604 for 2014)⁴. Demonstration participants will not be required to pay a deductible prior to receiving coverage. Providers will collect all applicable co-payments at the point of care. QHPs will monitor Private Option beneficiaries' aggregate amount of co-payments to ensure that they do not exceed the annual limit.

Arkansas will pay QHP issuers advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for Private Option beneficiaries. The advance monthly CSR payments will be calculated in the same way for individuals between 138 and 250% of the federal poverty level (FPL) who are eligible for federal CSRs and for individuals at or below 138% FPL enrolled in the Private Option; the only difference will be that HHS will make the federal CSR payments and Arkansas Medicaid will make the Private Option CSR payments. Under this method, issuers would, before each benefit year, estimate monthly allowed claims for essential health benefits for each standard silver plan and report this information to the Exchange (for APTC/CSR eligible enrollees) and Arkansas Medicaid (for Private Option enrollees). For the zero cost sharing plan variation, HHS or Medicaid will multiply this estimate by 1.12 to reflect induced utilization for the higher AV and then multiply that

⁴ Arkansas will make adjustments to the cost-sharing cap for Private Option enrollees in two adult households.

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product by the difference between zero cost sharing plan variation AV and standard silver plan AV (i.e. 0.3). The same formula is used for the high-value silver plan variant, using the same induced demand factor of 1.12 and substituting 0.24 for 0.3 for the AV factor. Issuers will receive per member per month payments during the benefit year on the basis of this formula. These payments will be subject to reconciliation at the conclusion of the benefit year based on actual CSRs that are utilized. If an issuer’s actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the issuer will be entitled to at reconciliation, the issuer may ask HHS or Arkansas Medicaid to adjust the advance payments. See 45 C.F.R. § 156.430; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15487-88, 15494-95 (Mar. 11, 2013).

At the conclusion of the benefit year, each QHP issuer will report actual cost-sharing reduction amounts to HHS (for members receiving APTCs/CSRs) and Arkansas Medicaid (for members enrolled in the Private Option) to reconcile CSR amounts with the advance payments. The Arkansas Medicaid process for such reconciliations will be modeled on the HHS process. HHS has announced that issuers may choose one of two methods to calculate the actual cost sharing reductions. The standard method requires the issuer to adjudicate each claim and determine the plan’s liability twice: first calculating plan liability using the standard silver plan cost sharing and a second time with reduced cost sharing under the silver plan variant. The CSR payment the issuer is entitled to is the difference between the second number and the first. The simplified methodology does not require readjudication of claims. Instead, issuers will enter certain basic cost sharing parameters of its silver plans into a formula that will model the amount of CSR payments, based on total incurred claims. Issuers may choose either method, but a single issuer must apply the same method to all its plans. Furthermore, if an issuer selects the standard method in 2014, it may not select the simplified method in future years. 45 C.F.R. § 156.430(c).

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

10) Indicate if there are any exemptions from the proposed cost sharing.

Yes. All individuals who are statutorily required to be exempt from cost sharing will be exempt from cost sharing under the Demonstration, including pregnant women and American Indians/Alaskan Natives

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

Yes

No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

By leveraging premium assistance to purchase private coverage for Private Option beneficiaries, the Demonstration will improve quality and value in the healthcare system for all Arkansans. First, as a result of provisions included in the Arkansas Healthcare Independence Act which establishes the Private Option, all carriers offering QHPs in the Marketplace will be required to participate in the AHCPH—an innovative, multi-payer initiative to improve quality and reduce costs statewide. Because the Demonstration will add approximately 225,000 individuals to these carriers' enrollment rosters, the Demonstration dramatically expands the number of patients for whom providers are held accountable for the cost and quality of care.

Second, the Demonstration will improve access to care for Private Option beneficiaries by expanding the number of in-network providers. Because reimbursement rates in Medicaid have historically been lower than Medicare or commercial rates, many providers in Arkansas accept only limited numbers of Medicaid patients and expansion of the Medicaid network to absorb an expansion population would not succeed without meaningful increases in provider reimbursement. Private Option beneficiaries will have access to the full provider networks of their QHPs, which include many providers who do not currently participate in Medicaid. Moreover, had Arkansas expanded Medicaid without leveraging QHPs the number of Medicaid beneficiaries accessing care through the existing Medicaid fee-for-service network would increase by 40% creating access problems for all Medicaid beneficiaries.

Finally, 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.

Taken together, the three factors described above will improve quality, promote access, and reduce costs statewide. All Arkansans, regardless of the underlying subsidy for their health insurance, will benefit from improved quality and reduced costs spurred by the Demonstration. And all Medicaid beneficiaries, including those served through fee-for-service Medicaid will

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benefit from spreading the growing Medicaid population across a broader network of providers.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- Managed care**
 - Managed Care Organization (MCO)**
 - Prepaid Inpatient Health Plans (PIHP)**
 - Prepaid Ambulatory Health Plans (PAHP)**
- Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)**
- Health Homes**
- Other (please describe)**

The Demonstration will use premium assistance to purchase QHP coverage for Private Option beneficiaries. Each Private Option beneficiary will have the option to choose between at least two high-value silver plans offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums; all cost-sharing in the high-value silver plans will comply with Medicaid requirements. Additionally, the State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment services for individuals participating in the Demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT services to the extent such services are not covered under the QHP). EPSDT services are relevant to the Private Option only because the Affordable Care Act defines 19 and 20 year olds as children for purposes of service benefit requirements, but adults for purposes of eligibility. If family planning services are accessed at out-of-network providers, the State’s fee-for-service Medicaid program will cover those services, as required under federal Medicaid law. Because of Arkansas’s Any Willing Provider Law, few, if any, such providers are expected to be outside of private insurance carrier networks.

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Delivery System Chart

Eligibility Group	Delivery System	Authority

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5) If the Demonstration will utilize a managed care delivery system:

The Demonstration is utilizing premium assistance to purchase QHPs in the individual market, and not Medicaid managed care plans, to deliver benefits. Although the Medicaid managed care regulations do not apply to the proposed premium assistance model, the State responds to the questions below to provide additional detail and context for its proposal to leverage qualified health plans as the delivery system for the Demonstration.

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

For individuals who are eligible for the Private Option, enrollment in a QHP will be mandatory. Individuals who are determined to be medically frail/have exceptional medical needs are not eligible for the Private Option and such individuals will be excluded from enrolling in QHPs. Individuals excluded from enrolling in QHPs through the Private Option as a result of medical frailty/exceptional medical needs will be eligible for coverage under Title XIX and will have the option of receiving either the ABP or the standard Medicaid benefit package through the State Plan.

Arkansas will institute a process to determine whether an individual is medically frail/has exceptional medical needs—such as individuals who would benefit from long-term services and supports and targeted outreach and care coordination through the State’s emerging plans to establish health homes and to provide services through the Community First Choice state plan option.

Arkansas is working with researchers from the University of Michigan and the Agency for Healthcare Research & Quality to develop a questionnaire with approximately twelve questions to assess whether an individual may be medically frail/have exceptional medical needs (“the Screening Tool”). The screening tool will include the following domains: health self-assessment; living situation; assistance with activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs); overnight hospital stays (both acute and psychiatric); and number of physician, physician extender or mental health professional visits. The Screening Tool will be conducted online (unless an individual requests a paper copy) and will consist of yes/no and multiple choice answers. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional medical needs criteria. The screening tool methodology is a combination of threshold qualifying characteristics, such as the presence of an ADL or IADL, and a weighted scoring algorithm based on applicant responses to other screening questions that will initially be calibrated to identify the top ten percent expected costs among the newly eligible population. Downstream refinements to the questionnaire algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

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The medical frailty/exceptional medical needs screening process is meant to be prospective at the time of enrollment and will be conducted annually by Arkansas Medicaid. Self-attestation to the questions in the Screening Tool will be accepted in year one. In the case of false negatives and for individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during the plan year, Medicaid will develop a process for making mid-year transitions to traditional Medicaid. The State may also develop a process to monitor claims experience to identify individuals who were initially identified as medically frail/having exceptional medical needs but no longer appear to meet those criteria.

The exact details of the process will differ slightly depending on whether an individual applies for the Private Option through the federally facilitated marketplace (FFM) or through the State's eligibility system.

- *Individuals Applying Through FFM:* After the FFM determines that an individual is eligible for Medicaid, the State will send a notice informing the individual that he/she appears to be eligible for the Private Option. The notice will, among other things, direct individuals who appear Private Option eligible to the State portal where they will first see the Screening Tool described above. If the answers on the Screening Tool indicate that the individual is not medically frail/has exceptional medical needs, the individual will move on to shopping and enrollment through the State portal. If the results of the Screening Tool indicate that the individual is medically frail/has exceptional medical needs, instead of advancing to the shopping and enrollment pages, the individual will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for-service Medicaid.
- *Individuals Applying Through the State Portal:* Immediately after an individual is determined to be Medicaid-eligible, the individual will be asked to complete the Screening Tool. Once the individual completes the Screening Tool, the individual will be directed to shopping and enrollment, if not determined to be medically frail/have exceptional medical needs, or will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for-service Medicaid.

The State will comply with all requirements set forth in Section 1937 of the Social Security Act, including, but not limited to, ensuring that all individuals determined to be medically frail, as well as individuals in other ABP-exempt populations identified in Section 1937 of the Social Security Act, will be given the option to receive through fee-for-service Medicaid either the ABP or the standard Medicaid benefit package.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

The Demonstration will be statewide.

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c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

There will not be a phased-in rollout. The Demonstration will begin statewide on January 1, 2014.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

Through AID's plan management process, the State will assure that Private Option beneficiaries will be able to choose from at least two high-value silver plans in each rating area of the State. Private Option beneficiaries will be permitted to choose among all high-value silver plans offered in their geographic area, and thus all Private Option beneficiaries will have a choice of at least two qualified health plans. Additionally, AID will evaluate network adequacy, including QHP compliance with Essential Community Provider network requirements, as part of the qualified health plan certification process. As a result, Private Option beneficiaries will have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the access the general population in the geographic area has.

The State expects to implement policies over time that will further ensure cost-effective QHP purchasing. Given the expansion of health insurance coverage associated with the Private Option, uncompensated care is expected to decline significantly in 2014 and beyond, reducing the need for providers to "cost-shift", i.e., raise their contractual prices with private health insurance plans to make up for losses incurred by serving uninsured (or under-insured) patients. Also, the Private Option will result in the enrollment of a large number of Medicaid beneficiaries into QHPs, resulting in increased payments to providers for existing uninsured patients.

In sum, the Private Option helps transform and significantly expand the private insurance marketplace, and this new marketplace will establish competitive price points for provider reimbursement. As a result of these large shifts in payment and compensation for providers, actuaries projecting the expected costs of Arkansas's Private Option for DHS estimated that contractual rates of reimbursement for providers participating in QHPs that serve Private Option participants would be, on average, lower than existing provider contracts with commercial insurers today due to the reduced need for cost-shifting. (This general assumption does not necessarily imply the impact of the Private Option on commercial payer reimbursement to any specific provider.) To help ensure cost-effective use of taxpayer funds, the Private Option is employing a purchasing standard consistent with a transition to more competitive insurance markets

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during Plan Year 2014, and in future Plan Years expects to develop and adopt additional strategies to ensure the purchase of both competitively-priced and cost-effective plans.

e) Describe how the managed care providers will be selected/procured

Qualified health plans will be selected through AID's QHP certification process. As noted above, Private Option beneficiaries will be able to choose among high-value silver plans available in their geographic region. Products with proposed premiums that the AID determines are outliers will not be certified to be offered on the Marketplace, ensuring that Private Option beneficiaries choose among only cost-effective QHPs. In the second and third years of the Demonstration, the State will review carrier competition and premiums and may establish more selective criteria for QHP eligibility for the Private Option to ensure both beneficiary choice and cost-effective purchasing that meets the terms and conditions of this waiver.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Wrap-Around Benefits

All services will be provided through QHPs, except for two services that are not fully covered under the QHP benefit package but that must be included in the ABP. Specifically, the State will provide a fee-for-service wrap around benefit for: (1) non-emergency medical transportation; and (2) Early Periodic Screening Diagnosis and Treatment for individuals under age 21 (to the extent the service is not otherwise included in the QHP benefit). In addition, if a Private Option beneficiary accesses family planning services through an out-of-network provider, those services will be covered through fee-for-service Medicaid, consistent with federal law.

Retroactive Coverage

Arkansas will also use the fee-for-service delivery system to provide retroactive coverage for the three months prior to the month in which an individual is determined eligible for Medicaid.

Coverage Prior To QHP Enrollment

The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for Medicaid until the individual's enrollment in the QHP becomes effective. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment). For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional

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information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

Yes
 No

The Demonstration will not provide long-term services and supports or personal care.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Providers will be reimbursed for care provided to Private Option beneficiaries at the rates the providers have negotiated with the QHP. The State anticipates that provider payment rates under QHPs will be at least as high as provider payment rates offered under the State Plan.

Arkansas recognizes the value of the State's FQHCs/RHCs and the important role they play in serving Medicaid and uninsured patients. To assure their continuing viability, Arkansas Medicaid, in consultation with the FQHCs/RHCs, intends to develop an alternative payment methodology to reimburse FQHCs for serving Private Option enrollees, as permitted under Section 1902(bb). During 2014, FQHCs/RHCs will be reimbursed for services provided to Private Option enrollees by QHPs at commercial rates consistent with Arkansas law and market dynamics, with supplemental payments made by the Arkansas Medicaid. Arkansas Medicaid will require FQHCs to provide historic and prospective cost and utilization data to enable the development of an alternative payment methodology that moves away from a flat fee-for-service, per-visit payment framework and toward a methodology that accounts for the intensity of the services provided, and the delivery of cost-effective, quality care to Private Option enrollees. Additionally, the alternative payment methodology will reflect the expansion of coverage under Title XIX, including efficiencies created by expansion and changes in utilization patterns as individuals move from uninsured to insured status. The State intends to implement this alternative payment methodology as early as possible after initiation of the Demonstration. Arkansas believes that, working with the FQHCs/RHCs, it can develop a sound payment methodology that reflects the value of the FQHCs/RHCs and advances the goals of the Private Option and a value-based payment and delivery system; however, if an alternative payment methodology cannot be developed on a timely basis, Arkansas reserves the right to seek a waiver of FQHC reimbursement rules during year one of the waiver and/or for years two and three of the Demonstration.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

N/A

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10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Arkansas Medicaid will not make supplemental payments directly to providers through the Demonstration. All QHP carriers, however, will be required to participate in the AHCPII by assigning enrollees a primary care provider, supporting patient-centered medical homes, and accessing clinical performance data for providers, and thus providers caring for Private Option beneficiaries will be eligible to receive payments under applicable components of the AHCPII.

The AHCPII is intended to shift the delivery system in Arkansas from one that primarily rewards volume to one that rewards quality and affordability. This statewide, multi-payer initiative is designed to be practical and data-driven in its approach to promoting patient-centered, clinically appropriate care. The AHCPII comprises a comprehensive approach to payment reform phased-in over the next several years. Two of those components are already being implemented on a multi-payer basis:

- ***Episode-Based Care Delivery: Retrospective Risk Sharing.*** For specified medical episodes, such as episodes of congestive heart failure or total joint replacement, participating payers have established comprehensive retrospective episode-based payment. Each payer designates one or more providers as the Principal Accountable Provider (PAP) for the episode of care. The PAP is responsible for the overall quality and cost effectiveness of all care included in the episode. Payers then calculate each PAP's average costs and quality across all of episodes delivered during the year. Payers compare the average costs and quality against performance thresholds specifically set by each payer. If a PAP achieves an average episode cost below a "commendable" threshold and meets quality requirements, the PAP is eligible to receive a portion of the savings. Conversely, if a PAP's performance reflects an average cost in excess of the "acceptable" threshold, the PAP is responsible for a share of costs in excess of the threshold. PAPs not meeting quality targets are not eligible for shared savings.
- ***Medical homes.*** Payers participating in the AHCPII will support primary care transformation in the form of patient-centered medical homes through care coordination fees and shared savings. Medical homes will be paid care coordination fees on a per member per month (PMPM) basis. The PMPM fees will be linked to demonstrated practice transformation, based on outcomes used in the Comprehensive Primary Care initiative and eventually expanded to include nationally recognized metrics (e.g., AHRQ) for pediatric care. The AHCPII will also measure the value created by a provider, on a risk-adjusted basis, based on both (a) absolute performance and (b) performance improvement, and reward the provider based on the greater of the two amounts.

A third component is available through the Medicaid program and would be included in the benefits that a medically frail/exceptional needs individual could access:

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- Health homes.** Health home payment will cover the full range of health home responsibilities and will include a PMPM fee. A portion of the PMPM will be at risk based on process and outcome metrics and only paid when these metrics show that an acceptable level of care management and coordination has been delivered. PMPM payments will be risk adjusted based on the results of a universal assessment of a person’s level of developmental disability, long-term services and supports, or behavioral health needs and their medical complexity. In addition, episode-based payments will be made for care of specific conditions.

Through each of these programs, the AHCPII aims to redesign the payment and delivery system to promote quality improvement and affordability. Providers who can successfully provide high-quality care while controlling costs will be eligible to receive payments in excess of their ordinary reimbursement.

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Applications for the expansion population will begin on October 1, 2013 for Private Option QHP enrollment effective January 1, 2014. A proposed implementation timeframe is included below:

Milestone	Timeframe
Issue public notice of waiver	June 24, 2013
Accept comments on waiver	June 24 – July 24, 2013
Hold public hearings on waiver	July 2 – 9, 2013
Submit waiver application to CMS	August 5, 2013
Receive waiver approval	By October 1, 2013
Open enrollment period	October 1, 2013 – March 31, 2014
Post medically frail/exceptional medical needs screening tool on website	October 2013
Launch shopping and enrollment function on State Portal	October 2013
Coverage under Private Option becomes effective	January 1, 2014

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2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Notices

Upon enrollment in Medicaid funded coverage, Private Option beneficiaries will receive a notice from Arkansas Medicaid advising them of the following:

- *QHP Plan Selection.* The notice will include, among other things, information regarding how Private Option beneficiaries can select a QHP, including advice on selecting the plan that will best address their health needs and information on the State’s auto-enrollment process in the event that the beneficiary does not select a plan.
- *Access To Services Until QHP Enrollment is Effective.* The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.
- *Wrapped Benefits.* The notice will also include information on how beneficiaries can use the CIN number to access wrapped benefits. The notice will include specific information regarding wrapped benefits, including what services are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services.
- *Appeals.* The notice will also include information regarding the grievance and appeals process. Specifically, the notice will inform Private Option beneficiaries that, for all services covered by the QHP, the beneficiary should begin by filing a grievance or appeal pursuant to the QHP’s grievance and appeals process.
- *Exemption from the Alternative Benefit Plan.* The notice will include information describing how Private Option beneficiaries who believe they may be exempt from the ABP, including pregnant women and the medically frail, can request a determination of whether they are exempt from the ABP and, if they are exempt, choose between receiving coverage through the standard Medicaid benefit package or the ABP. The notice will include information on the difference in benefits under the ABP as compared to the standard (State Plan) benefit package. The exemption process is described in Section IV.5.a.

Enrollment

Individuals eligible for QHP enrollment through the Private Option will begin to enroll during the open enrollment period (October 1, 2013 –March 31, 2014) through the following process:

- Individuals will submit a joint application for insurance affordability programs— Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions— electronically, via phone, by mail, or in-person.
- An eligibility determination will be made either through the FFM or the Arkansas Eligibility & Enrollment Framework (EEF).

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- Once individuals have been determined eligible for coverage under Title XIX, they will enter the State's web-based portal. They will then have an opportunity to complete the Medical Frailty/Exceptional Medical Needs Screening Tool.
- Individuals who are determined eligible to receive coverage through the Private Option will enter the State's web-based portal to shop among QHPs available to Private Option eligible individuals and to select a QHP.
- The MMIS will capture their plan selection information and will transmit the 834 enrollment transactions to the carriers.
- Carriers will issue insurance cards to Private Option enrollees.
- MMIS will pay premiums on behalf of beneficiaries directly to the carriers.
- MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be more effectively treated due to complexity of need through the fee-for-service Medicaid program.
- In the event that an individual is determined eligible for coverage through the Private Option, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's county.

Auto-assignment

The State's goal is to minimize the number of Private Option participants who do not complete the QHP selection process, and therefore need to be auto-assigned. However, particularly in 2014, operational aspects of the enrollment process may result in a significant number of individuals being auto-assigned.

The State anticipates that the majority of Private Option eligible individuals who apply for Medicaid directly through the state portal (EEF) will complete the eligibility and enrollment process, including QHP selection.

Importantly, due to the inability of the FFM to support shopping and enrollment of Arkansas Private Option eligible individuals who apply for coverage through the FFM portal, the State must rely on the EEF to effectuate QHP selection and enrollment. As a result of this disjointed consumer experience, significantly higher levels of auto-assignment are expected for those Private Option beneficiaries who apply for coverage through the FFM. For Private Option beneficiaries who do not select a QHP, the eligible individual will be assigned a QHP and notify the new enrollee of the effective date of his or her QHP enrollment.

In Plan Year 2014, Private Option auto-assignments will be distributed among issuers offering certified silver-level QHPs certified by AID with the aim of achieving a target minimum market share of Private Option enrollees for each issuer in a rating region. Specifically, the target minimum market share for an Issuer offering a high-value silver QHP in a rating region will vary based on the number of competing issuers as follows:

- Two issuers: 33% of Private Option participants in that region.
- Three issuers: 25% of Private Option participants in that region.
- Four issuers: 20% of Private Option participants in that region.
- More than four issuers: 10% of Private Option participants in that region.

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AID and Arkansas Medicaid will collaborate to refine and revise the auto-assignment methodology for Plan Years 2015 and 2016, based on factors including QHP premium costs, quality and performance experience.

Individuals who are auto-assigned will be notified of their assignment and will be given a thirty-day period to request enrollment in another plan, consistent with the timeframes for changing coverage that are currently found in Arkansas's commercial market.

Access To Wrap Around Benefits

In addition to receiving an insurance card from the applicable QHP carrier, Private Option beneficiaries will have a Medicaid client identification number (CIN) through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN will include information about which services Private Option beneficiaries may receive through fee-for-service Medicaid and how to access those services. Similar information will be provided on Arkansas Medicaid's website. Staff at the Arkansas Medicaid beneficiary call centers will be trained to provide information regarding the scope of wrap-around benefits and how to access them. Finally, Arkansas Medicaid will work closely with carriers to ensure that the carriers' call center staff is aware that Private Option beneficiaries have access to certain services outside of the QHP and that staff can direct the Private Option beneficiaries to the appropriate resources to learn more about wrap-around services.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

No procurement action is needed.

Arkansas Medicaid will not contract directly with the QHPs. Instead, Arkansas Medicaid will enter into a memorandum of understanding (MOU) with the plans to outline the process for verifying plan enrollment and paying premiums. Under the terms of the MOU, the QHP will provide a roster of its enrollees who are Private Option beneficiaries. The State will verify that the individuals listed on the roster are Private Option beneficiaries. The MMIS will then transmit payment for premiums to the QHP.

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form:

[http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf)

Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will

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be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf> includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

The Budget Neutrality approach recognizes that the population covered by this Demonstration, known as “Private Option beneficiaries”, represents a hypothetical population for Budget Neutrality purposes. Hypothetical populations are individuals that otherwise could have been made eligible for Medicaid under: 1) section 1902(r)(2), 2) 1931(b), or 3) 1902(a)(10)(A)(i)(VIII) (as modified by Section 2001 of the ACA), via a State Plan Amendment. Because they could have been made eligible without a waiver, savings are not available. As a result, the projected enrollment and costs for the Private Option Beneficiaries are shown as identical in the without waiver and with waiver scenarios.

Specifically, this waiver will cover individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or incarcerated or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare. The State of Arkansas intends to use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace. These Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) and have cost sharing obligations consistent with the State Plan. To determine the hypothetical enrollment associated with the Private Option Beneficiaries, the State’s actuaries, Optumas, reviewed estimates for uninsured populations by income band (corresponding the income eligibility for the Medicaid expansion by Federal Poverty Level) provided by the Arkansas Center for Health Improvement and then adjusted them for overlap with current Arkansas Medicaid eligibility categories and the resulting woodwork effect expected as a result of the ACA. Optumas then projected the costs for this hypothetical population by reviewing the access and quality of care standards required under 1902(a)(30)(a) and determining that the most appropriate benchmark for network access and quality of care would be the commercial reimbursement anticipated to be used on the Marketplace. Using 2 years of Arkansas Medicaid data for utilization, Optumas applied the commercial reimbursement anticipated to be used on the Marketplace to the projected utilization, adjusted for approved cost-sharing, trend, comprehensive private market care coordination, reinsurance, and non-medical load (administration and profit/risk/contingencies) to determine the estimated premium for the Private Option beneficiaries. Combining the projected enrollment with the expected premium yielded the projected costs for the hypothetical population in both the without and with waiver scenarios.

Section VII – List of Proposed Waivers and Expenditure Authorities

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1) Provide a list of proposed waivers and expenditure authorities.

- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries’ freedom of choice among providers to the providers participating in the network of the Private Option beneficiary’s QHP.
- § 1902(a)(54): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(17)	To permit the State to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the State to provide coverage for Private Option eligible Medicaid beneficiaries through QHPs offered in the individual market. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.	This waiver authority will allow the State to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid beneficiaries.
§ 1902(a)(23)	To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries’ freedom of choice among providers to the providers participating in the network of the Private Option beneficiary’s QHP.	This waiver authority will allow the State to require that Private Option eligible beneficiaries receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the state to align the network available to Private Option beneficiaries with the network offered to QHP

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Waiver Authority	Use for Waiver	Reason for Waiver Request
		enrollees who are not Medicaid beneficiaries.
§ 1902(a)(54)	To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the State to align prior authorization standards for Private Option beneficiaries with standards in the commercial market.

Section VIII – Public Notice

1) Start and end dates of the state’s public comment period.

The State’s comment period was June 24, 2013 to July 24, 2013.

2) Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Arkansas certifies that it provided public notice of the application on the State’s Medicaid website (<https://www.medicaid.state.ar.us/>) beginning on June 24, 2013. Arkansas also certifies that it provided notice of the proposed Demonstration in the *Arkansas Democrat-Gazette*—the newspaper of widest circulation in Arkansas—on June 24, 25, and 26. A copy of the notice that appeared in the newspaper is attached here at Appendix A.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Arkansas certifies that it convened three public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, Arkansas held the following hearings:

- *Little Rock – July 2, 2013 from 10 am – 12 pm.* Andy Allison, Arkansas’s Medicaid Director, provided an overview of the Demonstration in a one-hour presentation. Members of the public provided comments for the remainder of the hearing. All members of the public that requested the opportunity to provide public comments were able to do so. Individuals could also access this public hearing by teleconference and webinar.

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- *Fort Smith – July 8, 2013 from 11 am – 1 pm.* Andy Allison provided an overview of the Demonstration in a one-hour presentation. Members of the public provided comments for the remainder of the hearing. All members of the public that requested the opportunity to provide public comments were able to do so.
- *Monticello – July 9, 2012 from 9 am – 11 am.* At the request of state legislators, Arkansas Medicaid added a third public hearing in the southern portion of the state. Like the other hearings, Andy Allison provided an overview of the Demonstration in a one-hour presentation. Members of the public provided comments for the remainder of the hearing. All members of the public that requested the opportunity to provide public comments were able to do so.

In addition to these three public hearings, Arkansas Medicaid also testified about the proposed Demonstration at a session of the Public Health Committee of the Arkansas Legislature. The hearing, held on June 27, 2013, was open to the public and was listed on the Public Health Committee's public schedule.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

Arkansas certifies that it used an electronic mailing list to provide notice of the proposed Demonstration to the public. Specifically, Arkansas Medicaid provided notice through email lists of key stakeholders, including payers, providers, and advocates, as well as legislators. Arkansas Medicaid also provided a second notice by email to these groups to publicize the third hearing that was added to ensure participation by residents of the southern region of Arkansas.

5) Comments received by the state during the 30-day public notice period.

Arkansas received 408 comments during the public notice period. Of the 408 comments, 389 were nearly identical letters.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

We attach here at Appendix B a document summarizing and responding to the comments received.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

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Arkansas contains no federally recognized tribes or Indian health programs. As a result, tribal consultation was not required.

Section IX – Demonstration Administration

Please provide the contact information for the state’s point of contact for the Demonstration application.

Name and Title: Andy Allison, Director, Division of Medical Services, Arkansas
Department of Human Services

Telephone Number: (501) 683-4997

Email Address: Andy.Allison@arkansas.gov

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Appendix A

Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers of Medicare and Medicaid Services (CMS) a written application to request approval of a Health Care Independence 1115 Demonstration waiver and to hold public hearings to receive comments on this Demonstration.

To implement the Arkansas Health Care Independence Act, the State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace for individuals eligible for expanded coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare (collectively “Private Option beneficiaries”). Individuals in two groups—(1) those who are medically frail or (2) other individuals with exceptional medical needs for whom coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care—will not participate in the Demonstration.

Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace.

The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals (and in the longer run, families), improving access to providers, smoothing the “seams” across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives. Ultimately, the Demonstration will provide truly integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Private Option beneficiaries. Additionally, by nearly doubling the size of the population enrolling in QHPs offered through the Marketplace, the Demonstration is expected to drive health care system reform and more competitive premium pricing for all individuals purchasing coverage through the Marketplace.

The Demonstration will be statewide and will operate during calendar years 2014, 2015, and 2016. The State anticipates that approximately 225,000 individuals will be eligible for the Demonstration. The State expects that, over the life of the Demonstration, covering Private Option beneficiaries will be comparable to what the costs would have been for covering the same group of Arkansas adults using traditional Medicaid.

The Demonstration will test hypotheses related to provider access, churning, emergency room use, cost-comparability, usage of Medicaid wrap benefits, quality improvement, preventive services, and uncompensated care costs.

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The State will request the following waivers to operate the Demonstration:

- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.

The State continues to evaluate whether it will request other waivers.

The complete version of the current draft of the Demonstration application is available for public review at <https://www.medicaid.state.ar.us/Download/general/comment/InitialHCIWApp.doc>. The Demonstration application may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

Public comments may be submitted until midnight on July 24, 2013. Comments may be submitted by email to hciw@arkansas.gov or by regular mail to PO Box 1437, S-295, Little Rock, AR 72203-1437.

To view comments that others have submitted, please visit:
<https://www.medicaid.state.ar.us/Download/general/comment/HCIWComments.doc>.

Comments may also be viewed from 8 AM – 4:30 PM Monday through Friday at:

Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72201
Contacts: Becky Murphy or Jean Hecker

The State will host two public hearings during the public comment period.

Little Rock
July 2, 2013
10 AM – 12 PM CST
University of Arkansas for Medical Sciences

Fort Smith
July 8, 2013
11 AM – 1 PM CST
University of Arkansas - Fort Smith

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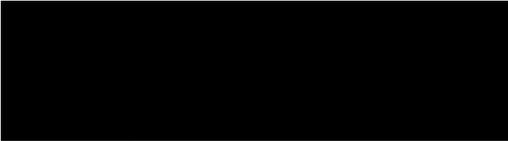
I. Dodd Wilson Building - Room 126
4301 W Markham
Little Rock, Arkansas 72205

Math-Science Building - Room 101
5210 Grand Avenue
Fort Smith, Arkansas 72904

Individuals may access the hearing on July 2, 2013 by webinar. To participate by webinar, please register at:

<https://afmcevents.webex.com/afmcevents/onstage/g.php?t=a&d=664738225>.

EL 4501272097



Andy Allison, PhD
Director, Arkansas Medicaid
Department of Human Services

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Appendix B

Public Comments and Responses

Federally Qualified Health Centers

Comment: Several commenters requested that Arkansas eliminate its proposed waiver of 1902(a)(15) to permit federally qualified health centers (FQHC) and rural health centers (RHC) to be reimbursed at market-based rates negotiated with QHP carriers, supplemented by incentive payments available through the Arkansas Health Care Payment Improvement Initiative (AHCPPII). Commenters stated that the requirement to pay FQHCs and RHCs the prospective payment system (PPS) rate is intended, in part, to ensure access to FQHCs. Additionally, several commenters emphasized that waiving the PPS rate is not necessary to carry out the Demonstration, and that a waiver of the PPS rate will not save the State money due to enhanced federal funding for newly eligible Medicaid beneficiaries. Finally, several commenters emphasized that FQHCs/RHCs provide high-quality healthcare for their patients and, in many instances, are certified as Level 3 Patient-Centered Medical Homes.

Response: We recognize that FQHCs and RHCs are important sources of high-quality care for many low-income Arkansans and serve as critical access points for the uninsured and underinsured. Arkansas is committed to ensuring that FQHCs/RHCs are included in the networks of QHPs through the Arkansas Insurance Department's review of network adequacy (including essential community provider requirements) and enforcement of the State's any willing provider law.

Upon further consideration, Arkansas Medicaid has decided to eliminate its request to waive the FQHC reimbursement rules. Instead, Arkansas Medicaid, in consultation with the FQHCs/RHCs, intends to develop an alternative payment methodology to reimburse FQHCs for serving Private Option enrollees, as permitted under Section 1902(bb). During 2014, FQHCs/RHCs will be reimbursed for services provided to Private Option enrollees by QHPs at commercial rates consistent with Arkansas law and market dynamics, with supplemental payments made by the Arkansas Medicaid. Arkansas Medicaid will require FQHCs to provide historic and prospective cost and utilization data to enable the development of an alternative payment methodology that moves away from a flat fee-for-service, per-visit payment framework and toward a methodology that accounts for the intensity of the services provided, and the delivery of cost-effective, quality care to Private Option enrollees. Additionally, the alternative payment methodology will reflect the expansion of coverage under Title XIX, including efficiencies created by expansion and changes in utilization patterns as individuals move from uninsured to insured status. The State intends to implement this alternative payment methodology as early as possible after initiation of the Demonstration. Arkansas believes that, working with the FQHCs/RHCs, it can develop a sound payment methodology that reflects the value of the FQHCs/RHCs and advances the goals of the Private Option and a value-based payment and delivery system; however, if an alternative payment methodology cannot be developed on a timely basis, Arkansas reserves the right to seek a waiver of FQHC

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reimbursement rules during year one of the waiver and/or for years two and three of the Demonstration.

Comment: One commenter expressed concern that the request to waive the right of Medicaid beneficiaries to have freedom of choice among providers would negatively affect FQHCs and RHCs. Specifically, the commenter expressed concern that FQHCs and RHCs would need to join the networks of the private plans providing coverage under the Demonstration to continue to treat Private Option enrollees. The commenter stated that FQHCs and RHCs could be required, as a condition of joining plans' networks, to participate in programs in which FQHCs and RHCs do not currently participate, such as the AHCPH.

Response: Plans may establish their own criteria for network participation, which may include requiring that providers participate in the AHCPH—which is intended to improve care for all patients. Providers will be free to assess whether they are able to comply with the conditions of participation set forth in the plans' provider contracts.

Comment: Several commenters urged that the State not limit access to FQHC and RHC services for individuals enrolled in the Private Option.

Response: Arkansas is committed to ensuring that FQHCs/RHCs are included in QHP networks through the Arkansas Insurance Department's review of network adequacy (including essential community provider requirements) and enforcement of the State's any willing provider law. Additionally, nearly all services that FQHCs/RHCs provide will be covered through the QHP's benefit package (including, among others, primary and preventive care) or through medical home payments under the AHCPH (including, among others, case management, outreach, and medical education). The State therefore anticipates that Private Option enrollees will have access to the full range of FQHC/RHC services that must be covered under federal Medicaid law.

Comment: Several commenters questioned whether the Secretary of Health and Human Services has the legal authority to waive the requirement to pay the PPS rate to FQHCs/RHCs since, the commenters argue, a waiver of the PPS rate does not further the purposes of Title XIX and endangers the well-being of Medicaid beneficiaries.

Response: As noted above, Arkansas has revised the waiver to eliminate the request to waive FQHC reimbursement rules.

Eligibility and Enrollment

Comment: Several commenters expressed both support for and concerns regarding the State's proposal to provide 12-month continuous eligibility for Private Option enrollees.

Response: We thank the commenters for their interest in our 12-month continuous coverage proposal. Based on further conversation with CMS regarding the requirements of administering 12-month continuous coverage, Arkansas has decided not to seek a waiver for 12-month

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continuous for the first year of the Demonstration. We leave open the possibility of revisiting this issue in future years of the Demonstration.

Comment: One commenter expressed support for 12-month continuous eligibility for children from 6 to 12 months.

Response: We thank the commenter for this idea, but since children will not be eligible for the Demonstration in 2014, we will revisit this issue in future years of the Demonstration.

Comment: One commenter requested that Arkansas permit retroactive enrollment in Medicaid for individuals receiving coverage through the Demonstration.

Response: The draft waiver application states that Arkansas will provide retroactive coverage for three months prior to when the beneficiary is determined eligible for the Private Option and that such coverage will be provided through the Medicaid Agency (*i.e.*, there will be no retroactive enrollment in QHPs for the retroactive coverage period). Arkansas intends to retain retroactive coverage in the final waiver application.

Comment: One commenter expressed concern that some parents who would be newly eligible for Medicaid would not be permitted to enroll in the Private Option. Specifically, the draft waiver application states that individuals with incomes above 17% FPL will have coverage through the Demonstration in 2014. The commenter noted that non-working parents, however, must have incomes below 13% FPL to be eligible for Medicaid currently, and thus non-working parents with incomes between 13-17% FPL would be newly eligible for Medicaid but not eligible for the Private Option.

Response:

The State will not enroll parents with incomes below 17% FPL in the Private Option in 2014. Non-working parents with incomes from 13-17% FPL will be eligible for benefits under Title XIX, and the State will provide such benefits through its traditional Medicaid program.

Comment: One commenter requested that the State defer enrolling children in the Private Option.

Response: Arkansas will not enroll children in the Private Option in 2014. Prior to enrolling children in the Private Option, the State will issue a notice of its proposed changes to the Demonstration and afford the public the opportunity to provide additional comments.

Comment: Several commenters expressed concern that the eligibility and enrollment process described in the draft waiver application could prove burdensome for families in which individuals are eligible for multiple insurance affordability programs (*e.g.*, advance payment tax credits, Medicaid, and CHIP). Additionally, commenters expressed concern that individuals with inflexible work hours or limited internet access may have problems completing the enrollment process. Commenters also included several other suggestions related to eligibility and

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enrollment system, including, among others, suggestions to target outreach efforts to individuals who are likely newly eligible for coverage under Title XIX, to extend the “opt-out” of the auto-assignment process to 60-90 days, and to modify the auto-assignment process to account for existing provider relationships.

Response: We thank the commenters for underscoring the importance of creating a streamlined and accessible eligibility and enrollment process. All eligibility determinations will comply with federal standards, and individuals will be able to request an eligibility determination through a single-streamlined application that may be completed online, by phone, in person, or submitted by mail. Arkansas continues to develop its process for enrolling individuals eligible for coverage in the Private Option, but, at a minimum, the State will ensure that Private Option enrollees have notice of the process for selecting a qualified health plan (QHP) and that such process is not overly burdensome. Although the plan selection process will be as simple as possible, the State recognizes that a significant number of Private Option enrollees will likely be auto-assigned in the first year of the Demonstration. Throughout the Demonstration, Arkansas will continue to refine the plan selection process to enable increasing numbers of Arkansans to affirmatively select their plan, including the opportunity to change plans for a limited period of time after auto-assignment.

Comment: Several commenters encouraged the State to develop consumer outreach and assistance programs to ensure individuals can enroll in the appropriate programs. Commenters also requested that Arkansas ensure consumer outreach and assistance programs not steer beneficiaries to any particular plan.

Response: Arkansas intends to develop a consumer outreach and assistance plan to ensure that eligible individuals can enroll in the Private Option and have the information needed to make informed choices prior to QHP selection. Arkansas will prohibit consumer assisters from steering individuals to a particular QHP.

Comment: Several commenters requested additional information on the medically frail screening process and tool. Commenters also asked whether the public will have the opportunity to comment on the definition of “medically frail” or the contents of the screening tool. Commenters also asked whether Medicaid will monitor claims to determine whether an individual should be classified as medically frail.

Response: The State continues to work closely with experts at the University of Michigan and at the Agency for Healthcare Research & Quality to develop a screening tool to identify individuals who may be medically frail. We will provide additional information on the screening tool as it becomes available. Currently, the State anticipates that the screening tool will address the following domains: health self-assessment; living situation; assistance with activities of daily living (ADLs) or Instrumental Activities of Daily Living (IADLs); overnight hospital stays (both acute and psychiatric); and number of physician, physician extender or mental health professional visits. The Screening Tool will be conducted online (unless an individual requests a paper copy) and will consist of yes/no answers to a short series of questions that focus on a

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person's use of long term supports and services and mental health resources, and presence of complex medical conditions. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional medical needs criteria. The screening tool methodology is a combination of threshold qualifying characteristics, such as the presence of an ADL or IADL and a weighted scoring algorithm based on applicant responses to other screening questions, initially calibrated to identify the top ten percent expected costs among the newly eligible population. Downstream refinements to the questionnaire algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

The State does not currently intend to have a separate comment period regarding the definition of medically frail. The State will, however, provide a notice and comment period for the State Plan Amendment required to implement the Alternative Benefit Plan, and the State Plan Amendment will include additional details regarding how the State intends to implement the medically frail exemption. Arkansas intends to develop a mid-year process to identify individuals who were not initially identified as medically frail, but who may be or become medically frail. Additionally, individuals will have the right to request a re-determination of whether they are medically frail at any point during the year. Finally, the State will establish a process to re-evaluate medical frailty each year.

Comment: One commenter requested that individuals have a right to appeal the determination of whether they are medically frail.

Response: We do not anticipate having a process to appeal a medically frail determination. However, individuals will be able to request a redetermination of whether they are medically frail at any time during the coverage year. In the case of individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during the plan year, Medicaid will develop a process for making mid-year transitions to traditional Medicaid. The State may also develop a process to monitor claims experience to identify individuals who were initially identified as medically frail/having exceptional medical needs but no longer appear to meet those criteria.

Comment: One commenter suggested that the medically frail screening tool incorporate questions regarding social determinants of health.

Response: We acknowledge the importance of social determinants of health and the value of identifying populations at risk for poor health outcomes. The medically frail screening tool, however, will be targeted solely at identifying individuals who fall within the federal definition of medically frail or have exceptional medical needs for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care and these individuals will not be eligible for the Demonstration.

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Comment: One commenter requested that the State establish a timeline for announcing operational details related to the eligibility and enrollment system for the Demonstration, as well as mechanisms to pay plans.

Response: The State continues to refine the eligibility and enrollment processes, and the State intends to release additional details as they become available. Although the State will not have a formal comment process related to the eligibility and enrollment system, the State welcomes input from stakeholders. Additionally, the State intends to work closely with QHPs to ensure that the enrollment and payment processes run as smoothly as possible.

Comment: One commenter noted that the Demonstration excludes some Arkansans, including some lawful permanent residents, who would likely benefit from coverage under the Private Option.

Response: We appreciate the commenter's concern for the well-being of all Arkansans. Federal law prohibits the use of federal Medicaid funds for residents with certain immigration statuses. The Demonstration was drafted to comply with the requirements for federal funding.

Benefits & Cost-Sharing

Comment: One commenter noted that the draft waiver application stated that Private Option enrollees who are 19 or 20 years old would be able to receive Early Periodic Screening, Diagnosis, and Treatment Services (EPSDT) through fee-for-service Medicaid. The commenter noted that the draft waiver application refers only to dental and vision services when discussing EPSDT, but that EPSDT covers a broader range of services. The commenter requested additional details on how the State would provide access to the full range of EPSDT services.

Response: The draft waiver application references dental and vision services as an example of the EPSDT services that will most commonly be provided to 19- and 20-year old Private Option enrollees through fee-for-service Medicaid. The State anticipates that most EPSDT services other than dental and vision services will be covered by the QHPs. In the event that a 19- or 20-year old Private Option enrollee requests a service (other than dental and vision) that is not covered by the QHP, Arkansas Medicaid will review the request for services on a case-by-case basis to determine whether the service must be covered under EPSDT. We have revised the waiver application to clarify that 19- and 20-year olds will have access to the full range of EPSDT services.

Comment: Several commenters expressed concerns with Arkansas's proposed request for a waiver to enable Private Option enrollees to be limited to their QHPs' formularies. Commenters stated that some Private Option enrollees may be unable to access drugs they are currently taking—particularly specialty biologicals—if their plans' formularies do not cover those drugs.

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Response: Due to a clarification included in final rules released by the federal government on July 5, 2013,⁵ Arkansas will no longer need to request a waiver to limit Private Option enrollees to their QHPs' formularies. Under federal Medicaid law, the benefit package known as the Alternative Benefit Plan may include a closed formulary of drugs, based on the formulary of the reference plan selected to develop the Alternative Benefit Plan. Because Arkansas will use the same plan to define the benefit package of QHPs and the Alternative Benefit Plan, the formularies for the Alternative Benefit Plan and QHPs will be subject to the same requirements, and thus a waiver is not required.

Comment: One commenter asked whether individuals who are newly eligible for Medicaid but who are identified as medically frail and who elect to receive the benefit package offered under the State Plan, rather than the Alternative Benefit Plan, will receive the benefit package currently offered to individuals who are categorically eligible for Medicaid or the package offered to individuals who are medically needy.

Response: Individuals who are newly eligible for Medicaid but who are identified as medically frail and who elect to receive the benefit package offered under the State Plan will receive the benefit package offered to individuals who are categorically eligible for Medicaid.

Comment: One commenter asked whether Private Option enrollees will be able to receive inpatient psychiatric services.

Response: Inpatient psychiatric services will be covered for Private Option enrollees.

Comment: One commenter flagged that the draft waiver application refers to monitoring Private Option enrollee cost-sharing on an annual, rather than quarterly or monthly, basis and tracking cost-sharing against an individual, rather than family, cap. The commenter suggested that the approach proposed in the waiver might be inconsistent with federal Medicaid laws governing cost-sharing.

Response: We appreciate the feedback regarding the importance of beneficiary cost-sharing protections. The State is working with the federal government to develop an approach to monitor cost-sharing for Private Option enrollees. The State's approach will comply fully with the Medicaid rules governing limits on cost-sharing. We note that the State had contemplated requesting a waiver from the federal government of the requirements regarding limitations on cost-sharing, and therefore included the proposed waiver request in the draft application. We have since determined that such waiver is not necessary to implement the Private Option.

Comment: One commenter noted that federal Medicaid law requires that pregnant women be exempt from cost-sharing for maternity-related services. The commenter also flagged that all Medicaid beneficiaries receive family planning services with no-cost sharing.

⁵ 78 Fed. Reg. 42,159 (July 15, 2013).

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Response: We thank the commenter for emphasizing the particular importance of these two cost-sharing exemptions. The Demonstration will comply with all requirements relating to cost-sharing, unless requesting a waiver. Specifically, the State will comply with the requirement that pregnant women pay no cost-sharing for maternity-related services. The State is currently developing an operational process to effectuate this cost-sharing exemption. QHPs will cover family planning services at no cost-sharing to comply with the federal requirement to cover preventive services at no cost-sharing.

Comment: One commenter flagged that the proposed cost-sharing design imposes cost-sharing on emergency room use, in violation of federal Medicaid law. Additionally, the commenter notes that non-emergency use of the emergency room may be subject to a copay of not more than \$8—less than the \$20 in the cost-sharing design.

Response: Arkansas Medicaid will ensure that Private Option enrollees are not liable for any cost-sharing for emergency use of the emergency room, consistent with federal law. Non-emergency use of the emergency room is not a covered benefit under the Alternative Benefit Plan, since non-emergency use of the emergency room is neither an Essential Health Benefit nor a mandated service in the Alternative Benefit Plan. As is noted in the waiver application, the State will provide educational materials describing the appropriate use of the emergency room and will notify beneficiaries that non-emergency use of the emergency room is not covered under the Alternative Benefit Plan. Arkansas Medicaid will also monitor non-emergency use of the emergency room.

Comment: One commenter expressed concern about the State's plan to apply cost-sharing for individuals with incomes from 50-100% FPL in year 2 of the Demonstration.

Response: To impose cost-sharing on individuals with incomes from 50-100% FPL, Arkansas will be required to submit an amended waiver application and provide the public with notice of and an opportunity to comment on the amended waiver. Arkansas has not yet developed its proposal for how to impose cost-sharing on this group, and we will keep these comments under advisement as we design the proposal.

Comment: Several commenters asked for clarification on whether Private Option enrollees would be required to pay the deductible included in the standard cost-sharing design for the high-value silver plan.

Response: We thank the commenters for flagging this ambiguity. We have revised the waiver to clarify that Private Option enrollees will not be required to pay the deductible. Arkansas Medicaid will wrap the deductible for all Private Option enrollees.

Comment: Several commenters asked for additional information about the design of the Alternative Benefit Plan, including whether the Alternative Benefit Plan will be the same in fee-for-service Medicaid and in the Private Option.

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Response: The State is currently drafting the State Plan Amendment adopting the Alternative Benefit Plan. The State will issue a public notice of and provide an opportunity to comment on the State Plan Amendment, consistent with the requirements of federal law. The Alternative Benefit Plan will include the same benefits in fee-for-service Medicaid as in the Private Option.

Comment: One commenter asked whether Arkansas would use the same process to contract with non-emergency medical transportation vendors to serve Private Option enrollees as it does for vendors serving traditional fee-for-service Medicaid enrollees.

Response: Arkansas Medicaid will use its existing network of vendors to provide non-emergency medical transportation to Private Option enrollees.

Comment: One commenter expressed concern that the Demonstration will cover contraception and sterilization, as well as abortion services in some circumstances.

Response: The benefits covered through the Demonstration comply with federal requirements. Contraception, sterilization, and abortion services in some limited circumstances are Essential Health Benefits, and therefore, they must be covered by the Alternative Benefit Plan. We note that abortions are covered by the Alternative Benefit Plan only if:

1. they are at the direction of a physician;
2. they are performed in an in-patient hospital or outpatient hospital setting; and
3. circumstances comply with the Hyde Amendment, i.e., specifically in cases where the life of the mother is endangered or where the pregnancy is the result of rape or incest.

Comment: One commenter asked for additional details on the notices discussing eligibility determinations, QHP plan selection, the medically frail screening process, access to wrapped benefits, and selecting the Alternative Benefit Plan or traditional Medicaid benefit package (if applicable).

Response: The State continues to develop the notices that will be issued to beneficiaries addressing these topics. All notices will comply with federal law and regulation. Although the State does not intend to have a formal notice and comment process regarding the notices, the State welcomes suggestions on the content or structure of its notices.

Comment: One commenter asked if Medicaid beneficiaries would have separate cards to access both benefits covered under the QHP and benefits provided by Medicaid through a fee-for-service wrap.

Response: Arkansas intends for Private Option enrollees to have a single card to access benefits covered through the QHP and through a fee-for-service Medicaid wrap. If this approach proves operationally infeasible, however, the State will consider issuing a separate card to access wrapped benefits.

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Provider Networks

Comment: One commenter noted that Private Option enrollees may not have in-network coverage for school-based health care providers and other types of providers that are not commonly in the networks of commercial plans.

Response: We recognize that Private Option enrollees will not have in-network coverage for all providers and provider-types throughout Arkansas, but we nevertheless believe that Private Option enrollees will have ample choice of providers within their QHPs' networks. We note that all QHPs will be required to demonstrate that they have adequate networks of providers, including sufficient numbers of essential community providers that commonly serve low-income and medically underserved patients.

Comment: One commenter expressed concern that Private Option enrollees would have existing provider relationships disrupted if their current provider does not participate in the QHPs' network.

Response: During the plan selection process, Private Option enrollees will have access to information about the providers in the networks of each QHP. With this information, Private Option enrollees with long-standing provider relationships can choose to enroll in plans in which their providers participate. For Private Option enrollees who are auto-assigned to a plan, they will have thirty days to select a different plan if the enrollee's preferred providers are not in the plan's network. We also reiterate that because of Arkansas's Any Willing Provider law, providers will have the opportunity to participate in plan networks if they are willing to agree to the terms and conditions offered by the carriers.

Comment: One commenter encouraged the state to provide out-of-network coverage for Private Option enrollees.

Response: Arkansas continues to develop a plan to address out-of-network coverage for Private Option enrollees that complies with federal and state laws. We note that even without out-of-network coverage, Private Option enrollees will have access to a robust network of participating providers.

Comment: One commenter expressed concern with language in the draft application suggesting that reductions in provider rates would be beneficial. The commenter noted that some providers are currently reimbursed at less than cost and that further rate reductions could threaten the provider's viability.

Response: We acknowledge the commenter's statement that provider reimbursement levels vary by plan and by provider. We have revised the waiver application to avoid any suggestion that all commercial reimbursement to providers could be reduced.

Comment: One commenter requested clarification regarding whether Private Option enrollees could receive services from nurse practitioners, since the draft of the waiver application refers

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to “providers” in some places and “physicians” in others. The commenter also supports providing care through nurse-managed clinics.

Response: We thank the commenter for flagging this ambiguity. Private Option enrollees will be permitted to receive covered services from any licensed health care professional (including a nurse-managed clinic), so long as the services are within the professional’s scope of practice and the professional participates in the QHP’s network. We have revised the waiver application to replace references to “physicians” with references to “providers.”

Evaluation Plan

Comment: One commenter noted that the evaluation methodology for assessing whether providing coverage under the Demonstration is comparable to what it would have cost under traditional, fee-for-service Medicaid is not described in the draft waiver application.

Response: Arkansas continues to work with the Centers for Medicare and Medicaid Services to develop an appropriate evaluation approach for determining whether the cost of coverage under the Demonstration is comparable to the cost of providing similar coverage under traditional, fee-for-service Medicaid. The State’s formal waiver submission to CMS includes a discussion of cost-comparability.

Comment: One commenter recommended that Arkansas revise its plan to evaluate the Demonstration. Specifically, the commenter suggested that Arkansas not use traditional Medicaid expansion states as a point of comparison, since those states’ programs differ substantially from Arkansas’s Medicaid program.

Response: The State continues to discuss the Demonstration evaluation plan with the Centers for Medicare and Medicaid Services. Although we agree that the Medicaid programs in traditional expansion states may differ considerably from the current Arkansas Medicaid program, we also recognize that services and populations covered under the Demonstration differ significantly from those of the current Arkansas Medicaid program. Arkansas continues to work with the federal government to identify the most appropriate comparison group to evaluate the Demonstration. We will keep the commenter’s suggestions regarding the comparison group under advisement as we continue to refine the evaluation plan with the federal government.

Comment: Several commenters expressed concern that, as part of its evaluation of the Demonstration, Arkansas would track healthcare utilization and spending for Private Option enrollees, infringing on the privacy of Private Option enrollees.

Response: To evaluate the Demonstration effectively, Arkansas will need to track and analyze data relating to healthcare utilization and spending. During this process, Arkansas will limit, to the extent practicable, its use of individually identifiable health information, and Arkansas will ensure that all individually identifiable health information is protected in a manner consistent with federal and state privacy laws.

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Appeals

Comment: Several commenters suggested that Private Option enrollees have the right to access the Medicaid coverage appeals process.

Response: Arkansas continues to discuss with the federal government its approach regarding coverage appeals for Private Option enrollees. As is noted in the current draft of the waiver application, the State proposes to use the QHPs' robust internal and external appeals processes. Because of the stringent federal and state requirements governing QHPs' internal and external appeals and the oversight by the Arkansas Insurance Department, the State believes that the internal and external appeals processes of QHPs will protect the rights of Private Option enrollees. Accordingly, we have not modified the waiver application to provide Private Option enrollees with the right to access the Medicaid coverage appeals process.

Comment: One commenter asked whether providers would continue to have rights to appeal denials of coverage under the Medicaid Fairness Act.

Response: Since the Medicaid Fairness Act is a state law, the waiver application to CMS does not address whether the Medicaid Fairness Act would continue to apply. Counsel to Arkansas Medicaid has determined that Medicaid Fairness Act does not apply to Private Option enrollees.

Comment: One commenter supports using the QHP appeals process to address coverage appeals for Private Option enrollees.

Response: We thank the commenter for their support.

Premium Assistance, Generally

Comment: Several commenters expressed their support for the Demonstration.

Response: We thank the commenters for their support of this innovative Demonstration.

Comment: One commenter noted that a recent GAO report finding that few states have successfully implemented premium assistance programs.

Response: Although the GAO report referenced describes the challenges states have faced when implementing premium assistance programs, the Demonstration differs significantly from the premium assistance programs described in the report. Historically, premium assistance has not been used in the individual market as Arkansas proposes to do through its Demonstration. The GAO study referenced focuses on premium assistance in the group market. Also, the premium assistance programs studied in the GAO report were considerably smaller than the Demonstration proposal, and thus those smaller premium assistance programs were unable to leverage economies of scale in administration. Additionally, the premium assistance programs referenced in the GAO study provided premium assistance for employer-sponsored coverage,

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meaning that beneficiaries would receive premium assistance for the specific package of benefits offered by their employers. In these premium assistance programs, the Medicaid agency must review each employer-sponsored benefit package to determine what services need to be wrapped, leading to administrative challenges. By contrast, under the Demonstration, the State will be providing premium assistance to purchase a single benefit—the QHP benefit package. Furthermore, Arkansas’s Demonstration is specifically designed to minimize the need for wrap-around services through the universal screening process for those with medical frailty/exceptional needs. For these reasons, the GAO study is not directly applicable to the use of premium assistance outlined in the Demonstration waiver.

Comment: One commenter suggested that Arkansas establish a program to provide premium assistance for employer-sponsored coverage.

Response: Arkansas is open to considering other innovative approaches to providing access to high-quality coverage for individuals eligible for coverage under Title XIX, including a premium assistance program for employer-sponsored coverage. We note that Arkansas currently has a small program to provide premium assistance for employer-sponsored coverage. Because of the operational challenges related to premium assistance programs for employer-sponsored coverage, Arkansas declines to expand at this time the Demonstration to include a broader premium assistance program for employer-sponsored coverage.

Other

Comment: One commenter encouraged Arkansas to retain Medicaid as the payer of last resort.

Response: Federal law requires that Medicaid is the payer of last resort, and Arkansas intends to ensure that the Demonstration complies with this requirement.

Comment: One commenter requested that the State impose the same program integrity requirements on QHPs enrolling Private Option beneficiaries as it does on Medicaid providers.

Response: QHPs enrolling Private Option beneficiaries will be subject to robust oversight by the Arkansas Insurance Department. The State does not currently intend to apply Medicaid-specific program integrity requirements directly to QHPs. The State, however, will monitor the program integrity of the Demonstration.

Comment: One commenter expressed concern that there would be no direct contract between Medicaid and the QHPs covering Private Option enrollees.

Response: The State currently does not intend to have a direct contract between the QHPs and Arkansas Medicaid; instead, the State intends to have a memorandum of understanding in place among AID, Arkansas Medicaid, and the QHPs to establish processes related to payment of premiums, cost-sharing wraps, and other reporting.

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Comment: One commenter asked whether discharges for Private Option enrollees would count as “Medicaid discharges” for federal cost reporting purposes.

Response: Unless CMS requires otherwise, discharges for Private Option enrollees will count as “Medicaid discharges” for federal reporting purposes.

Comment: One commenter expressed concern that the Demonstration might affect funding for graduate medical education.

Response: We agree with the commenter about the importance of training the next generation of physicians. The State intends to work with the hospitals to develop an approach to funding graduate medical education.

Comment: One commenter requested that Arkansas maintain eligibility for individuals who are medically needy.

Response: The Demonstration will not alter eligibility standards for individuals who are medically needy, but Arkansas Medicaid may alter eligibility standards through a State Plan Amendment.

Comment: One commenter requested that Arkansas create a temporary disability standard so that individuals with short-term, but serious, health conditions can access Medicaid coverage.

Response: We thank the commenter for this interesting idea. The Demonstration will not change eligibility criteria for Medicaid, and thus we do not believe that the Demonstration waiver application is the best vehicle to consider this idea more fully.

Comment: One commenter noted that the draft waiver application stated that Arkansas would consider amending the waiver application to move children from the current ARKids “B” program into the Private Option. The commenter expressed concern that the waiver amendment would not be subject to the same transparency requirements as the initial waiver application.

Response: As the commenter notes, the Demonstration will not affect children enrolled in ARKids “B” until Arkansas requests (and the federal government approves) an amendment to the Demonstration. Arkansas will provide public notice of and an opportunity to comment on any significant amendment to the Demonstration, including an amendment to expand the Demonstration to include children in ARKids “B.”

Comment: One commenter noted that plans covering Private Option enrollees should be subject to quality and data reporting standards that mirror those in Medicaid.

Response: We agree that QHPs should be subject to robust quality and data reporting standards. QHPs will be required to comply with federal requirements governing quality and

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data reporting, though those requirements have not yet been released, as well as additional quality requirements that may be jointly developed by AID and Arkansas Medicaid. Additionally, Arkansas will monitor quality and utilization data as part of its evaluation of the Demonstration.

Comment: Several commenters stated that they were concerned that the Private Option would lead to rationing of care if payers reimburse providers for each episode of care, rather than for each individual service the provider renders.

Response: We thank the commenters for underscoring the importance of ensuring access to all medically necessary services. QHPs will negotiate payment terms, including whether payments will be on a fee-for-service or per episode basis, with providers in their networks. Medical episodes established through AHCPH do not bundle reimbursements as implied. Further, QHPs are not required to participate in episodes of care under existing guidance from the Arkansas Insurance Department (AID). To the extent that QHPs are required to participate in payment reforms as a part of the AHCPH, plans will continue to be required to cover all medically necessary services in the plan's benefit package, and Private Option enrollees will retain the right to appeal denials of coverage. Additionally, QHPs will be required to report on various quality measures, including enrollee satisfaction.

Comment: Several commenters expressed concern that Congress will reduce the federal government's portion of the cost of coverage for individuals newly eligible for coverage under Title XIX, thereby imposing a significant financial burden on the State.

Response: We appreciate the concern for the fiscal health of the State. The draft waiver application is based on the federal funding levels for individuals who are newly eligible for coverage under Title XIX that are established in current law. We will continue to monitor developments in Congress that could affect the federal matching rate for Private Option enrollees. Additionally, the Arkansas Health Care Independence Act includes provisions to terminate the Demonstration in the event that Congress reduces funding for Private Option enrollees.

Comment: One commenter noted that one of the arguments in support of the Arkansas Healthcare Independence Act was that fewer employers would be subject to the employer shared responsibility payment if the State expanded coverage under Title XIX to include individuals with incomes up to 138% FPL. The commenter stated that since the federal government has announced that it is delaying implementation of the employer shared responsibility payment until 2015, the Arkansas Healthcare Independence Act should not be implemented in 2014.

Response: As the commenter notes, the argument that fewer employers would be subject to the employer shared responsibility payment if the State expanded coverage under Title XIX to include individuals with income up to 138% FPL was among the many arguments in support of the Arkansas Health Care Independence Act. The recent announcement by the federal government to delay implementation of the employer shared responsibility payment until 2015

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merely suspends its effect on Arkansas employers; it does not eliminate it. Additionally, the Arkansas Healthcare Independence Act does not prohibit implementation in the event of a delay of the employer shared responsibility payment.

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

- State General Funds
- Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).
- Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).
- Provider taxes. (Provide description the narrative section – Section VI of the application).
- Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

- Yes No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

- Yes No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

Yes No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Yes No Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Yes No

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program? Yes No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding

Budget Neutrality Form

Section 1115 Medicaid Demonstrations should be budget neutral. This means the Demonstration cannot cost the federal government more than what would have otherwise been spent absent the Demonstration. In this section, the state must provide its explanation of how the Demonstration program will achieve budget neutrality and the data to support its rationale.

New Demonstration Request: The following form provides guidance on some of the most commonly used data elements for demonstrating budget neutrality. CMS is available to provide technical assistance to individual states to identify any other elements needed to demonstrate budget neutrality for their specific request. Use the accompanying Excel Workbook to submit supporting data, following the instructions below. All expenditure totals in the Excel Workbook are total computable expenditures (both federal and state shares combined), unless indicated otherwise.

I. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual or Estimated Data

Provide historic data, actual or estimated, for the last five years pertaining to the Medicaid Populations or sub-Populations (Populations broken out by cost categories) in the Demonstration program.

The “Historical Data” tab from the Table Shell contains a structured template for entering these data. There are slots for three Medicaid Populations; more slots should be added as needed. The year headers “HY 1,” “HY 2,” etc., should be replaced with the actual historical years.

The Medicaid Populations submitted for budget neutrality purposes should correspond to the Populations reported in Section II. If not identical, a crosswalk must be provided that relates the budget neutrality Populations to the Section II populations. Use the tables below to provide descriptions of the populations defined for budget neutrality, and the cross-walk to Section II.

States that are submitting amendments or extension requests and that wish to add new Medicaid populations can use the “Historical Data” tab to provide 5 years of historical data for the new populations.

Population/Sub-Population Name:	TANF 18+
Brief Description	Non-disabled, non-child, non-Dual population
Relationship to Section II	Comparable population to non-Medically Frail Medicaid expansion population

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

The WOW tab of the Excel Workbook is where the state displays its projections for what the cost of coverage for included Medicaid populations would be in the absence of the demonstration. A block of cells is provided to display the WOW estimates for each Medicaid population specified. Next to “Pop Type,” the correct option should be selected to identify each group as a Medicaid population.

The workbook is programmed to project without-waiver (WOW) PMPM expenditures and member months using the most recent historical data, historical enrollment and per capita cost trends, and the length of bridge period specified. CMS policy is to use the lower of the state’s historical trends and President’s Budget trends to determine the WOW baseline.

Note that the workbook includes a projected Demonstration Year 0 (DY 00), which is an estimate of the last full year immediately prior to the projected demonstration start date. DY 00 is included to provide a common “jumping off point” for both WOW and with waiver (WW) projections.

D. Risk

CMS will provide technical assistance to states to establish an appropriate budget neutrality methodology for their demonstration request. Potential methodologies include:

PER CAPITA METHOD: The state will be at risk for the per capita (PMPM) cost of individuals served by the Demonstration, to the extent these costs exceed those that would have been incurred absent the Demonstration (based on data shown and to be agreed to above). The state shall be at risk to repay CMS for the federal share of any costs in excess of the "Without Demonstration" cost, based on historical data shown above, which are the sum of the estimated PMPM costs times the number of member months by Population. The state shall not be at risk for the number of member months of participation in the Demonstration, to the extent that they may increase above initial projections.

AGGREGATE METHOD: The state will be at risk for both the number of member months used under the Demonstration, as well as the per capita cost for Demonstration participants; to the extent these exceed the "without waiver" costs and member months that are agreed to based on the data provided above.

E. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The “WW” tab of the Excel Workbook is for use by the State to enter its projected WW PMPM cost and member month projections for historical populations. In general, these can be different from the proposed without-waiver baseline. If the State's demonstration is designed to reduce

PMPM costs, the number of member months by category and year should be the same here as in the without-waiver projection. (This is the default formulation used in the Excel Workbook.)

F. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

The State must provide below a justification for the proposed with-waiver trend rate and the methodology used by the State to arrive at the proposed trend rate, estimates of PMPM costs, and number of member months.

II. Cost Projections for New Populations

This section is to report cost projections for new title XIX Populations. These could be Populations or sub-Populations that will be added to the state's Medicaid program under the Demonstration, including "Expansion Populations" that are not provided for in the Act but are created under the Demonstration.

In the table below, list all of the New Populations and explain their relationship to the eligibility groups listed in Section II.

Population Name	Brief Description	Cross-Walk to Section II
Medicaid Expansion	Childless adults <138% or parents 17-138%	Same population as Section II

Justification for New Populations' Trend Rate, PMPM and Member Month Projections

The state must provide below a justification for the proposed trend rate, estimates of PMPM costs, and number of member months for new populations, including a description of the data sources and estimation methodology used to produce the estimates. Historical data provided to support projections for new populations can be displayed in the Excel Workbook's Historic Data tab.

Some state proposals may include populations that could be made eligible through a State plan amendment, but instead will be offered coverage strictly through the Demonstration. These populations are referred to as "hypotheticals" and CMS is available to provide technical assistance to states considering whether a Demonstration population could be treated as a hypothetical population.

III. Disproportionate Share Hospital Expenditure Offset

Is the state is proposing to use a reduction in Disproportionate Share Hospital (DSH) Claims to offset Demonstration costs in the calculation of budget neutrality for the Demonstration?

Yes No

If yes, the state must provide data to demonstrate that the combination of Demonstration expenditures and the remaining DSH expenditures will not exceed the lower of the state's historical DSH spending amount or the state's DSH Allotment for each year of the Demonstration. The state may provide Adjusted DSH Claim Amounts if additional DSH claims are pending due to claims lag or other reasons.

In the DSH tab of the Excel Workbook, enter the state's DSH allotments and actual DSH spending for the five most recent Federal fiscal years in Panel 1. All figures entered should represent the federal share of DSH allotments and spending.

Provide an explanation for any Adjusted DSH Claim Amounts:

In Panel 2 of the Excel Workbook, enter projected DSH allotments for the federal fiscal years that will overlap the proposed Demonstration period, and in the following row, enter projections for what DSH spending would be in the absence of the demonstration. All figures entered should represent the federal share of DSH allotments and spending.

The Excel Workbook is set up to allow for the possibility that Demonstration Years will not coincide with federal fiscal years. If this is the case, and the Demonstration is proposed to last for five full years, then the Demonstration will be in existence for parts of six federal fiscal years. FFY 00 is the federal fiscal year during which the Demonstration is proposed to begin, and FFY 05 is the federal fiscal year that contains the Demonstration's proposed end date. CMS encourages states that use DSH diversion in their budget neutrality model to define Demonstration Years so that they align with the Federal fiscal years. (If Demonstration Years do align with Federal fiscal years, it is not necessary to populate the column for FFY 00.)

In Panel 3 of the Excel Workbook, the rows are set up to be used as follows. All amounts entered in Panel 3 are Federal share.

- State DSH Allotment: Formulas in the Excel Workbook automatically enter the same DSH allotment projects as are shown in Panel 2.
- State DSH Claim Amount: Enter the amounts that the state projects will be spent on DSH payments to hospitals for each federal fiscal year that overlaps with the proposed demonstration period.
- Maximum DSH Allotment Available for Diversion: If the state wishes to propose a dollar limit on the amount of potential DSH spending that is diverted each year, enter those amounts here. If no such limit is proposed, leave blank.
- Total DSH Allotment Diverted: The Excel Workbook is structured to populate the cells in this row from amounts entered in Panel 4. CMS's default assumption is that DSH diversion spending will align with the Federal fiscal year DSH allotments based on date of service. The Excel Workbook allocates DSH diversion spending from one or two overlapping Demonstration Years to each Federal fiscal year DSH allotment.
- DSH Allotment Available for DSH Diversion Less Amount Diverted: This row provides a check to ensure that diverted DSH spending does not exceed the Maximum DSH Allotment amount specified by the State. If no Maximum DSH Allotment, delete the formulas in this row.

- DSH Allotment Projected to be Unused: This row provides a check to ensure that the combination of diverted DSH spending plus DSH payments to hospitals does not exceed the DSH allotment each year.

Panel 4 of the Excel Workbook provides space for the state to indicate amounts of DSH diversion spending are planned for each Demonstration Year, and specify how much of that amount is to be assigned to the overlapping Federal fiscal years. DSH diversion spending is entered here as a total computable expenditures. An FMAP rate is needed for each total computable spending amount entered to enable it to be converted into a federal share equivalent that will appear in Panel 3. The amounts shown in the Total Demo Spending From Diverted DSH row automatically appear in the Summary tab in the Without Waiver panel.

Explanation of Estimates, Methodology and Data

IV. Summary of Budget Neutrality

The Excel Workbook's Summary tab shows an initial assessment of budget neutrality for the Demonstration. Formulas are included that reference cells in the WOW, WW, and DSH tabs so that projected WOW and WW expenditures for each category of expenditure appear in tabular form and can be summarized by Demonstration Year, and for the entire proposed duration of the Demonstration. The Variance shown for the entire duration of the demonstration must be non-negative.

As indicated above, spending estimates for Other WOW Categories and Other WW Categories should be entered directly into the Summary tab where indicated.

V. Additional Information to Demonstrate Budget Neutrality

Provide any additional information the State believes is necessary for CMS to complete its analysis of the budget neutrality submission.

	Budget Neutrality		
	Without Waiver		
	CY14	CY15	CY16
Member Months	250,000	255,000	260,100
Medicaid Services* PMPM	\$ 472.19	\$ 495.79	\$ 520.58
Total Expense	\$ 118,046,422	\$ 126,427,718	\$ 135,404,086

* Medicaid Services (consistent with Alternative Benefit Plan), excluding Long Term Supports and Services (LTSS)

	With Waiver		
	CY14	CY15	CY16
Member Months	250,000	255,000	260,100
QHP Services** PMPM	\$ 463.60	\$ 486.78	\$ 511.12
Wrap Services*** PMPM	\$ 8.58	\$ 9.01	\$ 9.46
Total PMPM	\$ 472.19	\$ 495.79	\$ 520.58
Total QHP Expense	\$ 115,901,172	\$ 124,130,155	\$ 132,943,396
Total Wrap Expense	\$ 2,145,250	\$ 2,297,563	\$ 2,460,690
Total Expense	\$ 118,046,422	\$ 126,427,718	\$ 135,404,086

** QHP Services (consistent with Alternative Benefit Plan), excluding LTSS

*** Wrap Services covers Medicaid services provided FFS (e.g. NEMT) to Private Option QHP enrollees