Arkansas's Application Certification Statement - Section 1115(a) Extension

This document, together with the supporting documentation outlined below, constitutes Arkansas's application to the Centers for Medicare & Medicaid Services (CMS) to extend the Tax Equity and Fiscal Responsibility Act (TEFRA-like) program (#11-W-00163/6) for a period of 5 years pursuant to section 1115(a) of the Social Security Act.

Type of Request (*select one only*):

_____ Section 1115(a) extension with no program changes

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration without any programmatic changes. The state is requesting to extend approval of the demonstration subject to the same Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period [insert current demo period].

The state is submitting the following items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.
- **Appendix B:** Budget/allotment neutrality assessment, and projections for the projected extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projections through the end of the current approval that incorporate the latest data. CMS will also review the state's Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.
- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the requested extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.
- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

____X____ **Section 1115(a) extension with minor program changes**

This constitutes the state's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration with minor demonstration program changes. In combination with completing the Section 1115 Extension Template, the state may also choose to submit a redline version of its approved Special Terms and Conditions (STCs) to identify how it proposes to revise its demonstration agreement with CMS.

With the exception of the proposed changes outlined in this application, the state is requesting CMS to extend approval of the demonstration subject to the same STCs, waivers, and expenditure authorities currently in effect for the period January 1, 2023 through December 31, 2027.

The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information requested in Appendices A through E above, along with the Section 1115 Extension Template identifying the program changes being requested for the extension period. Please list all enclosures that accompany this document constituting the state's whole submission.

1. Section 1115 Extension Template
2. Attachment 1: TEFRA-like Demonstration Special Terms and Conditions
3. Attachment 2: State's original narrative summary of the initial TEFRA-like Demonstration
4. Attachment 3: TEFRA-like Demonstration Waiver's 2021 Beneficiary Satisfaction Survey
5. Attachment 4: TEFRA-like Demonstration Budget Neutrality Workbook
6. Attachment 5: Arkansas TEFRA-like Demonstration Draft Interim Evaluation Report
7. Attachment 6: Abbreviated Public Notice
8. Attachment 7: Newspaper clippings of the notice
9. Attachment 8: Public input hearing transcript
10. Attachment 9: Comprehensive Public Notice
11. Section 1115 Demonstration FAST TRACK Extension Template for Program Changes

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature: [redacted] **Date:** 6-22-22

[Governor]

CMS will notify the state no later than 15 days of submitting its application of whether we determine the state's application meets the requirements for a streamlined federal review. The state will have an opportunity to modify its application submission if CMS determines it does not meet these requirements. If CMS reviews the state's submission and determines that any proposed changes significantly alter the original objectives and goals of the existing demonstration as approved, CMS has the discretion to process this application full scope pursuant to regular statutory timeframes for an extension or as an application for a new demonstration.

Appendix A:

Historical Summary

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave individual states the option to provide health care benefits to children living with disabilities whose family income was too high to qualify for traditional Medicaid. Sometimes called the Katie Beckett option, this program is associated with the child whose experience with viral encephalitis at a young age left her family in financial hardship. If Katie continued receiving treatment at the hospital, she qualified for Supplemental Security Income (SSI) through Medicaid; however, if she were treated at home, her parents' income would make her ineligible for Medicaid. Interestingly, the hospital-based care was six times more than the cost of home-based care. To address the issues associated with this act, President Ronald Reagan and the Secretary of Health and Human Services created a committee to review the regulations and ensure that children with disabilities could receive home-based treatment (the Katie Beckett option), which then recommended Section 134 of the TEFRA.

Prior to 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to transition the disabled children from traditional Medicaid to a TEFRA-like, 1115 demonstration waiver program.

Section 1115 demonstration waivers are designed to provide services not traditionally covered by Medicaid programs and to expand Medicaid coverage to individuals who otherwise would not be eligible. These waivers facilitate states' approaches to innovative service delivery; they are intended to improve patient care while increasing efficiency, lowering costs and allowing states more flexibility in designing and implementing their programs. These combined elements made the 1115 demonstration waiver a viable solution for continuing to provide services to this special population of Arkansas children.

Using the flexibility available within a demonstration waiver, Arkansas was able to develop and implement a sliding scale premium fee structure based on the family's income, effectively passing a portion of the cost to the eligible child's family. Families with annual incomes at or below 150% of the federal poverty level (FPL) are exempted from the premium requirement, and program eligibility is determined solely on the assets and resources of the child.

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), Arkansas was granted the following expenditure authority to enable Arkansas to operate the program.

1. Demonstration Waiver Population – Expenditures for services provided to children ages 18 and under, who require an institutional level of care, and would otherwise be Medicaid-eligible under a TEFRA state plan option.

Additionally, the following provision is considered not applicable to the TEFRA program

1. Cost Sharing Section 1902(a)(14) insofar as it incorporates Section 1916—To enable Arkansas to charge a sliding scale monthly premium to custodial parent(s) of eligible children with annual family income above $25,000, except that no premium may be charged to families with incomes less than 150 percent of the federal poverty level.

Arkansas's 1115 TEFRA-like demonstration waiver was originally approved in October 2002 and implemented January 1, 2003. Following the initial five-year demonstration period (October 1, 2002 – December 31, 2007) , the waiver was twice renewed with three-year extensions (January 1, 2008 – December 31, 2010 and January 1, 2011 – December 31, 2013) and once for a one 1-year extension (January 1, 2014 – December 31, 2014) when CMS was unable to give states' extension renewal applications the attention needed for thorough reviews due to the number of 1115 demonstration waiver extension renewal applications submitted to CMS at the end of 2013. CMS renewed all affected demonstration waivers for an additional 12-month period (January 1, 2014 – December 31, 2014). Then, because not all could be reviewed/approved in that 12-month period, some states' demonstrations, including Arkansas's TEFRA-like demonstration, were renewed for additional months to complete the review/approval process. Arkansas's TEFRA-like demonstration's renewal was extended for an additional 4 months (January 1, 2015 – May 11, 2015) until the review/approval process was completed. CMS approved a three-year extension for the period May 12, 2015 – December 31, 2017, and another extension through December 31, 2022. (See Attachment 1 for State's TEFRA-like demonstration waiver's Special Terms and Conditions for the January 1, 2018 – December 31, 2022, period.) With this application, Arkansas is requesting a five-year extension of the state's TEFRA-like demonstration.

Objectives

The State's original objective was to replace the Medicaid state plan optional TEFRA aid category with a TEFRA-like demonstration. (See Attachment 2 for the State's original narrative summary of the initial TEFRA-like demonstration.) The State, with its budgetary limitations, wanted to continue to provide services to this population of children but needed to reduce the State's financial obligations. The State chose to reduce its financial obligations by requiring a sliding-scale family premium. If the TEFRA child's family had health insurance coverage for the child from another source, the family was, and still is, required to retain that insurance.

The State's current objective is to continue providing medical services to disabled children eligible for Medicaid under Section 134 of the Tax Equity and Fiscal Responsibility Act through the TEFRA-like 1115 demonstration waiver. Additionally, the State would like to continue to achieve the following four goals, established in its current demonstration evaluation:

Goal 1: *Ensure demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population.*

Goal 2: *Ensure demonstration enrollees have access to timely and appropriate preventive care.*

Goal 3: *Ensure enrollment in the demonstration increases clients' perceived access to health care services and experience in the quality of care received.*

Goal 4: *Ensure premium contributions are affordable, that they do not create a barrier to health care access, and that the proportion of clients who experience a lockout period for nonpayment of premiums is relatively low.*

Program Overview

To be eligible for the TEFRA-like demonstration, a child must meet the requirements for medical necessity, appropriateness of care, and financial need.

Medical necessity: The TEFRA-like demonstration waiver provides coverage to children ages 18 and under with substantial disabilities. The child must be disabled according to the SSI definition of disability. If disability has not been established by SSA, it must be determined by the State's Medical Review Team. The child(ren) of families applying to participate in the TEFRA-like demonstration waiver are also evaluated for likely eligibility in Arkansas's Title XIX Medicaid state plan programs.

Appropriateness of care: Clients must meet the medical necessity requirement for institutional placement, but their needed medical services must be appropriate to provide outside an institution.

Financial need: Clients must have income and resources that do not exceed established limits. The income limit for TEFRA applicants/clients is three times the SSI/SPA (which calculates to $2,523 per month). Only the child's income is considered. Parental income in not considered in the eligibility determination but is considered for the purpose of calculating monthly premium. The resource limit is $2,000. A child can enroll in TEFRA and must retain any other creditable health insurance coverage he or she has.

The following chart outlines the eligibility criteria for Arkansas's TEFRA-like demonstration.

Income Limit	Income Disregards	Resource Limit	Excluded From Resources	Counted Toward Resource Limit	Other Requirements
$2,523 per month (Only child's income is counted)	N/A	$2,000 (Only child's resources are counted)	• A home • 1 car excluded A 2nd car can be excluded if it is essential to the means of self-support of the individual • Some non-home income producing properties • Life insurance without a cash surrender value • Burial spaces • Irrevocable burial arrangements • Personal effects (e.g., antiques)	• Cash on hand & in bank (less income received that month) • Stocks & bonds • Real property other than the home • Personal property (ex. Nonexcludable car, trailers, boats, etc.) • Life insurance with a cash surrender value if face value is over $1,500 • Revocable burial fund (less $1,500 exclusion per spouse if $1,500 exclusion is not used through application of other burial arrangements	• Functional eligibility • Children who would otherwise be institutionalized • Custodial parents with taxable income at or above the 150% of the FPL or over $25,000 in annual income, whichever is more, must pay a premium based on income

Cost Sharing

The TEFRA-like demonstration waiver allows the State to require a sliding-scale premium for eligible children based on the income of the custodial parent(s). A monthly premium can be assessed only if the family income is above 150% of the FPL and more than $25,000 (see tables below). There are no co-payments charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed 5% of the family's gross income.

A premium is assessed only if the family has income (after allowable deductions) above the amount listed for the household size indicated as 150% of the FPL in the table below.

Persons in household	2022 Poverty Guideline	150% of FPL
1	$13,590	$20,385
2	$18,310	$27,465
3	$23,030	$34,545
4	$27,750	$41,625
5	$32,470	$48,705
6	$37,190	$55,785
7	$41,910	$62,865
8	$46,630	$69,945

The table below provides the TEFRA monthly premium range for TEFRA families' various income ranges. The maximum premium assessed is $5,500 per year, for incomes above $200,000 annually. Families are not charged additional premium if they have more than one child in the TEFRA program. And a family's total annual out of pocket cost sharing cannot exceed 5 percent of the family's gross income.

Annual Income		Monthly Premiums		
From	To	Percent %	From	To
$0	$25,000	0.0%	$0	$0
$25,001	$50,000	1.00%	$20	$41
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$93	$125
$100,001	$125,000	1.75%	$145	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$364	$416
$200,001	Unlimited	2.75%	$458	$458

Benefits and Delivery System

Individuals enrolled in the TEFRA-like demonstration waiver receive the full range of State Medicaid benefits and services. Services provided under the TEFRA-like demonstration waiver are delivered through the State's existing network of Medicaid providers. Demonstration waiver clients must select a primary care physician. The most utilized services for TEFRA clients in 2021 are listed in the following table.

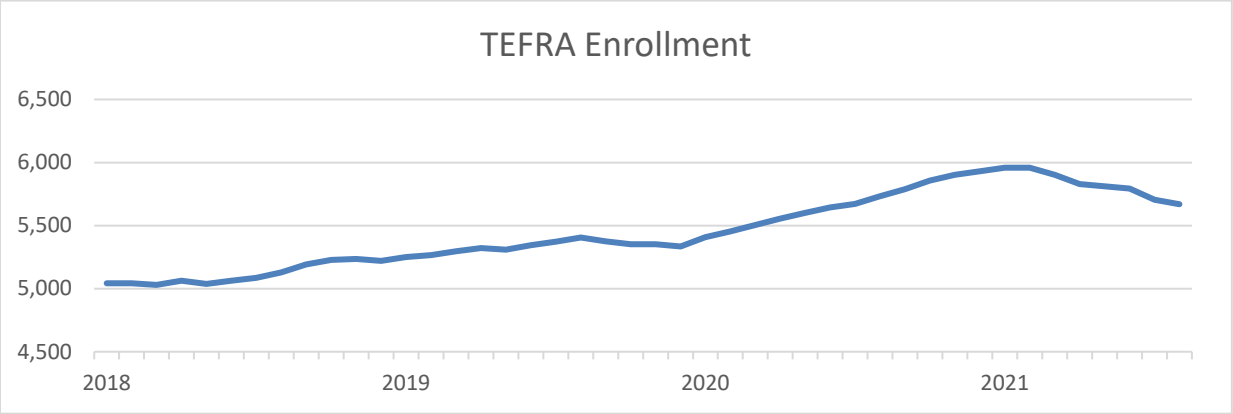
Top Services	Claims for TEFRA Clients
71 –Early Intervention Day Treatment (EIDT)	187,429
B5 - SPEECH/LANGUAGE THERAPY GENERAL	66,844
B4 - OCCUPATION THERAPY GENERAL	62,061
56 - PRESCRIPTION SERVICES	48,091
B3 - PHYSICAL THERAPY GENERAL	41,702
E4 - SPEECH/LANGUAGE THERAPY EIDT	39,842
E3 - OCCUPATIONAL THERAPY EIDT	33,365
55 - PHYSICIAN SERVICES	26,365
E2 - PHYSICAL THERAPY EIDT	24,480
AE - AUTISM-EPSDT	22,003
C7 - SPEECH/LANGUAGE THERAPY SCHOOL BASED	10,557
PE - PEDIATRIC OUTPATIENT HOSPITAL	10,203
C6 - OCCUPATIONAL THERAPY SCHOOL BASED	9,511
12 - DURABLE MEDICAL EQUIPMENT (DME)/OXYGEN	6,848
C5 - PHYSICAL THERAPY SCHOOL BASED	5,912
51 - OUTPATIENT HOSPITAL	5,064
79 - THERAPY - INDIVIDUAL/REGULAR GROUP	4,204
36 - MENTAL HEALTH CLINIC - RSPMI	4,165
93 - DME-EXPANSION-EPSDT	2,959

Evidence of how objectives have been met

Evidence of how the four program goals have been met is described in Appendix C, which provides results from the Interim Evaluation. This section describes the TEFRA clients being served, the premiums they incur, and the benefits they receive, as evidence of the program's objectives having been achieved.

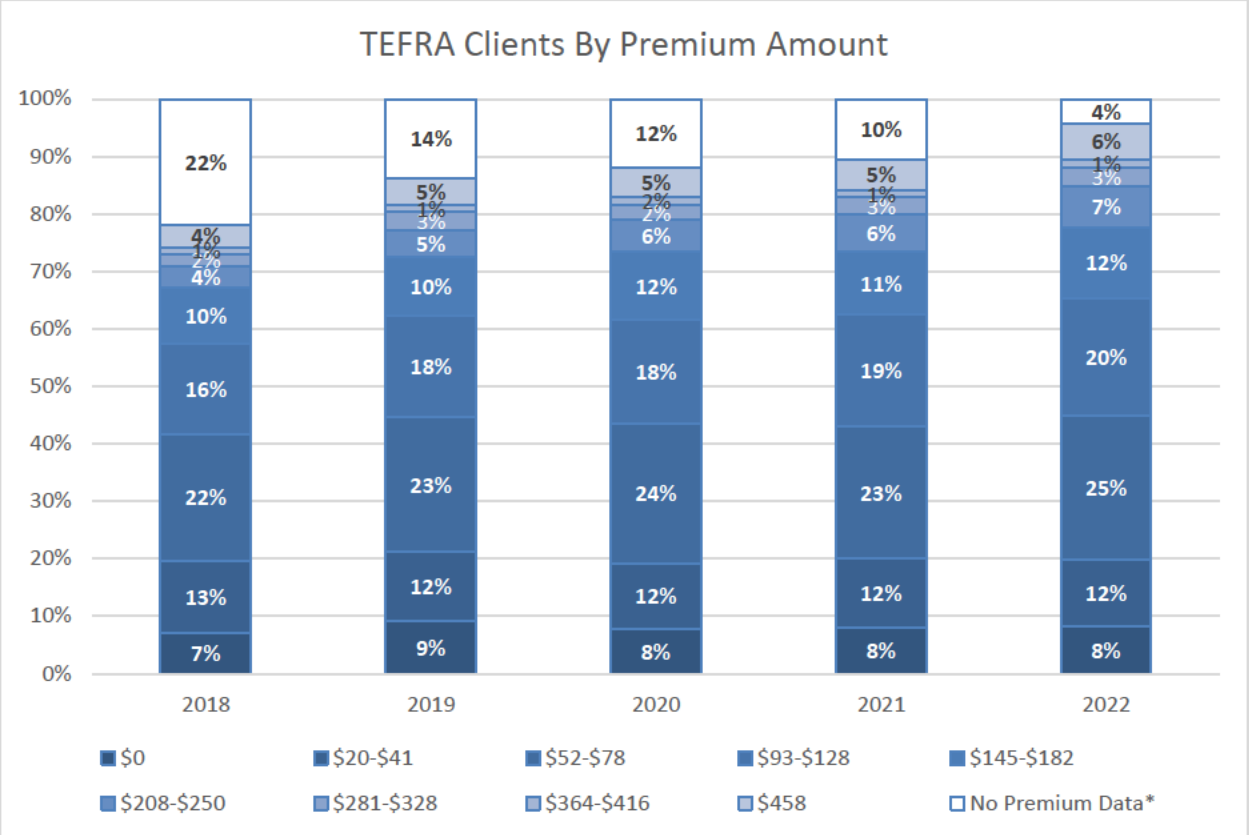
Client Enrollment

Throughout the current demonstration period the TEFRA program has served an increasing number of enrollees, allowing Medicaid to serve more clients who would otherwise require institutional care. During the current demonstration period enrollment started at just under 5,000 TEFRA enrollees. Enrollment rose by more than 20%, peaking at just under 6,000 enrollees by June of 2021. The following charts show the number of enrollees by month since the beginning of the currently approved renewal period.



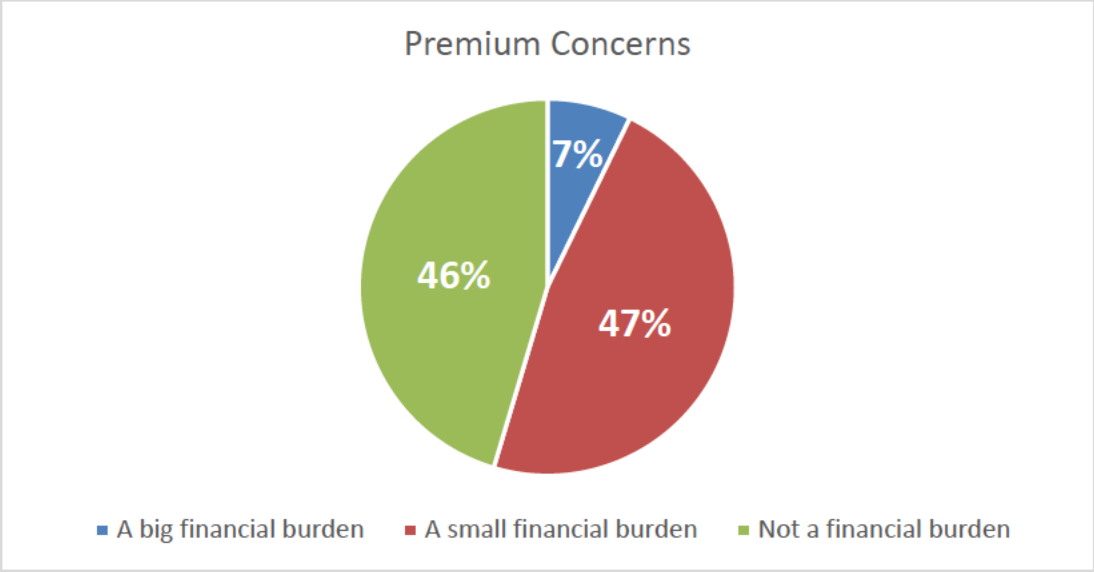
Monthly Enrollment				
	2018	2019	2020	2021
Jan	4,946	5,192	5,375	5,788
Feb	4,966	5,228	5,353	5,856
Mar	5,023	5,236	5,353	5,902
Apr	4,996	5,220	5,334	5,930
May	5,044	5,251	5,408	5,959
Jun	5,043	5,265	5,453	5,959
Jul	5,030	5,296	5,505	5,903
Aug	5,062	5,323	5,555	5,829
Sep	5,038	5,309	5,600	5,812
Oct	5,063	5,345	5,645	5,793
Nov	5,087	5,373	5,671	5,705
Dec	5,129	5,405	5,734	5,670

At the start of 2022, 88% of clients were required to pay a monthly premium. The majority of clients (between 60% and 70% each year of the demonstration) pay premiums between $20 and $182 per month.



*No premium data were available for some clients for the date the numbers were obtained. There are two main factors resulting in clients with no premium data: 1.) The client's eligibility was approved less than a month before the date the data were obtained. According to Division of County Operations policy F-172, premiums begin a month after eligibility is approved or 2.) The client shifted between TEFRA coverage and SSI. Some children who receive SSI may intermittently lose their SSI due to fluctuating parental income and may be eligible for TEFRA in the non-SSI months. According to DCO policy I-540, children with alternating TEFRA and SSI eligibility will not be assessed a premium for the TEFRA months.

In the 2021 TEFRA Beneficiary Survey (see Appendix D and Attachment 3), just 7% of respondents said the premiums were "a big financial burden." The other 93% said it was only a small financial burden or not a burden at all.



The premiums collected from clients ranged from $5.3 million in 2018 to $6.5 million in 2021, as shown in the following table. The premium payments continue to provide an important offset to the cost of providing this care under the TEFRA program. In 2021, the premiums collected reduced program expenditures by 8%.

Premiums Collected			
2018	**2019**	**2020**	**2021**
$5,302,962	$5,595,945	$5,448,201	$6,503,116

Future goals of the program.

Improve customer service experience: While TEFRA clients responding to the 2021 Beneficiary Satisfaction Survey (see Appendix D and Attachment 3) highly rate their ability to access care through the TEFRA program and the care they receive from providers, some components of the TEFRA program do not score as high. Just 44.1% of clients who responded to the survey and had an interaction with TEFRA customer service rated their experience 8 or higher on a scale of 1 to 10. While most gave customer service high marks for courteous treatment, only 61.2% said they received the help they needed. Clients noted that the most frequent problems were related to long wait times, frequent transfers and staff who could not answer their questions.

In 2021, DHS initiated monthly meetings between the Division of Medical Services (DMS), the Division of County Operations (DCO) and the TEFRA Premium Unit to discuss and resolve TEFRA beneficiary issues and facilitate better communication between the three areas. Representatives from the Developmental Disabilities Services and the Medical Review Team will be added to the group. Responses to the TEFRA

beneficiary survey have been shared with DCO and the TEFRA Premium Unit, including a breakdown of respondents' scores for the two units individually. These meetings will also ensure policy information and implementation are streamlined and that DHS provides the same information to beneficiaries across the organization.

DHS also proposes the development of a TEFRA procedure manual that describes eligibility processes, notification schedules, premium payment procedures and frequently asked client questions. The manual will be developed in coordination with DMS, DCO, the Premium Unit and our Medicaid call center, and it will be distributed to all partners to ensure client questions are answered quickly, accurately and with consistency.

DHS is also adding a question to the 2022 TEFRA beneficiary survey specific customer service help with inquiries related to family changes in income for premium reconsideration. DHS has requested that a question be added to the 2022 TEFRA survey to allow the agency to better gauge any issues specific to that issue.

Improve eligibility application process: TEFRA survey respondents also rated the TEFRA application process lower than other aspects of the program. When rating the application process from a 0 to 10, nearly 22% rated the process 5 or below. About 33% of respondents said they "never" or "sometimes" have enough time to complete the TEFRA renewal packet they receive before the deadline.

In April 2018, the State implemented and completed the Tax Equity and Fiscal Responsibility Act "TEFRA" Application Process Improvement Project. Lean Sigma Six methods were used to improve the processes for the TEFRA program, with primary focus on the application process. The ultimate goal for this project was to improve client satisfaction with the TEFRA Program. This project resulted in a variety of improvements the state has already implemented, including the following:

- TEFRA forms were revamped and simplified for TEFRA parents.
- The re-evaluation process was lengthened from 90 days to 120 days to allow more time for the required information to be returned and the re-evaluation to be processed in more timely manner.
- The state converted to a new integrated eligibility system in 2021, which allowed TEFRA applicants to perform a variety of functions online, including completing the application and re-evaluations, reporting changes, uploading documents, submitting requested verifications, and checking the status of their case.

Require less frequent medical redeterminations for clients with certain conditions: Some TEFRA clients have long-term or chronic conditions that do not need to be reidentified every year. DHS would like to establish a list of long-term or chronic conditions and require TEFRA clients with these conditions to obtain a medical redetermination only every three years, rather than the current annual process. These TEFRA clients would still reapply and meet financial requirements annually, but they would no longer need to be medically redetermined every year. Reducing the frequency of medical redeterminations would eliminate unnecessary paperwork and reduce some of the burden of renewals on these families, providers and DHS staff processing renewals.

Formalize the grievance process for the TEFRA program: Currently DHS's vendor for handling beneficiary relations and Medicaid call centers accepts and documents client grievances. However, DHS would like to develop a more formalized process for taking grievances, processing them and developing program corrections based on valid grievances.

Improve convenience for TEFRA clients by enabling premium payment by credit card: Currently TEFRA clients can make their monthly premium payment by check or by bank draft. Clients have asked for the ability to pay their premium by credit card as a third payment option. DHS is working to allow this functionality to offer additional convenience for TEFRA families without adding any additional expense to the TEFRA program.

Appendix B:

See Attachment 4 for the TEFRA-like Demonstration Budget Neutrality Workbook.

During the current demonstration period, the Arkansas TEFRA-like program has consistently operated under the budget neutrality levels set by #43 of the Special Terms and Conditions. The total expenditures increased 5% on average each year during the period, while the number of member months increased an average of 4% each year.

	CY2017	CY 2018	CY 2019	CY 2020	CY 2021
-	DY15	DY16	DY17	DY18	DY19
TOTAL EXPENDITURES	$67,168,894	$64,101,606	$75,331,470	$74,432,259	$82,324,145
TOTAL PREMIUMS COLLECTED	$(3,700,729)	$(5,302,962)	$(5,595,945)	$(5,448,201)	$(6,503,116)
ELIGIBLE MEMBER MONTHS	59,623	60,427	63,443	65,986	70,106
PMPM COST	$1,126.56	$1,060.81	$1,187.39	$1,128.00	$1,174.28
BUDGET NEUTRALITY LIMITS	$1,935.26	$1,143.87	$1,181.39	$1,220.14	$1,260.16

Arkansas proposes extending the current TEFRA demonstration with an expected 4.1% annual increase in member months. The per member per month cost will not exceed a 1% annual increase, provided in the table below.

	CY 2022		CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
			DEMONSTRATION YEARS (DY)				
	DY 00	DEMO TREND RATE	DY 01	DY 02	DY 03	DY 04	DY 05
Eligible Member Months	73,001	4.1%	76,016	79,156	82,425	85,829	89,374
PMPM Cost	$1,186.49	1%	$1,198.83	$1,211.30	$1,223.90	$1,236.63	$1,249.49
Total Expenditure			$91,130,665	$95,881,435	$100,879,892	$106,138,836	$111,671,718

Appendix C:

Evaluation Activities

Arkansas submitted the Interim Evaluation for the current demonstration period on Dec. 29, 2021, and is continuing work on the Summative Evaluation, which is due June 30, 2024. See Attachment 5, Arkansas TEFRA-Like Demonstration Draft Interim Evaluation Report.

The State's current evaluation has measured the demonstration's performance toward achieving the following four goals:

1. *Enrollees have equal or better access to health services compared to the Medicaid fee-for-service population.*
2. *Enrollees have access to timely and appropriate preventive care.*
3. *Clients perceive an increase in their access to health care services and experience in the quality of care after enrolling in TEFRA.*
4. *Client premiums are affordable, they do not create a barrier to health care access, and the proportion of clients who experience a lockout period for nonpayment of premiums is relatively low.*

The Interim Evaluation compared the TEFRA-like demonstration enrollees with a group of patients with specific medical conditions within the TEFRA-like target group. The evaluation used claims-based measures and Beneficiary Survey responses to examine the demonstration's outcomes and clients' experience with accessibility, therapy services, overall health care, premiums, and other relevant aspects of the program. (The most recent results of the Beneficiary Survey were not available when the Interim Evaluation was completed.)

Results presented in the interim evaluation show that the demonstration was effective in achieving the majority of goals and objectives established at the beginning of the current TEFRA-like demonstration.

Findings to date

Goal 1: *Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population.*

- Almost half of TEFRA-like population received at least one therapy service (speech, occupational, or physical therapy).
- On average, 90% of TEFRA-like survey respondents responded that they had no problem getting special therapy services between 2018 and 2019.
- In both CY2018 and CY2019, TEFRA-like clients had a slightly higher rate of Proportion for Days Covered (PDC) on general prescriptions as compared to non-TEFRA-like clients (57.4% vs. 56.1%).
- All regions of the state, except the southwest, decreased in the rate of TEFRA-like clients that met the PDC with a threshold of 50% on general prescriptions between CY2018 and CY2019.
- The average cost of prescription per TEFRA client decreased between CY2019 vs. CY2018.
- The percentage of clients younger than 19 years of age taking at least two seizure medications during CY2018 and CY2019 was significantly different between TEFRA-like (higher rates) vs. non-TEFRA-like clients (lower rates).

Goal 2: *Ensuring demonstration enrollees have access to timely and appropriate preventive care.*

The evaluation for utilization of preventive care service and access to care for new or existing enrolled Arkansas TEFRA-like clients suggests this population had improved access to timely care and higher (or not significantly different) utilization rates compared to a population of Medicaid non-TEFRA-like clients. The specific findings include the following.

- For CY2019, more than a third (38.7%) of newly enrolled TEFRA-like clients received their first health care visit with a PCP or for a speech, occupational, or physical therapy service within 60 days of enrollment.
- The measure regarding a first health care visit to a PCP within 60 days improved by 16% over 2018. However, the difference was not statistically significant.
- Nearly 75% of the TEFRA-like population had at least one Medicaid claim paid by third party liability (TPL) coverage during CY2018 and CY2019.
- TEFRA-like clients had a higher rate of utilization compared with non-TEFRA-like clients in both CY2018 and CY2019.
- Durable Medical Equipment (DME) coverage was significantly different between TEFRA-like (higher rates) and non-TEFRA-like clients in both CY2018 and CY2019.

Goal 3: *Ensuring enrollment in the demonstration increases clients' perceived access to health care services and experience in the quality of care received.*

- The TEFRA-like clients' experience of “getting care quickly” (obtaining care right away for an illness/injury/condition) slightly increased from 2018 to 2019 (97.0% and 97.9%).
- In comparing the TEFRA Beneficiary Satisfaction Survey vs. the Beneficiary Satisfaction Surveys for ARKids First A or ARKids First B, there was no significant difference found in the scores for “getting care quickly,” “how well doctors communicate,” and “overall health care.”
- Clients reported fewer problems after enrolling in TEFRA with seeing a “personal doctor or nurse” and getting prescription medications/urgent care.

Goal 4: *Ensuring premium contributions are affordable, that they do not create a barrier to health care access, and that the proportion of clients who experience a lockout period for nonpayment of premiums is relatively low.*

- The Beneficiary Survey’s financial burden scores found premiums in the last six months to be less of a cost barrier in 2019 than in 2018.
- The 2018 TEFRA Disenrollee Beneficiary Survey scores identified the top five reasons a client’s case was closed as:
  1. "No longer eligible"
  2. "Other"
  3. "Could not afford premium payment"
  4. "TEFRA services no longer needed"
  5. "Could not complete paperwork on time", and "Obtained other coverage"

Plans for evaluation activities over the requested extension period.

For the summative evaluation of the current TEFRA-like demonstration and the evaluation of the requested extension period, DHS is considering changes to its TEFRA evaluation design to enhance its methodology, if approved by CMS. The potential changes include:

1) Changing the comparison population to include the Provider-Led Arkansas Shared Savings Entity (PASSE) population if the primary medical and behavioral health conditions are similar to the TEFRA-like population. The current evaluation uses a comparison group that consists of patients of similar age and diagnosis characteristics as the TEFRA-like population, but DHS believes the comparison population could be a better match if PASSE clients were included in the analysis.
2) Exploring other data sources including other payors' medical claims from the Arkansas All-Payer Claims Database (APCD) for the TEFRA-like population. Nearly three-quarters of TEFRA clients have additional health insurance coverage. Because the analysis for the interim evaluation included only Fee for Service (FFS) claims, the evaluation did not consider health services TEFRA clients received that were covered by third party liability. The inclusion of additional data will ensure the evaluation explores a broader array of information in the measure calculations. The two data sources are Provider-Led Arkansas Shared Savings Entity (PASSE) encounter claims for clients enrolled in the new Medicaid program (launched March 1, 2019) and medical claims from other insurance carriers for individuals with TPL medical claims.
3) Adding a longitudinal analysis by trending the TEFRA-like population over time. Since the TEFRA demonstration waiver has been successful in serving a population with high treatment needs and the population medical needs are unique, DHS would like to explore a longitudinal design for future evaluations.

Appendix D:

Quality of and Access to Care

The TEFRA program does not employ External Quality Review Organizations or managed care organizations to provide quality assurance monitoring. Instead, quality of and access to care provided by the demonstration are measured by the program evaluation discussed in Appendix C and by annual surveys of TEFRA clients. See Attachment 3 for the TEFRA-like demonstration waiver's 2021 Beneficiary Satisfaction Survey Report.

Beneficiary Satisfaction Survey Report

TEFRA clients responding to the Beneficiary Satisfaction Survey highly rate their ability to access care quickly through the TEFRA program as well as the care they receive from providers. Clients rated their access to special therapies (speech, occupational and physical therapies) particularly high. The Beneficiary Survey found the number of respondents reporting as "no problem" the ability to see a personal doctor or nurse, get prescriptions, and receive urgent care increased after enrolling in the TEFRA program compared with their experience before enrolling. Improvements have also been made in clients' ability to get the specialty items (e.g., diapers, formula, dietary supplements) and special medical equipment or devices (e.g., walker, wheelchair, nebulizer, feeding tubes) they need. Additionally, more than 70% of respondents rated the TEFRA program overall as an 8 or higher on a scale of 0-10.

	2019	2020	2021
Composite Scores (Respondents who answered favorably ("usually"/"always" or "not a problem") to questions in each category. Percentages for category questions are averaged for composite percentage.)			
Getting care quickly	95%	92%	96%
How well doctors communicate	95%	94%	95%
Customer service	66%	76%	74%
Special equipment and supplies	64%	71%	73%
Special therapies	90%	91%	90%
Ratings Percent of respondents who gave an 8, 9, or 10 on a scale of 0 to 10.			
Rating of health care professional	92%	93%	93%
Rating of health care	90%	90%	93%
Rating of treatment or counseling	70%	81%	76%
Rating of TEFRA program	73%	76%	71%
Rating of customer service	39%	52%	44%
Rating of TEFRA application process	53%	55%	54%

The following are additional highlights from the TEFRA Beneficiary Survey demonstrating the program provides high quality care and client satisfaction.

CHILD'S HEALTH CARE PROFESSIONAL

- A majority (60.2%) of parents/caregivers responding to the survey indicated that the type of health care professional their child sees most often was a personal doctor/ family doctor/primary care physician.
- Of those who needed a referral to see a specialist, 77.9% reported that it was not a problem getting a referral.
- A large majority (88.8%) reported no problem getting a health care professional with whom they are happy.
- 93.1% of respondents rated their child's health care professional an 8 or higher on a scale from 0 to 10. More than half (55.5%) of the parents/caregivers rated their child's health care professional as the "Best health care professional."
- In all, 89.6% of parents/caregivers indicated their child went to his or her doctor's office or clinic at least one time in the last six months.

TEFRA PREMIUMS

- Just 7.2% of respondents indicated that the premiums were a big financial burden.
- Less than 1% of respondents reported losing TEFRA eligibility because the premiums were too expensive to pay.

EXPERIENCE WITH TEFRA/MEDICAID PROGRAM

While TEFRA clients responding to the 2021 Beneficiary Satisfaction Survey highly rate their ability to access care through the TEFRA program and the care they receive from providers, some components of the TEFRA program do not score as high.

- Just 44.1% of clients who responded to the survey and had an interaction with TEFRA customer service rated their experience 8 or higher on a scale of 1 to 10.
- Of all the respondents who called Medicaid customer service, 63.6% indicated that the person was able to answer all their questions about the TEFRA program. Of the respondents whose questions were answered, 94.3% "usually" or "always" understood the answers that customer service gave.
- Clients noted that the most frequent problems were related to long wait times, frequent transfers and staff who could not answer their questions. TEFRA survey respondents also rated the TEFRA application process lower than other aspects of the program.
- In the last six months, 19% of respondents looked for information in written materials or on the internet about how TEFRA works. About half of the respondents (49.4%) who searched for this information indicated that they "usually" or "always" found it.
- The percentage of respondents rating their experience with the TEFRA application process with a score of 8 or higher was 53.8%, which is slightly lower than the previous year of 54.5%.

- More than half of respondents (63.9%) were given forms to fill out from TEFRA in the last six months. Of those who completed paperwork, slightly more than half (52.1%) found the forms "usually" or "always" easy to fill out.
- About 33% of respondents said they "never" or "sometimes" have enough time to complete the TEFRA renewal packet before the deadline. These application process and customer service are program areas DHS has identified as opportunities for program improvement. See Appendix A for a description of DHS's plans for improvement in these areas.
- Less than one-third (28.9%) experienced some problem receiving care while they waited for their child's TEFRA application to be processed.

Appendix E:

Public Notice Process

An abbreviated public notice was run for three consecutive days in the *Arkansas Democrat Gazette*, the State's largest newspaper with the largest circulation, notifying of the places, dates and times of two public input hearings and 30-day comment period (May 22, 2022, through June 20, 2022) for the purpose of obtaining input from the public on the TEFRA-like 1115 demonstration waiver's extension renewal application to extend the demonstration for an additional five years. The notice provided information on where a copy of the TEFRA-like demonstration waiver's extension renewal application could be obtained and where comments could be sent (see Attachment 6 for a copy of notice and Attachment 7 for newspaper clippings of the notice). This notice was also posted to the State's Medicaid website, along with the full application, attachments and a full notice (see Attachment 9).

Public comments were accepted between May 22, 2022, and June 20, 2022. Two comments were received during the 30-day comment period.

One public input hearing was held May 24, 2022, in Little Rock, Arkansas. The meeting was held in conjunction with a meeting of the legislative Task Force on Autism. A video of the meeting can be found at this link: Arkansas Legislature (sliq.net). (The public hearing begins at 2:31:40.) No attendees asked to make a formal public comment at this hearing pertaining to the proposed TEFRA-like demonstration waiver extension renewal application were provided. However, one member of the Task Force on Autism expressed support for the proposed provision to allow some TEFRA clients to be medically redetermined only every three years.

The second public input hearing was held on June 2, 2022, in Little Rock, Arkansas. This public input hearing was held as a Zoom meeting and therefore involved web conference capabilities. No members of the public attended this hearing. See Attachment 8 for a transcript of this public hearing.

The following comment was received separate from the two public hearings. The comment comes from Renee Holmes, Director of Autism Services, Partners for Inclusive Communities, University of Arkansas:

> *We utilized TEFRA eligibility for Medicaid coverage for my son Carson for 18 years. He initially became eligible for TEFRA at 9 months old and remained covered under the program until just after his 18th birthday, when his adult SSI was approved. Carson has an SCN2A genetic mutation that causes intractable epilepsy and autism. We have been very grateful that Arkansas has made this service available for families like ours. We would not have been able to provide the support, therapies and seizure medications that are required to allow Carson to thrive with us in our home without his TEFRA coverage. Our premiums have always been a fraction of the cost of the services that were made available to him under his TEFRA coverage. I am very happy to hear that the required medical review process is being addressed in this renewal process. This would allow families the lighten their stress load that came with the TEFRA renewals. Even though I fully knew that Carson's diagnoses and needs would allow for continued TEFRA coverage, those MRT review years were always more stressful. This is a very welcomed relief for the other families who are currently utilizing Arkansas' TEFRA eligibility.*

DHS thanks the commenter for her submission.

Attachments

Attachment 1: TEFRA-like Demonstration Special Terms and Conditions
Attachment 2: State's original narrative summary of the initial TEFRA-like Demonstration
Attachment 3: TEFRA-like Demonstration Waiver's 2021 Beneficiary Satisfaction Survey
Attachment 4: TEFRA-like Demonstration Budget Neutrality Workbook
Attachment 5: Arkansas TEFRA-like Demonstration Draft Interim Evaluation Report
Attachment 6: Abbreviated Public Notice
Attachment 7: Newspaper clippings of the notice
Attachment 8: Public input hearing transcript
Attachment 9: Comprehensive Public Notice

ATTACHMENT 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

May 9, 2018

Dawn Stehle
Deputy Director for Health and Medicaid Director
Division of Health and Medicaid Services
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

Dear Ms. Stehle:

The Centers for Medicare & Medicaid Services (CMS) is approving Arkansas' request to extend its section 1115 demonstration project, entitled, "Arkansas TEFRA-like Section 1115 Demonstration" (Project No. 11-W-00163). CMS' approval of this demonstration extension is granted under the authority of section 1115(a) of the Social Security Act (the "Act") and is effective as of the date of this letter through December 31, 2022.

The Arkansas TEFRA-like Section 1115 Demonstration provides services to disabled children who meet the criteria for the optional Medicaid category commonly referred to as the "Katie Beckett Option" that was enacted into Medicaid law under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) (P.L. 97-248). The "TEFRA population" (also known as "Katie Beckett children") are children age 18 or younger with long-term disabilities, mental illness, or complex medical needs, in families with income that is too high to qualify for Medicaid, who could become Medicaid eligible if receiving extended care in an institutional setting. The TEFRA Medicaid eligibility option allows these disabled children to become Medicaid eligible based on their own income and resources in order to receive medical services in (less-costly) home-settings instead of in an institution. Arkansas uses section 1115 authority to provide coverage to TEFRA-eligible children but with a condition of coverage that monthly premiums are assessed for families with income above 150 percent of the Federal Poverty Level. However, a family's total annual cost-sharing is capped at five percent of the family's annual gross income.

All Medicaid title XIX requirements as expressed in law, regulation and policy statement not expressly waived or identified as not applicable in these approval documents shall apply to this demonstration. Arkansas' authority to deviate from Medicaid requirements is limited to the specific authorities described in the enclosed approval documents and to the purpose(s) indicated.

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstration is likely to assist with promoting the objectives of Medicaid. Consistent with federal transparency requirements, CMS also considers all public comments received during both the state and federal public input periods when evaluating whether the demonstration project as a whole will likely assist in promoting the objectives of Medicaid.

Arkansas and CMS did not receive any public comments during the state and federal public comment periods. However, several hundred comments noted in a Beneficiary Satisfaction Survey accompanying the state's extension application were reviewed. The commenters overwhelmingly were in support of the TEFRA-like demonstration and expressed gratitude for the services provided by this demonstration as being critical to being able to care for their children with special healthcare needs in the home instead of an institution. However, many of these same commenters, as well as others, expressed concerns about inefficient initial application and renewal processes, lack of timely notice and timeframe for families to submit annual renewal paperwork, lack of knowledgeable TEFRA-specific state workers/customer service representatives or long telephonic customer service wait times, and insufficient information and communication from the state regarding available TEFRA services, participating providers, and family requests for reconsideration of the monthly premium amount due to changes in income.

After review of all the materials submitted by the state, including the comments from the state's TEFRA Beneficiary Satisfaction Survey report, CMS has determined that Arkansas' TEFRA-like demonstration should be extended because it is likely to assist with promoting the objectives of title XIX of the Act by improving access to high-quality, person-centered services that produce positive health outcomes for individuals. Despite the concerns raised, Arkansas has achieved its stated objectives and successful demonstration outcomes such as access to care following TEFRA enrollment improving from 75 percent to more than 90 percent; more than 95 percent of surveyed TEFRA parents report a "high level of satisfaction" with obtaining physician services needed for their children; and the proportion of TEFRA beneficiaries who experienced a lockout period remained low at 3.94 percent instead of the projected 5 percent. CMS has determined based on the state's evaluation outcomes, that the issues raised during the state's public input period did not preclude the state from meeting its intended goals and objectives for the demonstration and for title XIX. However, to mitigate these concerns, CMS has included provisions in the enclosed set of STCs to require Arkansas to monitor and report to CMS its progress on remediating these issues until resolved as agreed upon by CMS and the state. Provisions also include requiring the state to solicit input on its progress from all interested stakeholders during the federally-required annual post-award public forum to be held by the state, with a summary report to be included in the state's annual monitoring report.

CMS' approval of this demonstration is also conditioned upon compliance with these STCs and associated expenditure and non-applicable authorities that define the nature, character, and extent of anticipated federal involvement in this demonstration project. This award is subject to the state's written acknowledgement of the award and acceptance of the enclosed STCs and associated expenditure and non-applicable authorities within 30 days of the date of this letter.

Your CMS project officer for this demonstration is Mr. Emmett Ruff, who can be contacted to answer any questions concerning the implementation of this demonstration at 410-786-4252 or at Emmett.Ruff@cms.hhs.gov. Official communications regarding program matters and correspondence concerning the demonstration should be submitted to him at the following address:

Emmett Ruff
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mailstop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Centers for Medicare & Medicaid Services
1301 Young Street
Room 714
Dallas, TX 75202
E-mail: Bill.Brooks@cms.hhs.gov

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

Sincerely,

/s/

Tim Hill
Acting Director

Enclosures

cc: Bill Brooks, ARA, CMS Dallas Region
Stacey Shuman, State Lead, CMS Dallas Region

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

NUMBER: **11-W-00163/6**

TITLE: **Arkansas TEFRA-like Section 1115 Demonstration**

AWARDEE: **Arkansas Department of Health and Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Arkansas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XIX plan. All requirements of the Medicaid statute will be applicable to such expenditure authorities (including adherence to income and eligibility system verification requirements under section 1137(d) of the Act), except those specified below as not applicable to these expenditure authorities.

The following expenditure authority and the provisions specified as "not applicable" enable Arkansas to operate its demonstration effective as of the date of the associated CMS approval letter through December 31, 2022:

- Expenditures for a targeted application process for services provided to children age 18 or younger, who require an institutional level of care, and meet the criteria for a child eligible for Medicaid under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) (promulgated in section 1902(e)(3) of the Act). This optional coverage group is also known as the "Katie Beckett" coverage option.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Cost Sharing **Section 1902(a)(14) insofar as it incorporates Section 1916**

To enable Arkansas to charge a sliding scale monthly premium to custodial parent/guardian(s) of eligible children with annual family income above 150 percent of the federal poverty level and to implement periods of enrollee ineligibility for failure to pay applicable monthly premiums.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00163/6**

TITLE: **Arkansas TEFRA-like Demonstration**

AWARDEE: **Arkansas Department of Health and Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Arkansas TEFRA-like section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the Arkansas Department of Health and Human Services (state) and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. This demonstration extension is approved through December 31, 2022. All previously approved STCs are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Arkansas TEFRA-like demonstration was initially approved October 17, 2002 and implemented on January 1, 2003. The demonstration provides services to disabled children eligible for Medicaid under section 134 of the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA (also known as the Katie Beckett Option after the child whose plight inspired Congress to enact this option into Medicaid law) is an optional Medicaid category of coverage that was developed to allow children with disabilities, whose family has income that is too high to qualify for Medicaid, to gain Medicaid eligibility based on the income and resources of the child. These TEFRA children receive medical care in home-based settings rather than in institutions (which was a requirement for these children to become Medicaid eligible before

enactment of the "Katie Beckett waiver" under the Tax Equity and Fiscal Responsibility Act (TEFRA)).

Prior to 2002, Arkansas opted to cover these children under the optional TEFRA coverage category under the Medicaid State Plan. While this Medicaid State Plan coverage allowed children with disabilities to remain in their homes, it ultimately placed an unsustainable financial burden on the state. To address the financial viability of the program while maintaining coverage of this population of children with disabilities, the state chose to transition coverage of the "TEFRA population" from the Medicaid State Plan to a section 1115 demonstration program, under which the state can charge premiums for the TEFRA child's coverage based on family income and implement a lock-out period for nonpayment of premiums. Accordingly, Arkansas has been providing coverage to the TEFRA population of children under section 1115 authority consistently since January 1, 2003 pursuant to several extensions approved by CMS.

On October 18, 2017, Arkansas submitted a request to extend the demonstration for a three-year period with no program changes. CMS is approving this extension request for a period of five years, through December 31, 2022, as agreed upon with the state, in accordance with guidance outlined in the November 6, 2017 Center for Medicaid & CHIP Services (CMCS) Informational Bulletin on Section 1115 Demonstration Process Improvements. These STCs, accompanying the CMS approval letter, permit section 1115 demonstration authority for the Arkansas TEFRA-like Demonstration through December 31, 2022.

The waiver and expenditure authorities granted by this demonstration meets the objective of Medicaid to improve access to high-quality, person-centered services that produce positive health outcomes for individuals because it permits Arkansas to continue to provide coverage to children with long-term disabilities, mental illness, or complex medical needs in home-settings instead of more costly institutions.

Arkansas will continue to test the below hypotheses and goals for this demonstration, which CMS and Arkansas expects will also continue to promote Medicaid program objectives by:

- Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population;
- Ensuring demonstration enrollees have access to timely and appropriate preventive care;
- Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and satisfaction in the quality of care received; and,
- Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low.

III. GENERAL PROGRAM REQUIREMENTS

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

of 1975.

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

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.

   b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **Changes Subject to the Amendment Process**. Changes related to demonstration features such as eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state must not implement changes to these demonstration elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 6 below.

6. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS in writing for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to,

the following:

a) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit;

c) An explanation of the public process used by the state consistent with the requirements of STC 14; and

d) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

7. **Extension of the Demonstration**. States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 8.

8. **Demonstration Phase Out.** The state may only suspend or terminate this demonstration, in whole or in part, at any time prior to the date of expiration consistent with the following requirements:

   a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the effective date and reason(s) for the suspension or termination. At least six months before the effective date of the demonstration's suspension or termination, the state must submit to CMS its proposed transition and phase-out plan, together with intended notifications to demonstration enrollees. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 14. Once the 30-day public comment period has ended, the state must provide a summary of public comments received, the state's response to the comments received, and how the state incorporated the comments received into the transition and phase-out plan submitted to CMS.

   b) Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or

determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c) Phase-out Plan Approval: The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

d) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, §431.210 and §431.213. In addition, the state must assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as found in 42 CFR §435.916.

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

f) Enrollment Limitation during Demonstration Phase-Out: If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

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

9. **CMS Right to Amend, Suspend, or Terminate.** CMS may amend, suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the amendment, suspension or termination, together with the effective date.

10. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $1,000,000 per deliverable (federal share) when items required by these STCs (e.g., monitoring reports, evaluation design documents, required data elements and analyses, presentations, and any other deliverable specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a) Thirty days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

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

i. CMS may decline the extension request.
ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

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

d) As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from extending a demonstration or obtaining a new demonstration.

e) CMS will consider with the state an alternative set of operational steps for implementing the deferral associated with this demonstration to align the process with any existing deferral process the state is undergoing (e.g., the quarter the deferral applies to and how the deferral is released).

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

12. **Withdrawal of Waiver/Expenditure Authority.** CMS reserves the right to amend or withdraw waiver and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the amendment or withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education,

outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice, Tribal Consultation and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR §431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a) (73) of the Act, 42 CFR §431.408(b), State Medicaid Director Letter #01-024, or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

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

IV. ELIGIBILITY AND ENROLLMENT

16. **Eligibility for the Demonstration.** The TEFRA-like demonstration provides Medicaid State Plan services to children who were previously included in the state's optional Medicaid TEFRA Program. To be eligible for this demonstration, all of the following eligibility criteria must be met:

    a) Child must be age 18 or younger;
    b) Child must met the Social Security Administration's definition of disability;
    c) Child must be a U.S. citizen or qualified alien;
    d) Child must have established residency in the state of Arkansas;
    e) Child must have a Social Security Number or have applied for one;
    f) Child's annual gross countable income must be less than the current Medicaid State Plan income limit established for long-term care services in accordance with section 1902(a)(10)(A)(ii)(V) of the Act (i.e., the child would be Medicaid eligible if institutionalized);
    g) Child countable assets do not exceed $2,000 (parent(s) assets are not considered);
    h) Child meets the medical necessity requirement for institutional placement, or level of care, or be at risk, in the future, for institutional placement. Institutional placement or level of care includes:

        i. An acute care facility including acute care mental health facilities;
        ii. A skilled nursing facility;
        iii. Residential placement at the Immediate Care Facility for Individuals

with Intellectual Disabilities (ICF/IID) level of care; or

iv. Alternative Home placement as a child if risk of placement is due to the medical condition of the child.

i) If eligibility criteria a – h is met, the child must also have access to medical care in the home, it must be deemed appropriate to provide such care outside an institution, and the estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

17. **Enrollment and Choice.** The state will facilitate eligibility and enrollment into the appropriate title XIX or title XXI program for families applying for the TEFRA-like demonstration. Families applying to participate in the TEFRA-like demonstration will be assessed for all basis of title XIX or title XXI eligibility and if found to be eligible under more than one eligibility group/program, the family shall be counseled on the benefits of and any applicable beneficiary cost-sharing for each eligible program, and given the opportunity to make an informed choice of which program to enroll.

18. **Enrollment in other Health Insurance.** A child can be enrolled and receive TEFRA-like demonstration services and retain other creditable health insurance coverage. A family who voluntarily drops other creditable health insurance coverage for the coverage provided by this demonstration, will result in the child being determined ineligible for demonstration benefits for a period of six months from the date the insurance is dropped. At the annual reevaluation of eligibility, if it is determined that creditable health insurance coverage was voluntarily dropped after TEFRA eligibility was approved, the case will be closed for six months beginning with the month following the month of discovery (i.e., TEFRA-like demonstration eligibility will end for a period of six months).

V. BENEFITS AND DELIVERY SYSTEMS

19. **Benefits**. Individuals enrolled in the demonstration receive coverage for all Medicaid State Plan benefits.

20. **Service Delivery.** Services provided under the demonstration are delivered through the state's existing network of Medicaid providers and reimbursed on a fee-for-service basis. Demonstration beneficiaries must select a primary care physician through which to receive eligible demonstration services.

VI. COST SHARING

21. **Program Premiums.** As a condition of participation, custodial parent(s) with income above 150 percent of the Federal Poverty Level (FPL) (after applicable deductions as determined by the state) will be required to pay a sliding monthly premium based on the following schedule:

Family Income		Monthly Premiums (applicable only to families with incomes in excess of 150 percent of the FPL)		
From	To	Percent	From	To
$0	$25,000	0%	$0	$0
$25,001	$50,000	1.00%	$20	$41
$50,001	$75,000	1.25%	$52	$78
$75,001	$100,000	1.50%	$93	$125
$100,001	$125,000	1.75%	$145	$182
$125,001	$150,000	2.00%	$208	$250
$150,001	$175,000	2.25%	$281	$328
$175,001	$200,000	2.50%	$364	$416
$200,001	No Limit	2.75%	$458	$458

22. Payment of Premiums.

a) At the time of the initial TEFRA eligibility determination, ~~P~~premium payments, if applicable, are assessed beginning in the month after TEFRA demonstration eligibility is approved. The premium will be charged on a monthly basis and will not be pro-rated. When a TEFRA applicant is approved for eligibility, a Notification Packet is auto-triggered from the state's Medicaid Management Information System (MMIS) and sent to the custodial parent(s)/guardian of the newly enrolled TEFRA beneficiary. This Notification Packet includes a notification letter of approval for TEFRA, a TEFRA Premium Payment Selection form on which the custodial parent(s)/guardian is provided the option of authorizing an automatic bank draft or making quarterly payments in advance for payment of the TEFRA premium and a postage paid envelope in which to return the completed TEFRA Premium Payment Selection form. After the custodial parent(s)/guardian selects the method they wish to use for payment of the TEFRA premium, the state's TEFRA Premium Unit thereafter collects the TEFRA premium payments and sends premium invoices to TEFRA eligible enrollees' custodial parent(s)/guardian.

For the custodial parent(s)/guardian who choose to pay their TEFRA premium through monthly bank draft, the state's TEFRA Premium Unit will draft the custodial parent(s)/guardian's account on the third month after initial approval and each following month thereafter. Each draft will be made on the first day of the covered month. The state's TEFRA Premium Unit will send monthly invoices to the custodial parent(s)/guardian notifying their bank account has been drafted. For the custodial parent(s)/guardian who choose quarterly payments, the custodial parent(s)/guardian must initially pay for the month after the month of approval and the following month in advance by check, after which the state's TEFRA Premium Unit will send monthly invoices requesting premium payment in the month prior to the covered quarter. The draft or quarterly payment will begin with the third month after the month of approval. Regardless of payment choice, everyone will be required to pay for the first two months' premiums by check which must be sent in with the Payment Selection Form. Failure to provide the Payment Selection Form or make the two month initial payment will cause the

TEFRA enrollee to be ineligible, and the case will be closed after proper advance notice. The Department of Human Services' (DHS) County Office is notified by the TEFRA Premium Unit if the Payment Selection Form has not been submitted and/or the two month initial payment has not been made.

b) For ongoing cases (i.e., active TEFRA demonstration enrollees), custodial parent(s)/guardian is allowed a 3-month grace period to pay past due premiums. During this 3-month grace period, the TEFRA enrollee's case will not be closed and providers will continue to be reimbursed for covered services. If the premium is not paid after this 3-month grace period, a 10-day advance notice of closure will be provided to the custodial parent(s)/guardian. If the premium payments in arrears are not made within the 10-day window, the case will be closed. If the arrearages are paid after the case is closed, a new application must be submitted for a new determination of demonstration eligibility. If medical necessity and appropriateness of care have been determined within the past 10 months, a new determination will not be necessary.

   If the case has been closed less than 12 months because of premium payments in arrears, the three months of past due premiums must be paid before the child can again be approved to receive TEFRA demonstration services.

   If a case is closed 12 months or more because of premium payments in arrears, the payment of the past due premiums will not be required.

   If TEFRA eligibility for a child ends during a quarter, any premiums already paid for months after the month of closure will be reimbursed. Whether paying by monthly bank drafts or through quarterly payments, if eligibility ends in the middle of the month in which payment has been made, the premium will be prorated and the custodial parent(s)/guardian will be reimbursed for the partial month.

c) The state may attempt to collect unpaid premium debts from the custodial parent(s)/guardian of TEFRA demonstration enrollees, but shall not report the debt to credit reporting agencies, place a lien on an individual's home, refer the case to debt collectors, file a lawsuit, or seek a court order to seize a portion of individual/family earnings. The state also shall not transfer the debt to a third-party. Further, while the debt is collectible by the state, re-enrollment in the TEFRA demonstration is not conditional on repayment after the case has been closed for 12 months as indicated in subpart "b" above.

23. Premium Adjustments. Custodial parent(s)/guardian income will be reviewed annually for purposes of calculating the premium; or, when there is a change that will make a difference of more than 10 percent in annual household income or there is a change in the number of family members. An adjustment can be made to the premium at any time during the year if the custodial parent(s)/guardian reports a significant change in excess of 10 percent of expected annual income or if the custodial

parent(s)/guardian reports there is a change in the household size. Verification of the income change must be provided. The premium can only be adjusted at a maximum of once every six months. If the change in income has significantly lowered enough that the custodial parent(s)/guardian's TEFRA enrolled child could be potentially eligible for full Medicaid or the Children's Health Insurance Program (CHIP) coverage, the state will conduct an eligibility determination for such coverage and work with the custodial parent(s) guardian to facilitate enrollment of the child. Income that fluctuates due to the type of employment (e.g. teachers, farmers, etc.) will not affect the monthly premium.

24. **Cost-sharing Limits.** There are no co-payment requirements for services to TEFRA demonstration enrollees. The total out-of-pocket cost sharing assessed on TEFRA enrollee's custodial parent(s)/guardian (i.e., the premiums assessed on custodial parent(s)/guardian with income in excess of 150 percent of the FPL) shall not exceed five percent of the family's gross income.

VII. GENERAL REPORTING REQUIREMENTS

25. **General Financial Requirements.** The state must comply with all general financial requirements under title XIX and as set forth in section VIII.

26. **Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality as set forth in section IX.

27. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

28. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

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

    b) Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and,

    c) Submit deliverables to the appropriate system as directed by CMS.

29. **Quarterly Operational Progress Updates and Monitoring Calls.** CMS and Arkansas will participate in quarterly conference calls, unless CMS determines that less frequent calls are necessary to adequately monitor the demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration in areas such as health care delivery, enrollment, quality of care, access, benefits, anticipated or proposed changes in monthly premium charges or payment rates, audits, lawsuits, changes in state sources of funding for financing this demonstration,

progress on evaluations, state legislative developments, and any demonstration amendments the state is considering submitting.

These quarterly calls will also be used to address the state's progress in addressing certain operational issues raised during the renewal period of the state's TEFRA demonstration. The primary areas to be addressed during these calls are as follows:

a) Progress with aligning TEFRA demonstration initial and renewal application processes with federal requirements at 42 CFR §435.911 and §435.916, including a report of timeframes for individuals actively pending TEFRA demonstration eligibility determinations;
b) Progress with providing TEFRA-related notices in alignment with federal requirements at 42 CFR §431.211, §435.917 and §435.918; including notices related to family changes in income for premium reconsideration;
c) Progress with improving TEFRA-specific customer service response rate; particularly regarding inquiries related to family changes in income for premium reconsideration; and,
d) Progress with improving information made available (minimally at time of initial application and at annual renewal) on TEFRA services, benefits, participating providers, changes to the sliding scale of monthly premiums required for families with income above 150 percent of the FPL, and instructions for how to pay any applicable premium or to request a change in how family pays any applicable premium.

The state shall submit a narrative update describing its implementation progress on each of these operational issues at least 10 days before the quarterly monitoring call between Arkansas and CMS is held. Arkansas and CMS will jointly develop the date/time and agenda for the quarterly monitoring calls. The state will also be required to report its progress on addressing these specific operational issues as part of the Annual Monitoring Report required in STC 30, until the issue has been deemed resolved upon agreement by CMS and the state.

30. Annual Monitoring Report. No later than 90 days following the end of each demonstration year, the state must submit an annual progress report that represents the status of the demonstration's various operational areas and any state analysis of program data collected for the demonstration year. The Annual Monitoring Report will include all elements required by 42 CFR §431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS (incorporated in these STCs as "Attachment A"), which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis. Each Annual Monitoring Report must minimally include the following:

a) Operational Updates - Per 42 CFR §431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration.

The reports shall provide sufficient information to document programmatic issues or key challenges, underlying causes of issues/challenges, how issues/challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; descriptions of any public forums held, and a summary of program integrity and related audit activities for the demonstration. The Annual Monitoring Report shall also include a summary of all public comments received through the post-award public forum required per 42 CFR §431.420(c) regarding the progress of the demonstration. The state's post-award public forum shall address beneficiary response to the state's reported progress with addressing the issues identified in STC 29(a) – (d), which shall be reported as part of the post-award public forum summary to be included in the Annual Monitoring Report.

b) Performance Metrics – Per 42 CFR §431.428, the Annual Monitoring Report must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys (if conducted) and grievances and appeals. The required monitoring and performance metrics must be included in writing in the Annual Monitoring Report, and will follow the framework provided by CMS to support federal tracking and analysis.

c) Budget Neutrality and Financial Reporting Requirements – Per 42 CFR §431.428, the Annual Monitoring Report must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Annual Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including a total annual member month count for the demonstration population, total annual expenditures for the demonstration population, total premiums collected for services to the demonstration population, and the resulting "per member, per month" calculation. The Annual Monitoring Report must also include the submission of corrected budget neutrality data upon request.

d) Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

31. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration. The state must confirm its process for ensuring there is no duplication of federal funding in each Annual Monitoring Report as specified in STC 30(a).

32. Draft and Final Close-out Report. Within 120 days prior to the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a) The draft final Close-Out Report must comply with the most current guidance from CMS.
b) The state will present to and participate in a discussion with CMS on the Close-Out Report.
c) The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.
d) The final Close-Out Report is due to CMS no later than 30 days after receipt of CMS' comments.
e) A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 10.

VIII. GENERAL FINANCIAL REQUIREMENTS

33. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 43.

34. Reporting Expenditures Subject to the Budget Neutrality Expenditure Limit. The following describes the reporting of expenditures subject to the budget neutrality limit:

a) Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS and the two digit project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made (e.g., For reporting expenditures with dates of services made in demonstration year 16 (1/1/2018 – 12/31/2018), the state would use "16" as the project number extension).

b) Use of Waiver Forms. The state must report demonstration expenditures on separate forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report title XIX expenditures for demonstration services. The state will continue to use the waiver name "TEFRA Children" to report expenditures in the MBES/CBES and in the budget neutrality workbook required to be submitted with the Annual Monitoring Report per STC 30.

c) Premium and Cost Sharing Adjustments. Premium contributions that are collected by the state for demonstration enrollees must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and Federal share) should also be reported separately by demonstration year on Form CMS-64 Narrative. The state shall also report the premium contributions reported during the demonstration year on the Form CMS-64 Narrative as an annual total (total computable) as part of the annual budget neutrality monitoring submission outlined in STC 30(c). In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits outlined in STC 43.

d) Cost Settlements**.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C.

35. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver. To the extent the state does not have administrative costs that are directly attributable to the demonstration, a certification to that effect must be included in the Annual Monitoring Report required by STC 30; including description of how the state is tracking administration of the TEFRA-like demonstration to ensure there are no separate demonstration-related administrative costs.

36. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

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

a) For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the Annual Monitoring Report required per STC 30, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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

38. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process set out in STC 10, CMS shall reconcile expenditures reported on Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

39. Extent of Federal Financial Participation (FFP) for the Demonstration. CMS shall provide FFP at the applicable federal matching rates for demonstration expenditures incurred by the state as outlined below, subject to the limits described in section IX.

a) Net expenditures reported on CMS-64 waiver forms as outlined in STC 34, as authorized in the CMS approved Expenditure Authority document associated with these STCs, and with dates of service during the operation of the demonstration; and,

b) Administrative costs associated with the administration of the demonstration.

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

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

b) Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

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

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

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

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

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

42. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The limit is determined using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to the budget

neutrality expenditure limit shall be reported by the state using the procedures described in STC 34. CMS' assessment of the state's compliance with these annual limits will be done using the expenditures reported by the state on the CMS-64 waiver forms as outlined in STC 34. No savings can be accrued or used with this budget neutrality model.

43. Budget Neutrality Expenditure Limit. For each demonstration year, an annual budget limit will be calculated for the demonstration. The Arkansas TEFRA-like demonstration annual demonstration cycle is January 1 through December 31 as originally approved. The state's demonstration years approved with this five year demonstration extension are as follows:

Demonstration Year 16 = January 1, 2018 – December 31, 2018
Demonstration Year 17 = January 1, 2019 – December 31, 2019
Demonstration Year 18 = January 1, 2020 – December 31, 2020
Demonstration Year 19 = January 1, 2021 – December 31, 2021
Demonstration Year 20 = January 1, 2022 – December 31, 2022

The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share.

PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth of 3.28 percent) and the PMPM ceiling (total computable, net of premiums paid by demonstration enrollees) for each demonstration year:

PMPM Ceilings for TEFRA-like Services	
DY 16	$1,143.87
DY 17	$1,181.39
DY 18	$1,220.14
DY 19	$1,260.16
DY 20	$1,301.49

a) Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the CMS-64 forms listed in STC 34 above, by total computable demonstration expenditures for the same period as reported on the forms. Should the demonstration be terminated prior to the end of the approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

b) Risk. Arkansas shall be at risk for the per capita cost (as determined by the method described in this section) for demonstration enrollees, but not for the number of

demonstration enrollees. By providing FFP for eligible enrollees, Arkansas shall not be at risk of changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs for enrollees in the demonstration, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

c) Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

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

45. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration extension, which will be from January 1, 2018 through December 31, 2022. No later than six months after the end of each demonstration year, the state will calculate and report to CMS an annual cumulative expenditure target for the completed year. This amount will be compared with the actual cumulative amount the state has claimed for FFP through the completed year. If cumulative spending exceeds the cumulative target by more than the indicated percentage, the state will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved plan.

Year	Cumulative Target Expenditures	Percentage
DY16	DY16 budget limit plus:	2 percent
DY17	DY16 and DY17 combined budget limit amount plus:	1.5 percent
DY18	DY16 through DY18 combined budget limit amount plus:	1 percent
DY19	DY16 through DY19 combined budget limit amount plus:	0.5 percent
DY20	DY16 through DY20 combined budget limit amount plus:	0 percent

46. Exceeding Budget Neutrality. The state, whenever it determines that the demonstration is not budget neutral or is informed by CMS that the demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which includes submitting a corrective action plan to CMS within 21 days of the date the state is informed of the problem. While CMS will pursue corrective actions with the state, CMS will work with the state to set reasonable goals that will ensure that the state is in compliance.

If at the end of this demonstration approval period, the cumulative budget neutrality expenditure limit has been exceeded, the excess federal funds must be returned to CMS.

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

X. EVALUATION OF THE DEMONSTRATION

47. **Draft Evaluation Design.** The draft evaluation design must be developed in accordance with CMS' separately provided guidance for family planning demonstrations. The state must submit, for CMS comment and approval, a draft evaluation design with an implementation timeline by no later than 120 days after the effective date of these STCs. Any modifications to an existing approved evaluation design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of an independent party in the development of the draft evaluation design.

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

49. **Evaluation Design Approval and Updates.** The state must submit a revised draft evaluation design within 60 days after receipt of CMS' comments. Upon CMS approval of the final evaluation design, the document will be included as "Attachment B" to these STCs. Per 42 CFR §431.424(c), the state will publish the approved final evaluation design within 30 days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each Annual Monitoring Report as required by STC 34, including any required rapid cycle assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

50. **Evaluation Questions and Hypotheses.** Consistent with CMS' separately provided guidance entitled, "Developing the Evaluation Design" and "Preparing the Evaluation Report," the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality

Forum (NQF).

51. **Interim Evaluation Report.** The state must submit an interim evaluation report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c) (2) (vi). When submitting an application for extension, the interim evaluation report should be posted to the state's website with the application for public comment.

    a) The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

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

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

    d) The state must submit the final interim evaluation report 60 days after receiving CMS comments on the draft interim evaluation report and post the document to the state's website.

    e) The interim evaluation report must comply with CMS' separately provided guidance entitled, "Preparing the Evaluation Report."

52. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR §431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 10.

53. **Summative Evaluation Report.** The draft summative evaluation report must be developed in accordance with CMS' separately provided guidance entitled, "Preparing the Evaluation Report." The state must submit a draft summative evaluation report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The summative evaluation report must include information as outlined in the approved evaluation design.

    a) Unless otherwise agreed upon in writing by CMS, the state shall submit the final summative evaluation report within 60 days of receiving comments from CMS on the draft.

    b) The final summative evaluation report must be posted to the state's Medicaid website within 30 days of approval by CMS.

54. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the evaluation design, the state's interim evaluation, and/or the summative evaluation.

55. **Public Access.** The state shall post the final documents (e.g., monitoring reports, approved evaluation design, interim evaluation report, summative evaluation report, and close-out report) on the state's Medicaid website within 30 days of approval by CMS.

56. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
Quarterly Monitoring Call & Progress Narrative	First Quarterly Monitoring call and Progress Narrative within 120 days of CMS approval, then on a quarterly basis (i.e., approximately every 90 days)	STC 29
Annual Monitoring Report	Within 90 days following the end of each demonstration year	STC 30
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	STC 47

Deliverable	Timeline	STC Reference
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	STC 49
Summative Evaluation Report	Within 18 months following the end of this demonstration extension period	STC 53

ATTACHMENT A –
Annual Monitoring Report Template

1. Preface

Complete the below table as the title page of all annual monitoring reports. The content of this transmittal table should stay consistent over time.

State	*Enter state name.*
Demonstration Name	*Enter full demonstration name as listed in the demonstration approval.*
Approval Date	*Enter approval date of the demonstration as listed in the demonstration approval letter.*
Approval Period	*Enter the entire approval period for the demonstration. This should include a start date and an end date*
Demonstration Goals and Objectives	*Enter summary of demonstration goals and objectives as summarized in the STCs and/or demonstration fact sheet.*

2. Executive Summary

This section should be brief and targeted to communicate key achievements, highlights, issues, and/or risks identified during the current reporting period. This section should also identify key changes since the last monitoring report, including the implementation of new program components; programmatic improvements (e.g., increased outreach or any beneficiary or provider education efforts); and highlight unexpected changes (e.g., unexpected increases or decreases in enrollment or complaints, etc.). Historical background or general descriptions of the waiver components should not be included in this section.

The state should embed substantive analytics in the sections that follow; this section is intended for summary level information only. The recommended word count for this section is 500 words or less.

3. Enrollment

In this section, the state should discuss any relevant trends that the data shows in enrollment, eligibility, disenrollment, access, and delivery network. Changes (+ or -) greater than two percent should be described here. As an example, the number of beneficiaries enrolled in the last quarter decreased by 5% due to a State Plan Amendment that decreased the FPL levels. The recommended word count for this section is no more than 250 words (1-2 paragraphs). Note that each distinct trend should be described more succinctly in the table below.

Enrollment Issues/Trends: New and Continued

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
EXAMPLE Managed Care Plan with 30% of County Y's enrollment will exit on 1/1/18	*9/1/17; DY 2 Qtr. 3*	*75,000*	*Plan is exiting county because it is leaving the Medicaid line of business.*	*State is working to redistribute plan's population among the remaining two plans. Outreach and mail notification is occurring throughout the fall with toll-free plan counseling lines also available.*

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

Anticipated Changes to Enrollment

The state should explain any anticipated program changes that may impact enrollment-related metrics. For example, the state projects an x% increase in enrollment due to an increase in the FPL limits which will be effective on "X" date. The recommended word count for this section is 150 words or less. If no changes are anticipated, the state should indicate so.

4. Benefits

In this section, the state should discuss any relevant trends that the data shows in benefit access, utilization, premium cost-sharing and delivery network. The recommended word count for this section is 150 words (1-2 paragraphs) or less. Note that issues should be described more succinctly in the sections that follow.

Benefit Issues: New and Continued

The state should explain any new benefit-related issues and provide updates on previously reported issues. For each issue, the state should provide a brief summary description of the issue, the estimated number of impacted beneficiaries, the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also provide updates on benefit-related issues identified in previous reports.

When applicable, the state should also note when issues are resolved. If the state is not aware of benefit issues, the state should indicate so.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
EXAMPLE Mental health services in X county were impacted this quarter.	*11/1/17: DY 3, Qtr. 3*	*10,000*	*X provider group unexpectedly exited the service area*	*State is working to contract with a new provider group. .*

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

Anticipated Changes to Benefits

The state should explain any anticipated program changes that may impact benefits. For example, new legislation was recently signed by the Governor which will add more dental benefits effective "X" date. The recommended word count for this section is 150 words or less. If none are anticipated, the state should indicate so.

5. Demonstration-related Appeals

The state should explain any appeals-related issues and provide updates on previously reported issues. For each issue, the state should provide a brief summary describing the issue, the estimated number of impacted beneficiaries, any known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on appeals-related issues identified in previous reports. When applicable, the state should also note when issues are resolved. If the state is not aware of appeals issues, the state should indicate so.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Previously Reported*
EXAMPLE State is reviewing Health Plan X's Appeals process due to	*3/1/17: DY 3 Qtr. 3*	*250*	*Under investigation by the state.*	*State has asked the plan to submit appeals data for the last two calendar years by 6/1/17. State is reviewing*

members' complaints that notifications are not being sent timely and appeals requests are not being reviewed timely.				*data and draft findings are due by 9/1/17.*

**Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

Appeal-related Program Changes

The state should explain any anticipated program changes that may impact appeals-related metrics. The recommended word count for this section is 150 words or less. If none are anticipated, the state should indicate so.

6. Quality

The state should explain quality activities occurring over the current demonstration reporting period, any new quality-related issues, and provide updates on previously reported issues. For each issue, the state should provide a brief description of the issue, the estimated number of impacted beneficiaries (if applicable), the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on quality-related issues identified in previous reports. When applicable, the state should also note when issues are resolved. If the state is not aware of quality issues, the state should indicate so.

Summary of Issue	Date and Report in Which Issue Was First Reported	Estimated Number of Impacted Beneficiaries	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported*
EXAMPLE Difficulty with collecting data for X measure (i.e. lack of EHR data or need for hybrid data)	*3/15/17; DY 3 Qtr. 3*	*N/A*	*Demonstration site in process of updating EHR to be completed X date.*	*Currently reporting X measure by deviating from current measure specifications in order to adhere to demo reporting requirements.*

** Note: If an issue was noted as resolved in the previous report, it should not be reported in the current report.*

Quality-related Program Changes

The state should use this section to explain any anticipated program changes that may impact quality-related metrics. If none are anticipated, the state should indicate so.

7. Financial/Budget Neutrality

This Financial/Budget Neutrality section incorporates a budget neutrality workbook for the demonstration. At the time of demonstration approval, CMS will work with states to confirm the appropriate workbook for this demonstration.

Financial/Budget Neutrality Issues: New and Continued

The state should provide an analysis of budget neutrality to date and to explain any new financial/budget neutrality-related issues using the below table. For each issue, the state should provide a brief summary description of the issue, including the fiscal impact on the demonstration population, the known or suspected cause(s) of the issue, and the plan to remediate the issue, including a timeline for resolution (if applicable). The state should also use this section to provide updates on issues identified in previous reports.

When applicable, the state should also note when issues are resolved.

Summary of Issue, Including Fiscal Impact and Impacted MEG(s)	Date and Report in Which Issue Was First Reported	Known or Suspected Cause(s) of Issue (if applicable)	Remediation Plan and Timeline for Resolution (if applicable)/Status Update if Issue Previously Reported
EXAMPLE: State is unable to report separate expenditures for Population MEG #2. In the interim, all Population MEG #2 expenditures are reported as part of Population MEG #1 on CMS 64 waiver form Pop MEG 1.	*DY 1, Q1*	*State's current system does not accommodate breaking out capitation payments between Population MEG 1 and Population MEG 2.*	*State is working on system changes so that Population MEG 1 and Population MEG 2 expenditures can be separately reported. Target date of system change is 12/31/2017.*

Financial/Budget Neutrality related Program Changes

The state should use this section to explain any anticipated program changes that may impact financial/budget neutrality metrics. The recommended word count for this section is 150 words or less. If none are anticipated, the state should indicate so.

8. Demonstration Operations and Policy

Using the table provided below, the state should highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. The state should use this section to highlight demonstration operations or policy considerations specifically in response to STC 29(a) – (d). The state should also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document. Such considerations could include the following, either real or anticipated:

- *Any changes to populations served, benefits, access, cost-sharing, delivery systems, or eligibility;*
- *Legislative activities and state policy changes;*
- *Fiscal changes that would result in changes in access, benefits, populations, enrollment, etc.;*
- *Related audit or investigation activity, including findings;*
- *Litigation activity;*
- *Status and/or timely milestones for health plan contracts;*
- *Market changes that may impact Medicaid operations;*
- *Any delays or variance with provisions outlined in STCs;*
- *Systems issues or challenges that might impact the demonstration [i.e. eligibility and enrollment (E&E), Medicaid management information systems (MMIS)];*
- *Changes in key state personnel or organizational structure;*
- *Procurement items that will impact demonstration (i.e. enrollment broker, etc.);*
- *Significant changes in payment rates to providers which will impact demonstration or significant losses for managed care organizations (MCOs) under the demonstration;*
- *Emergency Situation/Disaster; and/or,*
- *Other*

Consideration 1:

Type of Consideration	EXAMPLE *Ongoing litigation*
Summary of Consideration	*State is in ongoing state-court level litigation regarding inpatient hospital rate cuts under SPA 17-001 effective 10/1/17 in court case A vs. B filed on 8/1/17. There is a stay on the cuts effective 9/27/17.*
Date and Report in Which Consideration Was First Reported	8/5/17
Summary of Impact	*Stay on hospital rate cuts will prevent projected savings from being captured.*
Estimated Number of Beneficiaries	*3 million (state wide population)*
If Issue, Remediation Plan and Timeline for Resolution / Updates in Status if Previously Reported	*State will continue to follow state legal process.*

9. Implementation Update

The state should provide implementation updates on relevant aspects of the demonstration, as identified either during the approval process, in previous monitoring calls, or other implementation reviews or discussions pursuant to 42 CFR §431.420(b). The state should also report on any changes in implementation plans since the demonstration was approved, either via an amendment to the demonstration, or a change in how the state plans to execute the STCs.

In the table below, the state should include any relevant trends that the data shows in benefit access, utilization, and delivery network if not already reported elsewhere in this document.

Item	Date and Report in Which Item Was First Reported	Implementation Status
EXAMPLE State is planning to submit an 1115 amendment for a freedom of choice waiver as a companion to its pending Health Homes SPA 17-010, per CMS guidance.	*6/1/17*	*State will submit 1115 amendment by 12/1/17*

***NOTE**: If additional information is needed, the state should also provide a short narrative. The recommended word count is 150 words.*

10. Demonstration Evaluation Update

The state should highlight relevant updates to the demonstration evaluation pursuant to 42 CFR §431.424 and/or any federal evaluations in which the state is involved [per 42 CFR §431.420(f) or 42 CFR §431.400(a)(1)(ii)(C)(4)]. The state should include timely updates on evaluation work and timeline. Depending on when this report is due to CMS and the timing for the demonstration, this might include updates on progress with:

- *Evaluation design;*
- *Evaluation procurement;*
- *Evaluation implementation;*
- *Evaluation deliverables (information presented in below table);*
- *Data collection, including any issues collecting, procuring, managing, or using data for the state's evaluation or federal evaluation;*
- *For annual report per 42 CFR §431.428, the results/impact of any demonstration programmatic area defined by CMS that is unique to the demonstration design or evaluation hypothesis; and/or,*

- *Results of beneficiary satisfaction surveys, if conducted during the reporting year, grievances and appeals.*

The intent of this section is for the state to provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs. The recommended word count for any narrative related to the above is about 250 words (1-2 paragraphs) per update.

In addition to any status updates on the demonstration evaluation, the state should complete the below table to list anticipated evaluation-related deliverables and their due dates.

Type of Evaluation Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues
Interim Evaluation Report			
Summative Evaluation Report			

11. Other Demonstration Reporting

The state should report any pertinent information not captured in the above sections or in related appendixes. The recommended word count for each additional item reported should not exceed 250 words (2-3 paragraphs).

In addition to any status updates on the demonstration evaluation, the state should complete the below table to list any other deliverables related to this demonstration and associated due dates. Note that deliverables associated with the evaluation should be listed separately in the Demonstration Evaluation Update section.

Type of Other Post-Approval Deliverable	Due Date	State Notes or Comments	Description of Any Anticipated Issues or Requests for CMS Technical Assistance

12. Post Award Public Forum

The state should provide a summary of the annual post-award public forum held pursuant to 42 CFR §431.420(c) indicating any resulting action items or issues. The recommended word count for this narrative should not exceed 250 words (2-3 paragraphs).

13. Notable State Achievements and/or Innovations

This is a section for the state to provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes.

The narrative in this section should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries. The recommended word count for this narrative should not exceed 250 words (2-3 paragraphs).

ATTACHMENT B: Approved Evaluation Design

(Reserved pending CMS approval)

SECTION 1115(a) RESEARCH AND DEMONSTRATION WAIVER APPLICATION ARKANSAS DEPARTMENT OF HUMAN SERVICES TEFRA DEMONSTRATION

I. EXECUTIVE SUMMARY

The Arkansas Department of Human Services is proposing a Section 1115(a) demonstration waiver for a period of five (5) years to impose cost sharing requirements on children age 18 and under who are otherwise eligible for Medicaid under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), except where noted in the Eligibility Requirements section below. Parent(s), guardian(s) or custodian(s) whose children qualify for another Medicaid category with coverage comparable to the waiver services will be allowed to choose the regular Medicaid Program or the waiver program for their child. The proposed implementation date for the waiver is October 1, 2002.

The objective of DHS is to replace the TEFRA eligibility category with an alternative category. The Department appointed an advisory work group that includes TEFRA parents, advocates and physicians to provide input in designing the program. The following describes the proposed program:

A. Families of eligible children will not be required to drop their existing insurance. Any family who voluntarily drops creditable health insurance coverage for the waiver child will be ineligible for waiver benefits for the child with a disability for a period of six (6) months from the date the insurance is dropped. Recipients who have dropped insurance since the last annual review will lose six (6) months of coverage beginning with the month after the month of discovery.

B. There will be no cap on the number of children served.

C. Cost sharing measures will be based on the total income of the custodial parent(s) as reflected on the most recently filed IRS Federal Tax Return (i.e., line 22 of the 2001 version of the 1040 or line 15 of the 2001 version of the 1040A). Documentation provided to ADHS will also include any late or amended returns.

D. Recipients under the waiver will receive the full range of Medicaid benefits and services as described in the Arkansas Title XIX State Plan.

E. A committee appointed by the Director of the Division of Medical Services (DMS) will meet as needed to review the program. The committee will be comprised of appropriate pediatric specialists, state staff, two parent representatives and two provider representatives.

II. Public Notice

A notice will be printed in the Arkansas Democrat-Gazette on and allowed to run for seven consecutive days. The Democrat-Gazette is the only newspaper in Arkansas with statewide distribution. This notice includes a 30-day public comment period and instructions on how to obtain a copy of the waiver application.

III. The Environment

A. Overview of Current System

The population to be served by the waiver is currently receiving services under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

B. Experience with State Waivers

The state is currently operating the following waivers:

1. 1115(a)
   a. ARKids First
   b. Family Planning
2. 1915(b)
   a. PCCM
   b. Transportation
3. 1915(c)
   a. Alternatives for Persons with Physical Disabilities
   b. Elder Choices

The waivers listed above have been well received and there have been no major problems experienced with them.

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C. Input from Public Agencies/Advocates

An advisory work group was established to provide input into the development of the waiver. The group included representatives from advocacy groups, other state agencies and parents of disabled children. See Attachment A for a list of the work group members.

D. State Budget

1. What is the financial outlook of the current Medicaid program?

The financial outlook for the Arkansas Medicaid program is better than that for a number of states (e.g., California, New Jersey, Mississippi and Missouri). As in many other states the finances will be tight for the next couple of years. Arkansas believes we can maintain essential services, including medically necessary services for children.

2. Can the State sustain adequate financing for the life of the waiver?

We believe, with known factors at this date, Arkansas can maintain funding for this waiver.

IV. Program Administration

The demonstration will be administered by the Division of Medical Services (DMS) and the Division of County Operations (DCO). Both agencies are divisions of the Arkansas Department of Human Services (DHS). Attached is a copy of the organizational chart for DHS (Attachment B), an organizational chart for DMS (Attachment C) and an organizational chart for DCO (Attachment D).

The Division of Medical Services (DMS) is responsible for ensuring compliance with the waiver in regard to services and provider participation.

The Division of County Operations (DCO) is responsible for the dissemination of eligibility policy and ensuring that DHS county offices comply with the waiver when making applicant eligibility determinations. The application process currently in place for TEFRA will be used, which includes taking the application, interviewing and requesting the information necessary for processing the case. DCO is responsible for processing waiver applications.

H. The child must have access to medical care in the home. It must be deemed appropriate to provide such care outside an institution; and

I. The estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

VI. Benefits

A. Benefit Package

Eligible children will receive the full range of Medicaid services through the waiver.

B. Premiums

All waiver recipients will pay a monthly premium. The amount of the premium will be based on the custodial parent(s) total income as reported on the applicable Federal Income Tax Return (i.e., line 22 of the 2001 version of the 1040 or line 15 of the 2001 version of the 1040A) less the following deductions:

1. Six hundred dollars ($600) per child (biological or adopted) who lives in the home of the waiver child and is listed as a dependent child on the applicable Federal Income Tax Return of the parents (i.e., line 7.c on the 2001 version of form 1040 or 1040A; and

2. Excess Medical and dental expenses as itemized on Schedule A of the Federal Income Tax Return of the parent(s) (i.e., line 4 on the 2001 version of Schedule A).

NOTE: A stepparent living in the home will be considered a custodial parent and his or her income will be included in determining the premium.

See Attachment F for the amount of the premiums to be paid. The maximum annual premium amount to be paid by any family is $5,500. **Families that have more than one child receiving TEFRA waiver benefits and services will pay only one premium for all children based on Attachment F.** There will be no increase in premium for additional waiver children.

For late or amended returns that result in an increased premium, the increase shall be retroactive to the date that the initial return would have been due in the absence of an extension. Failure to supply required tax information shall render the child ineligible.

The premium will begin in the month eligibility is approved. The premium will be charged on a monthly basis and will not be pro-rated. Income will be reviewed annually, for purposes of calculating the premium; or, when there is a change that will make a difference of more than 10% in annual household income. An adjustment can be made to the premium during the year if the parents report a significant change in excess of 10% of expected annual income. Income that fluctuates due to the type of employment, e.g. teachers, farmers, etc., will not affect the monthly premium. The premium can only be adjusted at a maximum of once every 6 months.

The parent(s) will be required to pay monthly premiums through bank drafts or quarterly payments in advance. The premium must be paid in the month preceding the covered month or quarter. The child's case will not be closed and providers will continue to be reimbursed for covered services if the premium is not paid for three (3) months.

If after three (3) months, premiums are in arrears, coverage will be terminated following appropriate advance notice. If payment of all premiums in arrears is not made and the case closes, then the parent must reapply and eligibility will be determined at the point of application.

If the case has been closed less than 12 months because of premium payments in arrears, the three (3) months past due premiums must be paid before the child can again be approved for TEFRA Waiver services.

If a case is closed 12 months or more because of premium payments in arrears, payment of the past due premiums will not be required.

C. Special Populations

The population served by this waiver is made up of individuals age 18 and under.

VII. Delivery System

All services for the waiver population will be delivered through the current network of enrolled Medicaid providers.

Each recipient in the waiver population must receive Medicaid services through a primary care physician (PCP).

Reimbursement for services provided to the waiver population will be based on the current Medicaid fee schedule.

VIII. Access

A. Capacity

The ADHS Primary Care Case Management (PCCM) Waiver Program, 1915(b)(1) AR-01.R2, known as ConnectCare offers 1800 physicians statewide, who have a caseload availability of approximately 1,000,000 patients. Access availability is five to one.

B. Outreach/Enrollment

Applications will be available at local DHS offices or by mail, through hospitals, including Arkansas Children's Hospital, and Federally Qualified Health Centers (FQHC). Information will be available through First Connections, Division of Developmental Disabilities (DDS) Services Coordinators and providers. Information will also be available on the DHS/DMS website. This allows for a wide range of points of access into the program.

IX. Quality

The same grievance system in effect under the regular Medicaid program will apply to the waiver population. Recipients have available a formal appeal process under 42 CFR Part 431, Subpart E.

Arkansas Foundation for Medical Care, Inc. (AFMC) reviews allegations of substandard medical care for the Arkansas Medicaid Program.

A. Eligibility

1. A quality control program for waiver participants that meets the requirements of Section 1903(u) will be implemented if necessary.

2. Applicants and recipients have available to them a formal appeal process under 42 CFR Part 431, Subpart E, to assure that they are not inappropriately denied enrollment or medical care or terminated from the program.

B. Surveillance and Utilization Review Subsystem (SURS)

1. The State's SURS is used to identify aberrant provider practices for education and potential sanction purposes.

2. To assure quality of services, SURS reviews payment files to identify over or under recipient utilization and patterns of aberrant provider behavior.

C. Arkansas Foundation for Medical Care, Inc. (AFMC)

1. The SURS review is supplemented by an endeavor between the Division of Medical Services and AFMC to identify physicians whose practices are outside the norm.

2. The State implements appropriate education efforts based on trends that become apparent through the efforts of SURS and AFMC. AFMC conducts any provider education efforts on behalf of the State.

3. AFMC delivers specific improvement goals to the providers as necessary.

X. Financial Issues

See Attachments F through F-2.

XI. Systems Support

The Medicaid Management Information System (MMIS) will be modified to recognize the waiver recipients.

XII. Implementation Time Frames

The proposed effective date for implementation of the TEFRA Waiver Demonstration Program is October 1, 2002.

XIII Evaluation and Reporting

The evaluation will be based on two objectives:

A. Cost neutrality, and

B. Access to quality care

XIV. Waivers

Section 1916(a)(2)(A) – Cost Sharing

A monthly premium will be required of waiver participants as outlined in Section VI of the application.

C. Input from Public Agencies/Advocates

An advisory work group was established to provide input into the development of the waiver. The group included representatives from advocacy groups, other state agencies and parents of disabled children. See Attachment A for a list of the work group members.

D. State Budget

1. What is the financial outlook of the current Medicaid program?

The financial outlook for the Arkansas Medicaid program is better than that for a number of states (e.g., California, New Jersey, Mississippi and Missouri). As in many other states the finances will be tight for the next couple of years. Arkansas believes we can maintain essential services, including medically necessary services for children.

2. Can the State sustain adequate financing for the life of the waiver?

We believe, with known factors at this date, Arkansas can maintain funding for this waiver.

IV. Program Administration

The demonstration will be administered by the Division of Medical Services (DMS) and the Division of County Operations (DCO). Both agencies are divisions of the Arkansas Department of Human Services (DHS). Attached is a copy of the organizational chart for DHS (Attachment B), an organizational chart for DMS (Attachment C) and an organizational chart for DCO (Attachment D).

The Division of Medical Services (DMS) is responsible for ensuring compliance with the waiver in regard to services and provider participation.

The Division of County Operations (DCO) is responsible for the dissemination of eligibility policy and ensuring that DHS county offices comply with the waiver when making applicant eligibility determinations. The application process currently in place for TEFRA will be used, which includes taking the application, interviewing and requesting the information necessary for processing the case. DCO is responsible for processing waiver applications.

ATTACHMENT 3

Arkansas Medicaid

2021

TEFRA Client Satisfaction Survey Results

ARMedicaid

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Data analysis by

afmc℠

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ARKANSAS MEDICAID TEFRA SURVEY

2021 Client Satisfaction Survey Results

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Executive Summary

The Arkansas Department of Human Services' (DHS) Division of Medical Services (DMS) contracted with AFMC, A National Committee for Quality Assurance (NCQA) certified Healthcare Effectiveness Data and Information Set (HEDIS®)[1] survey vendor, to conduct its 2021 Tax Equity and Fiscal Responsibility Act (TEFRA) Client Satisfaction Survey. The survey is modeled after the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] 5.1H Child Medicaid Questionnaire. TEFRA is a cost-sharing Medicaid program available to children under the age of 19 who have a disability, live and receive care in their home, and requires families to pay a monthly premium based on parental income. Premiums are not required if annual income is below 150% of the federal poverty level.

This report provides a summary of the 2021 TEFRA survey results and compares the 2021 TEFRA survey results with 2020 and 2019 TEFRA survey results. This comprehensive analysis will assist DMS in determining which services TEFRA clients use, how clients evaluate the TEFRA program and its services, and how the program performs over time. This is the 16th TEFRA Client Satisfaction Survey AFMC has conducted for DMS.

After conducting a mail-only survey to evaluate 2021 TEFRA client satisfaction AFMC received 477 surveys from the TEFRA client sample (n=1,650) from late August 2021 to November 1, 2021. Clients with bad addresses were dropped from the sample along with the few respondents who were found to be otherwise ineligible. After these adjustments, 465 surveys were available for analysis from an analyzable sample size of 1,579, resulting in an analyzable response rate of 29%.

The TEFRA survey includes both composite measures and rating questions. A composite measure combines the responses from two or more questions to obtain a single score. The composite measure scores represent the percentage of clients who responded favorably. For questions scaled as "never," "sometimes," "usually," and "always," a favorable response represents the proportion of clients who selected "usually" or "always." For questions scaled as "a big problem," "a small problem," and "not a problem," a favorable response represents the proportion of clients who selected "not a problem." Rating questions are scaled from 0 to 10, where 0 represents "worst possible" and 10 represents "best possible." The rating scores show the percentage of clients who rated the question favorably by selecting a rating of 8, 9, or 10.

1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

2 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

TABLE 1. Composite and rating percentages

COMPOSITES/RATINGS	2021	2020	2019
Getting care quickly	96%	92%	95%
How well doctors communicate	95%	94%	95%
Customer service	74%	76%	66%
Special equipment and supplies	73%	71%	64%
Special therapies	90%	91%	90%
Rating of health care professional	93%	93%	92%
Rating of health care	93%	90%	90%
Rating of treatment or counseling	76%	81%	70%
Rating of TEFRA program	71%	76%	73%
Rating of customer service	44%	52%	39%
Rating of TEFRA application process	54%	55%	53%

The TEFRA survey includes five composite measures and six rating questions. The TEFRA composite measures include:

- **Getting care quickly:** Measures a client's access to timely urgent and nonurgent care
- **How well doctors communicate:** Measures how well doctors listen, explain, spend enough time with, and show respect for what clients have to say
- **Customer service:** Measures how often clients got the help they needed and were treated with courtesy and respect by TEFRA's customer service representatives
- **Special equipment and supplies:** Measures a client's access to additional specialty items and special medical equipment
- **Special therapies:** Measures a client's access to speech, occupational, and physical therapies

The TEFRA rating questions include:

- Rating of health care professional
- Rating of health care
- Rating of treatment or counseling
- Rating of TEFRA program
- Rating of customer service
- Rating of TEFRA application process

NOTABLE FINDINGS

The following paragraphs summarize how TEFRA's composite scores, ratings, and respondents' demographics trend over time. For the complete analysis, please refer to the TEFRA Demographics of Survey Sample and Respondents section (**Page 9)**, Comparing TEFRA Health Plan section (**Page 13**) and the Trend Analysis section (**Page 19**) of this report.

AFMC compared the 2021 TEFRA survey results with the results from the 2020 and 2019 surveys:

- The "Getting care quickly" composite has increased significantly from 2020's summary rate of 92.4% to 95.6% in 2021. The "Obtaining care right away" component of this composite did have a significant increase from 2020's summary rate of 93.5% to 97.5% in 2021.
- The "How well doctors communicate" composite and its components except for the "Doctors showing respect for what you had to say" component were all slightly higher than 2020 summary rates. None of these differences were significant.
- The 2021 composite measure and the "Treated with courtesy and respect" component for "Customer service" increased significantly over 2019.
- The best rating in all years is for "Health care professional" (93.1% in 2021, 92.8% in 2020, 91.7% in 2019).
- Both "Rating of health care professional" and "Rating of health care" have steadily increased since 2019.
- Within ratings, the positive "Rating of customer service" summary rate is significantly lower in 2021 (44.1%) when compared with the 2020 summary rate of 52.2%.

AFMC compared the 2021 TEFRA respondents' demographics with the 2020 and 2019 TEFRA respondents' demographics:

- A significantly lower proportion of respondents is noted among the male gender while a significantly higher proportion of respondents is noted among the female gender in 2021 when compared with 2020. However, no significant differences occur between 2021 and 2019 among genders.
- In 2021, the majority of respondents were white (84.7%) followed by 8.1% identifying as "Other" which includes multiracial.
- No significant changes were indicated between 2021 and 2020 respondents in children's age and race brackets.
- There were no significant differences comparing 2021 with 2020 household income brackets. However, when 2021 household income brackets were compared with 2019 household income brackets, the $0.00–$50,000 income bracket in 2021 had a significantly lower proportion of respondents than 2019, and a significantly higher proportion of respondents in the $100,001–$150,000 income bracket than 2019.

- For 2021, no significant differences occurred in the "years of enrollment" category when compared with 2020.
- Most respondents reported they experienced "No financial burden" or "A small financial burden" in paying TEFRA premiums. However, 33 respondents (7.2%) indicated it had been "A big financial burden" to pay TEFRA premiums in the last six months (**Question 55** in **Appendix A**). Financial burden distributions have remained stable in all brackets from 2019 to 2021 with no significant differences.

Survey Overview and Methodology

BACKGROUND AND SURVEY INSTRUMENT

As part of its contract with DMS, AFMC regularly surveys TEFRA clients about their health care experiences.

AFMC used the 2021 CAHPS 5.1H Child Medicaid Questionnaire as a model.

CAHPS surveys are a set of survey tools developed to assess patients' satisfaction with their health plan. CAHPS is funded by the Agency for Healthcare Research and Quality (AHRQ) and was developed by AHRQ and NCQA jointly. The baseline survey of TEFRA clients was conducted by AFMC in 2004. This is the 16th survey of this population.

SURVEY SIZE, SAMPLE DISPOSITION, AND RESPONSE RATE

A sample of 1,650 TEFRA clients was randomly selected from the Arkansas Medicaid Enterprise (AME) Decision Support System (DSS) claims data. AFMC tracks returned and nonreturned surveys according to NCQA guidelines. After eliminating ineligible surveys (5) and those with a bad address (66), 1,107 surveys were not returned. After eliminating surveys with no valid responses and surveys from clients who did not meet enrollment criteria, 465 TEFRA surveys (29.4%) were available for analysis from an analyzable sample size of 1,579.

TABLE 2. Sample size, survey disposition, and response rate

TEFRA SURVEY	2021
Total mailing sent	1,650
*Ineligible: According to population criteria	5
*Ineligible: Language barrier	0
*Ineligible: Mentally or physically incapacitated	0
*Ineligible: Deceased	0
†Bad address	66
Analyzable sample size	1,579
Refusal	7
§Nonresponse	1,107
Analyzable surveys returned	465
Analyzable response rate	29.4%

**Excluded from response rate denominator*

†Excluded from response rate denominator

§ Does not include bad addresses

SAMPLING FRAME

NCQA guidelines require each client to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, AFMC sets this criterion at 30 days because enrollment data is reported monthly. The enrollment period from which the sampling was drawn was January 1, 2021, through June 30, 2021. Only one client per household was selected for participation. A selected member may have been age 18 when selected and age 19 when filling out this survey.

SURVEY PROCEDURE

AFMC followed the mail-only methodology as presented in *HEDIS® MY2021 Volume 3, Specifications for Survey Measures*, with minor adjustments to accommodate the Arkansas enrollment data structure. An advance letter written on DMS letterhead and signed by the director of DMS was mailed to each selected TEFRA client. The letter explained the purpose of the survey, informed the client of its confidential and voluntary nature, and provided information on requesting a Spanish-language version of the survey. Approximately three weeks later, a packet was sent to the TEFRA client containing the TEFRA questionnaire, a postage-paid return envelope and a cover letter. The cover letter, also on DMS letterhead and signed by the DMS director, reiterated the information in the advance letter and gave specific instructions on completing and returning the survey. A reminder notice was mailed 10 days later to those clients who did not respond to the initial survey mailing. Approximately four weeks after the initial survey was sent, a second survey was mailed to any client who had not returned a survey. A second reminder notice was mailed after the second survey. Data collection continued through Nov. 1, 2021.

All mail was sent bulk rate with return receipt and address correction requested. Letters and surveys that were returned as undeliverable with an address correction were re-mailed.

SURVEY TIMETABLE

TABLE 3. Survey mailing dates

SURVEY MAILINGS	
Advance letter	Aug. 9, 2021
First survey	Aug. 27, 2021
First reminder postcard	Sept. 7, 2021
Second survey	Sept. 27, 2021
Second reminder postcard	Oct. 11, 2021
Data cutoff	Nov. 1, 2021

SURVEY TRACKING

A unique number was assigned to each survey for tracking purposes only. This tracking number was used to identify nonresponders for inclusion in a second mailing without compromising confidentiality.

DISQUALIFIED SURVEYS

Surveys received after the cutoff date of Nov. 1, 2021, were excluded from the survey analysis. Surveys without any valid responses and those no longer meeting enrollment criteria were also excluded from the analysis. These exclusions were made based on the standard HEDIS/CAHPS protocol and recommendation.

SPANISH-LANGUAGE SURVEYS

AFMC translates all surveys into Spanish and provides the Spanish-language version to clients upon request. No surveys were completed in Spanish of the 465 analyzable surveys returned.

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Demographics of Survey Sample and Respondents

The following table shows the percentage of respondents by demographic category: gender, age, race, household income, years of TEFRA enrollment, and financial burden of premiums for 2021, 2020 and 2019. Significance testing is performed comparing 2021 with 2020 and 2021 with 2019 (**Table 4**). **Table 5** shows how the 2021 sample (excluding ineligible clients and those with a bad address) compares to the population and to the returned surveys that were used for analysis. Since AFMC follows NCQA protocol, the survey sample should be similar to the TEFRA population.

AFMC highlights respondents' demographics that have significantly changed over time; a z-test was used to determine any significant differences at the 95% significance level.

A significantly lower proportion of respondents is noted among the male gender while a significantly higher proportion of respondents is noted among the female gender in 2021 when compared with 2020. However, no significant differences occur between 2021 and 2019 among gender. Consistent with previous years, TEFRA survey respondents were predominantly male (gender of the child for whom the survey was filled out). This is consistent with the general TEFRA client distribution, which includes a higher percentage of males (see **Table 5** comparing clients surveyed with the TEFRA population and survey respondents). In 2021, the majority of respondents were white (84.7%) followed by 8.1% identifying as "Other" which includes multiracial.

No significant changes were indicated between 2021 and 2020 respondents in children's age and race brackets. A significantly lower proportion of respondents with children ages 0–4 occurred in 2021 when compared with the same age bracket in 2019.

There were no significant differences comparing 2021 with 2020 household income brackets. However, when 2021 household income brackets were compared with 2019 household income brackets, the $0.00–$50,000 income bracket in 2021 had a significantly lower proportion of respondents than 2019, and a significantly higher proportion of respondents in the $100,001–$150,000 income bracket than 2019.

For 2021, no significant differences occurred in the "years of enrollment" category when compared with 2020. When comparing the "years of enrollment" category for 2021 with 2019, significantly lower proportions of respondents in 2021 were found in the "Less than 2 months" and "12 up to 24 months" brackets while the "2 up to 5 years" bracket was significantly higher.

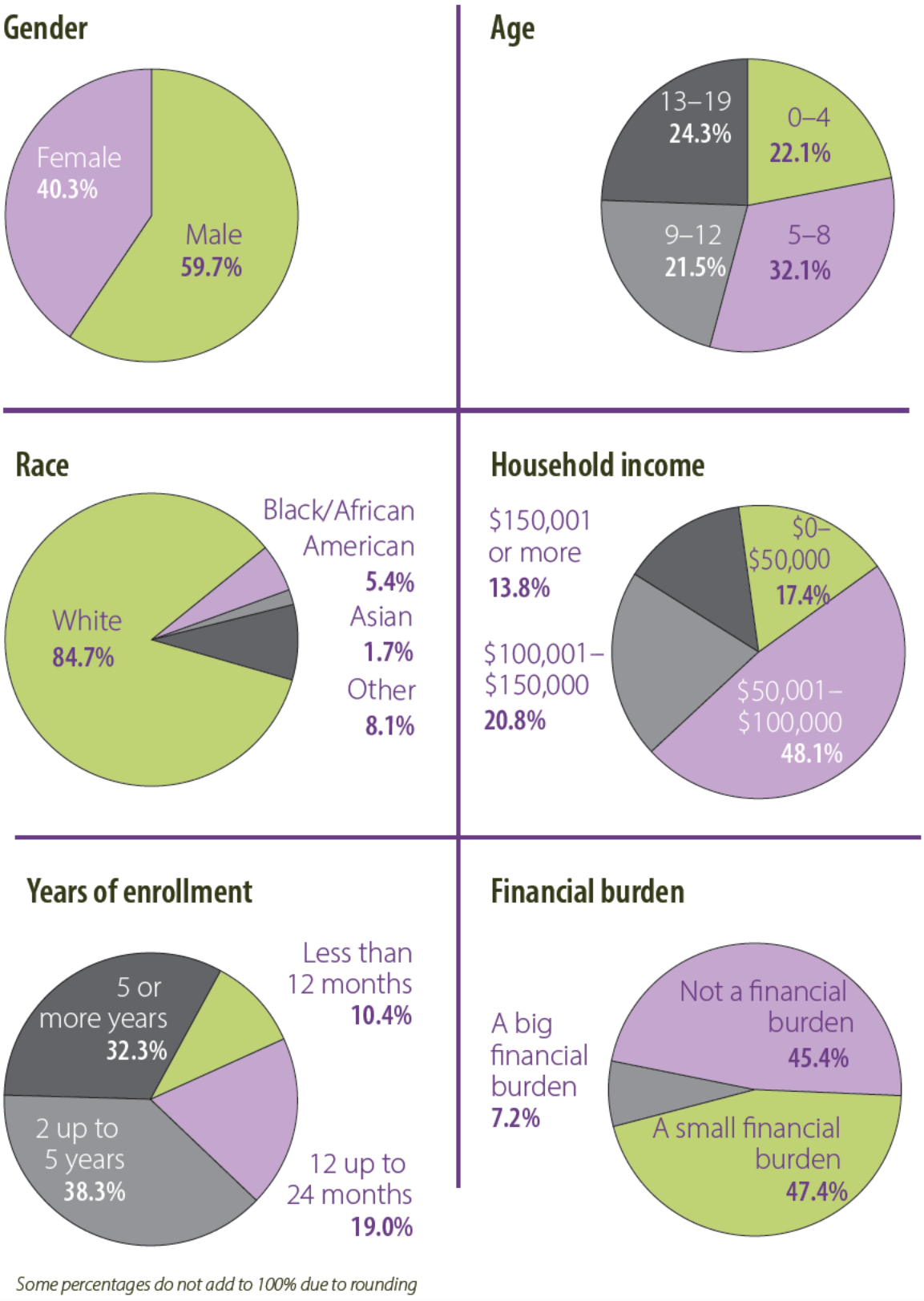
Most respondents reported they experienced "No financial burden" or "A small financial burden" in paying TEFRA premiums. However, 33 respondents (7.2%) indicated it had been "A big financial burden" to pay TEFRA premiums in the last six months (**Question 55** in **Appendix A**). Financial burden distributions have remained stable in all brackets from 2019 to 2021 with no significant differences.

TABLE 4. Profile of TEFRA survey respondents: Comparison with 2020 and 2019 results

DEMOGRAPHIC	CATEGORY	2021	2020	2019	SIGNIFICANT DIFFERENCE (2021 VS. 2020)	SIGNIFICANT DIFFERENCE (2021 VS. 2019)
Gender	Male	59.7%	66.8%	63.6%	**Signficantly lower**	Not significant
	Female	40.3%	33.2%	36.4%	**Signficantly higher**	Not significant
Age	0–4	22.1%	20.6%	29.1%	Not significant	**Signficantly lower**
	5–8	32.1%	31.2%	29.1%	Not significant	Not significant
	9–12	21.5%	24.6%	21.8%	Not significant	Not significant
	13–19	24.3%	23.6%	19.9%	Not significant	Not significant
Race	White	84.7%	80.2%	85.3%	Not significant	Not significant
	Black/African American	5.4%	6.2%	6.5%	Not significant	Not significant
	Asian	1.7%	3.0%	1.9%	Not significant	Not significant
	Other	8.1%	10.6%	6.2%	Not significant	Not significant
Household income	$0–$50,000	17.4%	21.5%	24.0%	Not significant	**Signficantly lower**
	$50,001–$100,000	48.1%	46.0%	48.1%	Not significant	Not significant
	$100,001–$150,000	20.8%	20.1%	15.9%	Not significant	**Signficantly higher**
	$150,001 or more	13.8%	12.4%	12.0%	Not significant	Not significant
Years of enrollment	Less than 12 months	10.4%	7.9%	14.7%	Not significant	**Signficantly lower**
	12 up to 24 months	19.0%	23.7%	27.9%	Not significant	**Signficantly lower**
	2 up to 5 years	38.3%	35.2%	30.5%	Not significant	**Signficantly higher**
	5 or more years	32.3%	33.3%	26.8%	Not significant	Not significant
Financial burden	Not a financial burden	45.4%	44.4%	44.6%	Not significant	Not significant
	A small financial burden	47.4%	47.4%	46.7%	Not significant	Not significant
	A big financial burden	7.2%	8.2%	8.7%	Not significant	Not significant

Some percentages do not add to 100% due to rounding

FIGURE 1. 2021 Demographics



Some percentages do not add to 100% due to rounding

The following table shows the demographic proportions of the TEFRA clients surveyed, the TEFRA population and the TEFRA respondents and compares them by gender, age, race, and geographic region (**Table 5**).

Notably, proportions from respondents remained consistent from the TEFRA population and clients surveyed in all demographic categories.

TABLE 5. TEFRA surveyed clients, population, and respondents' demographics

DEMOGRAPHIC	CATEGORY	CLIENTS SURVEYED	PCT. OF TOTAL	TEFRA POPULATION	ANALYZABLE RESPONSES	PCT. OF TOTAL	ANALYZABLE RESPONSE RATE
Gender	Female	548	34.7%	34.9%	188	40.4%	34.3%
	Male	1,031	65.3%	65.1%	277	59.6%	26.9%
	TOTAL	**1,579**	**100.0%**	**100.0%**	**465**	**100.0%**	**29.4%**
Age	0–4	347	22.0%	23.1%	114	24.5%	32.9%
	5–8	532	33.7%	32.6%	145	31.2%	27.3%
	9–12	320	20.3%	21.7%	95	20.4%	29.7%
	13–19	380	24.1%	22.6%	111	23.9%	29.2%
	TOTAL	**1,579**	**100.0%**	**100.0%**	**465**	**100.0%**	**29.4%**
Race	White	1,333	84.4%	84.7%	409	88.0%	30.7%
	Black/African American	119	7.5%	7.3%	24	5.2%	20.2%
	Asian	35	2.2%	2.1%	8	1.7%	22.9%
	Native Hawaiian or other Pacific Islander	4	0.3%	0.2%	1	0.2%	25.0%
	American Indian or Alaska Native	12	0.8%	0.9%	3	0.6%	25.0%
	Other/ Unknown	63	4.0%	4.3%	17	3.7%	27.0%
	Multiracial	13	0.8%	0.6%	3	0.6%	23.1%
	TOTAL	**1,579**	**100.0%**	**100.0%**	**465**	**100.0%**	**29.4%**
Geographic region*	Northwest	628	40.1%	38.8%	202	43.5%	32.2%
	Northeast	256	16.3%	17.5%	68	14.7%	26.6%
	Central	548	35.0%	35.3%	156	33.6%	28.5%
	Southwest	84	5.4%	5.3%	19	4.1%	22.6%
	Southeast	50	3.2%	3.0%	19	4.1%	38.0%
	TOTAL	**1,566**	**100.0%**	**100.0%**	**464**	**100.0%**	**29.6%**

**Clients with current out-of-state addresses were excluded from regional analysis. Totals may not add up to 100.0% due to rounding.*

Comparing TEFRA Health Plan

Survey recipients were asked to compare certain aspects of the health care plan their child had in the six months before enrolling in TEFRA to post-enrollment in the TEFRA health plan and their satisfaction during both periods. Response results are summarized below.

TABLE 6. Comparing TEFRA with other health plans

COMPARING HEALTH CARE BEFORE AND SINCE ENROLLING IN TEFRA	2021		2020		2019	
	PRE-TEFRA	POST-TEFRA	PRE-TEFRA	POST-TEFRA	PRE-TEFRA	POST-TEFRA
How much of a problem, if any, was it for your child to see a personal doctor or nurse?						
Big or small problem	103 (23.4%)	30 (6.5%)	113 (23.0%)	32 (6.0%)	134 (24.7%)	41 (7.2%)
No problem	338 (76.6%)	432 (93.5%)	379 (77.0%)	498 (94.0%)	409 (75.2%)	527 (92.8%)
How much of a problem, if any, was it to get your child's prescription medication?						
Big or small problem	125 (31.2%)	50 (11.5%)	141 (30.4%)	62 (12.1%)	163 (32.1%)	85 (15.5%)
No problem	276 (68.8%)	385 (88.5%)	323 (69.6%)	449 (87.9%)	345 (67.1%)	463 (84.5%)
How much of a problem, if any, was it for your child to get urgent care?						
Big or small problem	84 (23.1%)	23 (5.8%)	98 (23.1%)	24 (5.1%)	106 (23.1%)	37 (7.6%)
No problem	280 (76.9%)	375 (94.2%)	327 (76.9%)	445 (94.9%)	352 (76.9%)	451 (92.4%)

Clients have had significantly fewer problems seeing a personal doctor or nurse, getting prescription medication, and getting urgent care since enrolling in TEFRA compared with the six months before enrolling in TEFRA. This trend has been consistent since 2010 (2010–2018 numbers not included in table).

Further Analysis of TEFRA Program

Table 7 outlines premium levels, the amount of money one must pay monthly to receive services, by household income. The overall pattern indicates that the higher the household income, the more likely the parent/caregiver was to indicate having a higher premium level, which generally corresponds to the cost-sharing system implemented by the TEFRA program in determining enrollees' premiums.

TABLE 7. TEFRA premium levels by household income

TEFRA PREMIUM	$0–$25,000	$25,001–$50,000	$50,001–$75,000	$75,001–$100,000	$100,001–$125,000	$125,001–$150,000	$150,001–$175,000	$175,001–$200,000	$200,001 OR MORE
$0	5 (25.0%)	12 (60.0%)	3 (15.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
$20–$41	4 (8.7%)	31 (67.4%)	7 (15.2%)	2 (4.3%)	2 (4.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
$52–$78	0 (0.0%)	12 (11.7%)	67 (65.0%)	19 (18.4%)	3 (2.9%)	2 (1.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
$93–$125	2 (2.1%)	4 (4.3%)	25 (26.6%)	45 (47.9%)	10 (10.6%)	8 (8.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
$145–$182	0 (0.0%)	3 (4.5%)	8 (12.1%)	16 (24.2%)	25 (37.9%)	10 (15.2%)	3 (4.5%)	1 (1.5%)	0 (0.0%)
$208–$250	0 (0.0%)	0 (0.0%)	2 (6.5%)	4 (12.9%)	8 (25.8%)	13 (41.9%)	3 (9.7%)	1 (3.2%)	0 (0.0%)
$281–$328	1 (4.3%)	1 (4.3%)	3 (13.0%)	3 (13.0%)	0 (0.0%)	4 (17.4%)	6 (26.1%)	2 (8.7%)	3 (13.0%)
$364–$416	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (16.7%)	1 (5.6%)	4 (22.2%)	4 (22.2%)	5 (27.8%)	1 (5.6%)
$458	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.0%)	0 (0.0%)	0 (0.0%)	5 (15.2%)	6 (18.2%)	21 (63.6%)

Families of eligible children whose annual income, after adjusting for allowable deductions, exceeds 150% of the federal poverty level (FPL), are required to pay a monthly premium to participate in the program. Allowable deductions include $600 for each dependent child living in the home plus excess medical and dental expenses according to Schedule A as reported in the parents' federal tax returns. Premiums cannot be more than 5% of a family's gross annual income.

Respondents were asked to indicate their "current household income;" they may have interpreted this as gross or net income rather than the adjusted income amount calculated according to the eligibility policy that is the basis for determining the premium amount.

Clients were asked about their monthly TEFRA premium and how much of a financial burden, if any, it was to pay. **Table 8** below provides a cross tabulation with the number and percentage of respondents who answered both the question on the monthly TEFRA premium (**Question 54**) and the financial burden question (**Question 55**). The greatest number of respondents, 55 (51.4%), reported premiums were "Not a financial burden" in the "$52–$78" premium category followed by the "$93–$125" premium category with 51 (50.5%) respondents reporting a small financial burden in paying TEFRA premiums.

TABLE 8. Reported TEFRA premium and financial burden in paying TEFRA premiums

TEFRA PREMIUM	A BIG FINANCIAL BURDEN	A SMALL FINANCIAL BURDEN	NOT A FINANCIAL BURDEN
$0	0 (0.0%)	0 (0.0%)	21 (100.0%)
$20–$41	2 (4.3%)	18 (39.1%)	26 (56.5%)
$52–$78	4 (3.7%)	48 (44.9%)	55 (51.4%)
$93–$125	3 (3.0%)	51 (50.5%)	47 (46.5%)
$145–$182	5 (7.4%)	42 (61.8%)	21 (30.9%)
$208–$250	8 (23.5%)	14 (41.2%)	12 (35.3%)
$281–$328	4 (18.24%)	10 (45.5%)	8 (36.4%)
$364–$416	3 (16.7%)	10 (55.6%)	5 (27.8%)
$458	4 (11.8%)	20 (58.8%)	10 (29.4%)

CHILD'S HEALTH CARE PROFESSIONAL

- A majority (60.2%) of parents/caregivers responding to the survey indicated that the type of health care professional their child sees most often was a personal doctor/ family doctor/primary care physician.
- Less than half (43.6%) of respondents reported that their child needed a referral to see a specialist in the six months prior to the survey
- Of those who needed a referral to see a specialist, 77.9% reported that it was not a problem getting a referral.

- A large majority (88.8%) reported no problem getting a health care professional for their child whom they are happy with, while 11.2% reported having some problem.
- 93.1% of respondents rated their child's health care professional an 8 or higher on a scale from 0 to 10. More than half (55.5%) of the parents/caregivers rated their child's health care professional as the "Best health care professional." Less than 2% of the respondents gave a rating of 5 or below to their child's health care professional.

CHILD'S HEALTH CARE IN THE LAST SIX MONTHS

- In all, 89.6% of parents/caregivers indicated their child went to his or her doctor's office or clinic at least one time in the last six months, while 2.8% reported that their child went to his or her doctor's office or clinic 10 times or more during the same time period.
- Among respondents whose child had at least one doctor's visit in the past six months, less than half (45.0%) indicated that their child was able to talk with doctors about their health care.
- Of those who were able to talk with doctors, less than 4% reported that their child "usually" or "always" had a hard time speaking with or understanding doctors or other health care providers because they spoke different languages. However, 85.9% of those also reported that their doctors or other health care providers were "usually" or "always" able to explain things in a way their child could understand.

EXPERIENCE WITH TEFRA/MEDICAID PROGRAM

- Almost 1 in 3 (31.1%) respondents first heard about TEFRA through Arkansas Children's Hospital, while 20.6% first heard about the program from a friend or relative.
- Respondents also reported school/daycare (12.8%) and 12.3% reporting doctor's office as to where they first heard about TEFRA.
- 21.7% of respondents heard about TEFRA through other sources such as caseworkers and the social security office. The additional "other" responses are listed in **Appendix A**, **Question 39 Other**.
- Less than 2% of respondents reported first hearing about TEFRA on the internet.
- In the last six months, 19% of respondents looked for information in written materials or on the internet about how TEFRA works. About half of the respondents (49.4%) who searched for this information indicated that they "usually" or "always" found it.
- More than half of respondents (63.9%) were given forms to fill out from TEFRA in the last six months. Of those who completed paperwork, slightly more than half (52.1%) found the forms "usually" or "always" easy to fill out.

CUSTOMER SERVICE

- Less than one-third (31.7%) of the 461 parents/caregivers indicated they called Medicaid customer service during the last six months to get information or help for their child. The most frequently called number (38.1%) was TEFRA, 1-866-239-9938 followed by local county DHS offices (32.8%). A majority, 85.2% felt they were "usually" or "always" treated with courtesy and respect.
- Of the few (10) respondents who called ConnectCare, only eight spoke with someone who was able to help them.
- Of all the respondents who called Medicaid customer service, a large majority (63.6%) indicated that the person was able to answer all their questions about the TEFRA program. Of the respondents whose questions were answered, 94.3% "usually" or "always" understood the answers that customer service gave.

TEFRA PREMIUMS AND ENROLLMENT

- Almost half of the respondents (45.4%) indicated that their TEFRA premiums were not a financial burden, while 7.2% of respondents indicated that the premiums were a big financial burden.
- Four respondents, less than 1%, lost TEFRA eligibility because the premiums were too expensive to pay.
- Less than one-third (28.9%) experienced some problem receiving care while they waited for their child's TEFRA application to be processed.
- Almost half (40%) applied for TEFRA at a DHS county office, while slightly more than one-third (34.7%) of respondents applied for TEFRA at Arkansas Children's Hospital.
- More than one-third of respondents (35.2%) spoke with someone at the county DHS office in the last six months regarding questions they had about TEFRA. A majority (75.8%) indicated that the person at the county DHS office answered all their questions. Of those, 97.8% of respondents "usually" or "always" understood the answers they gave.
- The percentage of respondents rating their experience with the TEFRA application process with a score of 8 or higher was 53.8% which is slightly lower than the previous year of 54.5%.

TEFRA RENEWAL PROCESS

- In the last 12 months, 405 respondents (87.9%, n=461) received paperwork to renew TEFRA benefits for their child.
- Of those respondents who remembered the time span of receiving the TEFRA renewal packet until the deadline to turn it in, 26.8% indicated the span to be 1 to 7 days, 36.6% indicated the span to be 8 to 14 days, and 36.6% indicated the span to be more than 14 days. A large proportion, 98 of 396 (24.8%) respondents said they did not remember the time span. (Percentages are rounded and may not total 100%.)
- Forty-five respondents (11.4%) indicated they "never" had enough time to complete the TEFRA renewal packet before the deadline.
- More than half of respondents (66.2%) reported they "usually" or "always" had enough time to complete the TEFRA renewal packet before the deadline.

Trend Analysis

The following pages contain a trending table and graphs that show how TEFRA survey data changes over time. **Table 9** shows each composite measure, the questions that make up these composites, and rating questions for the current year (2021) and the previous two years (2020 and 2019). While the trending graphs in **Figure 2** provide a visual representation of the composites and rating questions over time, the trending table shows whether composites and respective components trend comparisons are significantly different over time. Any significant differences are highlighted.

The five composite measures are: "Getting care quickly," "How well doctors communicate," "Customer service,""Special equipment and supplies," and "Special therapies." The six rating questions cover health care professional, health care, treatment or counseling, TEFRA program, customer service, and the TEFRA application process. Composite questions are composed of component questions and therefore do not have valid n-values.

The summary rate is the percentage of respondents who chose the most positive question responses as specified by the National Committee for Quality Assurance (NCQA). For questions scaled as "never," "sometimes," "usually," and "always," a favorable response represents the proportion of clients who selected "usually" or "always." For questions scaled as "a big problem," "a small problem," and "not a problem," a favorable response represents the proportion of clients who selected "not a problem." Rating questions are scaled from 0 to 10, where 0 represents "worst possible" and 10 represents "best possible." The rating scores show the percentage of clients who rated the question favorably by selecting a rating of 8, 9, or 10.

TEFRA TREND ANALYSIS

A comparison of the 2021 TEFRA survey results with previous years found the following:

- In 2021 and 2019, the composite with the highest summary rate is the "Getting care quickly" composite at 95.6% and 95.1%, respectively. For 2020, the "How well doctors communicate" composite measured highest at 93.7%.
- The "Getting care quickly" composite has increased significantly from 2020's summary rate of 92.4% to 95.6% in 2021. The "Obtaining care right away" component of this composite did have a significant increase from 2020's summary rate of 93.5% to 97.5% in 2021.
- The "How well doctors communicate" composite and its components except for the "Doctors showing respect for what you had to say" component were all slightly higher than 2020 summary rates. None of these differences were significant.

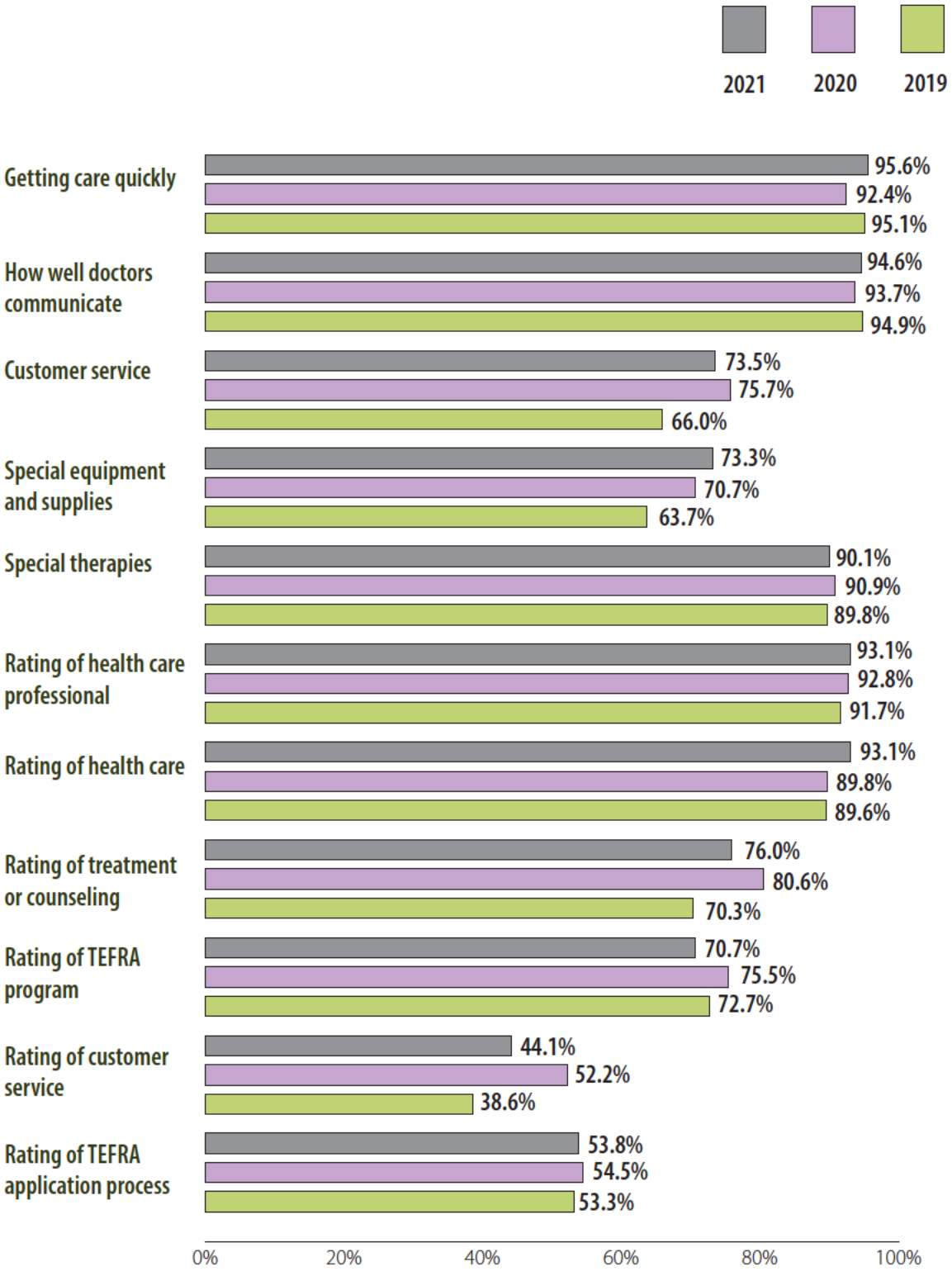
- The 2021 composite measure and the "Treated with courtesy and respect" component for "Customer service" increased significantly over 2019.
- 2021's "Special equipment and supplies" composite and its components increased significantly from 2019.
- Since 2019, summary rates for the "Special therapies" composite measure and its components have remained steady with very little difference between years.
- The best rating in all years was for "Health care professional" (93.1% in 2021, 92.8% in 2020, 91.7% in 2019).
- Both "Rating of health care professional" and "Rating of health care" have steadily increased since 2019.
- Significantly higher summary rates occur in 2021 from 2019 in the "Rating of health care" and "Rating of treatment or counseling" rating questions.
- Within ratings, the positive "Rating of customer service" summary rate is significantly lower in 2021 (44.1%) when compared with the 2020 summary rate of 52.2%.
- The summary rate for "Rating of TEFRA application process" has remained stable with no significant differences since 2019.

TABLE 9. TEFRA trending table

	2021		2020		2019		SIGNIFICANCE TESTING	
COMPOSITES/COMPONENTS RATING ITEMS	VALID n	SUMMARY RATE	VALID n	SUMMARY RATE	VALID n	SUMMARY RATE	2021 VS. 2020	2021 VS. 2019
Getting care quickly		**95.6%**		**92.4%**		**95.1%**	**Significantly higher**	**Not significant**
Q15. Obtaining care right away for an illness/injury/ condition	159	97.5%	169	93.5%	242	97.9%	**Significantly higher**	Not significant
Q17. Obtaining care when wanted, but not needed right away	398	93.7%	445	91.2%	483	92.3%	Not significant	Not significant
How well doctors communicate		**94.6%**		**93.7%**		**94.9%**	**Not significant**	**Not significant**
Q23. Doctors explaining things in an understandable way to your child	184	85.9%	226	85.0%	243	89.3%	Not significant	Not significant
Q19. Doctors listening carefully to you	412	97.8%	470	97.2%	515	97.9%	Not significant	Not significant

COMPOSITES/COMPONENTS RATING ITEMS	2021		2020		2019		SIGNIFICANCE TESTING	
	VALID n	SUMMARY RATE	VALID n	SUMMARY RATE	VALID n	SUMMARY RATE	2021 VS. 2020	2021 VS. 2019
Q20. Doctors showing respect for what you had to say	411	98.1%	470	98.5%	515	97.9%	Not significant	Not significant
Q24. Doctors spending enough time with your child	404	96.5%	468	94.2%	510	94.5%	Not significant	Not significant
Customer service		**73.5%**		**75.7%**		**66.0%**	**Not significant**	**Significantly higher**
Q48. Getting help when calling customer service	144	61.8%	90	66.7%	138	56.5%	Not significant	Not significant
Q49. Treated with courtesy and respect	142	85.2%	92	84.8%	135	75.6%	Not significant	**Significantly higher**
Special equipment and supplies		**73.3%**		**70.7%**		**63.7%**	**Not significant**	**Significantly higher**
Q27. Getting additional specialty items	106	74.5%	131	74.8%	124	64.5%	Not significant	**Significantly higher**
Q29. Getting special medical equipment	79	72.2%	87	66.7%	86	62.8%	Not significant	**Significantly higher**
Special therapies		**90.1%**		**90.9%**		**89.8%**	**Not significant**	**Not significant**
Q31. Getting speech therapy	303	89.8%	345	89.3%	380	89.5%	Not significant	Not significant
Q33. Getting occupational therapy	298	90.3%	356	90.7%	375	90.4%	Not significant	Not significant
Q35. Getting physical therapy	216	90.3%	262	92.7%	273	89.4%	Not significant	Not significant
Rating of health care professional (Q13)	461	93.1%	530	92.8%	569	91.7%	Not significant	Not significant
Rating of health care (Q25)	407	93.1%	469	89.8%	510	89.6%	Not significant	**Significantly higher**
Rating of treatment or counseling (Q38)	121	76.0%	155	80.6%	148	70.3%	Not significant	**Significantly higher**
Rating of TEFRA program (Q44)	458	70.7%	531	75.5%	565	72.7%	Not significant	Not significant
Rating of customer service (Q53)	136	44.1%	92	52.2%	132	38.6%	**Significantly lower**	Not significant
Rating of TEFRA application process (Q66)	459	53.8%	530	54.5%	561	53.3%	Not significant	Not significant

FIGURE 2. TEFRA trending chart



Demographic Analysis

The following tables show how clients in various demographic categories responded to the composite and the ratings questions. Range is the difference between the highest and lowest percentage on the specific composite or rating item. The number of respondents was small in some categories (<30), and caution should be exercised when making conclusions based on small numbers.

Values for "n" are not provided for composites as they are derived from multiple questions and may not have the same number of respondents for each question.

TABLE 10. Composite and rating questions by age category

	0–4		5–8		9–12		13–19		
AGE COMPOSITES AND RATINGS	n	%	n	%	n	%	n	%	RANGE
Getting care quickly		93.0%		96.1%		97.2%		96.3%	4.1
How well doctors communicate		97.9%		91.8%		95.7%		95.8%	6.1
Customer service		76.8%		71.1%		79.6%		66.1%	13.5
Special equipment and supplies		77.5%		68.6%		69.7%		75.0%	8.8
Special therapies		92.8%		88.1%		90.5%		89.7%	4.7
Rating of health care professional (Q13)	102	91.2%	147	93.9%	98	92.9%	110	94.5%	3.4
Rating of health care (Q25)	94	90.4%	123	93.5%	88	95.5%	98	94.9%	5.0
Rating of treatment or counseling (Q38)	16	87.5%	37	75.7%	32	71.9%	34	79.4%	15.6
Rating of TEFRA program (Q44)	102	70.6%	145	71.0%	96	74.0%	111	68.5%	5.5
Rating of customer service (Q53)	37	35.1%	41	39.0%	26	57.7%	31	48.4%	22.6
Rating of TEFRA application process (Q66)	100	50.0%	147	53.1%	98	57.1%	111	54.1%	7.1

When viewing composite measures: "Getting care quickly" and "How well doctors communicate" received high scores (>90.0%) in all age brackets. "Customer service" registered the most pronounced range among age groups with 13.5 percentage points between the lowest measure in the age bracket of 13–19 and highest measure in the age bracket of 9–12 years. "Special therapies" have relatively high measures in all age groups ranging from 88.1%–92.8%.

The smallest range (3.4) between age groups for rating questions occurred for "Rating of health care professional." Closely followed by "Rating of health care" with a range of 5.0 percentage points. These same composites have high scores (>90.0%) in all age categories. Age group comparison of "Rating of treatment or counseling" should be viewed with caution due to small numbers. The 0–4 age group for this rating question received the highest positive measure (87.5%).

Of age groups, the 9–12 age group rated the TEFRA program higher than other age groups (74.0%)

The "Rating of customer service" question has the greatest range among age groups (22.6) and received the lowest positive rating in the 0–4 age category (35.1%). The 9–12 age group rated the TEFRA application process 57.1% which is higher than the other age groups.

TABLE 11. Composite and rating questions by child's gender

	MALE		FEMALE		
GENDER COMPOSITES AND RATINGS	n	%	n	%	RANGE
Getting care quickly		96.0%		95.3%	0.7
How well doctors communicate		94.2%		95.0%	0.9
Customer service		74.3%		72.0%	2.3
Special equipment and supplies		73.5%		72.8%	0.7
Special therapies		92.4%		86.8%	5.6
Rating of health care professional (Q13)	273	93.4%	185	93.0%	0.4
Rating of health care (Q25)	237	94.5%	167	91.0%	3.5
Rating of treatment or counseling (Q38)	79	77.2%	40	72.5%	4.7
Rating of TEFRA program (Q44)	272	72.4%	183	68.3%	4.1
Rating of customer service (Q53)	78	44.9%	57	42.1%	2.8
Rating of TEFRA application process (Q66)	273	57.9%	184	47.8%	10.0

Satisfaction among males was less than three percentage points higher than females in three composites and slightly higher than five percentage points in the "Special therapies" composite. Females had one composite that was less than one percentage point higher than males. These positive percentages indicate parents/caregivers of both male and female clients were almost equally satisfied in each of the composite measures.

Five rating questions recorded a range of less than five percentage points. The largest difference between genders (10.0%) occurred in "Rating of TEFRA application process" with females reporting the lowest percentage of 47.8%. "Rating of health care professional" received the most favorable measures for female and "Rating of health care" received the most favorable measures for male among the rating questions.

TABLE 12. Composite and rating questions by child's race category

RACE COMPOSITES AND RATINGS	WHITE		BLACK		OTHER		RANGE
	n	%	n	%	n	%	
Getting care quickly		95.9%		100.0%		91.3%	8.7
How well doctors communicate		94.4%		97.9%		92.3%	5.5
Customer service		71.8%		87.5%		78.1%	15.7
Special equipment and supplies		73.1%		62.5%		74.1%	11.6
Special therapies		89.5%		90.3%		95.5%	6.0
Rating of health care professional (Q13)	386	93.0%	25	96.0%	44	90.9%	5.1
Rating of health care (Q25)	344	93.3%	24	91.7%	35	94.3%	2.6
Rating of treatment or counseling (Q38)	101	78.2%	8	62.5%	11	63.6%	15.7
Rating of TEFRA program (Q44)	385	68.6%	23	78.3%	44	86.4%	17.8
Rating of customer service (Q53)	116	43.1%	3	66.7%	15	46.7%	23.6
Rating of TEFRA application process (Q66)	385	52.7%	25	60.0%	44	59.1%	7.3

For **Table 12**, all respondents not identifying as "White" or "Black" are placed in the "Other" race category. As seen in **Question 73** in **Appendix A**, parents/caregivers identifying their child's race as "Black" and categorized as "Other" have a small representation. Caution should be exercised when making conclusions based on small numbers.

Those identifying their child's race as black indicated the highest composite measures among races in the "Getting care quickly" composite (100.0%), the "How well doctors communicate" composite (97.9%), and the "Customer service" composite (87.5%).

The "Customer service" composite is the only composite with more than a 15-percentage point range among the three race categories with the lowest measure (71.8%) from respondents indicating that their child's race is "White."

Rating questions provide varied ranges between races. The smallest difference of 2.6 percentage points occurred in the "Rating of health care" followed by "Rating of health care professional" with a range of 5.1 percentage points. The largest difference between races of 23.6% is found in "Rating of customer service" but has few in number within race categories. Caution should be exercised when making conclusions based on small numbers.

TABLE 13. Composite and rating questions by household income

INCOME COMPOSITES AND RATINGS	$0–$50,000		$50,001–$100,000		$100,001–$150,000		$150,001 OR MORE		RANGE
	n	%	n	%	n	%	n	%	
Getting care quickly		98.3%		96.6%		91.8%		93.6%	6.5
How well doctors communicate		94.5%		95.3%		93.5%		92.6%	2.6
Customer service		75.0%		73.9%		69.5%		71.4%	5.5
Special equipment and supplies		74.1%		73.9%		76.4%		61.3%	15.1
Special therapies		85.0%		90.8%		91.0%		93.1%	8.1
Rating of health care professional (Q13)	76	92.1%	212	93.4%	91	94.5%	61	90.2%	4.3
Rating of health care (Q25)	68	86.8%	188	93.6%	80	96.3%	51	94.1%	9.5
Rating of treatment or counseling (Q38)	23	73.9%	51	80.4%	27	74.1%	13	69.2%	11.2
Rating of TEFRA program (Q44)	74	64.9%	211	76.3%	90	65.6%	61	67.2%	11.4
Rating of customer service (Q53)	24	41.7%	68	51.5%	19	31.6%	21	33.3%	19.9
Rating of TEFRA application process (Q66)	76	56.6%	210	58.6%	92	52.2%	61	39.3%	19.2

Similar to **Table 12** on race, some of the household income categories had an insufficient number of respondents to make valid interpretations on the ranges for some composite and rating measures (**Appendix A**, **Question 77**). When computed by household income, the composite with the largest difference was the "Special equipment and supplies" composite (15.1 percentage points). Both composite measures for "Getting care quickly" and "How well doctors communicate" have high positive measures above 90.0 percent in all income categories.

Two out of six rating questions resulted in large variations with ranges of almost 20 percentage points. The largest difference of rating questions is "Rating of customer service" but representation is not sufficient in all income categories to draw valid conclusions. The largest range (19.2%) of rating questions with sufficient representation in all income categories is "Rating of TEFRA application process" with a high of 58.6% in the "$50,001–$100,000" category and the low of 39.3% found in the "$150,001 or more" category.

TABLE 14. Composite and rating questions by length of enrollment in TEFRA

LENGTH OF ENROLLMENT COMPOSITES AND RATINGS	LESS THAN 12 MONTHS		12 UP TO 24 MONTHS		2 UP TO 5 YEARS		5 OR MORE YEARS		RANGE
	n	%	n	%	n	%	n	%	
Getting care quickly		92.0%		94.3%		96.6%		97.1%	5.1
How well doctors communicate		91.5%		95.8%		95.1%		94.4%	4.3
Customer service		76.3%		69.4%		75.7%		72.2%	6.9
Special equipment and supplies		75.7%		74.3%		69.3%		76.2%	6.9
Special therapies		95.8%		91.4%		88.4%		88.8%	7.4
Rating of health care professional (Q13)	48	87.5%	86	88.4%	176	95.5%	148	95.3%	8.0
Rating of health care (Q25)	44	95.5%	82	87.8%	150	94.0%	129	94.6%	7.6
Rating of treatment or counseling (Q38)	12	91.7%	21	71.4%	55	78.2%	32	68.8%	22.9
Rating of TEFRA program (Q44)	48	64.6%	87	69.0%	173	72.3%	147	72.1%	7.7
Rating of customer service (Q53)	16	37.5%	34	35.3%	51	54.9%	34	41.2%	19.6
Rating of TEFRA application process (Q66)	47	51.1%	88	46.6%	175	54.3%	146	58.2%	11.6

The "Getting care quickly," "How well doctors communicate," and "Special therapies" composite questions have measures greater than 85.0% in each length of enrollment category. The largest range between length of enrollment categories occurred in the "Special therapies" composite with the high measure (95.8%) in the "Less than 12 months" category and the low measure found in the "2 up to 5 years" category. It should be noted that a smaller number of responses occur in Question 27 and Question 29, the components of the "Special equipment and supplies" composite, found in **Appendix A** and caution should be used in drawing conclusions on small numbers.

Rating measures for both "Rating of health care professional" and "Rating of health care" received high measures (>85.0%) in all the length of enrollment categories. The "Rating of health care professional," "Rating of health care," and "Rating of TEFRA program" have the smallest ranges (8.0% or less) with sufficient representation (n>30) in all length of enrollment categories.

TABLE 15. Composite and rating questions by financial burden of TEFRA premiums

FINANCIAL BURDEN OF TEFRA PREMIUMS COMPOSITES AND RATINGS	A BIG FINANCIAL BURDEN		A SMALL FINANCIAL BURDEN		NOT A FINANCIAL BURDEN		RANGE
	n	%	n	%	n	%	
Getting care quickly		96.6%		96.3%		95.3%	1.3
How well doctors communicate		89.3%		94.8%		95.6%	6.4
Customer service		67.1%		70.5%		78.4%	11.3
Special equipment and supplies		40.0%		70.1%		83.6%	43.6
Special therapies		61.3%		90.2%		94.3%	33.1
Rating of health care professional (Q13)	33	97.0%	213	94.4%	206	91.3%	5.7
Rating of health care (Q25)	30	93.3%	187	93.0%	182	93.4%	0.4
Rating of treatment or counseling (Q38)	13	61.5%	58	75.9%	48	79.2%	17.6
Rating of TEFRA program (Q44)	33	33.3%	214	66.4%	203	81.3%	47.9
Rating of customer service (Q53)	17	23.5%	62	38.7%	55	56.4%	32.8
Rating of TEFRA application process (Q66)	33	36.4%	213	52.1%	204	57.4%	21.0

The financial burden category "A big financial burden" has smaller numbers of respondents compared to the other financial burden categories. Generally, caution should be used in drawing conclusion on small numbers.

Similar to the gender and race tables, the burden of TEFRA premiums received high measures (>90.0%) in the "Getting care quickly" composite in all respective categories. This composite also recorded the smallest range between financial burden categories (1.3%). Caution should be used in viewing the large range in the "Special equipment and supplies" composite comprised of Questions 27 and 29, and the large range in the "Special therapy" composite comprised of Questions 31, 33 and 35 found in **Appendix A**. These questions have a smaller number of respondents.

Among rating questions, "A big financial burden" category had the greatest positive measure for "Rating of health care professional." The rating measures for "Rating of health care professional" and "Rating of health care" received high measures (>90.0%) in all financial burden categories. A large range of 47.9% is recorded in the "Rating of TEFRA program" with a high score of 81.3% from respondents in the "Not a financial burden" category while those respondents in "A big financial burden" category recorded a low score of 33.3%.

Regional Analysis

Mean ratings and utilization of services are further reported by geographic regions of the state. The map below shows the five regions and the counties that lie within them.

GEOGRAPHICAL REGIONS

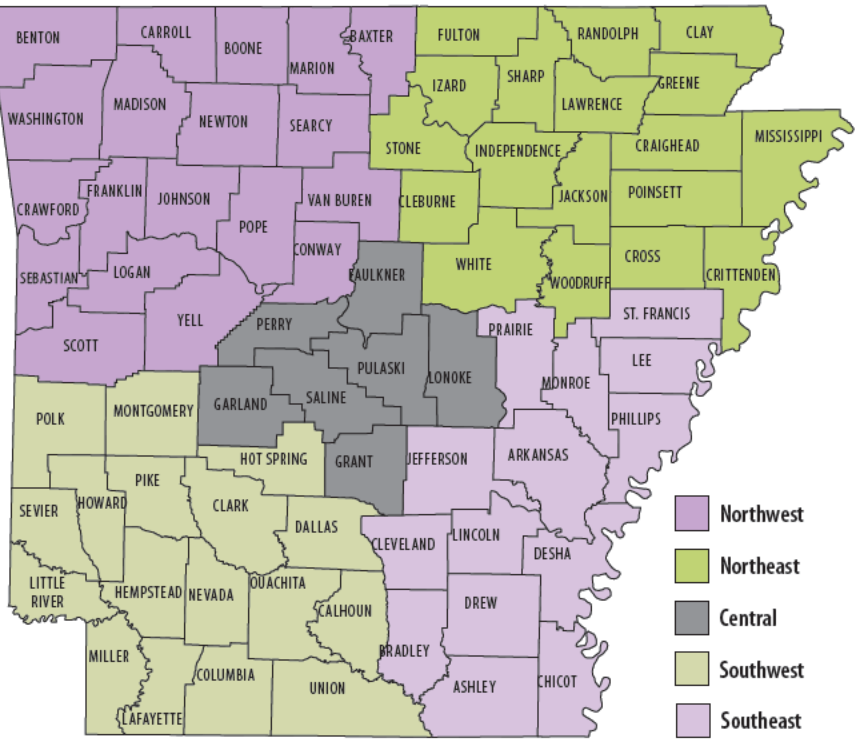
Northwest: Baxter, Benton, Boone, Carroll, Conway, Crawford, Franklin, Johnson, Logan, Madison, Marion, Newton, Pope, Scott, Searcy, Sebastian, Van Buren, Washington, and Yell counties

Northeast: Clay, Cleburne, Craighead, Crittenden, Cross, Fulton, Greene, Independence, Izard, Jackson, Lawrence, Mississippi, Poinsett, Randolph, Sharp, Stone, White, and Woodruff counties

Central: Faulkner, Garland, Grant, Lonoke, Perry, Pulaski, and Saline counties

Southwest: Calhoun, Clark, Columbia, Dallas, Hempstead, Hot Spring, Howard, Lafayette, Little River, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier, and Union counties

Southeast: Arkansas, Ashley, Bradley, Chicot, Cleveland, Desha, Drew, Jefferson, Lee, Lincoln, Monroe, Phillips, Prairie, and St. Francis counties



OVERALL MEAN RATINGS

The mean ratings are based on individual questions that ask clients to rate their child's health care professional, child's health care, child's treatment or counseling, TEFRA program, customer service, and the TEFRA application process. Ratings are based on a scale of 0–10, where 0 represents "worst possible" and 10 represents "best possible." The following table shows the mean ratings by region compared with the state mean as well as the number of clients who responded to the question.

TABLE 16. Mean ratings

	CENTRAL		NORTHEAST		NORTHWEST		SOUTHEAST		SOUTHWEST		STATEWIDE	
MEAN RATINGS	n	MEAN	n	MEAN	n	MEAN	n	MEAN	n	MEAN	n	MEAN
Rating of health care professional (Q13)	155	9.20	68	9.24	199	9.19	19	9.32	19	8.95	460	9.20
Rating of health care (Q25)	131	9.06	64	9.39	175	9.11	18	9.11	18	9.17	406	9.14
Rating of treatment or counseling (Q38)	44	8.09	17	8.94	56	8.45	3	9.33	1	10.00	121	8.42
Rating of TEFRA program (Q44)	152	8.08	67	8.40	201	8.06	19	8.89	19	8.68	458	8.18
Rating of customer service (Q53)	39	6.23	17	6.59	75	6.80	2	8.00	3	5.00	136	6.59
Rating of TEFRA application process (Q66)	153	7.33	67	7.21	200	7.02	19	8.00	19	7.47	458	7.21

Similar to 2020, the 2021 "Rating of health care professional" received the highest mean rating at 9.20 at the state level. This is a decrease from the 2020 state-level mean rating of 9.22 (not in table). In 2021, "Rating of customer service" received the lowest mean rating of 6.59 statewide which is a decrease from 2020's statewide "Rating of customer service" measure of 6.90 (not in table).

Mean ratings of less than 8.00 may be areas where improvements could be addressed. Statewide, this would include "Rating of customer service" and "Rating of TEFRA application process." Regionally, excluding the above-mentioned rating questions, no mean is less than 8.00.

The Southeast region aligns with the Southwest region having small numbers of respondents within these regions as well as two rating questions in the Northeast region. Caution should be applied when reviewing results in these regions.

Regionally, the Southeast region had the highest mean ratings for "Rating of health care professional" (9.32), and the Northeast had the highest mean rating for "Rating of health care" (9.39). The Southwest region had the highest mean rating for "Rating of treatment or counseling" (10.00) although there is only one respondent of record. The Southeast region had the highest mean for "Rating of TEFRA program" (8.89). The Southeast region had the highest mean rating for "Rating of customer service" (8.00) although the number of respondents is small. The Southeast had the highest mean rating for "Rating of TEFRA application process" (8.00).

UTILIZATION OF SERVICES

TABLE 17. Utilization of services

UTILIZATION OF SERVICES	CENTRAL		NORTHEAST		NORTHWEST		SOUTHEAST		SOUTHWEST		STATEWIDE	
	n	%	n	%	n	%	n	%	n	%	n	%
Visiting the doctor at least once	155	86.5%	68	95.6%	199	88.4%	18	100.0%	19	94.7%	459	89.5%
Visiting the doctor three or more times	155	36.1%	68	36.8%	199	34.2%	18	27.8%	19	57.9%	459	35.9%
Seeking routine medical care	154	83.1%	68	95.6%	200	87.0%	19	89.5%	19	68.4%	460	86.3%
Seeking medical care for illness/ injury	154	30.5%	68	44.1%	200	36.5%	19	21.1%	19	31.6%	460	34.8%
Getting treatment or counseling	156	28.2%	68	26.5%	201	27.9%	19	15.8%	18	5.6%	462	26.4%
Calling Medicaid customer service	154	27.3%	68	25.0%	202	40.1%	19	10.5%	18	22.2%	461	31.7%
Needing additional specialty items	156	21.8%	68	22.1%	202	23.8%	19	10.5%	19	42.1%	464	23.1%
Needing special medical equipment	156	12.8%	68	20.6%	199	17.6%	19	21.1%	19	26.3%	461	16.9%
Needing speech therapy	155	66.5%	68	63.2%	200	71.0%	19	42.1%	18	38.9%	460	65.9%
Needing occupational therapy	156	63.5%	68	61.8%	202	71.3%	19	36.8%	18	38.9%	463	64.6%
Needing physical therapy	155	39.4%	68	47.1%	202	54.0%	19	36.8%	18	44.4%	462	47.0%

Across the state, "Visiting the doctor at least once" recorded the highest utilization of services rate at 89.5%, followed by "Seeking routine medical care" at 86.3%. On the other hand, "Needing special medical equipment" and "Needing additional specialty items" were the least utilized services with rates of 16.9% and 23.1%, respectively.

Again, caution should be exercised when reviewing results in the Southeast and Southwest regions, where the number of respondents was small (<30.0%). Regionally speaking, "Needing occupational therapy" registered the most variability, with the highest utilization of services rate of 71.3% in the Northwest region and the lowest utilization of services rate of 36.8% in the Southeast. Every region has at least 3 utilization of services rates of less than 30.0% though the Southeast region has 6 utilization of services rates lower than 30.0%.

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Appendix A: TEFRA Frequency Tables and Comments

Q1. Our records show that your child is enrolled in the TEFRA program. Is that right?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	465	100.00	465	100.00

Q2. How many months or years in a row has your child been enrolled in the TEFRA program?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Less than 6 months	4	0.87	4	0.87
6 up to 12 months	44	9.52	48	10.39
12 up to 24 months	88	19.05	136	29.44
2 up to 5 years	177	38.31	313	67.75
5 up to 10 years	103	22.29	416	90.04
10 or more years	46	9.96	462	100.00

Q3. In the 6 months before your child was enrolled with TEFRA, how much of a problem, if any, was it for your child to see a personal doctor or nurse?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	29	6.25	29	6.25
A small problem	74	15.95	103	22.20
Not a problem	338	72.84	441	95.04
My child did not see a personal doctor or nurse in the 6 months before enrolling in TEFRA.	23	4.96	464	100.00

Q4. Since enrolling in TEFRA, how much of a problem, if any, has it been for your child to see a personal doctor or nurse?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	4	0.86	4	0.86
A small problem	26	5.60	30	6.47
Not a problem	432	93.10	462	99.57
My child did not see a personal doctor or nurse since enrolling in TEFRA.	2	0.43	464	100.00

Q5. In the 6 months before your child was enrolled with TEFRA, how much of a problem, if any, was it to get your child's prescription medicine?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	41	8.86	41	8.86
A small problem	84	18.14	125	27.00
Not a problem	276	59.61	401	86.61
My child did not need prescription medicine in the 6 months before enrolling in TEFRA.	62	13.39	463	100.00

Q6. Since enrolling in TEFRA, how much of a problem, if any, was it to get your child's prescription medicine?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	4	0.86	4	0.86
A small problem	46	9.91	50	10.78
Not a problem	385	82.97	435	93.75
My child has not needed prescription medicine since enrolling in TEFRA.	29	6.25	464	100.00

Q7. In the 6 months before your child was enrolled with TEFRA, when your child needed urgent care from a doctor's office or the emergency room, how much of a problem, if any, was it for your child to get this care?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	27	5.87	27	5.87
A small problem	57	12.39	84	18.26
Not a problem	280	60.87	364	79.13
My child did not need urgent care in the 6 months before enrolling in TEFRA.	96	20.87	460	100.00

Q8. Since enrolling in TEFRA, when your child needed urgent care from a doctor's office or the emergency room, how much of a problem, if any, was it for your child to get this care?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	3	0.65	3	0.65
A small problem	20	4.33	23	4.98
Not a problem	375	81.17	398	86.15
My child has not needed urgent care since enrolling in TEFRA.	64	13.85	462	100.00

Q9. A personal doctor or nurse can be a general doctor, a nurse practitioner, or a physician assistant. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. Which describes the type of health care professional your child sees most often?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Personal doctor/family doctor primary care physician	263	60.18	263	60.18
Specialist	174	39.82	437	100.00

Q10. In the last 6 months, did your child need a referral to see a specialist?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	200	43.57	200	43.57
No	259	56.43	459	100.00

Q11. In the last 6 months, how much of a problem, if any, did you have getting a referral to see a specialist?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	9	4.52	9	4.52
A small problem	35	17.59	44	22.11
Not a problem	155	77.89	199	100.00

Q12. With the choices the TEFRA program gave you, how much of a problem, if any, was it to get a health care professional for your child you are happy with?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	12	2.61	12	2.61
A small problem	35	7.63	47	10.24
Not a problem	372	81.05	419	91.29
I didn't get a new health care professional for my child.	40	8.71	459	100.00

Q13. We want to know your rating of your child's health care professional. Use any number from 0 to 10, where 0 is the worst health care professional possible and 10 is the best. How would you rate your child's health care professional now?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0 Worst health care professional	1	0.22	1	0.22
1	0	0.00	1	0.22
2	0	0.00	1	0.22
3	2	0.43	3	0.65
4	0	0.00	3	0.65
5	2	0.43	5	1.08
6	9	1.95	14	3.04
7	18	3.90	32	6.94
8	74	16.05	106	22.99
9	99	21.48	205	44.47
10 Best health care professional	256	55.53	461	100.00

Q14. In the last 6 months, did your child have an illness, injury or condition that needed care right away in a clinic, emergency room or doctor's office?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	160	34.71	160	34.71
No	301	65.29	461	100.00

Q15. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	0	0.00	0	0.00
Sometimes	4	2.52	4	2.52
Usually	18	11.32	22	13.84
Always	137	86.16	159	100.00

Q16. In the last 6 months, not counting the times your child needed care right away, did you make any appointments for your child's health care at a doctor's office or clinic?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	398	86.33	398	86.33
No	63	13.67	461	100.00

Q17. In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as your child needed?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	1	0.25	1	0.25
Sometimes	24	6.03	25	6.28
Usually	101	25.38	126	31.66
Always	272	68.34	398	100.00

Q18. In the last 6 months, how many times did your child go to his or her doctor's office or clinic?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
None	48	10.43	48	10.43
1	128	27.83	176	38.26
2	118	25.65	294	63.91
3	85	18.48	379	82.39
4	29	6.30	408	88.70
5 to 9	39	8.48	447	97.17
10 or more	13	2.83	460	100.00

Q19. In the last 6 months, how often did your child's doctors or other health care providers listen carefully to you?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	0	0.00	0	0.00
Sometimes	9	2.18	9	2.18
Usually	72	17.48	81	19.66
Always	331	80.34	412	100.00

Q20. In the last 6 months, how often did your child's health care professional show respect for what you had to say?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	0	0.00	0	0.00
Sometimes	8	1.95	8	1.95
Usually	61	14.84	69	16.79
Always	342	83.21	411	100.00

Q21. Is your child able to talk with doctors about his or her health care?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	185	45.01	185	45.01
No	226	54.99	411	100.00

Q22. In the last 6 months, how often did your child have a hard time speaking with or understanding doctors or other health providers because they spoke different languages?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	163	88.59	163	88.59
Sometimes	14	7.61	177	96.20
Usually	7	3.80	184	100.00
Always	0	0.00	184	100.00

Q23. In the last 6 months, how often did doctors or other health providers explain things in a way your child could understand?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	3	1.63	3	1.63
Sometimes	23	12.50	26	14.13
Usually	59	32.07	85	46.20
Always	99	53.80	184	100.00

Q24. In the last 6 months, how often did doctors or other health providers spend enough time with your child?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	2	0.50	2	0.50
Sometimes	12	2.97	14	3.47
Usually	108	26.73	122	30.20
Always	282	69.80	404	100.00

Q25. We want to know your rating of all your child's health care in the last 6 months from all doctors and other health providers. Use any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible. How would you rate all your child's health care?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0 Worst health care possible	0	0.00	0	0.00
1	0	0.00	0	0.00
2	1	0.25	1	0.25
3	0	0.00	1	0.25
4	1	0.25	2	0.49
5	3	0.74	5	1.23
6	5	1.23	10	2.46
7	18	4.42	28	6.88
8	75	18.43	103	25.31
9	97	23.83	200	49.14
10 Best health care possible	207	50.86	407	100.00

Q26. In the last 6 months, did your child have any health problems for which he or she needed additional specialty items such as diapers, formula, or dietary supplements? (Don't count diapers for infants or toddlers who are not yet potty trained.)				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	108	23.23	108	23.23
No	357	76.77	465	100.00

Q27. In the last 6 months, how much of a problem, if any, was it to get the additional specialty items your child needed through TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	14	13.21	14	13.21
A small problem	13	12.26	27	25.47
Not a problem	79	74.53	106	100.00

Q28. In the last 6 months, did your child have any health problems that required you to get or replace any special medical equipment or devices such as a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	79	17.10	79	17.10
No	383	82.90	462	100.00

Q29. In the last 6 months, how much of a problem, if any, was it to get the special medical equipment your child needed through TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	14	17.72	14	17.72
A small problem	8	10.13	22	27.85
Not a problem	57	72.15	79	100.00

Q30. In the last 6 months, did your child need speech therapy?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	304	65.94	304	65.94
No	157	34.06	461	100.00

Q31. In the last 6 months, how much of a problem, if any, was it to get the speech therapy your child needed through TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	13	4.29	13	4.29
A small problem	18	5.94	31	10.23
Not a problem	272	89.77	303	100.00

Q32. In the last 6 months, did your child need occupational therapy?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	300	64.66	300	64.66
No	164	35.34	464	100.00

Q33. In the last 6 months, how much of a problem, if any, was it to get the occupational therapy your child needed through TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	14	4.70	14	4.70
A small problem	15	5.03	29	9.73
Not a problem	269	90.27	298	100.00

Q34. In the last 6 months, did your child need physical therapy?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	218	47.08	218	47.08
No	245	52.92	463	100.00

Q35. In the last 6 months, how much of a problem, if any, was it to get the physical therapy your child needed through TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	6	2.78	6	2.78
A small problem	15	6.94	21	9.72
Not a problem	195	90.28	216	100.00

Q36. In the last 6 months, did your child have any treatment or counseling for an emotional or behavioral difficulty?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	122	26.35	122	26.35
No	341	73.65	463	100.00

Q37. In the last 6 months, how much of a problem, if any, was it for you to get this treatment or counseling through TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	18	14.75	18	14.75
A small problem	21	17.21	39	31.97
Not a problem	83	68.03	122	100.00

Q38. We want to know your rating of your child's treatment or counseling for emotional or behavioral difficulties. Use any number from 0 to 10, where 0 is the worst treatment or counseling possible and 10 is the best treatment or counseling possible. How would you rate your child's treatment or counseling now?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0 Worst treatment or counseling possible	0	0.00	0	0.00
1	1	0.83	1	0.83
2	1	0.83	2	1.65
3	1	0.83	3	2.48
4	1	0.83	4	3.31
5	7	5.79	11	9.09
6	9	7.44	20	16.53
7	9	7.44	29	23.97
8	18	14.88	47	38.84
9	27	22.31	74	61.16
10 Best treatment or counseling possible	47	38.84	121	100.00

Q39. Where did you first hear about TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Arkansas Children's Hospital	139	31.10	139	31.10
Doctor's office	55	12.30	194	43.40
Friend or relative	92	20.58	286	63.98
Internet	7	1.57	293	65.55
School/daycare	57	12.75	350	78.30
Other (Please print.)	97	21.70	447	100.00

Q39. Other	
	Frequency
AAROC IN LITTLE ROCK	1
ADH	1
ADOPTION AGENCY	1
AFTER SCHOOL PROGRAM FATHER OF AN AUTISTIC CHILD	1
ARKANSAS DOWN SYNDROME ASSOCIATION	1
ARKANSAS SUPPORT NETWORK	1
AUTISM WAIVER TO EPDST PROGRAM	1
CHILDREN'S THERAPY TEAM	5
CLIENT	1
CMS	1
DDS DEVELOPMENTAL DISABILITY SERVICES	1
DENNIS DEVELOMENTAL	1
DHS	4
DMS	1
DSCNWA SUPPORT GROUP	1
EARLY INTERVENTION PROGRAM	3
EASTER SEALS	1
EMPLOYER	2
FOLLOWING BABY BACK HOME PROGRAM EMPLOYEES	1
HOSPITAL	2
HOSPITAL - BAPTIST	2
HOSPITAL - ST MARY'S	1
HOSPITAL- CONWAY	1
I DON'T REMEMBER	1
KIDSOURCE, ARKANSAS THERAPY OUTREACH	3
PEDIATRICS PLUS	3
SOCIAL SECURITY ADMINISTRATION	4
SPEECH THERAPY/OCCUPATIONAL THERAPY/PHYSICAL THERAPY	42
STATE SENATOR	1
SUNSHINE SCHOOL	1
SUPPORT GROUP	1
UAMS	1
WE HAD AR KIDS B BUT MADE TOO MUCH MONEY	1
WIFE KNEW ABOUT IT THROUGH HER EDUCATION.	1

Q40. In the last 6 months, did you look for any information in written materials or on the Internet about how TEFRA works?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	87	18.95	87	18.95
No	372	81.05	459	100.00

Q41. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how TEFRA works?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	13	14.94	13	14.94
Sometimes	31	35.63	44	50.57
Usually	34	39.08	78	89.66
Always	9	10.34	87	100.00

Q42. In the last 6 months, did TEFRA give you any forms to fill out?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	294	63.91	294	63.91
No	166	36.09	460	100.00

Q43. In the last 6 months, how often were the forms from TEFRA easy to fill out?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	38	13.01	38	13.01
Sometimes	102	34.93	140	47.95
Usually	96	32.88	236	80.82
Always	56	19.18	292	100.00

Q44. We want to know your rating of all your experiences with the TEFRA program. Use any number from 0 to 10, where 0 is the worst experience possible and 10 is the best experience possible. How would you rate the TEFRA program now?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0 Worst experience possible	3	0.66	3	0.66
1	1	0.22	4	0.87
2	2	0.44	6	1.31
3	5	1.09	11	2.40
4	8	1.75	19	4.15
5	31	6.77	50	10.92
6	28	6.11	78	17.03
7	56	12.23	134	29.26
8	82	17.90	216	47.16
9	97	21.18	313	68.34
10 Best experience possible	145	31.66	458	100.00

Q45. In the last 6 months, did you call Medicaid customer service to get information or help for your child?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	146	31.67	146	31.67
No	315	68.33	461	100.00

Q46. Where did you call most often for Medicaid customer service information or help?				
	Frequency	Percent	Cumulative Frequency	Cumulativ Percen
TEFRA (1-866-239-9938)	51	38.06	51	38.0
Medicaid Resolution Center (1-888-474-8275)	9	6.72	60	44.7
Access AR Call Center (1-800-482-8988 or 1-855-372-1084)	5	3.73	65	48.5
Medicaid Claims Resolution Center (1-800-482-5431)	4	2.99	69	51.4
Medicaid Services, a division of AFMC (1-888-987-1200)	4	2.99	73	54.4
ConnectCare (1-800-275-1131)	10	7.46	83	61.9
Local county DHS office	44	32.84	127	94.7
Doctor's office	1	0.75	128	95.5
Other (Please print.)	6	4.48	134	100.0

Q46. Other	
	Frequency
DENTIST	1
LINCARE-SUPPLIES	1
TEFRA PREMIUM UNIT	1
TEFRA PROCESSING UNIT IN BERRYVILLE - ** IS SO HELFUL!	1
TRULY UNSURE	1

Q47. In the last 6 months, when you spoke to a person at ConnectCare, were they able to help you?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	8	80.00	8	80.00
No	2	20.00	10	100.00

Q48. In the last 6 months, how often did Medicaid customer service give you the information or help you needed?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	15	10.42	15	10.42
Sometimes	40	27.78	55	38.19
Usually	36	25.00	91	63.19
Always	53	36.81	144	100.00

Q49. In the last 6 months, how often did Medicaid customer service staff treat you with courtesy and respect?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	4	2.82	4	2.82
Sometimes	17	11.97	21	14.79
Usually	42	29.58	63	44.37
Always	79	55.63	142	100.00

Q50. In the last 6 months, when you called Medicaid customer service, was the person in customer service able to answer all your questions about the TEFRA program?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	89	63.57	89	63.57
No	51	36.43	140	100.00

Q51. How often did you understand the answers that they gave?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	0	0.00	0	0.00
Sometimes	5	5.75	5	5.75
Usually	25	28.74	30	34.48
Always	57	65.52	87	100.00

Q52. In the last 6 months, when you called Medicaid customer service, did any of these things happen to you? (Check all that apply.)			
	Frequency	Percent	Utilization
None	50	19.16	37.04
Long wait or no one called back	44	16.86	32.59
Kept getting transferred or could not get in touch with the right person	48	18.39	35.56
Staff could not answer questions	48	18.39	35.56
Staff members were rude	12	4.60	8.89
Left message(s) and no one returned my call	18	6.90	13.33
Kept getting disconnected	13	4.98	9.63
Voicemail full	17	6.51	12.59
Other (Please print.)	11	4.21	8.15

Q52. Other	
	Frequency
CONFUSED ABOUT TEFRA PROGRAM – UNFAMILIAR AND UNSURE HOW TO HELP	1
CONFUSION WITH NEW ONLINE RENEWAL – WISH I WOULDN'T HAVE USED IT AT ALL.	1
GAVE WRONG INFORMATION	1
I CALLED LOCAL AND USUALLY GET A PERSON	1
NEW SYSTEM, BUT NOT CLEAR WHO TO CONTACT.	1
NOT A WAY TO LEAVE A MESSAGE	1
RECEIVED DIFFERENT ANSWERS TO SAME QUESTION EACH TIME I TALKED TO DIFFERENT PERSON.	1
SAID MAIL WAS SLOW AND NEW UPDATE SENT WRONG FORMS AND WE WERE WORRIED WE WOULD MISS THE DEADLINE	1
TEFRA IS THE DEPT. I SPOKE TO, NOT MEDICAID. MAYBE YOU GUYS ARE THE SAME?	1
WHEN EMAILING, THINGS GO MUCH BETTER	1

Q53. We want to know your rating of your experience with Medicaid customer service. Use any number from 0 to 10, where 0 is the worst experience possible and 10 is the best experience possible. How would you rate the Medicaid customer service?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0 Worst experience possible	0	0.00	0	0.00
1	5	3.68	5	3.68
2	8	5.88	13	9.56
3	11	8.09	24	17.65
4	7	5.15	31	22.79
5	15	11.03	46	33.82
6	10	7.35	56	41.18
7	20	14.71	76	55.88
8	22	16.18	98	72.06
9	17	12.50	115	84.56
10 Best experience possible	21	15.44	136	100.00

Q54. A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
$0	21	4.62	21	4.62
$20 – $41	46	10.11	67	14.73
$52 – $78	109	23.96	176	38.68
$93 – $125	101	22.20	277	60.88
$145 – $182	69	15.16	346	76.04
$208 – $250	34	7.47	380	83.52
$281 – $328	23	5.05	403	88.57
$364 – $416	18	3.96	421	92.53
$458	34	7.47	455	100.00

Q55. In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big financial burden	33	7.24	33	7.24
A small financial burden	216	47.37	249	54.61
Not a financial burden	207	45.39	456	100.00

Q56. In the last 6 months, has your child lost TEFRA eligibility because the TEFRA program premiums were too expensive for you to pay?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	4	0.87	4	0.87
No	458	99.13	462	100.00

Q57. Please tell us which services you could not get in the last 6 months because your child lost TEFRA coverage. (Check all that apply.)			
	Frequency	Percent	Utilization
Regular physician visits	1	20.00	50.00
Visits to a specialist	0	0.00	0.00
Emergency room visits	1	20.00	50.00
Dental visits	1	20.00	50.00
Prescription medicine	0	0.00	0.00
Special therapy	1	20.00	50.00
Medical equipment	0	0.00	0.00
Other (Please print.)	1	20.00	50.00

Q57. Other	
	Frequency
LAB WORK	1

Q58. In the last 6 months, were there any medical services that you could not get for your child because those services were not included in the TEFRA program?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	51	11.09	51	11.09
No	409	88.91	460	100.00

Q59. Please tell us which services you could not get in the last 6 months because those services were not included in the TEFRA program. (Check all that apply.)			
	Frequency	Percent	Utilization
Regular physician visits	3	4.29	5.88
Visits to a specialist	6	8.57	11.76
Emergency room visits	1	1.43	1.96
Dental visits	4	5.71	7.84
Prescription medicine	17	24.29	33.33
Special therapy	8	11.43	15.69
Medical equipment	8	11.43	15.69
Other (Please print.)	23	32.86	45.10

Q59. Other	
	Frequency
(THERAPY) SPEECH, OCCUPATIONAL, PHYSICAL I WAS TOLD TEFRA WILL NOT PAY FOR THERAPIES	1
ABA THERAPY	1
AUTISM TESTING	1
BRACES	1
DEVELOPMENTAL SCHOOL/DAYCARE	1
GENE TESTING REQUESTED BY PCP	1
GENETIC TESTING	1
GUARDIAN SENSORS USED W/ (MEDTRONIC) CONTINUOUS GLUCOSE MONITOR SYSTEM	1
HEALTHY CONNECTIONS VISIT	1
LAB WORK	1
MEDICAL SUPPLIES	1
MEDICATION NOT COVERED BY MEDICAID	1
MENTAL HEALTH	1
NEUROFEEDBACK THERAPY	1
ORTHODONTIST	1
PHYCHIATRIST NUTRITIONAL COUNSELING FOR SPECIAL DIET	1
SERVICES IN DENTISTRY	1
SPECIALTY VITAMINS URGENT CARE FACILITY	1
SUPPORTED LIVING SERVICES RESIDENTIAL PLACEMENT	1
SYNAGIS	1
TRANSPORTATION	1
URGENT CARE VISITS WITH MEDEXPRESS	1
VISION DOC SAID TEFRA DID NOT COVER HER SERVICES AND SHE WOULDN'T EVEN FILE A CLAIM	1

Q60. When you enrolled your child in the TEFRA program, how much of a problem did you have receiving care while you waited for your TEFRA application to be processed?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
A big problem	38	8.24	38	8.24
A small problem	95	20.61	133	28.85
Not a problem	328	71.15	461	100.00

Q61. When you enrolled your child in the TEFRA program, where did you apply?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
DHS county office	182	40.00	182	40.00
Arkansas Children's Hospital	158	34.73	340	74.73
Federally qualified health center (doctor's office/day care center)	51	11.21	391	85.93
Other (Please print.)	64	14.07	455	100.00

Q61. Other	
	Frequency
AT CHILD'S SCHOOL	2
AT CHILD'S THERAPY	9
BY MAIL	27
CALLED DHS	1
DOCTORS OFFICE AT HOME	1
FAX APP IN	1
HOME	1
HOSPITAL PROVIDED PAPERWORK	2
JARVIS	1
NOT SURE	3
ONLINE	7
PEDIATRICS PLUS	2
TEFRA AN EMPLOYEE CAME AND MET ME TO HELP ME WITH PAPERWORK	1
REQUESTED PAPERWORK	1
VIA TELEPHONE	2
W/THE EPSDT PROGRAM **** W/PARTNERS FOR INCLUSIVE COMMUNITIES	1
WASHINGTON COUNTY DHS CASE MANAGER	1

Q62. At which county DHS office did you enroll your child in the TEFRA program? (Please print.)				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
BAXTER	1	0.58	1	0.58
BENTON	30	17.54	31	18.13
CARROLL	11	6.43	42	24.56
CLARK	1	0.58	43	25.15
CLAY	1	0.58	44	25.73
CLEBURNE	1	0.58	45	26.32
CLEVELAND	3	1.75	48	28.07
COLUMBIA	1	0.58	49	28.65
CONWAY	2	1.17	51	29.82
CRAIGHEAD	3	1.75	54	31.58
CRAWFORD	2	1.17	56	32.75
CROSS	1	0.58	57	33.33
DALLAS	2	1.17	59	34.50
FAULKNER	10	5.85	69	40.35
FULTON	1	0.58	70	40.94
GARLAND	2	1.17	72	42.11
GRANT	1	0.58	73	42.69
GREENE	1	0.58	74	43.27
HEMPSTEAD	1	0.58	75	43.86
HOT SPRING	1	0.58	76	44.44
IZARD	1	0.58	77	45.03
JEFFERSON	4	2.34	81	47.37
JOHNSON	2	1.17	83	48.54
LAWRENCE	1	0.58	84	49.12
MARION	1	0.58	85	49.71
MILLER	2	1.17	87	50.88
MISSISSIPPI	2	1.17	89	52.05
MONROE	1	0.58	90	52.63
NEWTON	1	0.58	91	53.22
OUACHITA	1	0.58	92	53.80
POINSETT	1	0.58	93	54.39
POLK	1	0.58	94	54.97
POPE	3	1.75	97	56.73
PULASKI	20	11.70	117	68.42

Q62. At which county DHS office did you enroll your child in the TEFRA program? (Please print.)				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
RANDOLPH	14	8.19	131	76.61
SALINE	5	2.92	136	79.53
SCOTT	2	1.17	138	80.70
SEBASTIAN	4	2.34	142	83.04
SHARP	1	0.58	143	83.63
ST. FRANCIS	1	0.58	144	84.21
UNION	1	0.58	145	84.80
VAN BUREN	12	7.02	157	91.81
WASHINGTON	11	6.43	168	98.25
WHITE	3	1.75	171	100.00

Q63. In the last 6 months (including enrollment), have you spoken with anyone at the county DHS office regarding questions you have about TEFRA?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	63	35.20	63	35.20
No	116	64.80	179	100.00

Q64. In the last 6 months, when you spoke to a person at the county DHS office, were they able to answer all your questions?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	47	75.81	47	75.81
No	15	24.19	62	100.00

Q65. How often did you understand the answers that they gave?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	0	0.00	0	0.00
Sometimes	1	2.17	1	2.17
Usually	11	23.91	12	26.09
Always	34	73.91	46	100.00

Q66. We want to know your rating of all your experience with the TEFRA application process. Think about when you first got the application, to when your child started getting services. Use any number from 0 to 10, where 0 is the worst application experience possible and 10 is the best application experience possible. How would you rate the TEFRA application process?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
0 Worst experience possible	7	1.53	7	1.53
1	9	1.96	16	3.49
2	11	2.40	27	5.88
3	14	3.05	41	8.93
4	20	4.36	61	13.29
5	39	8.50	100	21.79
6	45	9.80	145	31.59
7	67	14.60	212	46.19
8	94	20.48	306	66.67
9	61	13.29	367	79.96
10 Best experience possible	92	20.04	459	100.00

Q67. In the last 12 months, did you receive paperwork to renew TEFRA benefits for your child?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	405	87.85	405	87.85
No	56	12.15	461	100.00

Q68. From the time you received the TEFRA renewal packet until the deadline to turn it in, how many days did you have to complete the paperwork?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
1 to 7 days	80	20.20	80	20.20
8 to 14 days	109	27.53	189	47.73
More than 14 days	109	27.53	298	75.25
I don't remember	98	24.75	396	100.00

Q69. In the last 12 months, how often did you have enough time to complete the TEFRA renewal packet before the deadline?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Never	45	11.42	45	11.42
Sometimes	88	22.34	133	33.76
Usually	133	33.76	266	67.51
Always	128	32.49	394	100.00

Q70. What is your child's age now?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Less than 1 year old	0	0.00	0	0.00
1 year old	12	2.60	12	2.60
2 years old	23	4.99	35	7.59
3 years old	28	6.07	63	13.67
4 years old	39	8.46	102	22.13
5 years old	41	8.89	143	31.02
6 years old	36	7.81	179	38.83
7 years old	38	8.24	217	47.07
8 years old	33	7.16	250	54.23
9 years old	30	6.51	280	60.74
10 years old	22	4.77	302	65.51
11 years old	24	5.21	326	70.72
12 years old	23	4.99	349	75.70
13 years old	21	4.56	370	80.26
14 years old	21	4.56	391	84.82
15 years old	19	4.12	410	88.94
16 years old	20	4.34	430	93.28
17 years old	14	3.04	444	96.31
18 years old	14	3.04	458	99.35
19 years old	3	0.65	461	100.00

Q71. Is your child male or female?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Male	276	59.74	276	59.74
Female	186	40.26	462	100.00

Q72. Is your child of Hispanic or Latino origin or descent?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes, Hispanic or Latino	42	9.09	42	9.09
No, not Hispanic or Latino	420	90.91	462	100.00

Q73. What is your child's race? (Please mark one or more.)				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
White	389	83.66	389	83.66
Black or African American	25	5.38	414	89.03
Asian	8	1.72	422	90.75
Native Hawaiian or other Pacific Islander	1	0.22	423	90.97
American Indian or Alaska Native	5	1.08	428	92.04
Other	8	1.72	436	93.76
Multiracial	23	5.01	459	100.00

Q74. What is your age now?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
18 to 24	2	0.44	2	0.44
25 to 34	99	21.57	101	22.00
35 to 44	239	52.07	340	74.07
45 to 54	96	20.92	436	94.99
55 to 64	17	3.70	453	98.69
65 to 74	4	0.87	457	99.56
75 or older	2	0.44	459	100.00

Q75. Are you male or female?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Male	64	13.85	64	13.85
Female	398	86.15	462	100.00

Q76. How are you related to the child?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Mother or father	458	99.13	458	99.13
Grandparent	3	0.65	461	99.78
Aunt or uncle	0	0.00	461	99.78
Older brother or sister	1	0.22	462	100.00
Other relative	0	0.00	462	100.00
Legal guardian	0	0.00	462	100.00
Someone else	0	0.00	462	100.00

Q77. What is your current household income?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
$0 – $25,000	13	2.93	13	2.93
$25,001 – $50,000	64	14.45	77	17.38
$50,001 – $75,000	116	26.19	193	43.57
$75,001 – $100,000	97	21.90	290	65.46
$100,001 – $125,000	50	11.29	340	76.75
$125,001 – $150,000	42	9.48	382	86.23
$150,001 – $175,000	21	4.74	403	90.97
$175,001 – $200,000	15	3.39	418	94.36
$200,001 or more	25	5.64	443	100.00

Q78. Did someone help you complete this survey?				
	Frequency	Percent	Cumulative Frequency	Cumulative Percent
Yes	7	1.51	7	1.51
No	457	98.49	464	100.00

Q79. How did that person help you? (Check all that apply.)			
	Frequency	Percent	Utilization
Read the questions to me.	1	11.11	16.67
Wrote down the answers I gave.	2	22.22	33.33
Answered the questions for me.	2	22.22	33.33
Translated the questions into my language.	2	22.22	33.33
Helped in some other way.	2	22.22	33.33

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	2–5 years	$50,001–$100,000	13–19	THANK YOU FOR ALL THE HELP & SUPPORT, EMOTIONAL SUPPORT & FINANCIAL SUPPORT. ENGLISH BARRIER CONSUING WORDING.
5–7	2–5 years	$50,001–$100,000	0–4	THE PROBLEM I'M HAVING IS GETTING MY DAUGHTER'S PRIMARY CARE PHYSICIAN CHANGED THROUGH TEFRA. EVERY NUMBER I CALL, NO ONE IS ABLE TO HELP ME CHANGE IT! THANKS!
8–10	1–2 years	$50,001–$100,000	0–4	TEFRA HAS BEEN A BLESSING AND WE'RE THANKFUL WE WERE MADE AWARE OF IT.
8–10	More than 5 years	$50,001–$100,000	5–8	THANK YOU ACH! THEY WERE AWESOME, JUST VERY LONG APPLICATION LOTS OF FORMS & QUESTIONS SO IT TOOK A LONG TIME WHICH IS DIFFICULT WHEN YOU HAVE SO MANY THINGS GOING ON WITH YOUR CHILD THAT ALREADY DEMAND A LOT OF TIME & ENTERGY. ALSO, I THINK THE RENEWAL PROCESS WILL BE QUICKER BUT I DIDN'T UNDERSTAND A LOT OF IT & WOULD LIKE A LITTLE MORE INSTRUCTION ON WHAT INFORMATION IT WAS ASKING FOR. I WAS VERY UNCERTAIN IF I ANSWERED CORRECTLY ON MY LAST RENEWAL THAT WAS SUBMITTED IN AUGUST. I TRIED CALLING & NEVER GOT ANYONE AFTER SEVERAL TRIES I JUST TURNED IT IN.
5–7	More than 5 years	$50,001–$100,000	13–19	ARKANSAS HAS THE WORST SYSTEMS IN PLACE FOR CHILDREN WITH SPECIAL NEEDS. I AM APPALLED BY HOW DIFFICULT IT IS TO GET THE HELP MY CHILD NEEDS. PLEASE PASS THIS ON TO THE STATE REPRESENTATIVES. FEEL FREE TO CALL ME **–**
5–7	More than 5 years	$100,001–$150,000	5–8	ONLINE RENEWAL PROCESS WAS EXTREMELY CONFUSING AND NOT BENEFICIAL, ENDED UP CREATING MORE WORK. THANKFUL FOR PATIENT STAFF IN DHS OFFICE TOO STRESSFUL WHEN KEPT GETTING LETTERS OF DENIAL OF SERVICES.
8–10	2–5 years	$50,001–$100,000	0–4	MY FIRST APPLICATION FOR TEFRA WAS AT ARKANSAS CHILDRENS HOSPITAL BUT BEFORE THE PROCESS WAS COMPLETE, I STARTED COMMUNICATING WITH DHS OFFICE IN STUTTGART, ARKANSAS.
8–10	More than 5 years	$50,001–$100,000	13–19	TEFRA IS A WONDERFUL PROGRAM THAT HAS ALLOWED OUR MEDICALLY FRAGILE CHILD TO RECEIVE CARE. DHS TEFRA WORKER ARE SOME OF THE BEST.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
5–7	2–5 years	$100,001–$150,000	9–12	IT WOULD BE BENEFICIAL TO GET A LIST OF SERVICES YOU COVER OR HELP OFFER. DIDN'T KNOW THIS HELPS COVER MEDS OR COUNSELING.
8–10	Less than 1 year	$50,001–$100,000	0–4	ITS VERY HARD TO GET IN EVEN FOR SHOTS/CHECK–UPS
8–10	2–5 years	$100,001–$150,000	5–8	MORE TIME TO FILL OUT TEFRA RENEWAL FORMS & TO MAIL IN WOULD BE HELPFUL. WOULD LOVE TO HAVE THE OPTION TO FILL OUT ONLINE!
8–10	2–5 years	$0–$50,000	5–8	I HAVE CALLED MULTPLE NUMBERS WITH TEFRA QUESTIONS AND NO ONE HAS BEEN ABLE TO HELP ME OTHER THAN ** AT MILLER COUNTY. SHE IS KNOWLEDGEABLE AND SO PLEASANT TO DEAL WITH. THIS WOMAN IS AMAZING AND I HOPE SHE GETS THE RECOGNITION SHE DESERVES. ** **
5–7	1–2 years	$50,001–$100,000	0–4	SINCE THE TEFRA RENEWAL PROCESS REQUIRES INFORMATION TO BE FILLED BY THE CHILD'S DOCTOR AND/OR THERAPIST, THE WINDOW OF TIME PROVIDED IS NEVER ENOUGH. ESPECIALLY FOR WORKING/BUSY PARENTS.
5–7	Less than 1 year	$150,001 or more	0–4	FRUSTRASTING, WE MOVED AND CANNOT FIND A NEW PEDIATRICIAN– W/MEDICAID OPENINGS.
5–7	2–5 years	$50,001–$100,000	13–19	DOCTOR'S OFFICES NOT "BILLING MEDICAID SECONDARY" IS QUITE PROBLEMATIC. IF THEY CAN DO IT PRIMARILY, THEY SHOULD SECONDARY & FINDING A MEDICAID DO SHOULDN'T BE SO PROBLEMATIC. IT IS CLASSIST THAT MEDICAID RECEIPIENTS ARE DELEGATED TO ONLY CERTAIN DOCTORS & EVEN WORSE WHEN THOSE DOCTORS ONLY HAVE 2 OR 3 SPOTS OPEN BECAUSE OF SOMEONE ELSE'S MESSED UP PAPERWORK WHICH DROPS THEIR ENROLLMENT.
5–7	2–5 years	$50,001–$100,000	0–4	I FEEL TEFRA IS EXPENSIVE SINCE I ALREADY PAY MONTHLY BCBS INSURANCE SOME MEDICATIONS STILL HAVE CO–PAYS AND I SPEND $400 PER MONTH IN GAS TAKING MY BABY TO THERAPY. ALSO HATE YEARLY RENEWALS.
8–10	2–5 years	$150,001 or more	0–4	WE PAY OUR TEFRA PREMIUM ON TOP OF TWO PRIVATE INSURANCE PREMIUMS–MAYBE THAT COULD (OR MAYBE ALREADY IS & I'M UNAWARE) BE CONSIDERED WHEN THE PREMIUM AMOUNT IS DETERMINED.
0–4	1–2 years	$50,001–$100,000	0–4	YOUR WEBSITE TO RENEW TEFRA APPLICATION IS THE WORST AND CONFUSING.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	1–2 years	$0–$50,000	9–12	PLEASE NOTIFY APPLICANTS OF NEW CHANGES; FOR AS HAVING TO FILL OUT FORMS FOR TEFRA AND MEDICAID WHEN HAVEN'T RECEIVED FORMS FROM MEDICAID BEFORE WHEN ENROLLED IN TEFRA. MY LOCAL OFFICE WAS NOT KNOWLEDGEABLE, WHEN ASKED ABOUT COMPLETING FORM STATED TO CALLTHEM.
8–10	Less than 1 year	$50,001–$100,000	13–19	I WISH ALLERGY MEDICATION COULD BE COVERED UNDER MEDICAID SO I WOULD NOT HAVE TO PAY OUT OF POCKET EVERY MONTH. MY CASEWORKER ** IS WONDERFUL. SHE ALWAYS ANSWERED MY CALLS AND VERY INFORMATIVE.
8–10	More than 5 years	$100,001–$150,000	5–8	WE ARE VERY THANKFUL FOR THE TEFRA PROGRAM! THE COVERAGE ALLOWS MY TWINS THE ABILITY TO RECEIVE THE THERAPIES THEY NEED. WITHOUT TEFRA WE COULD NOT AFFORD THEIR THERAPIES BECAUSE MY WORK INSURANCE DOES NOT COVER THERAPIES FOR PRE–EXISTING CONDITIONS– EVEN FOR CHILDREN BORN PREMATURILY. AGAIN THANK YOU!
–	2–5 years	$0–$50,000	13–19	I'M PLEASED WITH THE SERVICES TEFRA PROVIDES. THANK YOU.
8–10	Less than 1 year	$50,001–$100,000	0–4	ALL BATH CHAIRS OPTIONS WEREN'T AVAILABLE TO US, WHEN OFFERED TO PAY CASH, SAID WE COULDN'T BECAUSE WE HAD MEDICAID.
8–10	1–2 years	$100,001–$150,000	13–19	TEFRA IS NOT ACCEPTED OUT–OF–STATE WHERE MY CHILD RECEIVED CARE FOR OVER 1 ½ YEARS. WE PAID THE PREMIUM OF RECEIVED 0 BENEFITS, FOR THAT CARE.
5–7	More than 5 years	$0–$50,000	13–19	NEED MORE TIME TO SUBMIT RENEWAL APPLICATION. 14 DAYS IS NOT ENOUGH TIME.
8–10	2–5 years	$100,001–$150,000	0–4	WE HAVE DIRECT CONTACT WITH A SUPERVISOR AT THE DHS OFFICE. INSTEAD OF THE FRONT OFFICE STAFF, DUE TO ERRORS WHILE PROCESSING OUR PAPERWORK THE PAST TWO YEARS. STAFF AT THE FRONT OFFICE NEED MORE TRAINING.
8–10	2–5 years	$100,001–$150,000	0–4	NOT ENOUGH THERAPISTS
8–10	More than 5 years	$100,001–$150,000	5–8	THE CLINTON OFFICE PERSONNEL ARE OUTSTANDING. I'VE NEVER HAD A PROBLEM WITH WORKING WITH THEM. ALWAYS NICE & MAKE THINGS AS SIMPLE AS POSSIBLE. EMAILING FORMS OR INFORMATION IS ESPECIALLY HELPFUL.
8–10	2–5 years	$50,001–$100,000	13–19	THERAPIST FOR MENTAL HEALTH THAT COVERS TEFRA ARE HARD TO FIND. THANK YOU.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
5–7	2–5 years	$100,001–$150,000	9–12	WE ARE GRATEFUL FOR TEFRA COVERAGE BUT EVERY TIME WE NEED TO RENEW IT IS DIFFICULT TO GET OUR CHILD'S PEDIATRICIAN TO PRODUCE ALL THE DOCUMENTS WE NEED.
5–7	More than 5 years	$0–$50,000	9–12	YOU CAN NEVER REACH ANYONE AT THE LOCAL LEVEL OF TEFRA.
8–10	1–2 years	$0–$50,000	13–19	MY SON HAS TYPE 1 DIABETES. IT'S BEEN DIFFICULT GETTING SUPPLIES APPROVED. IT TOOK THREE MONTHS JUST TO GET A COMPUTER UPGRADE FOR HIS T–SLIM INSULIN PUMP.
8–10	Less than 1 year	$50,001–$100,000	0–4	IF IT WERE NOT FOR TEFRA, WE WOULD NOT BE ABLE TO AFFORD THE SPECIAL FORMULA OUR CHILD NEEDS TO THRIVE OR SEE HER THERAPISTS AND SPECIALIST. THANK YOU SO MUCH!!! GOT TRANSFERRED A LOT ON A DIFFERENT NUMBERS TO CALL.
8–10	2–5 years	–	5–8	THE ONLY ISSUE I HAVE EVERY YEAR IS THE APPLICATION RENEWAL PROCESS. THE PACKET IS ALWAYS CONFUSING AND I'M ALWAYS REACHING OUT FOR HELP. OTHER THAN THAT, FANTASTIC SERVICE.
8–10	2–5 years	$100,001–$150,000	5–8	THANK YOU FOR THIS SERVICE!
8–10	More than 5 years	$50,001–$100,000	13–19	THE AMOUNT OF TIME TO RENEW PAPERWORK IS EXTREMELY SHORT CAUSING ME ANXIETY EVERYTIME. ALSO, A 15 YR WAIT FOR WAIVER IS RIDICULOUS. STILL WAITING!
5–7	1–2 years	$0–$50,000	5–8	THE PAPERWORK IS VERY EASY TO FILL OUT. THE RENEWAL PROCESS IS EASIER THAN THE INITIAL PAPERWORK. I AM VERY THANKFUL FOR THIS (TEFRA) SERVICE FOR MY SON. WE WOULD NOT BE ABLE TO AFFORD ALL OF HIS THERAPIES WITHOUT TEFRA. TEFRA COVERING ABA SERVICES HAS BEEN A BLESSING ALSO. THANK YOU!
5–7	2–5 years	$100,001–$150,000	13–19	IT HAS BEEN CONFUSING DURING THE COVID EMERGENCY ACT! I KEEP GETTING LETTERS SAYING I DIDN'T RENEW HER COVERAGE BUT IT GETS EXTENDED 30 DAYS. I HAVE NOT GOTTEN A RE–APPLICATION? AT LEAST NOT IN 9–10 MONTHS. CONFUSING PAPERWORK AND I HAVE A COLLEGE DEGREE.
5–7	More than 5 years	$0– $50,000	5–8	MY SON WAS A MICRO PREEMIE, SO HE TRANSITIONED FROM SSI TO TEFRA. IT WAS A VERY SMOOTH TRANSITION.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
0–4	More than 5 years	$50,001–$100,000	5–8	MY HUSBAND & I ARE VERY APPRECIATIVE OF THE TEFRA PROGRAM. IF IT WAN'T FOR TEFRA–OUR SON WOULD NOT HAVE THE HEALTHY LIFE HE CURRENTLY IS ABLE TO HAVE THANK YOU! **
5–7	1–2 years	$0– $50,000	0–4	REGARDING CUSTOMER SERVICE: I DID GET MY QUESTION ANSWERED EVENTUALLY. I JUST HAD TO KEEP CALLING BACK BC THE "RIGHT PERSON" WASN'T IN THE OFFICE AND DIDN'T CALL BACK.
8–10	2–5 years	$50,001–$100,000	5–8	EVEN WITH PRIVATE INSURANCE THROUGH WORK, TEFRA IS AN ABSOLUTE FINANCIAL LIFE SAVER FOR A KID WITH SPECIAL NEEDS. THE COSTS OF THERAPY ARE NOT FEASIBLE WITHOUT TEFRA.
5–7	Less than 1 year	$50,001–$100,000	0–4	INITIAL APPLICATION PROCESS SEEMED VERY OBSCURE & CONFUSING. IT DOES NOT SEEM CLEAR IF THERE IS A SINGLE PLACE TO GO ONLINE TO GET ALL INFORMATION NEEDED.
8–10	2–5 years	–	5–8	THE RENEWAL PREOCESS SHOULD BE MUCH MORE SIMPLE. I TRIED TO UPDATE SOMETHING ONLINE THIS YEAR & IT WAS BASICALLY IMPOSSIBLE. ALSO, NO ONE EVER VERIFIES WHEN THEY RECEIVE PAPERWORK WHICH MAKES ME NERVOUS EACH YEAR WORRIED OUR PAPERWORK WASN'T RECEIVED BY THE DEADLINE.
5–7	2–5 years	$50,001–$100,000	5–8	THE LOCAL DHS (WASHINGTON COUNTY) HAD A LONG (MORE THAN 1 HOUR) WHERE NO ONE ANSWERED THE PHONE LINE. THE STATE DHS ANSWERED THE PHONE RIGHT AWAY. THE ONLINE TEFRA RENEWAL FORM DOES NOT WORK CORRECTLY. I HAD TO COMPLETE ON PAPER. IT IS CONFUSING PAPERWORK.
8–10	1–2 years	$0–$50,000	0–4	I RATED THE APPLICATION PROCESS A "3" ONLY DUE TO THE FACT OF HAVING TO FILL OUT THE LONG APPLICATIONS EACH TIME. POSSIBLY GIVE AN OPTION ON SOME OF THE PAGES TO SAY "INFORMATION HAS NOT CHANGED" ESPECIALLY IF WE HAVE MULTIPLE KIDS ENROLLED, IT IS VERY TIME CONSUMING.
5–7	More than 5 years	$50,001–$100,000	5–8	MY CHILD WAS BORN WITH HIS DISABILITY. RENEWING EVERY YEAR IS NOT IDEAL FOR A CONDITION THAT WILL NOT CHANGE FOR HIS ENTIRE LIFE. THE RENEWAL PROCESS SHOULD NOT BE LONGER IN SOME CASES, SUCH AS THIS.
8–10	1–2 years	$50,001–$100,000	0–4	IT WOULD BE EASIER IF THERE WAS MORE THAN ONE FORM OF PAYMENT (CHECK BY MAIL).

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
5–7	2–5 years	$100,001–$150,000	5–8	WE APPRECIATE THE PROGRAM. IT KEEP INSURANCE FOR MY CHILD BUT HAVING TEFRA ON BOARD HAS HELPED SO MUCH. MY DAUGHTER HAS BEEN ABLE TO GET ALL THE THINGS SHE NEEDS ONE WAY OR ANOTHER.
8–10	More than 5 years	$100,001–$150,000	9–12	THANK YOU, WE APPRECIATE THE COVERAGE ALLOWING OUR CHILD TO GET THE SERVICES HE NEEDS!
0–4	2–5 years	$150,001 or more	0–4	HAVING TO RE–APPLY EACH YEAR AT TAX TIME IS A MASSIVE PROBLEM. MY SON HAS DS; WHAT'S THE POINT OF RE–APPLYING LIKE THAT WILL EVER CHANGE? IT'S AN UNNECESSARY BURDEN AND WASTE OF TIME ALL AROUND.
5–7	More than 5 years		13–19	WE NEVER SEEM TO MOVE UP THE WAIVER WAIT LIST AND IT IS UNACCEPTABLE.
8–10	More than 5 years	$100,001–$150,000	9–12	VISION COVERAGE NEEDS TO BE LOOKED AT. THE ONE PAIR OF GLASSES ALLOWED PER YEAR NEEDS TO BE ADDRESSED. THE QUALITY OF THE FRAMES AND LENSES IS LESS THAN DESIRABLE.
5–7	2–5 years	$50,001–$100,000	13–19	MY DAUGHTER HAS T1D. THE ONLY THING TEFRA DOES FOR US IS COVERS HER DIABETIC APPOINTMENTS AT ACH. WE NEED HELP COVERING COST OF INSULIN, PUMP, PUMP SUPPLIES, DEXCOM, ETC.
5–7	1–2 years		9–12	WE WENT OUTSIDE OF TEFRA.
8–10	1–2 years	$50,001–$100,000	5–8	THANK YOU, TEFRA FOR SUPPORT & CARE! WITHOUT YOU, WE WOULDN'T BE ABLE TO GET THERAPIES NEEDED NOR AFFORD IT FOR OUR SWEET AUTISTIC BOY! MOTHER. HE'S NON–VERBAL.
5–7	2–5 years	$50,001–$100,000	13–19	THE NEW RENEWAL PROCESS WAS NOT AS EASY AS IT HAS BEEN IN THE PAST. SO THANFUL FOR THE LADY OUT OF POCAHONTAS FOR HER HELP!!
8–10	Less than 1 year	$100,001–$150,000	0–4	THE FACT THAT I HAVE NEVER HAD TO DEAL WITH A PROCESS LIKE THIS IT WOULD HAV BEEN NICE TO HAVE HELP WHEN I INTIALLY TRIED TO GET TEFRA. THE DHS OFFICE IN SALINE COUNTY IS AWFUL. NO HELP AT ALL AND THE PHONE IS NEVER ANSWERED. THEY WOULD NOT EVEN MAKE A COPY OF MY 1ST APPLICATION FOR ME TO HAVE A COPY. SO SINCE THEN I JUST HAVE TO FIND MY OWN ANSWERS AND NAVIGATE IT ALONE. THE TEFRA PROGRAM AS A WHOLE IS AMAZING I HAVE NO COMPLAINTS ABOUT SERVICES PROVIDED AT ALL. AND I WILL NOT CALL ANYONE FROM THIS OFFICE BECAUSE NO ONE ANSWERS, THEY WILL NOT ANSWER THE PHONE.; MOSTLY BECAUSE OF THE LOCAL DHS OFFICE IN SALINE COUNTY .

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
5–7	Less than 1 year	$100,001–$150,000	5–8	ONLY MAJOR ISSUE IS LOST CHECKS AT PROCESSING & MULTIPLE APPLICATIONS FOR DIRECT PAY BEFORE PROCESSED CORRECTLY. THANK YOU!
8–10	2–5 years	$50,001–$100,000	5–8	APPLICATION & RENEWAL NOT EVER ENOUGH TIME B/C DR OFFICES TAKE A WHILE TO FILL OUT & RETURN OR REQUIRE AN APPT. ENVELOPES DO NOT HOLD REQUIRED PAPERWORK (EVALS, MED RECORDS, APPLICATIONS) LARGER ONES WOULD BE WONDERFUL IF MORE THAN THE TWO PAGE SIGNATURE PAGES ARE NEEDED BACK. I PREFER TO EMAIL IT ALL IT IS MUCH EASIER. **, DHS IS THE BEST TO TALK TO AND HELP. SHE KNOW ME & MY KIDS BY NAME & TAKES CARE OF EVERYTHING WE EVER NEED.
8–10	2–5 years	$50,001–$100,000	5–8	I AM THANKFUL FOR TEFRA– WITH MY SON'S SEVERE SPEECH & OTHER DELAYS, IT WOULD HAVE BEEN IMPOSSIBLE TO AFFORD ALL THE HELP HE NEEDED/NEEDS.
8–10	2–5 years	$100,001–$150,000	9–12	IT NEEDS TO BE NOTED THAT ** W/PARTNERS FOR INCLUSIVE COMMUNITIES WAS/IS AMAZING. SHE HELPED US EVERY STEP OF THE WAY WITH THE AUTISM WAIVER AND THE EPSDT PROGRAM PAPERWORK I WOULD HAVE STRUGGLED SIGNIFICALLY IF NOT FOR HER HELP. *WE USE OUR INSURANCE FOR MOST OF OUR SON'S CARE. WE MAINLY USE TEFRA FOR HIS ABA THERAPY. WE HAVE NOT HAD ANY DENIALS OF SERVICE DUE TOTHIS FACT. WE GOT TEFRA BECAUSE OUR INSURANCE DOES NOT COVER ABA THERAPY OR ANYTING AUTISM. THANK YOU FOR PROVIDING WHAT MY SON NED TO BE SUCCESSFUL IN LIFE. GETS SPEECH, PT, OT THROUGH PUBLIC SCHOOL SYSTEM SO I AM NOT SURE IF TEFRA IS BILLED; I HAD TO RUSH TO GET IT COMPLETE AND DRIVE 45 MINUTES TO HAND DELIVERY B/C MAIL WOULD NOT HAVE GOTTEN TO THE OFFICE IN TIME.
8–10	2–5 years	$50,001–$100,000	9–12	THE PAPERWORK FOR RENEWAL IS ALWAYS CONFUSING AND DIFFICULT TO UNDERSTAND. BOTH MY WIFE AND I ARE COLLEGE EDUCATED AND STILLHAVE A HARD TIME FILLING OUT PAPERWORK. NOT UNDERSTANDING EVERYTHING THAT IS NEEDED.
5–7	2–5 years	$100,001–$150,000	0–4	PAPERWORK IS VERY CONFUSING TO ME EACH TIME I HAVE TO RENEW. THANK YOU FOR YOUR HARD WORK IN HELPING MY DAUGHTER AND FAMILY GOD BLESS.
8–10	More than 5 years		13–19	I AM A GREAT–GRANDMOTHER. I ADOPTED ** WHEN VERY SMALL. HE GRADUATES THIS YEAR.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	2–5 years	$50,001–$100,000	5–8	TEFRA HAS ALLOWED MY CHILD TO RECEIVE SERVICES FOR OT, SPEECH, AND PT THAT HE OTHERWISE WOULD NOT HAVE BECAUSE PRIVATE INS DOES NOT COVER THEM.
8–10	More than 5 years	$100,001–$150,000	13–19	INSTEAD OF NOTIFICATIONS WHEN COVEAGE IS DENIED, IT WOULD BE MORE BENEFICIAL TO SEE WHAT IS PAID BY TEFRA ON BEHALF OF MY CHILD, AT THE LEAST I WOULD KNOW IF ANY MISTAKES OR INCORRECT CHARGES WERE BILLED TO HIS ACCOUNT, THEN WE COULD NOTIFY TEFRA.
0–4	More than 5 years	$150,001 or more	5–8	PLEASE ALLOW ONLINE PAYMENTS. PLEASE MAKE YEARLY RE–ENROLLMENT EASIER FOR OBVIOUS PAPERWORK. FOR INSTANCE, MORE OF A QUESTIONAIRE ABOUT ANY RECENT CHANGES SINCE YOUR LAST APPLICATION. PLEASE ALLOW YOUR CUSTOMER SERVICE WORKERS TO LOOK UP A CHILD BY THEIR SSN. PLEASE ALLOW YOUR OFFICES/SYSTEMS TO SHARE INFORMATION TO MAKE ADDRESS CHANGES. PLEASE CREATE AN ONLINE PORTAL WITH ACCESS TO MY CHILD'S ACCOUNT. WHEN DRAFT PAYMENT IS SETUP IT ONLY WORKS FOR 2 PAYMENTS THEN STOPS. IT HAS DONE THIS FOR ABOUT 6 YEARS NOW.
5–7	More than 5 years	$100,001–$150,000	9–12	RENEWAL THROUGH DHS WAS EASIER WHEN I HAD THEM FAX/SUBMIT MY COMPLETED DOCUMENTS. THE FIRST TIME WAS UNSUCCESSFUL, BUT THE SECOND TIME SEEMED TO BE BETTER. I SAW A DIFFERENT INDIVIDUAL EACH TIME. SECOND MUCH MORE KNOWLEDGEABLE.
5–7	2–5 years	$50,001–$100,000	13–19	WHY DID I GET A LETTER SAYING THEY ARE KICKING HER OFF TEFRA? MUSCULAR DYSTROPY DOES NOT GO AWAY. PLEASE ANSWER**.
5–7	Less than 1 year	$50,001–$100,000	5–8	PLEASE MAKE THE RENEWAL PROCESS EASIER. THE ONLINE DIDN'T WORK RIGHT. I THOUGHT I HAD DONE IT, BUT I GOT A NOT DONE LETTER IN THE MAIL. HAD TO GO TO DHS. MAJOR INCONVENIENCE!
0–4	More than 5 years	$150,001 or more	13–19	I FILLED THIS SAME THING OUT 1 YR AGO! WASTE OF TIME AND MONEY. I ALSO HAVE PRIVATE INSURANCE, DIDN'T EVEN TRY–PAID FOR IT MYSELF
8–10	2–5 years	$50,001–$100,000	0–4	TEFRA WAS A HUGE HELP TO OUR FAMILY WHEN OUR 12 DAY OLD BABY WAS DIAGNOSED W/ A HEART CONDITION. THANK YOU!
8–10	More than 5 years	$0–$50,000	13–19	THE LADY AT THE CLEVELAND CO. DHS THAT IS OVER TEFRA IS WONDERFUL & HELPFUL!!!

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
0–4	1–2 years	$0–$50,000	5–8	IN 2019 MY CHILD WAS DROPPED BY TEFRA WITHOUT ADEQUATE NOTICE, NO ATTEMPTED PHONE CALL. WE WERE HAVING PROBLEMS WITH OUR MAIL ROUTE, MAIL GETTING DELIVERED TO MY NEIGHBORS & I HAD NO IDEA WE DIDN'T RECEIVE RENEWAL NOTICE. THIS WAS DEVASTING TO OUR HOME & MY SON'S ABA THERAPY SERVICES STOPPED. HE WAS NON–VERBAL & LEARNING HOW TO USE A DEVICE TO COMMUNICATE. WE WERE BEGINNING TO SEE PROGRESS & THIS CAME TO A COMPLETE STOP & THE DEVICE WAS TAKEN AWAY. FOR A YEAR I STRUGGLED TO GET TEFRA SERVICES BACK. DURING THIS TIME HE AGED OUT OF THE AR WAIVER AS WELL. I BORROWED MONEY FOR PRIVATE SERVICES BUT THIS WAS TOO EXPENSIVE, I AM A SINGLE MOTHER, HAD A GOOD JOB IN PUBLIC HEALTH & SERVED NORTHWEST ARKANSAS BUT NOT AFFORD, ABA THERAPY FOR MY AUTISTIC SON. THIS PROCESS OF TRYING TO GET SERVICES, RENEWAL AND TERMINATION IS ANTIQUATED & RIGID. I COULD NOT BELIEVE AS A NURSE, HOW DIFFICULT THE PROCESS WAS & CONTINUES TO BE YET HOW EASY IT WAS TO TERMINATE OUR SERVICES BY BERRYVILLE OFFICE. AS A NURSE HELPING FAMILIES
8–10	Less than 1 year	$150,001 or more	5–8	TEFRA INCLUDED THE ABA THERAPY COMPANY (BLUE SPRIG) MY DAUGHTER USE STARTING THIS YEAR. THAT IS A BIG HELP! THANKS! I ALSO LIKE THAT DENTAL SERVICE IS ALSO COVERED.
8–10	More than 5 years	$50,001–$100,000	9–12	THANK YOU, MAY EVERYONE IN THE TEFRA TEAM STAY SAFE AND HEALTHY. GOD BLESS
8–10	Less than 1 year	$50,001–$100,000	9–12	DEVELOPMENTAL DELAYS ARE HARD TO FIND EXPERTS FOR. I'M SO THANKFUL FOR PEOPLE LIKE **, WHO IS WILLING TO HELP LOOK FOR PROFESSIONALS THAT ARE UP TO DATE ON CURRENT RESEARCH.
0–4	2–5 years	–	0–4	THE MOST FRUSTRATING PART OF TEFRA ARE THE PAYMENTS. IT WOULD BE INCREDIBLY CONVENIENT TO BE ABLE TO MAKE PAYMENTS ONLINE OR BY PHONE! WE CANNOT AFFORD TO HAVE PAYMENTS ON AUTODRAFT AND IT IS INCONVENIENT TO MAIL PAYMENTS. ALSO, WE DON'T USE OR HAVE CHECKS TO SIGN UP FOR AUTODRAFT.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	1–2 years	$0–$50,000	9–12	I AM VERY GRATEFUL THAT WE HAVE TEFRA. I DO NOT KNOW WHO TO TALK TO ABOUT WHAT HAPPENS IF MY CHILD NO LONGER NEEDS THERAPY, BUT STILL NEEDS TO SEE AN ALLERGY SPECIALIST FOR WEEKLY SHOTS & MEDICINE. LOOSING TEFRA IS A CONCERN THAT GREATLY WORRIES ME. WAS A LOT OF PAPERWORK AND INFO TRACKING DOWN; I GOT AN EXTENTION
5–7	1–2 years	$100,001–$150,000	5–8	I'VE HAD A VERY ROCKY EXPERIENCE W/ TEFRA THIS YEAR, RESULTING IN AN APPEAL THAT CAME OUT IN OUR FAVOR, BUT IS/WAS VERY FRUSTRATING EXPERIENCE WITH A LOT OF BACK AND FORTH. IF IT HAD NOT BEEN FOR THE PERSISTANCE AND WORK WE WOULD HAVE HAD TO CANCEL OUR COVERAGE BECAUSE OF FINANCIAL BURDEN OF THE PREMIUM.
5–7	1–2 years	$100,001–$150,000	0–4	WE HAVE BEEN EXTREMELY FORTUNATE TO HAVE TEFRA AS A RESOURCE. WE WOULDN'T BE ABLE TO FINANCIALLY PROVIDE EVERYTHING MY SON NEEDS WITHOUT IT.; HOWEVER, THE INITIAL APPLICATION & RENEWAL APPLICATIONS ARE NOT USER FRIENDLY.
8–10	1–2 years	$50,001–$100,000	0–4	I KEEP GETTING 2 TEFRA RENEWAL APPLICATION EACH YEAR. THEY ALWAYS ASK ME TO COMPLETE IT TWICE. PLEASE ONLY SEND ONE RENEWAL APP.
5–7	More than 5 years	$100,001–$150,000	13–19	SOME OF THE MEDICAID FORMS THAT WE ARE SENT ARE VERY CONFUSING AND DO NOT SEEM TO APPLY TO OUR SON. THIS YEAR WE RECEIVED A 2ND SET OF FORMS THAT WERE NEW TO US AND WERE VERY CONFUSING. TRYING TO CALL THE COUNTY DHS OFFICE HAS ALWAYS PROVED HOPELESS, YOU WAIT ON HOLD FOREVER THEN THEY CAN'T ANSWER YOUR QUESTION. AND AFTER ONE IN PERSON VISIT MY HUSBAND VOWED NEVER TO ENTER THE BUILDING AGAIN BECAUSE HE WAS TREATED SO RUDELY.
5–7	More than 5 years	$0–$50,000	13–19	THERE IS A HUGE ISSUE WITH REFERRALS. OUR PCP SENDS THE REFERRALS AND WHEN WE GO TO THE SPECIALIST APPT THEY SAID THEY DIDN'T RECEIVE IT, SO WE WERE CHARGED FOR THE APPT. AND THE SAME FOR ER VISITS BECAUSE THE HOSPITAL DID NOT BILL IT CORRECTLY, WE END UP WITH THE BILL. PATIENTS SHOULD NOT BE CHARGED DUE TO HOSPITAL & DR OFFICES MISTAKES.
5–7	More than 5 years	$150,001 or more	9–12	RECIPIENTS OF TEFRA BENEFITS THROUGH THE PASSE DESERVE TO HAVE ACCESS TO THE SAME NETWORK OF PROVIDERS AND SAME SERVICES THAT TRADITIONAL TEFRA MEDICAID CLIENTS GET!

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	More than 5 years	$150,001 or more	13–19	WHY DOES RENEWAL HAVE TO BE SO EXTENSIVE IF THE CHILD HAS A PERMANENT DISABILITY? MY CHILD WAS BORN WITH DOWN SYNDROME AND WILL ALWAYS HAVE IT.
8–10	1–2 years	$50,001–$100,000	5–8	THANK YOU!
5–7	2–5 years	$100,001–$150,000	5–8	TEFRA IS A FANTASTIC RESOURCE. MY ONLY COMPLIANT IS PERSCRIPTION COVERAGE. WE GET TONS OF DENIALS, PA REQUESTS, ETC, FOR MEDICATION MY CHILD NEEDS TO PREVENT SEIZURES AND FURTHER HOSPITAL STAYS.
5–7	Less than 1 year	$50,001–$100,000	13–19	MY SON WAS TAKEN OFF OF TEFRA IN 2019 AND WAS APPROVED AGAIN IN 2020. HE SUFFERED THAT YEAR DUE TO NOT BEING ABLE TO GET THE SERVICES, MEDICINES AND DOCTOR VISITS THAT HE NEEDED. HE WAS APPROVED BY THE SAME MEDICAL DX. THE MEDICAL REVIEW TEAM AND APPEAL DEPT. NEEDS SOME MUCH NEEDED TRAINING!!!
5–7	More than 5 years	$150,001 or more	5–8	MY CHILD HAS ACHONDRAPLASIA. WHY IS IT NECESSARY FOR ME TO CONTINUALLY FILL OUT PAPERWORK STATING SHE STILL NEEDS TEFRA? IT'S NOT GOING AWAY!!
5–7	2–5 years	$50,001–$100,000	9–12	THANK YOU. GETTING FEEDBACK IS A CHALLENGE AND I AM SO GRATEFUL FOR THIS PROGRAM. YOU HELP KEEP THIS SINGLE MAMA AND SPECIAL NEEDS KIDDO AFLOAT!
8–10	1–2 years	$50,001–$100,000	0–4	TEFRA HAS HELPED MY DAUGHTER (W/APRAXIA) SO MUCH, BY ALLOWING HER TO RECEIVE THE INTENSIVE SPEECH AND OT SHE NEEDS. PREVIOUS INSURANCE WAS ONLY ALLOWING 6 SPEECH SESSIONS A YEAR AND MY DAUGHTER IS SHOWING GREAT IMPROVEMENT BY RECEIVING THE AMOUNT SHE ACTUALLY NEEDS WITH TEFRA.. WHICH IS 3–4 SPEECH SESSIONS A WEEK AND 2 OT SESSIONS A WEEK. NEEDED EXTENSIVE SPEECH (3–4X WEEK) WE GAVE HER A FEW WEEKS DOWNTIME WHILE WE WAITED.
5–7	2–5 years	$50,001–$100,000	5–8	WE RECENTLY MOVED TO A DIFFERENT CITY IN ARKANSAS. IT WAS CHALLENGING TO CHANGE OUR ADDRESS & CHANGE PCPS.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
5–7	1–2 years	$100,001–$150,000	5–8	THE RENEWAL AND MEDICAL REVIEW PROCESS IS HORRIBLE! PUBLIC SCHOOLS WILL NOT REPLY TO MEDICAL REVIEW AND WE WERE CANCELLED! WE'VE BEEN DENIED & HAD TO APPEAL AT INITIAL & RENEWAL DUE TO MEDICAL REVIEW. IMPROVE MEDICAL REVIEW!!! RENEWAL IS A TERRIBLE PROCESS!
8–10	More than 5 years	$150,001 or more	9–12	THE NEW TEFRA RENEWAL IS SUPER EASY. TEFRA HAS IMPROVED THEIR PROCESS EVERY YEAR SINCE WE'VE BEEN WITH THEM. THE GRACE SCHOOL ABA INTERVENTIONAL THERAPY; TEFRA IS THE DEPT. I SPOKE TO, NOT MEDICAID.MAYBE YOU GUYS ARE THE SAME?; FIRST INS. WE HAVE BCBS ADVANTAGE AR W/WALMART HOME OFFICE; TEFRA 2ND INS.
5–7	2–5 years	$0–$50,000	13–19	MY CHILD STILL NEEDS TEFRA. CUT OFF AGE??
8–10	2–5 years	$50,001–$100,000	5–8	I WAS RUSHED ON THE LAST RENEWAL BECAUSE WE WERE WAITING ON GETTING OUR TAXES BACK IN FEBRUARY. I FELT THE DEADLINE SHOULD BE AFTER TAX DEADLINE IN APRIL.
5–7	Less than 1 year	$50,001–$100,000	0–4	OUR SPECIALIST DOCTORS ARE IN MEMPHIS AND NOT COVERED, SORRY FOR ANY CONFUSION ON ANSWERS, PDPC IS IN STATE & COVERED.
8–10	More than 5 years	–	13–19	HOW LONG DOES IT TAKES TO GET TEFRA WAVIER? MY DAUGHTER HAS BEEN IN THE WAITING LIST SINCE A LONG TIME THAT I CAN'T REMEMBER. I'M TALKING ABOUT WHERE SHE WOULD BE ABLE TO GET SOMEBODY TAKE CARE OF HER AT HOME LIKE RESPITE CARE SO AS TO HELP HER PARENTS HAVE SOME EASE.
8–10	Less than 1 year	$100,001–$150,000	5–8	DUE TO COST IF UNCOVERED BY TEFRA. DESPITE HAVING PRIVATE MEDICAL INSURANCE BEFORE TEFRA COVERAGE. WE WERE UNALBE TO AFFORD MY SONS NEEDED SPEECH THERAPY. WE GREATLY APPRECIATE TEFRA.
8–10	1–2 years	$50,001–$100,000	13–19	I REALLY APPRECIATE ALL THE HELP THE TEFRA PROGRAM HAS GIVEN US. AR CHILDRENS HOSPITAL WAS WONDERFUL IN HELPING US APPLY AND UNDERSTAND THE PROGRAM.
8–10	2–5 years	$150,001 or more	5–8	I WISH THERE WAS A SIMPLE, ONLINE PROCESS TO RENEW EVERY YEAR.
8–10	More than 5 years	$150,001 or more	9–12	WE ARE VERY THANKFUL FOR TEFRA.
5–7	1–2 years	$100,001–$150,000	5–8	GIVEN THAT MY CHILD HAS A DIAGNOSIS THAT WILL NOT RESOLVE, IT IS FRUSTRATING GETTING A DR'S NOTE DOING THE APPLICATION PROCESS EACH YEAR THAT OFTEN DELAYS TURNING IN THE FORMS.

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5–7	2–5 years	$50,001–$100,000	5–8	I WOULD LOVE AN ONLINE PORTAL TO SUBMIT PPWK & ASK QUESTIONS. THEY HAVE IT FOR MEDICAID BUT SAID TEFRA CANNOT USE IT.
5–7	1–2 years	$50,001–$100,000	13–19	WE WERE GIVEN 2 WEEKS TO COMPLETE REDETERMINATION INCLUDING GETTING HIM IN TO SEE HIS DR TO FILL OUT THE FORMS. THIS 2 WEEKS WAS OVER THE CHIRSTMAS & NEW YEAR HOLIDAY DURING A PANDEMIC. I HAD TO PAY $40 TO OVERNIGHT THE PAPERWORK TO BE SURE WE MET THE DEADLINE.
8–10	2–5 years	$50,001–$100,000	0–4	TEFRA HAS BEEN WONDERFUL TO HAVE THESE PAST 3 YEARS! WE ARE VERY HADD WITH OUR EXPERIENCE, AND IT HAS OPENED UP MANY DOORS, MAKING OUR SON TO GET TO THE BEST DOCTORS IN THE AREA AND RECEIVE ALL OF THE RECOMMENDED HEALTH CARE THAT HE NEEDS.
8–10	2–5 years	$100,001–$150,000	0–4	THANK YOU FOR HELPING US GET THE EXTRA SUPPORT OUT SWEET GIRLS (TWINS) NEED TO GROW & DEVELOP!
8–10	1–2 years	$150,001 or more	9–12	** IS ALSO COVERED BY OTHER HEALTH INSURANCE THROUGH HIS DAD'S WORK, SO THE QUESTIONS ASKING ABOUT HOW DIFFICULT/EASY IT WAS FOR HIM TO GET HEALTHCARE WASN'T JUST BASED ON TEFRA.
8–10	1–2 years	$50,001–$100,000	0–4	IT IS FRUSTRATING TO HAVE TO CONTINUE FILING INFORMATION ABOUT MY CHILD WHEN HE HAS A DISABILITY THAT WILL NEVER GO AWAY OR BE CURED. IT IS ALSO FRUSTRATING TO FILL OUT THE SAME INFORMATION FOR THE STATE IN ORDER TO RECEIVE THE MEDICAL CARE/BENEFITS AVAILABLE TO THE DISABLED THROUGH THE STATE.
5–7	2–5 years	$100,001–$150,000	5–8	I WISH THERE WAS MORE INFORMATION GIVEN ON THE NEW RENEWAL PROCESS. I COULD NEVER GET THE NEW WEBSITE TO WORK. I ALSO RENEWED EARLIER IN THE YEAR. PROVIDED MY TAX RETURNS, ETC., AND NOW I MAY LOSE MY DAUGHTERS TEFRA COVERAGE, BECAUSE YOU DECIDED TO MOVE TO ONLINE??
8–10	1–2 years	$150,001 or more	0–4	PLEASE COSIDER LOWERING PREMIUM FOR ALL FAMILIES, PLEASE. PLEASE ENSURE RENEWAL PACKETS ARE SENT TO TEFRA FAMILIES IN A TIMELY MANNER–OUR COVERAGE WAS ALMOST CANCELLED DUE TO NOT RECEIVING OUR PACKET! THANK YOU FOR CONSIDERATIONS. IT WAS NEVER SENT OUT TO US AND WE ALMOST GOT OUR POLICY CANCELLED UNTIL I CALLED AND GOT RENEWAL PACKET SENT TO US!

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	Less than 1 year	$150,001 or more	0–4	APPLYING FOR TEFRA IS EXTREMLY CONFUSING. IT COULD BE MUCH MORE STRAIGHT FORWARD & THE MOST HELPFUL PERSON WAS OFFICE AT LEARN PLAY GROW. NO ONE @ ANY MEDICAID OFFICE SEEMS TO KNOW ANYTING EVEN ABOUT COVERAGE BUT I WILL SAY, EVERYONE HAS BEEN VERY POLITE!
5–7	1–2 years	$150,001 or more	9–12	I AM GRATEFUL FOR TEFRA AND HOW IT HELPS PROVIDE THE THERAPIES MY DAUGHTER NEEDS. THE APPLICATION AND RENEWAL PROCESS FEEL COMPLICATED & DIFFICULT, HOWEVER ALSO RECOGNIZE IT ONLY ONCE A YEAR!
5–7	–	$150,001 or more	0–4	THE RENEWAL PROCESS HAS BEEN TERRIBLE THIS YEAR. WE WERE SENT A DENIAL LETTER BEFORE PAPERWORK EVEN HAD A CHANCE TO BE PROCESSED BECAUSE THE VARIOUS OFFICES ARE SO FAR BEHIND. MORE COMMUNICATION NEEDS TO TAKE PLACE BETWEEN OFFICES BEFORE THOSE LETTERS ARE SENT TO PARENTS.
8–10	1–2 years	$100,001–$150,000	0–4	TEFRA IS EXCELLENT ONCE YOU ARE APPROVED. WE WOULDN'T BE ABLE TO AFFORD OUR SON'S THERAPIES WITHOUT IT.
8–10	2–5 years	$150,001 or more	5–8	YOU GUYS ARE AMAZING & HAVE HELPED US IN SO MANY WAYS. THANK YOU. MY SON COULD NOT HAVE GOTTEN HIS LIFE–SAVING MEDICAL EQUIPMENT ($16,000!) W/O TEFRA. THE 4 CHALLENGES I HAVE HAD: 1. PRESCRIPTIONS ARE DELAYED DUE TO REQUIRED PA'S SOMETIMES. 2. OUT OF STATE DOCS HAVE BEEN A CHALLENGE TX IN PARTICULAR. 3. THE COUNSELORS THAT ACCEPT TEFRA ARE NOT THE BEST IN THE AREA & THERE IS A LIMITED # OF THEM. 4. SOME PROVIDERS WON'T SUBMIT TO TEFRA FOR COPAYS ON SPECIALISTS – $75 FOR OUR PLAN.
5–7	2–5 years	$100,001–$150,000	5–8	TEFRA IS A WONDERFUL BENEFIT THAT HELPS MY DAUGHTER RECEIVE THE THERAPY SHE NEEDS AT A REASONABLE COST. MY MAIN FRUSTRATION IS THE RENWAL PROCESS. IT NEEDS TO BE STREAMLINED AS MUCH OF THE REQUESTED INFO IS REDUNDANT.
0–4	2–5 years	$150,001 or more	5–8	THE TEFRA RENEWAL PROCESS IS TERRIBLE AND HARD TO UNDERSTAND & ACCESS ARKANSAS DOESN'T WORK AND NO ONE CAN HELP YOU!
5–7	2–5 years	$100,001–$150,000	13–19	BESIDES THE COPAY THAT'S PRETTY HIGH. WE HAVE BEEN VERY HAPPY WITH THE COVERAGE TEFRA HAS PROVIDED!

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	1–2 years	$50,001–$100,000	0–4	AT FIRST, I THOUGHT I WAS FILLING OUT THE SURVEY FOR ARHIPP. THAT IS THE PLACE I CALLED. I DIDN'T CALLTHE TEFRA MEDICAID. I MARKED THOUGH THOSE ANSWERS.
8–10	Less than 1 year	$0–$50,000	0–4	APPLICATION APPROVAL PROCESSING TIME IS LITTLE LONGER, IT SHOULD BE QUICK PROCESS. DEADLINE FOR PREMIUM PAYMENT SHOULD BE AT LEAST NOT BEFORE 15 DAYS.
8–10	More than 5 years	$0–$50,000	9–12	THE CHILD'S PARENT ARE DIVORCING, MOTHER IS NOT WORKING AND IS HOME SCHOOLING THE CHILD, FATHER WORKS AND SHARES CUSTODY WITH MOTHER.
5–7	Less than 1 year	$50,001–$100,000	0–4	I HAVE HAD THE MOST PROBLEMS GETTING MY PREMIUMS PAID DUE TO THE BANK DRAFT FORM BEING RETURNED 2 TIMES.
8–10	2–5 years	$50,001–$100,000	5–8	THE TEFRA PROGRAM HAS BEEN A BLESSING FOR OUR FAMILY. WE HAVE HEALTH INSURANCE THROUGH WORK BUT IS DOESN'T PAY FOR HIS THERAPIES AND TEFRA/MEDICAID PAYS FOR THESE.
8–10	2–5 years	$50,001–$100,000	9–12	WISH IT HAD AN OPTION TO NOT DISCLOSE OR HAVE LARGER BRACKETS.
5–7	More than 5 years	$50,001–$100,000	9–12	COMPUTER PROCESS TO REUP TEFRA THIS SPRING/SUMMER WAS TERRIBLE!! CLEARLY NOT WRITTEN FROM THE CLIENTS PERSPECTIVE!!
8–10	More than 5 years	$50,001–$100,000	5–8	WE WOULDN'T HAVE COVERAGE FOR MY SON'S DIABETIC SUPPLIES WITHOUT TEFRA!! I'M THANKFUL!
5–7	1–2 years	$100,001–$150,000	5–8	URGENT CARES NEED TO BE COVERED. YOU END UP W/ NON–EMERGENT PATIENTS AT THE ER BECAUSE DOCTOR'S OFFICE IS FULL AND TEFRA WON'T PAY FOR URGENT CARE BUT DOES PAY FOR ER VISITS.
8–10	Less than 1 year	$50,001–$100,000	0–4	TEFRA HAS MADE IT EXTREMELY POSSIBLE FOR MY DAUGHT WITH CP. WE WERE PAYING OVER $1000 PER MONTH FOR HER MEDICINE, THERAPY SERVICES, DR. VISITS & MEDICAL EQUIPMENT COPAYS. WE ARE VERY GRATEFUL FOR THIS SERVICE.
5–7	More than 5 years	$100,001–$150,000	9–12	MY SON'S PSYCHIATRIST DOESN'T ACCEPT MEDICAID, THUS TEFRA DOESN'T PAY FOR RX'S HE PRESCRIBES.
5–7	2–5 years	$50,001–$100,000	9–12	THERE NEEDS TO BE AN ONLINE PORTAL.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
8–10	1–2 years	$100,001–$150,000	0–4	CHILDREN'S FINANCIAL COUNSELOR WAS A HUGE HELP IN THE APPLICATION PROCESS, OR IT WOULD HAVE BEEN OVERWHELMING/CONFUSING. BUT ONCE WE WERE ACCEPTED, WE HAVE LOVED & APPRECIATED TEFRA!
8–10	Less than 1 year	$150,001 or more	0–4	GREAT PROGRAM, WITHOUT IT OUR CHILD WOULD NOT BE ABLE TO RECEIVE HIS SERVICES.
8–10	2–5 years	$0–$50,000	5–8	I'M HAPPY WITH TEFRA COVERS ME ALL THANK YOU.
8–10	2–5 years	$50,001–$100,000	0–4	THE NEW RENEWAL FORM WAS SOMEWHAT CONFUSING AS TO WHAT DOCUMENTS WERE NEEDED SO I JUST SENT IN THE SAME BUT UPDATED INFORMATION AS THE PREVIOUS YEAR. WE RARELY HAVE ISSUES & APPRECIATE HER TEFRA!
0–4	More than 5 years	$150,001 or more	13–19	VERY DIFFICULT TO FIND A CASE MANAGER OR SOMEONE TO TALK TO ABOUT WHAT SERVICES ARE & ARE NOT COVERED FOR MY CHILD AND WHY. FORMS ARE VERY DIFFICULT TO COMPLETE AND SHOULD BE COMPUTERIZED SO WE DO NOT HAVE TO DO THEM OVER EVERY YEAR.
8–10	1–2 years	$0–$50,000	0–4	EVERYTHING IS GREAT THE ONLY HARD PART ABOUT THIS PROCESS WAS THE 1ST PACKET TO FILL OUT, IT WAS VERY HARD, THANK GOODNESS AR CHILDREN'S HOSPITAL HELPED ME.
5–7	1–2 years	$100,001–$150,000	0–4	BEING TOLD MY SON LOST TEFRA B/C I DIDN'T COMPLETE FORMS WAS VERY SCARY/FRUSTRATING WHEN I MAILED THEM IN DAY AFTER RECEIVING. THEN CALLING MONDAY TO FIND OUT THEY HAD FORM ALL ALONG.
0–4	1–2 years	–	9–12	VERIFIED MY EMAIL WITH ONLINE PORTAL AND THRU DHS SAID IT WASN'T SO THEY CAN'T COMMUNICATE WITH ME?! DAUGHTERS CASE CLOSED/DENIED B/C I DIDN'T RETURN REQUEST PAPERWORK (BOTH REQUEST AND DENIAL WERE PRINTED THE SAME DAY). DHS CLOSED DUE TO NOT RETURNING PAPERWORK THE SAME DAY THEY PROVIDED THE REQUESTED INFORMATION. HOW IS THAT SUPPOSED TO BE POSSIBLE PAPERWORK HADN'T EVEN BEEN MAILED. 0 DAYS!

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
	2–5 years	$100,001–$150,000	9–12	APPLYING FOR AND WAITING FOR APPROVAL WAS TEDIOUS. WE HAVE BEEN VERY GRATEFUL FOR TEFRA & HOW IT HELPED OUR DAUGHTER. IT WAS ALSO EXTREMELY DIFFICULT TO GET EVERYTHING TOGETHER IN THE RIGHT ORDER GET A COMMUNICATION DEVICE. IT ALSO WAS DIFFICULT TO CHANGE DOCTORS IF I DIDN'T LIKE OURS OR THEIR OFFICE STAFF. WE ARE GLAD FOR IT & WOULD GO THROUGH IT ALL AGAIN IF IT MEANT OUR DAUGHTER RECEIVED THE SERVICES SHE NEEDED.
5–7	More than 5 years	$50,001–$100,000	5–8	WHEN YOUR CHILD HAS A DIAGNOSIS SUCH AS DOWN SYNDROME OR OTHERS THAT ARE NOT SOMETHING THEY "GROW" OUT OF. WHY DO WE NEED TO FILL OUT YEARLY PAPERWORK TO RENEW? SHOULD IT NOT JUST AUTO–RENEW?
8–10	2–5 years	$50,001–$100,000	9–12	THE ONLINE APPLICATION WAS NIGHTMARISH IDEALLY, IT WOULD GIVE A "TEFRA RENEWAL" OPTION AT THE VERY START. THE PROCESS OPENED AND CLOSED AN ENTIRELY NEW CASE FOR US. CONFUSING! VERY GLAD IT IS MOVING ONLINE. BUT TRANSITION IS AWFUL!
5–7	2–5 years	$50,001–$100,000	13–19	MY CHILD HAS LUPUS IT WILL NOT GO AWAY EVERY YEAR HAVING TO HAVE HER SAYING SHE STILL HAS IT. THIS STUPID AND A WASTE OF TIME ALL I SHOULD HAVE TO DO IS INCOME.
5–7	More than 5 years	$100,001–$150,000	9–12	WE ARE VERY THANKFUL FOR THE TEFRA PROGRAM!
8–10	2–5 years	$50,001–$100,000	0–4	WE LOVE TEFRA!!!
8–10	2–5 years	$100,001–$150,000	5–8	WE ARE VERY THANKFUL FOR TEFRA. OUR CHILD IS GETTING ALL THE THERAPHY SHE NEEDS. SHE GOES TO SCHOOL AND GOES TO THERAPY AFTER. THANK YOU ALL. GOD BLESS.
8–10	2–5 years	$50,001–$100,000	13–19	THANKFUL FOR THE EXTRA TIME DURING THIS CRAZY TIME.
5–7	2–5 years	$50,001–$100,000	5–8	INVOICING PROCESS– VERY CONFUSING AND RENEWAL PAPERWORK CHANGE THIS YEAR WAS NOT CLEAR AND NOT NOTIFIED OF CHANGE ALMOST LOST TEFRA THROUGH CONFUSION.
5–7	Less than 1 year	$100,001–$150,000	0–4	SO THANKFUL FOR TEFRA, BUT WAS (AND STILL AM) CONFUSED BY PAYMENTS AND KEEP ANTICIPATING A BILL FROM MY CHILD'S CLINC ON TOP OF WHAT I AM PAYING.

Level of Satisfaction	Length of Enrollment	Household Income	Age Range	Comments ** Indicates de-identification
5–7	Less than 1 year	–	5–8	WE'VE HAD CONSIDERABLE ISSUES WITH THE PRESCRIPTION AUTHORIZATIONS BY MEDICAID. I FEEL IT IS A SHAME THAT OUR SON'S NEUROLOGIST W/AR CHILDRENS CAN NOT BE TRUSTED TO KNOW WHO BEST TO TREAT–HIS SEVERE INSTRACTABLE EPILEPSY WO/MEDICAID TELLING THE DOCTOR HOW MY SON NEEDS TO BE TREATED, OR WHAT MEDICATIONS OR QUANITIES OF MEDS THEY WILL OR WILL NOT COVER. PLUS THE EXTRA EG'S THEY REQUIRE BEFORE AUTHORIZING FURTHER NECESSARY TREATMENTS WITH HIS HISTORY.
8–10	2–5 years	$50,001–$100,000	5–8	WHY DO WE NOT GET COPY OF BILLS?
8–10	2–5 years	$150,001 or more	5–8	LOST MY RENEWAL APPLICATION FOR TEFRA. SEND ANOTHER ONE PLEASE.

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ARMedicaid

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Data analysis by

afmc℠

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	A	B	C	D	E	F	G	H	I	J
1	**5 YEARS OF HISTORIC DATA**									
2										
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**					**DY 19**				
4		**CY 2017**	**CY 2018**	**CY 2019**	**CY 2020**	**CY 2021**				
5	**Medicaid Pop 1**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**			
6	**TOTAL EXPENDITURES**	$ 67,168,894	$ 64,101,606	$ 75,331,470	$ 74,432,259	$ 82,324,145	$ 363,358,375	Per Sch C + Cap pmts		
7	**ELIGIBLE MEMBER MONTHS**	59,623	60,427	63,443	65,986	70,106		historic MM		
8	**PMPM COST**	$ 1,126.56	$ 1,060.81	$ 1,187.39	$ 1,128.00	$ 1,174.28				
9	**TREND RATES**						**5-YEAR**			
10			**ANNUAL CHANGE**				**AVERAGE**			
11	TOTAL EXPENDITURE		-4.57%	17.52%	-1.19%	10.60%	5.22%			
12	ELIGIBLE MEMBER MONTHS		1.35%	4.99%	4.01%	6.24%	4.13%			
13	PMPM COST		-5.84%	11.93%	-5.00%	4.10%	1.04%			
14										
34										
35	**Other Data**	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**			
36	**TOTAL EXPENDITURES**	$ (3,700,729)	$ (5,302,962)	$ (5,595,945)	$ (5,448,201)	$ (6,503,116)	$ (26,550,953)	Premiums collected		
37	**ELIGIBLE MEMBER MONTHS**	59,623	60,427	63,443	65,986	70,106		historic MM		
38	**PMPM COST**	$ (62.07)	$ (87.76)	$ (88.20)	$ (82.57)	$ (92.76)				
39	**TREND RATES**						**5-YEAR**			
40			**ANNUAL CHANGE**				**AVERAGE**			
41	TOTAL EXPENDITURE		43.30%	5.52%	-2.64%	19.36%	15.14%			
42	ELIGIBLE MEMBER MONTHS		1.35%	4.99%	4.01%	6.24%	4.13%			
43	PMPM COST		41.39%	0.51%	-6.39%	12.35%	10.57%			

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**														
2															
3						**CY 2023**	**CY 2024**	**CY 2025**	**CY 2026**	**CY 2027**					
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**				
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00**	**RATE 2**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**				
6															
7	**Medicaid Pop 1**														
8	**Pop Type:**	**Medicaid**													
9	Eligible Member Months	4.1%	12	73,001	4.1%	76,016	79,156	82,425	85,829	89,374					
10	PMPM Cost	1.0%	12	$ 1,186.49	1.0%	$ 1,198.83	$ 1,211.30	$ 1,223.90	$ 1,236.63	$ 1,249.49					
11	Total Expenditure					$ 91,130,665	$ 95,881,435	$ 100,879,892	$ 106,138,836	$ 111,671,718	$ 505,702,546				
12															
25	**Hypo 1**														
26	**Pop Type:**	**Hypothetical**													
27	Eligible Member Months					76,016	79,156	82,425	85,829	89,374		MM as shown above			
28	PMPM Cost					$ 905.02	$ 943.03	$ 982.64	$ 1,023.91	$ 1,066.91		Forecast PMPM (premium deducted)			
29	Total Expenditure					$ 68,796,386	$ 74,646,459	$ 80,993,991	$ 87,881,282	$ 95,354,232	$ 407,672,349	State growth rate of 4.2%			

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	CY 2023 DEMONSTRATION YEARS (DY) DY 01	CY 2024 DY 02	CY 2025 DY 03	CY 2026 DY 04	CY 2027 DY 05	TOTAL WW
Medicaid Pop 1								
Pop Type:	**Medicaid**							
Eligible Member Months	73,001	4.1%	76,016	79,156	82,425	85,829	89,374	
PMPM Cost	$ 1,186.49	1.0%	$ 1,198.83	$ 1,211.30	$ 1,223.90	$ 1,236.63	$ 1,249.49	
Total Expenditure			$ 91,130,665	$ 95,881,435	$ 100,879,892	$ 106,138,836	$ 111,671,718	$ 505,702,546
Hypo 1								
Pop Type:	**Hypothetical**							
Eligible Member Months			76,016	79,156	82,425	85,829	89,374	
PMPM Cost			$ 905.02	$ 943.03	$ 982.64	$ 1,023.91	$ 1,066.91	
Total Expenditure			$ 68,796,386	$ 74,646,459	$ 80,993,991	$ 87,881,282	$ 95,354,232	$ 407,672,349

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS		DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)						
FMAP for Leading FFY						
DSH Diversion to Trailing FFY (total computable)						
FMAP for Trailing FFY						
Total Demo Spending From Diverted DSH (total computable)		$ -	$ -	$ -	$ -	$ -

Budget Neutrality Summary

Without-Waiver Total Expenditures

	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027	
	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid Pop 1	$ 91,130,665	$ 95,881,435	$ 100,879,892	$ 106,138,836	$ 111,671,718	$ 505,702,546
TOTAL	$ 91,130,665	$ 95,881,435	$ 100,879,892	$ 106,138,836	$ 111,671,718	$ 505,702,546

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Medicaid Pop 1	$ 91,130,665	$ 95,881,435	$ 100,879,892	$ 106,138,836	$ 111,671,718	$ 505,702,546
TOTAL	$ 91,130,665	$ 95,881,435	$ 100,879,892	$ 106,138,836	$ 111,671,718	$ 505,702,546
VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 1	$ 68,796,386	$ 74,646,459	$ 80,993,991	$ 87,881,282	$ 95,354,232	$ 407,672,349
TOTAL	$ 68,796,386	$ 74,646,459	$ 80,993,991	$ 87,881,282	$ 95,354,232	$ 407,672,349

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 1	$ 68,796,386	$ 74,646,459	$ 80,993,991	$ 87,881,282	$ 95,354,232	$ 407,672,349
TOTAL	$ 68,796,386	$ 74,646,459	$ 80,993,991	$ 87,881,282	$ 95,354,232	$ 407,672,349
HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

TEFRA	CY 2017	CY 2018	CY 2019	CY 2020	DY 19 CY 2021	
Medicaid Pop 1	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
Schedule C	$66,617,075	$62,161,627	$59,514,336	$53,724,089	$61,052,998	**$303,070,125**

Manually removed WY 20 expenses due to system not separating WY 19 and 20

Cumulative Data Ending Quarter/Year : 1/2022

Capitation Payments	CY 2017	CY 2018	CY 2019	CY 2020	DY 19 CY 2021	
Medicaid Pop 1	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
M1 - MANAGED CARE FEE	$152,724	$153,660	$141,384	$157,635	$161,262	**$766,665**
M2 - CPC MANAGED CARE FEE						
M3 - PCMH CARE COORDINATION PAYMENTS	$205,092	$204,008	$184,040	$192,352	$204,322	**$989,814**
M5 - DENTAL MANAGED CARE		$1,371,942	$1,406,092	$1,483,991	$1,579,619	**$5,841,644**
NT - NET MANAGED CARE WAIVER	$193,993	$210,369	$189,169	$201,756	$218,628	**$1,013,915**
SE - PASSE	$10		$13,896,449	$18,672,437	$19,107,316	**$51,676,212**
Total	**$551,819**	**$1,939,979**	**$15,817,134**	**$20,708,170**	**$21,271,147**	**$60,288,250**

Note: Capitated payments for waiver services listed above are reported under their respective waivers on the CMS 64 report. Theses services are not reported on the CMS 64 TEFRA pages. The State ensured these amounts are not double counted. Utilization of these services by TEFRA waiver participants was determined through evaluation of the MMIS data base to identify TEFRA participants and their total spending for each listed waiver.

Totals are reported on the "Historic Data" tab under "Medicaid Pop 1 ,Total expenditures".

Population Status Drop-Down
Medicaid
Hypothetical
Expansion

ARKANSAS TEFRA-LIKE
Section 1115
Project Number 11W001636

Draft Interim Evaluation Report

December 31, 2021

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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I. Executive Summary

In this interim evaluation, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 is examined based on the demonstration's goals. These goals include improving access to care, access to preventative care, beneficiaries' perception and satisfaction with their care, and affordability of TEFRA premiums. An evaluation design was developed by an Independent Evaluator (IE) to better understand the relationship between these aims, hypotheses, and outcome measures used to analyze performance. Please note, the terms "contractor," "data evaluator," and "IE" all refer to the same entity in this report. Specifically, to evaluate these aims, logic models were developed to link each proposed aim with measurable outcome measures that could be monitored throughout the term of the demonstration. Outcome measures were then linked to testable hypotheses, which allowed for a more robust quantitative assessment. In the following sections of this executive summary, the IE provides a high-level overview of key interim findings, interpretations, policy implications, and any recommendations for this demonstration.

II. General Background Information

Demonstration Overview

History

The TEFRA of 1982 gave individual states the option to provide health care benefits to children living with disabilities and with a family income too high to qualify for traditional Medicaid. Sometimes called the Katie Beckett Option 1, this program is associated with a child whose experience with viral encephalitis at a young age left her family in financial hardship. If Katie continued receiving treatment at the hospital, she qualified for Supplemental Security Income (SSI) through Medicaid. However, if she were treated at home, her parents' income would make her ineligible for Medicaid. Interestingly, the hospital-based care was six-times more than the cost of home-based care. To address the issues associated with this act, President Ronald Reagan and the Secretary of Health and Human Services created a committee to review the regulations and ensure that children with disabilities could receive home-based treatment (the Katie Beckett option), which then resulted in the recommendation for Section 134 of the TEFRA.

Before 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the

State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to transition the disabled children from traditional Medicaid to a TEFRA-like 1115 Demonstration Waiver program. Arkansas' 1115 TEFRA-like Demonstration Waiver[1] was originally approved on October 17, 2002 and implemented on January 1, 2003. Following the initial five-year demonstration period, the program has continued to be renewed. The TEFRA Waiver is a cost sharing Medicaid program that enables certain children with a disability to receive care in their homes, rather than in an institution. Using the flexibility available within a Demonstration Waiver, Arkansas was able to develop and implement a sliding scale premium fee structure based on a family's income. This effectively passes a portion of the cost to the eligible child's family. Families with annual incomes of less than $25,000 were exempted from the premium requirement; program eligibility was determined solely on the assets and resources of the child.

Current

The original request for a three-year extension renewal for the TEFRA-like Demonstration Waiver (with no program change) was provided to Centers for Medicare & Medicaid Services (CMS) on June 30, 2017. The review/approval process for the extension renewal application was not completed by the December 31, 2017, end date of the May 12, 2015 – December 31, 2017 demonstration period. Therefore, initially, CMS approved an extension of the demonstration through April 30, 2018. This allowed the state additional time to complete the review/renewal process. Also, this allowed time for the new renewal period for the Special Terms & Conditions (STC) to be finalized. Thus, on October 18, 2017, Arkansas submitted a follow-up request to extend the demonstration for a three-year period (with no program changes). Lastly, on May 9, 2018, CMS approved the demonstration extension request for a period of five years, spanning through December 31, 2022. Since the initial TEFRA Demonstration Waiver approval in 2003, the state was only given the option of three-year renewal periods. This changed during the last renewal request, when the state was offered a five-year renewal option, which the state opted to accept. Overall, the TEFRA extension renewal was approved on May 9, 2018, for a demonstration period from May 9, 2018 – December 31, 2022.

No program changes were made in the TEFRA-like Demonstration Waiver since CMS approved the evaluation design on September 26, 2019. In accordance with CMS' demonstration requirement, the Arkansas Division of Medical Services (DMS) accepted a five-year renewal option for the demonstration. A draft of the interim evaluation report for the TEFRA-like demonstration must be developed one year prior to the end of the demonstration as described in STC 51. The

[1] https://humanservices.arkansas.gov/divisions-shared-services/county-operations/health-care-programs/. https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/tefra/.

state must submit the final interim evaluation report 60 days after receiving CMS comments on the draft interim evaluation report. The measurement period for the interim evaluation report is 2018 – 2019 for claims-based data and satisfaction survey-based outcomes. **Appendix C** includes more information on dates of service included in the interim report, as listed on "Measurement Period" row for each measure table.

Target Population

The target population impacted by the TEFRA-like demonstration includes all beneficiaries, covered under Title XIX of the Social Security Act in the State of Arkansas that are ages 18 or younger, meet the medical necessity requirement for institutional care, have income that is less than the long-term care Medicaid limit, and do not have countable assets greater than $2,000. The target population includes enrolled TEFRA-like beneficiaries meeting all the following eligibility criteria:

a) Child must be age 18 or younger,

b) Child must meet the Social Security Administration's definition of disability,

c) Child must be a U.S. citizen or qualified alien,

d) Child must have established residency in the state of Arkansas,

e) Child must have a Social Security Number or have applied for one,

f) Child's annual gross countable income must be less than the current Medicaid State Plan income limit established for long-term care services, in accordance with section 1902(a)(10)(A)(ii)(V) of the Act (i.e., the child would be Medicaid eligible if institutionalized),

g) Child's countable assets do not exceed $2,000 (parent(s) assets are not considered),

h) Child meets the medical necessity requirement for institutional placement, or level of care, or be at risk, in the future, for institutional placement, and

i) If eligibility criteria a – h are met, the child must also have access to medical care in the home. It must be deemed appropriate to provide such care outside an institution, and the estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

Comparison Populations

The comparison population consists of Medicaid non-TEFRA-like program beneficiaries of similar age and beneficiary primary diagnosis conditions (as described under criteria (g) below) as the TEFRA-like population. The claims-based comparison population of enrolled Medicaid non-

TEFRA-like beneficiaries includes those beneficiaries that meet the following criteria:

a) Child must be age 18 or younger,

b) Child must be a U.S. citizen or qualified alien,

c) Child must have established residency in the state of Arkansas,

d) Child must have a Social Security Number or have applied for one,

e) Child must have continuous enrollment of Medicaid non-TEFRA-like program,

f) Not enrolled in TEFRA-like program 12 months prior/post evaluation measurement periods, and

g) Child must be identified in at least one of the nine selected primary diagnosis conditions, which include the following: Child/ Adolescent Emotional Disorders, Other Congenital Anomalies, Attention Deficit Hyperactivity Disorders, Anxiety/ Nonpsychotic Disorders, Mood Disorders, Nervous System Congenital Anomalies, Cardiac and Circulatory Congenital Anomalies, Adjustment Disorders, and Hereditary and Degenerative Nervous System Conditions

III. Evaluation Questions and Hypotheses

Demonstration Goals

The interim evaluation report includes findings regarding the impacts of the demonstration on the quality and affordability of health care for all children eligible for the program (promoting the objectives of Title XIX). It explores and evaluates the effectiveness of the demonstration for each research hypothesis, as provided in the evaluation design report.

- ***Goal 1:*** *Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population.*
- ***Goal 2:*** *Ensuring demonstration enrollees have access to timely and appropriate preventive care.*
- ***Goal 3:*** *Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received.*
- ***Goal 4:*** *Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for*

nonpayment of premiums is relatively low.

As illustrated in the "Methodology" section, each research hypothesis includes one or more evaluation design measure(s). Included in the evaluation design (see **Appendix C**) are the demonstration's performance set of outcome and satisfaction measures over time. This is relative to a comparable population in the Arkansas Medicaid program, where applicable. Each measure includes the numerator and denominator descriptions, the data sources, and the analytic method used to test the hypotheses. Both cross-sectional and sequential trend analyses were used, depending on whether the measure spanned a single point in time or multiple points in time, along with the specific research hypothesis being addressed. In learning from the previous evaluation design, interim/final reports, and experience of state specific data, Arkansas has value-added components to its current evaluation design and interim evaluation. For example, Arkansas included specific TEFRA-like DMS homegrown measures for interim evaluation findings (see **Appendix C** Measure 2.2a as an example). TEFRA-like population homegrown measures were developed with oversight from Arkansas' Medical Director and derived from an exploratory analysis of CY2016 findings. This evaluation report does not expand on the earlier demonstration evaluation findings due to a different set of measures and the previous comparison population including an ARKids A population.

Driver Diagram

The driver diagram is included to help clearly depict the fundamental relationship between the primary drivers, secondary drivers, and ultimate aims of the demonstration. This is an important aspect to determine if the demonstration is achieving each of the state's four goals. In order to provide a visual display of DMS's evaluation design of what "drives" or contributes to the achievement of the demonstration goals, the driver diagram is provided in **Appendix A**. One of the primary drivers contributing directly to achieving ***Goal 1*** of *Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population* is equal or better access to speech, occupational, and physical therapy services. Claims-based and survey-based measures of speech, occupational, and physical therapy services are the secondary drivers. From the claim's side, this captures the utilized speech, occupational, and physical therapy services in the doctors' offices. From the caretaker's viewpoint on the survey's side, this captures a child enrolled in TEFRA not having a problem getting the needed therapy services. One moderating factor examines the high volume of third-party liability (TPL) coverage of enrolled TEFRA-like beneficiaries.

Evaluation Hypotheses and Research Questions

The TEFRA-like demonstration's four goals showcase the Centers for Medicare & Medicaid Services' (CMS) three-part aim of better care for individuals, better health for population, and lower costs. The interim evaluation follows these goals as descripted in the evaluation design, which is organized around nine hypotheses and 28 research questions.

Goal 1: Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population

DMS' mission statement is as follows: "To ensure that high-quality and accessible healthcare services are provided to citizens of Arkansas who are eligible for Medicaid or Nursing Home Care." This statement aligns with the intent of evaluating the success of the demonstration through analysis of health services used by the TEFRA-like beneficiaries as compared to the non-TEFRA-like beneficiaries. Primarily, under **Goal 1**, the evaluation assesses the utilization rates of speech, occupational, and physical therapy services of TEFRA-like beneficiaries. Also, the evaluation assesses how these rates are similar or better compared to those for non-TEFRA-like beneficiaries. **Goal 1** has two hypotheses and eight research questions:

Hypothesis 1.1: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for **Hypothesis 1.1**

1.1a. What are the claim-based rates of TEFRA-like beneficiaries for speech, occupational, and physical therapy services? Do demographics have an impact on the access to health services for speech, occupational, and physical therapy services?

1.1b. How do claims-based utilization rates for therapy service compare to TEFRA Satisfaction Survey scores of getting speech, occupational, and physical therapies?

1.1c. How does PCP access look for TEFRA-like beneficiaries? What age group is the lowest and highest utilizers to preventive care?

Hypothesis 1.2: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for **Hypothesis 1.2**

1.2a. How does TEFRA-like beneficiaries' prescriptions coverage change over time?

1.2b. What geographic regions of the state for TEFRA-like beneficiaries have both low and high access to health services on at least two prescriptions? Who achieved a PDC of at least 50%?

1.2c. Are TEFRA-like beneficiaries seeing a change in the level of cost based on the average cost of prescription (Rx) per beneficiary over time?

1.2d. Are TEFRA-like beneficiaries receiving similar or better (Rx) per beneficiary per month (PBPM)?

1.2e. Do TEFRA-like beneficiaries maintain refills on seizure medications over time?

Goal 2: Ensuring demonstration enrollees have access to timely and appropriate preventive care

Under **Goal 2**, frequency of gaps in TEFRA-like coverage and the average length (in months) a TEFRA-like beneficiary is enrolled are examined. An incentive for a patient to enroll under the TEFRA-like program is to receive the services of speech, occupational, and physical therapy. The state reviewed the percent of newly enrolled TEFRA-like beneficiaries receiving therapy services within 60 days of enrollment. A marker for timely preventative care is a beneficiary's experience of obtaining care right away. As described in the "Driver Diagram" section, the majority of TEFRA-like beneficiaries have third-party liability coverage. Therefore, the state researched what parts of the state have high and low percentages of TPL coverage. Another indicator for appropriate preventative care examines the percent of TEFRA-like beneficiaries who have durable medical equipment coverage. **Goal 2** has three hypotheses and eight research questions:

Hypothesis 2.1: ***Preventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar or better over time.***

Research Questions for **Hypothesis 2.1**

2.1a. How soon after enrollment are newly enrolled TEFRA-like beneficiaries getting access to first health care PCP visit?

2.1b. What is the rate of newly enrolled TEFRA-like beneficiaries receiving speech, occupational, and physical therapies within a certain number of days from enrollment?

2.1c. What is the average length (in months) of TEFRA-like segments within the measurement period?

Hypothesis 2.2: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for **Hypothesis 2.2**

2.2a. What are the rates of third-party liability (TPL) coverage?

2.2b. Are TEFRA-like beneficiaries who have TPL receiving preventive care with a PCP visit?

2.2c. What geographic regions of the state have high percentages of TPL coverage? What geographic regions of the state have low percentages of TPL coverage?

Hypothesis 2.3: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for **Hypothesis 2.3**

2.3a. Do TEFRA-like beneficiaries have equal or higher rates of durable medical equipment (DME) coverage?

2.3b. What are the top five primary diagnosis conditions/codes and condition types for TEFRA-like beneficiaries who have durable medical equipment (DME) coverage?

Goal 3: Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received

Patient experience over time with the TEFRA-like demonstration program is assessed by analyzing responses from the TEFRA Beneficiary Satisfaction Survey domains of “Getting care quickly,” “How well doctors communicate,” and “Overall health care.” An indicator for comparing the TEFRA-like plan with other health plans is used to investigate the impact on patient experiences of health care services. This is determined by comparing responses pre-enrollment of six months to post enrollment in the TEFRA-like program. **Goal 3** has two hypotheses and six research questions:

Hypothesis 3.1: ***Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration has remained the same or improved over time.***

Research Questions for **Hypothesis 3.1**

3.1a. Have TEFRA-like beneficiaries' experience scores of getting care quickly improved or stayed the same over time?

3.1b. Do TEFRA-like beneficiaries have confidence in how well doctors communicate?

3.1c. Is the overall health care rating showing improvement over time?

Hypothesis 3.2: ***Patient’s experience with access to health care services improve with enrollment into TEFRA-like program.***

Research Questions for **Hypothesis 3.2**

3.2a. Are TEFRA-like beneficiaries' experiencing better access to health care when seeing a personal doctor or nurse with enrollment into TEFRA-like program?

3.2b. Are TEFRA-like beneficiaries experiencing better pharmacy access on prescription medications with enrollment into TEFRA-like program?

3.2c. Are TEFRA-like beneficiaries experiencing any problems when needing urgent care access with enrollment into TEFRA-like program?

Goal 4: Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low

The financial burden of the TEFRA-like premiums is an important way to gauge beneficiaries' experiences on health care access and financial impact. This is analyzed from the respondents perceiving premiums as a financial burden on the TEFRA Beneficiary Satisfaction Survey. Also, the reported TEFRA-like premium range is studied over time to determine the differences for respondents paying the program premiums as a financial burden. **Goal 4** has two hypotheses and six research questions:

Hypothesis 4.1: ***Premium barriers for TEFRA-like beneficiaries will remain stable over time.***

Research Questions for **Hypothesis 4.1**

4.1a. What is the percentage of TEFRA-like beneficiaries experiencing a premium barrier?

4.1b. How does the premium range differ for those experiencing a premium barrier?

Hypothesis 4.2: ***Reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access.***

Research Questions for **Hypothesis 4.2**

4.2a. What are the top five reasons why Arkansas TEFRA-like beneficiaries' cases were closed?

4.2b. How does patient perception of 'getting care quickly' during lockout periods compare with similar perceptions among enrolled patients?

4.2c. How difficult it is to get speech, occupational, and physical therapy during lock-out period?

4.2d. What are the types of medical services that were not met for patients experiencing a lockout period? How does this patients experience vary by common diagnosis?

IV. Methodology

Evaluation Design

Arkansas analyzed the hypotheses and drivers described in **Appendix B** to address the four goals, as listed in the approved Special Terms and Conditions (STCs) document. By examining the hypotheses and research questions listed in the "Evaluation Hypotheses and Research Questions," the contractor assessed the performance of the demonstration and its potential effect on TEFRA-like population. As illustrated in **Appendix C**, each hypothesis includes two or more research questions, which then help assess the desired evaluation outcome and measure. Survey-based outcomes (more on surveys discussed below) are in a standardized form, comparable to and compared against national values, where applicable. The evaluation design examines the demonstration's performance on a set of outcomes and measures, along with the beneficiary's experience scores for accessibility, therapy services, overall health care, financial burden on TEFRA-like premiums, and other relevant scores. DMS and the evaluation contractor use multiple data sources for the nine hypotheses and 28 research questions. The interim evaluation report and evaluation design provide details of data sources on collected data for both administrative and Consumer Assessment of Healthcare Providers and Systems (CAHPS) or CAHPS-like survey-based data. The analytic methods offer quantitative or qualitative approaches to answer the research questions. Both cross-sectional and sequential trend analyses are used, depending on whether the outcome or measure spans one point in time or multiple points in time.

Target and Comparison Populations

The target population includes all beneficiaries covered under Title XIX of the Social Security Act in the State of Arkansas that are ages 18 or younger, meet the medical necessity requirement for institutional care, have income that is less than the long-term care Medicaid limit, and do not have countable assets greater than $2,000. The comparison population includes similar age and beneficiary diagnosis characteristics as the TEFRA-like population. This is used for selected claims-based outcomes and measures. For additional information of the target and comparison populations, please refer to the "General Background Information" section. A consideration to establish a comparison group with TEFRA or TEFRA-like programs was to review relevant material from other states[2]. For consideration within future evaluation reports and to serve as background

[2] https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

information, this material was reviewed and will be reviewed regularly.

Evaluation Period

The interim evaluation report was submitted to CMS on December 31, 2021 and the summative evaluation report will be provided by June 30, 2024. The observation period of interest will include the years 2018 – 2022. This includes both claims-based and survey reporting timeframes, with the time origin representing over five months prior to the demonstration renewal on May 9, 2018. The measurement period for the interim evaluation report is years 2018 – 2019. The summative (final) evaluation report will consist of years 2018 – 2022. **Appendix C** includes more information on the dates of services included in the interim evaluation report. This will be included in the summative evaluation report, as listed on the "Measurement Period" row for each measure table.

Evaluation Outcomes and Measures

Appendix C exhibits the interim evaluation outcome and measure description names, along with numerator and denominator descriptions. The analyses use data from publicly available national surveys, where applicable for benchmarking. Outcomes are examined. These outcomes include quality of care, access to health care, health outcomes, and beneficiary experience. Also, Arkansas uses nationally selected interim evaluation measures, where applicable, as provided in CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP[3] and Pharmacy Quality Alliance (PQA-like)[4] sources.

Data Sources

The Arkansas Division of Medical Services (DMS) and its contractor use multiple sources of data to assess the research hypotheses. The interim evaluation report leverages claims-based administrative data, enrollment data, and survey-based scores, as applicable. Administrative data sources include information extracted from DMS' Medicaid Management Information System (MMIS). Accurate and timely data reporting is essential for the TEFRA-like evaluation to be successful in achieving its goals of accessibility to health services, beneficiary experience in program, and affordable premiums. In order to meet this requirement, the contractor used its own Arkansas Medicaid Data Warehouse (a vendor approved priority warehouse system). Data analytics is performed without direct engagement from the State, as to avoid biased opinion or skewed

[3] Centers for Medicare & Medicaid Services, Children's Health Care Quality Measures. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[4] Pharmacy Quality Alliance. https://www.pqaalliance.org/pqa-measures.

results. The data evaluator runs the analytics and provides data as necessary for the analysis. Data from administrative claims is used and will not alter input data or the output of results.

Administrative Data

The Medicaid Management Information System (MMIS) data source is used to collect, manage, and maintain Medicaid beneficiary files (i.e., eligibility, enrollment, and demographics) and fee-for-service (FFS) claims. Use of FFS claims were limited to final, paid status claims. Interim transaction and voided records were excluded from all evaluations because these types of records introduce a level of uncertainty that can impact reported rates. The contractor used raw, full sets of Medicaid data. This data is provided on a weekly basis and consists of claims, provider, beneficiary, and pharmacy data subject areas. To ensure accurate and complete data, the contractor's Arkansas Medicaid Data Warehouse utilized the pre-snapshot data claims process, along with a full 12-month claims run out. This allowed all claims to be processed through MMIS. This was applied to the 2018 and 2019 performance period claim-based results. The contractor used fee-for-service claims and followed Healthcare Effectiveness Data and Information Set (HEDIS®) or CMS Core Set national specifications for related national measures. Applicable claim types, such as institutional, professional, and pharmacy claims, were used to calculate the various evaluation design measures. Beneficiary demographic files were used to assess beneficiary age, gender, and other demographic information. Eligibility files were used to verify a beneficiary's enrollment in the State's Medicaid programs. Each measure (see **Appendix C**) associated with each research hypothesis lists the data source(s) used in addressing it.

Survey Data

TEFRA Beneficiary Satisfaction Survey

The TEFRA Beneficiary Satisfaction Survey is designed and based on the CAHPS® 5.0H Medicaid Child survey. It covers topics such as getting care quickly, how well doctors communicate, and access to care, among others. This instrument can include specific survey items designed to elicit information. This information addresses the research hypotheses regarding the financial burden of the program and access to medical equipment and medical therapies. On an annual basis, the TEFRA Beneficiary Satisfaction Survey (TEFRA survey) has been conducted by the Arkansas Division of Medical Services (DMS). This has been done in collaboration with the Arkansas Foundation for Medical Care (AFMC), a National Committee for Quality Assurance (NCQA) Certified Healthcare Effectiveness Data and Information Set (HEDIS®) survey vendor. All beneficiaries in the TEFRA-like demonstration were included in the analyses. The TEFRA survey

follows a traditional NCQA sampling strategy—1,650 beneficiaries are randomly selected from the Medicaid Management Information System (MMIS). To be eligible for the study, beneficiaries must be enrolled in the program for at least six months with no more than one 30-day gap in enrollment.

TEFRA Disenrollee Beneficiary Survey

The survey vendor also conducted a TEFRA Disenrollee Beneficiary Survey. This is administered on as needed basis and is a CAHPS-like survey. The survey was modeled after the CAHPS® 5.0H Medicaid Child survey. This additional survey was only conducted in 2018 by the survey vendor and it was used to assess the impact of premium contributions. It accomplished this by asking additional questions of beneficiaries disenrolled from the program. Results provided important information about TEFRA premiums and the experiences of those that lost TEFRA coverage. The disenrollee survey looks at the reasons TEFRA beneficiaries were disenrolled and if disenrollment was voluntary. Beneficiaries with a break of at least one month in previous years' premium payments were identified. This included all TEFRA beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries that showed premium payments for all 12 months in the previous year were excluded from the population. The sample was de-duplicated by one beneficiary per household, where the youngest beneficiary was utilized for survey purposes.

Medicaid ARKids A and ARKids B Beneficiary Satisfaction Surveys

For additional survey outcomes, two other surveys overseen by the survey vendor were used as potential sources of data for plausible comparison groups. The ARKids First A and ARKids First B beneficiary satisfaction survey results and applicable national rates are addressed.

The ARKids First A Beneficiary Satisfaction Survey is a CAHPS® 5.0H Medicaid child survey and is currently conducted every two years. Thus, monitoring results provided during the year ARKids First A is not conducted includes the previous survey year's results. The CAHPS 5.0H Medicaid child survey included five composite measures, four rating questions, two question summary rates, and five effectiveness of care measures. NCQA guidelines require each beneficiary be enrolled for a minimum of six months, with no more than one gap in enrollment up to 45 days prior to participating in the survey. Due to the state's enrollment data being reported monthly, the survey vendor set the criteria at 30 days. The sampling frame for children consisted of all ARKids First A Arkansas Medicaid primary care case management (PCCM) enrollees who were 17 years old or younger as of the end of the reported calendar year. The child beneficiaries' six-month continuous enrollment began six months prior to the reported calendar year. Beneficiaries selected within the last 24 months were excluded from the population. Only one beneficiary per household was selected.

The beneficiary satisfaction survey for the ARKids First B is a CAHPS-like survey and is currently conducted on an annual basis. The survey was adopted using HEDIS/CAHPS® guidelines and protocol, along with the CAHPS 5.0H survey to assess beneficiaries' experiences with their health plans. The ARKids First B Beneficiary Satisfaction Survey included five composite measures, six rating questions, and two summary rates. The survey vendor used a systematic sampling method, as provided by NCQA's protocol for administering HEDIS/CAHPS surveys. Similar to ARKids First A, the criteria at 30 days were used. This is because the enrollment data is reported monthly. The sampling frame consisted of all ARKids First B PCCM enrollees ages 17 and younger at of the end of the reported calendar year. The beneficiaries' six-month continuous enrollment began six months prior to the reported calendar year. Beneficiaries selected for other surveys within the last 12 months were excluded from the population this year. Only one beneficiary per household was selected.

Medicaid Beneficiary Survey Comparison

A comparison group of selected measures for the survey-based questions (i.e., timely and appropriate preventive care) use a variety of state driven beneficiary satisfaction surveys. For example, selected composite individual scores (i.e., *Getting care quickly* and *How well doctors communicate*) and individual scores (i.e., *Rating of health care*) from the TEFRA beneficiary satisfaction survey results, if applicable, is compared to ARKids First A and First B beneficiary satisfaction survey results. Also, TEFRA disenrollee beneficiary survey results were only available in 2018 and not in 2019. This is compared to TEFRA beneficiary satisfaction survey individual scores in the domain of *Special equipment and supplies*. For comparison purposes, evaluation survey results reviewed national survey results provided by National CAHPS Benchmarking Database (NCBD) (see **Appendix C**, under "National Benchmark" row for applicable measures). The NCBD is a national repository funded by the Agency for Healthcare Research and Quality (AHRQ). It contains data from the CAHPS health plan survey in order to provide comparative data on health plans. Benchmarking survey scores calculated by NCBD reflected only the most positive response. Therefore, the ARKids First A composite and ARKids First B composite and ratings were not able to be used for comparison purposes. For the benchmark composite and summary questions, only the response choices of "always" or "yes" were provided by the survey vendor. In the ratings questions, response choices of "9" and "10" were provided by the survey vendor. For the purposes of this evaluation, only the response choices of "usually" or "always" were used for the survey composite and summary questions. In the rating questions, responses choices of 8, 9, or 10 for overall health care were used.

Analytic Methods

The interim evaluation uses univariate and bivariate analyses to test the hypotheses associated with the goals of the TEFRA-like program and related research questions. Univariate analyses are used to compute measures such as central tendency (i.e., mean, mode, and median), spread (i.e., range, variance, max, min, quartiles and standard deviation), and frequency distributions. The interim evaluation discusses the generalization of results in the context of data limitations. Statistical testing, such as t-tests (i.e., Wilcoxon-Mann-Whitney test) and chi-square testing, with 95% confidence intervals are utilized. **Appendix C** specifies the comparison strategies, descriptions of outcomes and measures, high-level technical specifications, data sources, and analytical approaches for each hypothesis. Appropriate statistical analyses are selected for each hypothesis.

Cross-sectional analysis (such as the Wilcoxon-Mean-Whitney test) and longitudinal data analysis are the two main analytic methods used to determine if beneficiaries in the TEFRA-like population are doing as well, or better than, non-TEFRA-like Medicaid beneficiaries with selected primary diagnosis conditions on various measures in the evaluation. The Wilcoxon-Mann-Whitney test is used for TEFRA-like vs. non-TEFRA-like single group methods of assessment. This test is also used for cross-sectional comparisons of two groups, at one point in time, for event-based measures. Chi-squared tests are used on beneficiary-based measures. A chi-squared test is used to compare the proportion of respondents' experiences on selected questions (from TEFRA beneficiary satisfaction survey) against similar questions (from Medicaid ARKids A and ARKids B beneficiary satisfaction surveys). The longitudinal nature of the data is exploited to establish trends in outcomes for the TEFRA-like population trend.

V. Methodological Limitations

The demonstration evaluation, from the perspective of beneficiaries, provides an opportunity to understand the impact of services that improve or maintain a child's health, or prevent a child's health from getting worse. Two methodological considerations that impacted our choice of evaluation approaches include the following: 1) the long-standing nature of the TEFRA-like program, with a lack of baseline data, and 2) the difficulty of identifying a comparison group for the specificities of the target population. Since the program was launched many years ago, a true baseline where a similar group can be compared year over year is difficult to establish. Additionally, since the program has a very specific population of TEFRA-like beneficiaries, the complexity of determining a true comparison population is challenging. The target population consists of a small sample size of less than 6,000 beneficiaries. As such, the comparative methods are descriptive. They include survey comparisons of TEFRA beneficiary satisfaction survey results against ARKids First A and First B beneficiary satisfaction survey results. Survey-based beneficiary level data are not available to the

independent evaluator contractor. Survey results were used from the survey vendors' executive summary reports[5]. This limitation involved using chi-squared testing strictly for survey score comparison over time, and for other applicable survey results. Where feasible, evaluation survey results incorporate national survey results (provided by the National CAHPS Benchmarking Database (NCBD)) for comparison purposes. The interim evaluation has limitations surrounding the lack of a truly comparative TEFRA-like population for selected measures. TEFRA-like enrollees may not have prior Medicaid coverage. Thus, there are limitations surrounding baseline values for the evaluation design measures. The interim evaluation treats Year 1 of the current demonstration performance period, 2018, as a baseline to measure changes over the course of the demonstration. Also, the evaluation analyzes survey scores for a patient's experience of their health care plan within the six months prior to enrollment in TEFRA (pre-TEFRA). This is compared to post enrollment within a TEFRA health plan (post-TEFRA). In addition, the evaluation conducts an in-state analysis that compares a TEFRA-like population to a comparison group with similar primary diagnosis conditions. Another drawback related to surveys is obtaining scores on an annual basis for the purpose of comparison to the ARKids First A Beneficiary Satisfaction Survey. It's challenging to compare between the two different surveys since one is conducted every two years and other survey is conducted on an annual basis.

VI. Results

Goal 1: Improve access to care

"Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population." The IE examined each year of the demonstration period for the TEFRA-like beneficiaries' access to health care (therapy services, perception of access to services and medication coverage). Within each year of the demonstration period, the results show the following:

- Almost half of TEFRA-like population received at least one therapy service of speech, occupational, or physical.
- On average, 90% of TEFRA-like survey respondents responded that they had no problem getting special therapy services between 2018 and 2019.
- In both CY2018 and CY2019, TEFRA-like beneficiaries had a slightly higher rate of Proportion for Days Covered (PDC) on general prescriptions as compared to non-TEFRA-like beneficiaries (57.4% vs. 56.1%).
- All regions of the state, except the southwest, decreased in the rate of TEFRA-like beneficiaries

[5] https://afmc.org/health-care-professionals/arkansas-medicaid-providers/surveys-and-reporting/.

that met the PDC with a threshold of 50% on general prescriptions between CY2018 and CY2019.

- Regarding the average cost of prescription (Rx) per beneficiary over time, there was a decrease in the cost of prescriptions for TEFRA-like beneficiaries between CY2019 vs. CY2018.

- The percentage of beneficiaries < 19 years of age and taking at least two seizure medications during CY2018 and CY2019 was significantly different between TEFRA-like (higher rates) vs. non-TEFRA-like beneficiaries (lower rates).

Therefore, because of the utilization of services and high satisfaction, our recommendation is to continue the state's work to address **Goal 1**. Further explanation for our recommendation is located in the hypotheses and conclusion sections of this document.

Goal 2: Access to preventative care

"Ensuring demonstration enrollees have access to timely and appropriate preventive care." The IE examined each year of the demonstration period for the TEFRA-like beneficiaries' access to timely preventative health care. Within each year of the demonstration period, the results show the following:

- For CY2019, over a third (38.7%) of newly enrolled TEFRA-like beneficiaries received their first health care visit with a PCP or for a speech, occupational, or physical therapy service within 60 days of enrollment.

- The measure regarding a first health care visit to a PCP within 60 days showed a 16% relative improvement over 2018. However, this was not significantly different for newly enrolled TEFRA-like beneficiaries between CY2019 and CY2018.

- Nearly 75% of the TEFRA-like population had at least one Medicaid claim paid by TPL coverage during CY2018 and CY2019. This was expected due to the TEFRA-like cost sharing Medicaid program, where the majority of beneficiaries have other health insurance coverage.

- TEFRA-like beneficiaries had a higher rate of utilization in comparison to non-TEFRA-like beneficiaries in both CY2018 and CY2019.

- Durable Medical Equipment (DME) coverage was significantly different between TEFRA-like and non-TEFRA-like beneficiaries in both CY2018 and CY2019.

The evaluation for utilization of preventive care service and access to care for new or existing enrolled Arkansas TEFRA-like beneficiaries suggests this population had improved access to timely care and higher (or not significantly different) utilization rates compared to a population of Medicaid non-TEFRA-like beneficiaries. Therefore, our recommendation is to continue the state's work to address **Goal 2**. Further explanation for our recommendation is located in the hypotheses and conclusion sections of this document.

Goal 3: Beneficiaries' perception and satisfaction with their care

"Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services

and experience in the quality of care received." The IE examined each demonstration year's beneficiary perception of the services that were received. When examining the TEFRA, ARKids First A, or ARKids First B Beneficiary Satisfaction Surveys, the results show the following:

- The TEFRA-like beneficiaries' experience of "getting care quickly" (obtaining care right away for an illness/injury/condition) slightly increased from 2018 to 2019 (97.0% and 97.9%).
- In comparing the TEFRA Beneficiary Satisfaction Survey vs. the ARKids First A or ARKids First B Beneficiary Satisfaction Surveys, there was no significant difference found in the scores for "getting care quickly," "how well doctors communicate," and "overall health care."
- In addition, beneficiaries reported fewer problems seeing a "personal doctor or nurse" and had fewer problems getting prescription medications/urgent care post-TEFRA vs. pre-TEFRA (significantly different).

Therefore, due to this high satisfaction of the TEFRA program, it is our recommendations based on the results of the beneficiary satisfaction survey scores the state should continue this work to address this **Goal 3**. Further explanation for our recommendation is located in the hypotheses and conclusion sections of this document.

Goal 4: Affordability of TEFRA premiums

"*Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low."* The IE examined each demonstration year the TEFRA premiums and barriers to beneficiaries being on TEFRA. The results show the following:

- The analysis to determine if premium barriers for beneficiaries will remain stable over time derive from survey scores identifying potential barriers for cost and disenrollment. The financial burden survey scores assess the burden to pay TEFRA premiums in the last six months. This revealed less of a cost barrier in 2019 than in 2018.
- TEFRA Disenrollee Beneficiary Survey scores identify the top five reasons why a beneficiary's case was closed. The top five reasons for closure of a child's TEFRA case consist of the following:
    1. "No longer eligible" (40 respondents),
    2. "Other" (39 respondents),
    3. "Could not afford premium payment" (17 respondents),
    4. "TEFRA services no longer needed" (14 respondents),
    5. "Could not complete paperwork on time", and "Obtained other coverage" (tie with 8 respondents each).

Since “Other” was the 2nd highest reason for disenrollment, the evaluator suggests investigating who closed the enrollee case and why. Due to its significant ranking in the survey scores, the “Other” category might need more probing questions to determine relevance. Therefore, our recommendation is to update the survey structure or explore another source for this type of information such as the Division of County Operations (DCO)This will clearly identify the reasons for disenrollment, as noted in the “Other” category, and also identify who disenrolled the beneficiary and why.

Final Recommendations

For **Goals 1-3**, our recommendation is to continue the state’s work to address these goals. For **Goal 4**, our recommendation is that the survey structure be reviewed and updated based on the results of the beneficiary survey scores. Further explanation for our recommendation is located in the hypotheses and conclusion sections of this document.

Hypothesis 1.1

For **Hypothesis 1.1,** the IE assessed if Arkansas TEFRA-like beneficiaries have equal or better access to health services compared to the Medicaid FFS population (Medicaid non-TEFRA-like).

For the first part of **Question 1.1a**, the IE states the claim-based rates for TEFRA-like beneficiaries receiving speech, occupational, and physical therapy services. **Table 1** results show all three therapy services in the TEFRA-like population sustained a higher rate during CY2018 and CY2019, as compared to the Medicaid non-TEFRA-like population (significantly different).

Table 1. TEFRA-Like and non-TEFRA-Like Populations - Measure 1.1a (Claims-based therapy services)[6]:

	% of TEFRA-Like Beneficiaries		% of Non-TEFRA-Like Beneficiaries		Statistically Significance Testing ($p < 0.05$)	
	CY2018	CY2019	CY2018	CY2019	CY2018	CY2019
Speech Therapy	59.0%	59.6%	15.5%	15.6%	Significantly different	Significantly different
Occupational Therapy	49.2%	44.6%	9.5%	9.0%	Significantly different	Significantly different
Physical Therapy	64.2%	64.4%	13.6%	13.7%	Significantly different	Significantly different

When considering the results of **Table 1**, an inference can be made about access to services. Yes, the TEFRA-like beneficiaries had significantly higher utilization rates as compared to the non-TEFRA-like beneficiaries. However, this can be contributed to the severity level of the TEFRA-like beneficiaries (i.e., a higher severity of illness will equate to higher utilization of these services).

For the second part of **Question 1.1a**, the IE reviewed the impact of demographics on access to health services for speech, occupational, and physical therapy. The results show the following:

- During CY2018 and CY2019, at least 65% of TEFRA-like beneficiaries received physical therapy services in the central, northeast, and northwest regions of the state.
- During CY2018 and CY2019, within the TEFRA-like population, the age group for children ages 0 - 4 years showed the highest utilization therapy rates in all three services (i.e., highest rate of physical therapy at 80.6% in CY2018 and speech therapy at 81.1% in CY2019).
- During CY2018 and CY2019, at least 65% of TEFRA-like beneficiaries received physical therapy services in the central, northeast, and northwest regions of the state. This result is much higher compared to the non-TEFRA-like population (see **Figure 1** for the TEFRA-like population and **Figure 2** for the non-TEFRA-like population).
- The majority of eligible beneficiaries in the central region utilized speech, occupational, and physical therapy services during both years (with the lowest rate being 48.8% in occupational therapy during CY2019 and the highest rate being 66.5% in physical therapy during CY2018).

[6] Table 1 measure is defined as the percentage of beneficiaries < 19 years of age who are utilizing therapy services during the measurement period (by a) speech, b) occupational, and c) physical therapy services) for CY2018 and CY2019

- During CY2018 and CY2019, the southwest and southeast regions were impacted the most by lower therapy services rates for all three therapy services received by the TEFRA-like population (when compared to the applicable therapy service rate in **Table 1)**.

Figure 1. TEFRA-Like Population by Region - Measure 1.1a (Claims-based therapy services): The percentage of beneficiaries < 19 years of age who are utilizing therapy services during the measurement period (by a) speech, b) occupational, and c) physical therapy services) for CY2018 and CY2019.

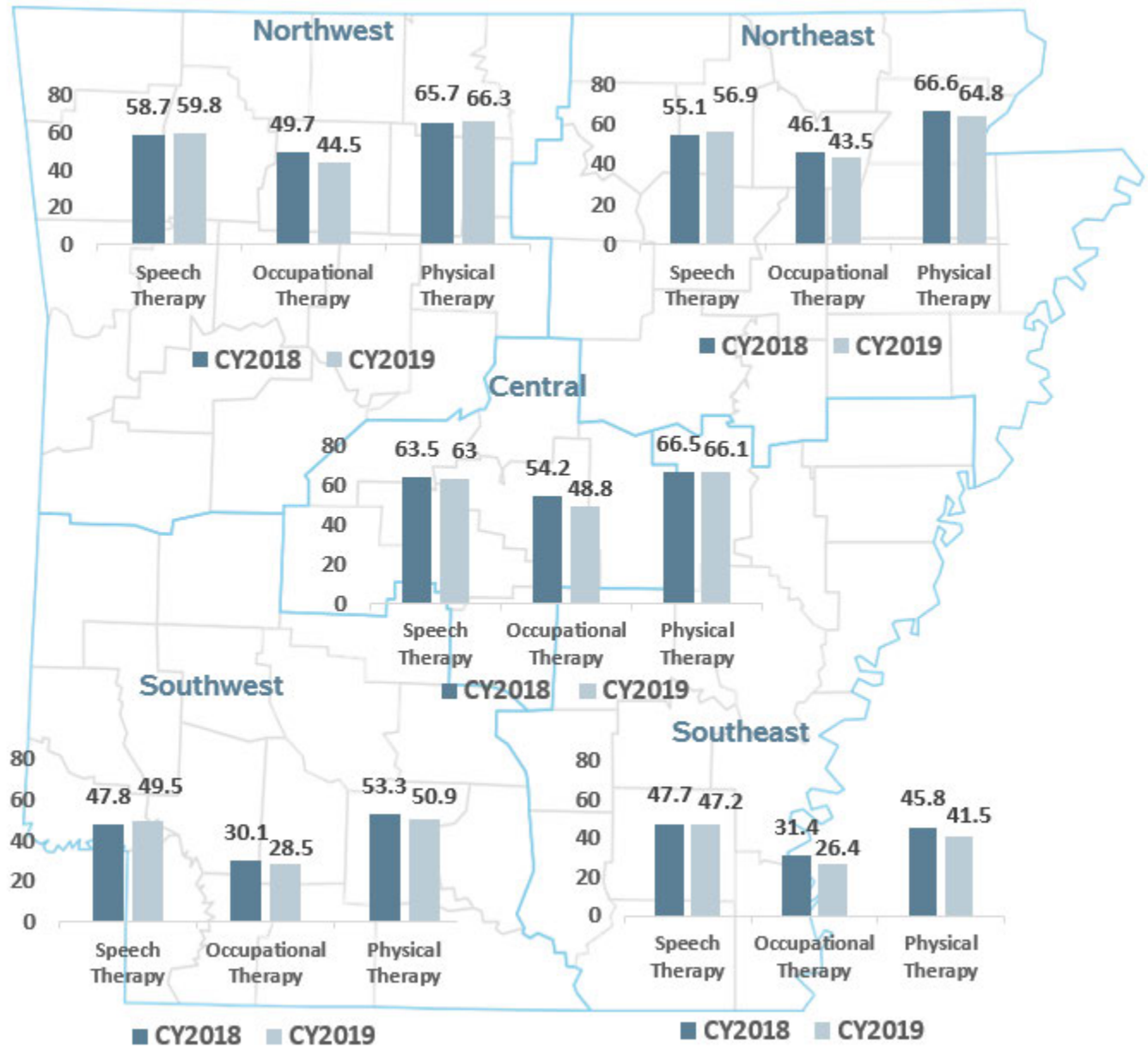
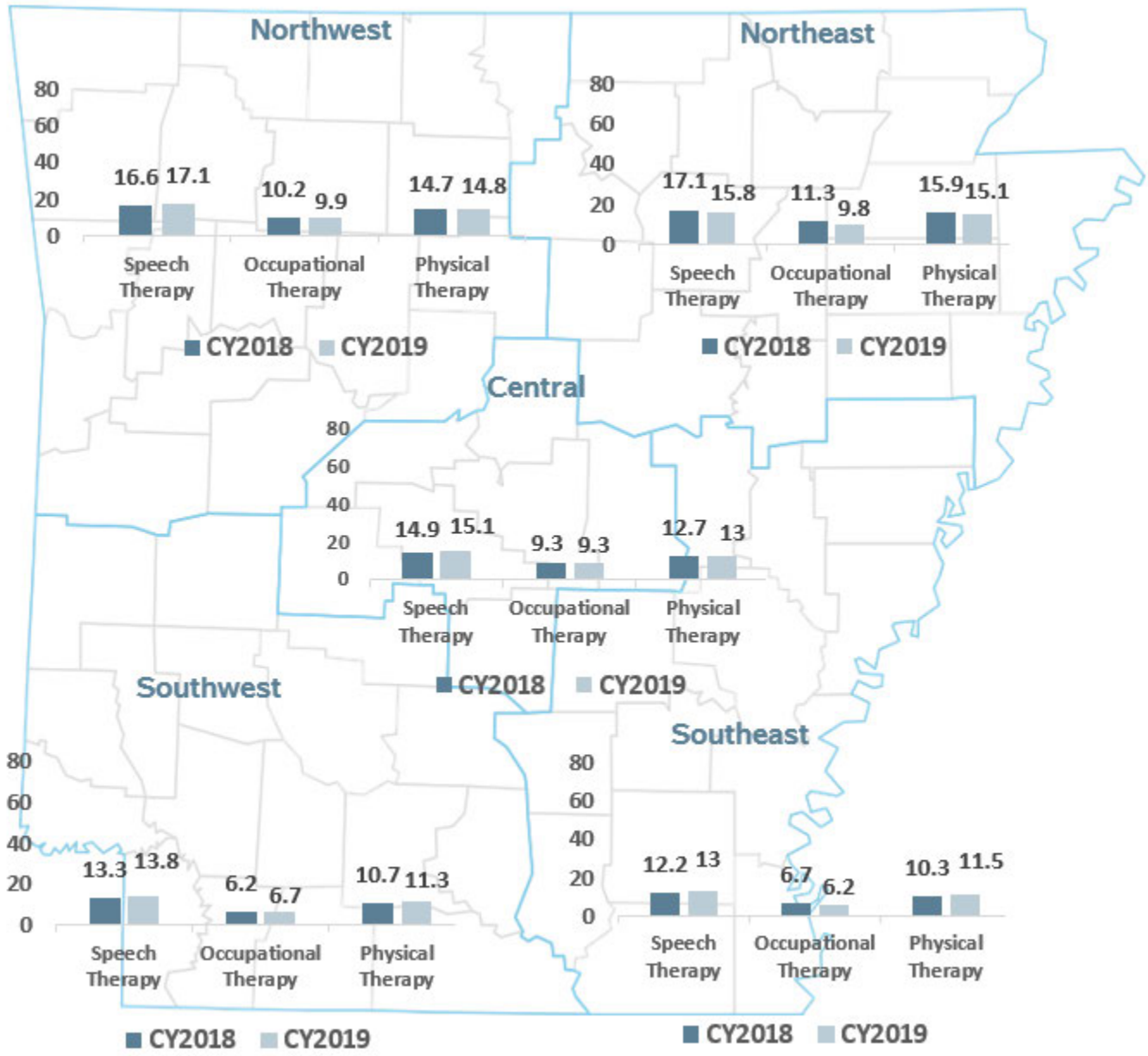


Figure 2. Non-TEFRA-Like Population by Region - Measure 1.1a (Claims-based therapy services): The percentage of beneficiaries < 19 years of age who are utilizing therapy services during the measurement period (By a) speech, b) occupational, and c) physical therapy services) for CY2018 and CY2019.



For **Question 1.1b,** the IE investigated the TEFRA-like's perception of their access to care by analyzing the TEFRA Beneficiary Satisfaction Survey. The measures that were utilized are the 2018 and 2019 individual and composite scores for therapy services. The results of **Table 2** show the following:

- The composite scores for 2018 and 2019 (89.6% and 89.8%, respectively) indicate a high level of beneficiary satisfaction getting services. This is for getting speech, occupational, and physical therapy services.
- The survey composite score of 90% shows that the TEFRA-like population, on average, reported no issue receiving special therapy services. This score is higher than the claims-based results. Individual, survey-based therapy services scores were tested for any difference in occurrence between 2019 vs. 2018 TEFRA surveys. No significant difference between the two years was found.

Table 2. Measure 1.1b (Survey-based therapy services (i.e., special therapies)).[7]

Therapy Services (Survey-Based)	Scores (Percentage) "Not a problem"		Statistically Significance Testing ($p < 0.05$)
	2018	2019	
Q31. Getting speech therapy	88.5%	89.5%	Not significantly different between 2018 vs. 2019 TEFRA Survey Scores
Q33. Getting occupational therapy	89.1%	90.4%	Not significantly different between 2018 vs. 2019 TEFRA Survey Scores
Q35. Getting physical therapy	91.2%	89.4%	Not significantly different between 2018 vs. 2019 TEFRA Survey Scores
Total (Composite) (Special therapies)	**89.6%**	**89.8%**	N/A

For **Question 1.1c**, the IE analyzed the access/utilization to Primary Care Physicians (PCP) for TEFRA-like beneficiaries. The results show the following:

[7] Scores of the TEFRA beneficiary satisfaction survey questions of "In the last 6 months, how much of a problem, if any, was it to get the therapy services your child needed through TEFRA?" by a) speech, b) occupational, and c) physical therapy services for 2018 and 2019

- During CY2018 and CY2019, non-TEFRA-like beneficiaries had higher Children and Adolescents' Access to Primary Care Practitioners (CAP) rates compared to the TEFRA-like population.

- As shown in **Figure 4**, 97.7% of non-TEFRA-like beneficiaries (12 months to 6 years of age) had one or more visits with a PCP during CY2019. This is compared to 90.8% of TEFRA-like beneficiaries in **Figure 3**.

- For non-TEFRA-like CAP rates, the age group for children 12 months to 24 months had the highest rate of 99.7% during CY2019. Among TEFRA-like beneficiaries, the age group for adolescents 12 to 18 years had the highest CAP rate of 96.0% during CY2019.

- Also, the age group 25 months to 6 years had the lowest rate of 90.4% for CY2019. TEFRA-like beneficiaries in the southeast region displayed the highest adolescent CAP rate at 97.6% during CY2019. This rate was comparable to the non-TEFRA-like beneficiaries adolescent CAP rate of 98.3%. Statistically testing performed on CAP results indicated significant difference between TEFRA-like vs. non-TEFRA-like during both years.

For national comparisons, NCQA's State of Healthcare Quality Report provided national Medicaid HMO CAP rates for children and young adults from 12 months to 19 years of age for 2018 and 2019. CMS' Quality of Care for Children in Medicaid and CHIP 2019 Child Core Set Chart Pack[9] provided performance rates for states reporting during CY2018. In addition, for CY2018 only, the evaluator calculated Arkansas Medicaid CAP rates and then compared them to TEFRA-like CAP rates. During CY2018, the Arkansas Medicaid only (non-TEFRA-like) CAP rate was 94.8% for children 12 to 24 months and 88.0% for children 25 months to 6 years of age. During CY2018, the Arkansas Medicaid only (non-TEFRA-like) CAP rate for access to primary care was 90.6% for children 7 to 11 years of age and 90.0% for adolescents 12 to 19 years of age.

Figure 3. displays the IE calculated TEFRA-like CAP rates for CY2018 and CY2019 above the bars. The figure also displays the state and national comparison CAP rates in the text boxes for the different age groups. TEFRA-Like Population by Age Groups - Measure 1.1c (Children and Adolescents' Access to Primary Care Practitioners (CAP)): The percentage of beneficiaries 12 months – 18 years of age who had a visit with a PCP for CY2018 and CY2019.

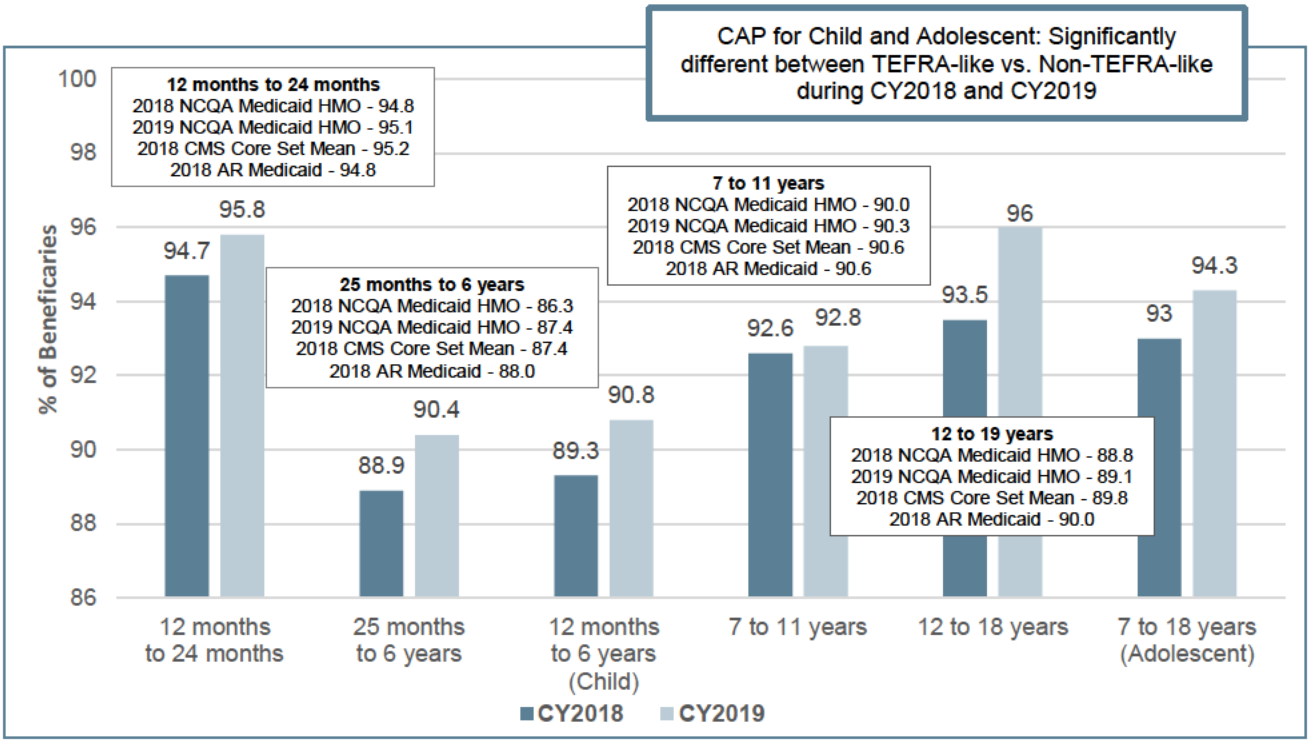
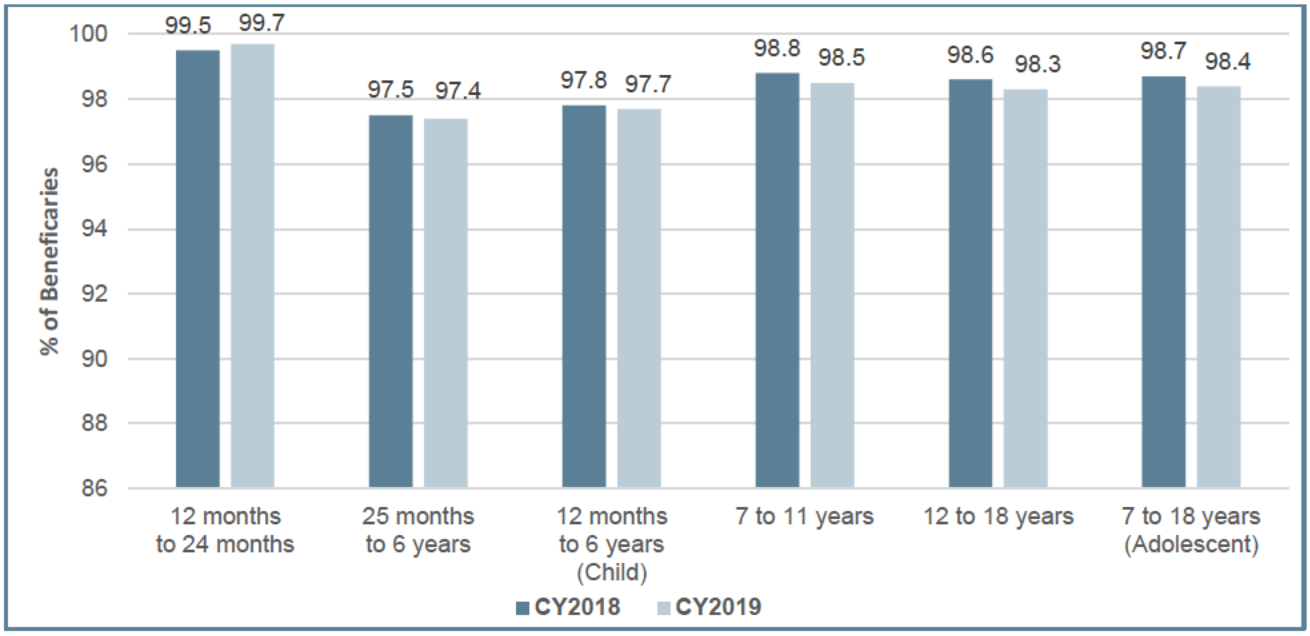


Figure 4. Non-TEFRA-Like Population by Age Groups - Measure 1.1c (Children and Adolescents' Access to Primary Care Practitioners (CAP)): The percentage of beneficiaries 12 months – 18 years of age who had a visit with a PCP for CY2018 and CY2019.



In summary for **Hypothesis 1.1**, Arkansas TEFRA-like beneficiaries had better access to special therapies health services. Satisfaction remained high among all three therapy services (around 90% between both years).

Hypothesis 1.2

For **Hypothesis 1.2**, the IE continued their investigation into healthcare access by looking at prescriptions. This examination of prescription coverage compared TEFRA-like and non-TEFRA-like beneficiaries. The measures calculated to draw conclusions are the Proportion of Days Covered (PDC), prescription costs, and amount of prescription filled. PDC threshold of 50% assesses beneficiaries who were dispensed at least two prescriptions on two unique dates of service and met 50% PDC threshold during the measurement period. PDC measures a beneficiary's medication adherence.

For **Question 1.2a**, the IE analyzed how beneficiaries' prescriptions coverage changed over time. The results show the following:

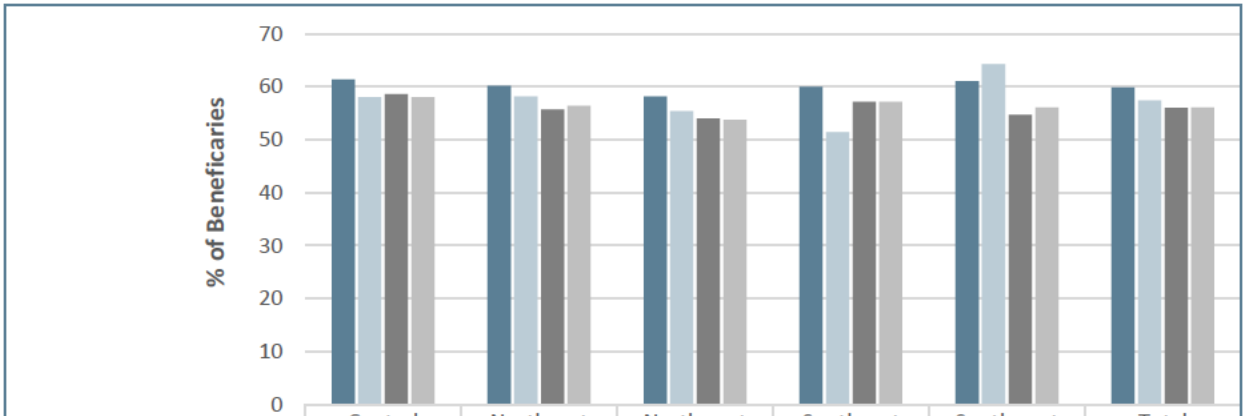
- In comparing the two populations, both in CY2018 (59.9% vs. 56.0%) and CY2019 (57.4% vs. 56.1%), at least half of the time, TEFRA-like beneficiaries had a slightly higher rate of beneficiaries with PDC on general prescriptions as compared to non-TEFRA-like beneficiaries.

- The geographic regions of the state where TEFRA-like beneficiaries reported both low and high access to health services for at least two prescriptions (and achieved a PDC for at least 50%) are listed in in **Question 1.2b**.

For **Question 1.2b**, the IE examined potential demographic factors on PDC measure outcomes. The results show the following:

- All regions, except the southwest region, decreased in the rate of TEFRA-like beneficiaries that met the PDC threshold of 50% for general prescriptions between CY2018 and CY2019, as shown in **Figure 5**.
- The southwest displayed the highest rate of TEFRA-like beneficiaries that met the PDC threshold of 50% for general prescriptions (64.3%) during CY2019.
- The northeast and southwest regions increased in the rate of non-TEFRA-like beneficiaries that met PDC threshold of 50% for general prescriptions between CY2018 and CY2019. Other regions either decreased or remained the same.
- The age group of adolescents 13 - 18 years had almost three-fourths of TEFRA-like beneficiaries that met PDC, at least half, of the time on general prescriptions during both years. This was compared to the age group of children 0 - 4 years, with the lowest rate being 40.2% for CY2018 and 34.8% for CY2019. During CY2018, the PDC threshold of 50% between TEFRA-like and non-TEFRA-like was significantly different. However, it was not significantly different during CY2019.

Figure 5. TEFRA-Like and Non-TEFRA-Like Populations by Region - Measure 1.2a (Proportion of days covered (PDC) threshold of 50%): Percentage of beneficiaries < 19 years of age who met the proportion of days covered (PDC) threshold of 50% during the measurement period (General Prescriptions) for CY2018 and CY2019.

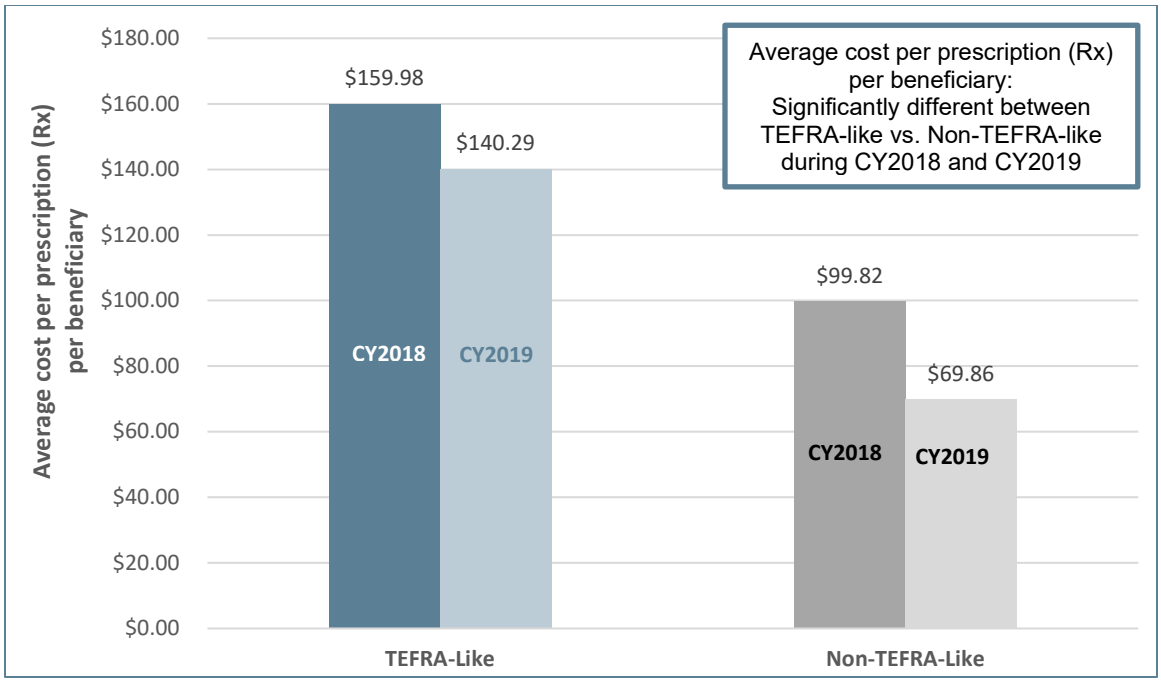


	Central	Northeast	Northwest	Southeast	Southwest	Total
CY2018 TEFRA-Like	61.4	60.2	58.2	60	61.1	59.9
CY2019 TEFRA-Like	58.1	58.2	55.4	51.4	64.3	57.4
CY2018 Non-TEFRA-Like	58.6	55.7	54	57.2	54.7	56
CY2019 Non-TEFRA-Like	58.1	56.4	53.8	57.2	56.1	56.1

For **Question 1.2c**, the IE examined pharmacy costs to determines if TEFRA-like beneficiaries saw a change in the level of cost based on the average cost of prescription (Rx) per beneficiary over time. The IE classified the top five generic drug descriptions based upon beneficiary counts and found four out of five generic drug descriptions the same between TEFRA-like and non-TEFRA-like beneficiaries during CY2019. The IE analysis shows the following:

- In CY2018, TEFRA-like beneficiaries had a higher average cost per prescription (Rx) per beneficiary ($160), as compared to non-TEFRA-like beneficiaries ($100) (see **Figure 6**).
- There was a similar pattern in CY2019, with a drop in average cost per prescription (Rx) per beneficiary in both sets of populations ($140 in TEFRA-like beneficiaries vs. $70 in non-TEFRA-like beneficiaries).
- An absolute average cost per prescription (Rx) per beneficiary difference between female ($209) and male ($131) was $78, despite the majority of the population being male (66%).
- Between female and male TEFRA-like beneficiaries, this trend continued for CY2019, with a larger spread of $100 between females and males ($210 vs. $100). The Beta-adrenergic agents inhaled, short acting and Tx for ADHD/narcolepsy had the highest average cost per prescription per beneficiary. These prescriptions were within the top five HIC3 descriptions, which were based respectively on beneficiary counts of TEFRA-like and non-TEFRA-like beneficiaries during CY2019.
- During CY2019, at least one in five of TEFRA-like beneficiaries were prescribed a penicillin, as compared to over 30% of non-TEFRA-like beneficiaries. During CY2019, almost 20% of non-TEFRA-like beneficiaries were prescribed Tx for ADHD/narcolepsy, with an average cost per prescription (Rx) per beneficiary of $169.

Figure 6. TEFRA-Like and Non-TEFRA-Like Populations - Measure 1.2b (Average cost per prescription (Rx) per beneficiary): The average cost per prescription (Rx) per beneficiary for < 19 years of age that were continuously enrolled during the measurement period for CY2018 and CY2019.



For **Question 1.2d**, the IE analyzed medical prescription as a measure of access to care by examining if TEFRA-like beneficiaries are receiving similar or better (Rx) per beneficiary per month (PBPM) as compared to non-TEFRA-like beneficiaries. The results show the following:

- The TEFRA-like population had a similar Per Beneficiary Per Month (PBPM) prescription fill rate as compared to the non-TEFRA-like population (1.0 vs. 1.1) in CY2018 and (0.9 vs. 1.1) in CY2019.
- The age group for adolescents 13-18 years had the highest Rx PBPM (1.6 during CY2018 and 1.5 during CY2019) for TEFRA-like beneficiaries.
- The age group for children 0-4 years had the lowest Rx PBPM (0.5 during CY2018 and CY2019) for TEFRA-like beneficiaries. A similar pattern was found in the non-TEFRA-like population. For the TEFRA-like population, the southwest region had the highest PBPM rate of 1.4 during CY2018 and 1.3 during CY2019.

For **Question 1.2e**, the IE analyzed a specific medical prescription, anti-seizure, refills as a measure of access to care by examining if TEFRA-like beneficiaries are receiving similar or better (Rx) per beneficiary per month (PBPM) as compared to non-TEFRA-like beneficiaries. The results show the following:

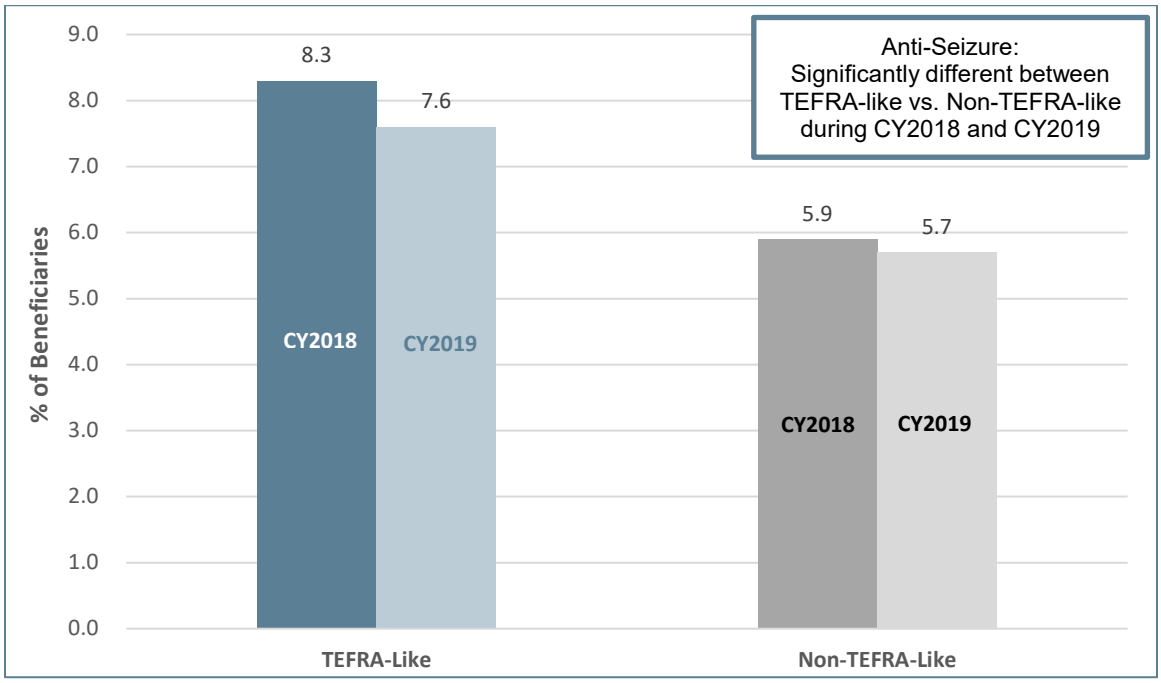
- The TEFRA-like population's higher rate of beneficiaries taking at least two anti-seizure medications (8.3% in CY2018 and 7.6% in CY2019), as compared to the lower rate for non-

TEFRA-like population (5.9% in CY2018 and 5.7% in CY2019). See **Figure 7**.

- The age group for adolescents 13-18 years showed the highest rate among the four age groups. Also, this age group had almost double the rate of TEFRA-like beneficiaries as compared to non-TEFRA-like beneficiaries (i.e., 16.4% vs. 8.6% during CY2018). CY2019 had a decrease in anti-seizure rates for both populations.

- During both CY2018 and CY2019, the southwest region had the highest percentage of beneficiaries taking at least two anti-seizure prescriptions. This was among both population sets.

Figure 7. TEFRA-Like and Non-TEFRA-Like Populations - Measure 1.2d (Anti-Seizure): The percentage of beneficiaries < 19 years of age taking at least two seizure medications during the measurement period for CY2018 and CY2019.



In summary for **Hypothesis 1.2**, Arkansas TEFRA-like beneficiaries had better access to PDC and anti-seizure medications. The number of prescriptions filled per beneficiary per month was slightly lower for the TEFRA-like population in both years. However, the average cost per prescription was higher for the TEFRA-like population due to medical necessity requirement.

Hypothesis 2.1

For **Hypothesis 2.1**, the IE compared Arkansas TEFRA-like beneficiaries between 2018 and 2019 to determine if preventive care services perform similarly or better over time for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration.

For **Question 2.1a**, the IE addressed how soon after enrollment the newly enrolled TEFRA-like beneficiaries received access to a first health care PCP visit (see **Table 3**). The results show the following:

- Between CY2019 and CY2018, a 16% relative improvement was found for the rate of newly enrolled TEFRA-like beneficiaries that received a first health care PCP visit within 60 days of enrollment.
- In CY2018, newly enrolled TEFRA-like female beneficiaries had a slightly higher rate of 33.7% as compared to a rate of 30.6% for TEFRA-like male beneficiaries (these populations received a first health care PCP visit within 60 days of enrollment). The opposite was found in CY2019. Newly enrolled TEFRA-like male beneficiaries had a slightly higher rate of 36.9% as compared to a rate of 36.2% for TEFRA-like female beneficiaries (these populations received a first health care PCP visit within 60 days of enrollment).
- The southeast region had the highest relative improvement of 35% between CY2019 and CY2018 for the rate of newly enrolled TEFRA-like beneficiaries' first health care PCP visit within 60 days of enrollment. The northwest region showed the lowest rate of 24.1% during CY2018, and again at 27.9% during CY2019 (for the newly enrolled TEFRA-like beneficiaries that received their first health care PCP visit within 60 days of enrollment).

Table 3. TEFRA-Like Population - Measure 2.1a (First health care visit to PCP w/in 60 days) and Measure 2.1b (First health care visit for therapy services w/in 60 days) for CY2018 and CY2019.

	% of TEFRA-Like Beneficiaries		Statistically Significance Testing ($p < 0.05$)
	CY2018	CY2019	
Measure 2.1a - First health care visit to PCP w/in 60 days	31.7%	36.7%	Not significantly different between CY2018 vs. CY2019 TEFRA-like
Measure 2.1b - First health care visit for therapy services w/in 60 days	43.9%	38.7%	Not significantly different between CY2018 vs. CY2019 TEFRA-like

For **Question 2.1b**, the IE lists what rate of newly enrolled TEFRA-like beneficiaries received speech, occupational, and physical therapies within a certain number of days from enrollment. The results show the following:

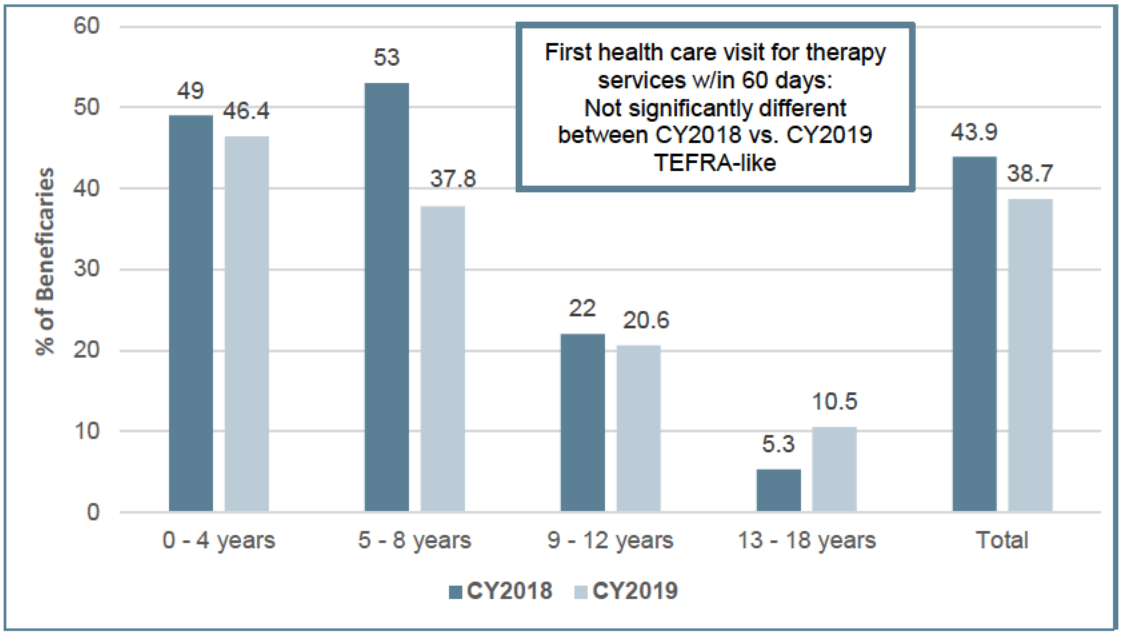
- During CY2018, over 43% of newly enrolled TEFRA-like beneficiaries received their first health care visit to speech, occupational, or physical therapy services within 60 days of enrollment. (see

Table 3). This rate dropped to 38.7% during CY2019.

- During CY2018, the age group for children 5-8 years had more than half of the eligible population receiving their first health care visit to speech, occupational, or physical therapy services within 60 days of TEFRA-like enrollment, as shown in **Figure 8**. Unfortunately, the rate had a 30% decrease between CY2019 (37.8%) and CY2018 (53.0%) for the age group for children 5-8 years. However, between CY2019 and CY2018, the age group for adolescents 13-18 years showed an absolute double (i.e., driven by small numbers in the numerator) in the percentage of newly enrolled TEFRA-like beneficiaries that received first health care visit for at least one therapy service within 60 days of enrollment.

- The southwest region was the only region that displayed improvement between CY2019 and CY2018. Between CY2019 and CY2018, there was a substantial drop in the southeast region's rate of newly enrolled TEFRA-like beneficiaries receiving their first health care visit to speech, occupational, or physical therapy services within 60 days of enrollment.

Figure 8. TEFRA-Like Population by Age Groups and Total - Measure 2.1b (First health care visit for therapy services w/in 60 days): The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit for speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period for CY2018 and CY2019.



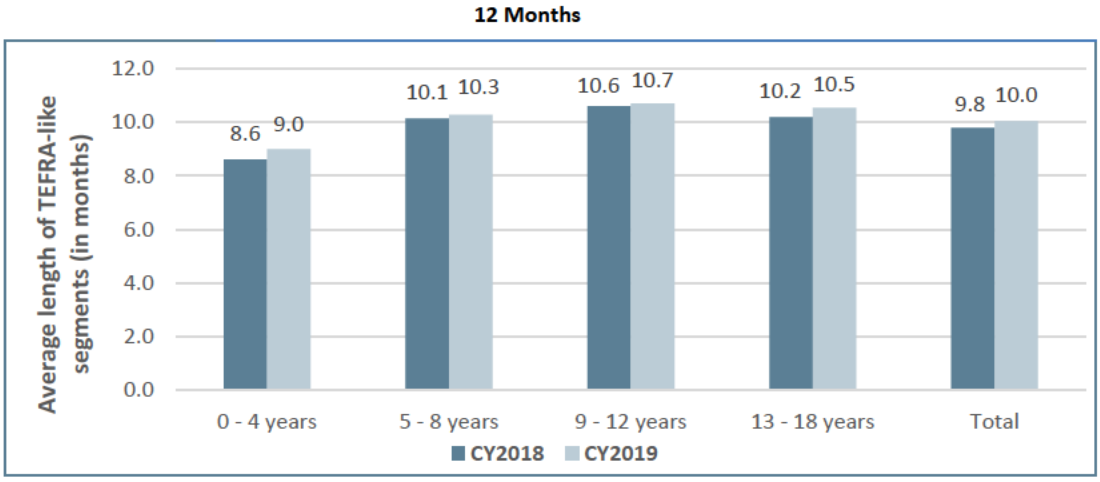
For **Question 2.1c.**, the IE reviewed the average length (in months) of TEFRA-like segments. The results show the following:

- TEFRA-like beneficiaries had an overall average of 10 months (out of the 12-month measurement period of CY2018) where they were enrolled in the TEFRA program. This was similar during CY2019 (see **Figure 9**).

- The age group for children 9 - 12 years had the highest average retention length (in months) of TEFRA-like segments. This was reported as almost 11 months enrolled (out of the 12-month measurement period during both CY2018 and CY2019).

- The average length (in months) of TEFRA-like segments between CY2019 vs. CY2018 for TEFRA-like beneficiaries was significantly different.

Figure 9. TEFRA-Like Population by Age Groups and Total - Measure 2.1c (Average length of TEFRA-like segments): The average length (in months) of TEFRA-like segments for beneficiaries <19 years of age during the measurement period for CY2018 and CY2019.



In summary for **Hypothesis 2.1**, newly enrolled Arkansas TEFRA-like beneficiaries performed similarly or better on preventative care services, such as first health care visit to PCP or therapy service within 60 days of enrollment, between CY2018 and CY2019 on all three measures.

Hypothesis 2.2

For **Hypothesis 2.2**, the IE assessed if the Arkansas TEFRA-like beneficiaries have equal or higher rates of third-party liability (TPL) coverage for appropriate preventive care in comparison to the Medicaid FFS population (Medicaid Non-TEFRA-like). A child may have both Arkansas Medicaid TEFRA-like coverage and other health insurance. The other insurance is billed first and then Arkansas Medicaid provides coverage for medically necessary services that other health insurance may not cover. During the TEFRA-like enrollment process third-party (TPL) medical insurance coverage is captured. To assess appropriate preventive care, the volume of TPL coverage was reviewed by the percentage of TEFRA-like beneficiaries over time.

For **Question 2.2a**, the IE explored the rates of third-party liability (TPL) coverage. Seventy to almost seventy-five percent of the TEFRA-like population had at least one Medicaid claim paid for by TPL coverage (non-Medicaid) during CY2018 and CY2019, respectively. This is vastly different compared to the Medicaid

non-TEFRA-like population, which was over 8% during CY2018 and over 22% during CY2019 (significantly different).

For **Question 2.2b**, the IE explored if beneficiaries are receiving preventive care with a PCP visit (since the majority of TEFRA-like beneficiaries do have TPL coverage). The results show the following:

- The TEFRA-like population, with at least one Medicaid claim paid by TPL coverage (non-Medicaid), had slightly lower, but not significantly different, rates of beneficiaries that had one or more visits with a PCP. This was compared to the non-TEFRA-like population for children and adolescents with at least one TPL claim during CY2018 and CY2019.

- The southwest region in the TEFRA-like child population had the highest rate, at 98.3%, during CY2019. The northwest region in child (i.e., 85.9% during CY2019) and adolescent (i.e., 92.2% during CY2019) age groups showed the lowest TPL coverage for beneficiaries that had one or more visits with a PCP during both years.

For **Question 2.2c**, the IE investigated what geographic regions of the state had high and low percentages of TPL coverage. The results show the following:

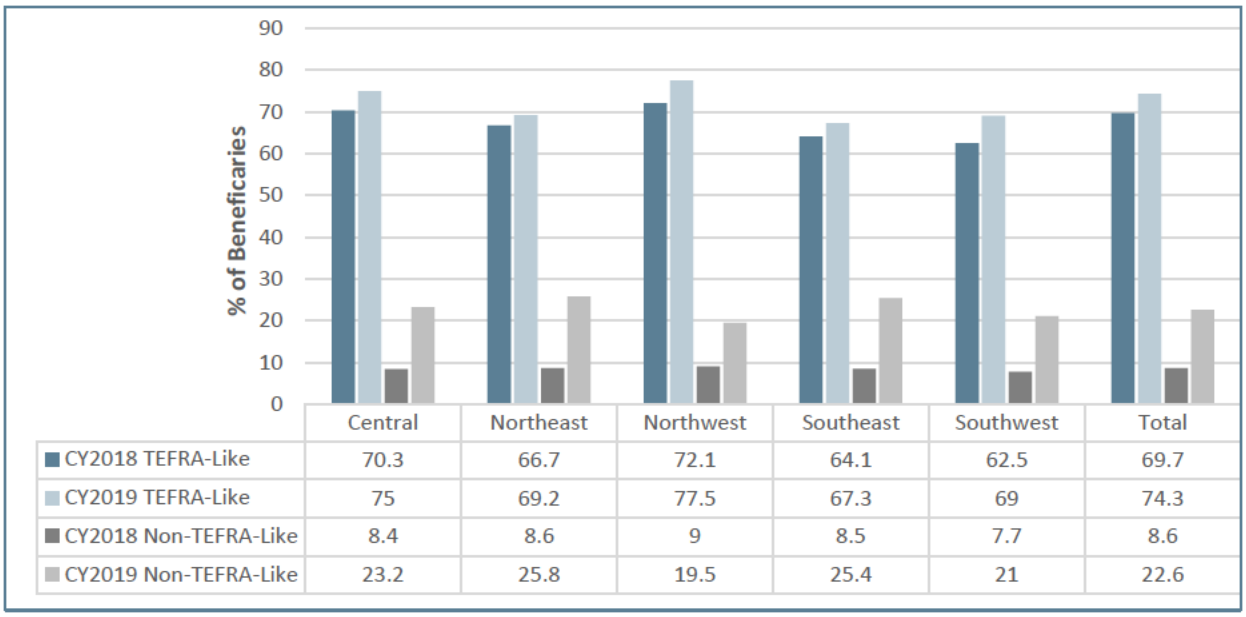
- The northwest region had the highest percentages of TPL coverage in both years.

- 72.1% of TEFRA-like beneficiaries received TPL coverage with at least one Medicaid claim during CY2018. This percentage then rose to 77.5% during CY2019.

- The southwest region had the lowest percentage of TPL coverage at 62.5% in CY2018. In CY2019, the southeast region rose to 67.3%, but still had the lowest percentages of TPL coverage for TEFRA-like beneficiaries (see **Figure 10**).

- During CY2019, the counties of Clay, Cross, and Ouachita had at least 83% of TEFRA-like beneficiaries that received TPL coverage with at least one Medicaid claim. Additional research was conducted for TPL differences between CY2018 and CY2019 within the non-TEFRA-like population. Please see the “Lessons Learned and Recommendations” section in this report for more details.

Figure 10. TEFRA-Like and Non-TEFRA-Like Populations by Region - Measure 2.2a (Third Party Liability (TPL) coverage): The percentage of beneficiaries <19 years of age who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) that were continuously enrolled during the measurement period for CY2018 and CY2019.



	Central	Northeast	Northwest	Southeast	Southwest	Total
CY2018 TEFRA-Like	70.3	66.7	72.1	64.1	62.5	69.7
CY2019 TEFRA-Like	75	69.2	77.5	67.3	69	74.3
CY2018 Non-TEFRA-Like	8.4	8.6	9	8.5	7.7	8.6
CY2019 Non-TEFRA-Like	23.2	25.8	19.5	25.4	21	22.6

In summary for **Hypothesis 2.2**, Arkansas TEFRA-like beneficiaries had higher rates of TPL coverage for appropriate preventative care compared to rates for non-TEFRA-like beneficiaries in the adolescent age group 7 to 18 years. However, this was not the case for child age group 12 months to 6 years, where the comparison group of non-TEFRA-like beneficiaries outperformed.

Hypothesis 2.3

For **Hypothesis 2.3**, the IE examined durable medical equipment (DME) coverage to determine if Arkansas TEFRA-like beneficiaries have equal or higher rates of DME coverage for appropriate preventive care when compared to the Medicaid FFS population (Medicaid Non-TEFRA-like).

For **Question 2.3a**, the IE inquired if TEFRA-like beneficiaries had equal or higher rates of durable medical equipment (DME) coverage. The results show the following:

- It was determined that TEFRA-like beneficiaries do have higher absolute rate differences for DME coverage when compared to the non-TEFRA-like beneficiaries in CY2018 (i.e., 40.8% vs. 13.3%) and CY2019 (i.e., 38.0% vs. 12.9%).
- The percentage of TEFRA-like and non-TEFRA-like beneficiaries that had at least one DME coverage claim went slightly down between CY2019 vs. CY2018.

- The TEFRA-like population had 47% (highest rate) for 0 to 4-year-olds and 32% (lowest rate) for 13–18-year-olds. This was among age groups that had at least one durable medically equipment (DME) coverage claim during CY2018. A similar trend was displayed for the non-TEFRA-like population.

- Genitourinary Symptoms, Nutrition Endocrine and Metabolic Disorders, and Other GI Disorders were in the top ten primary diagnosis conditions based off highest volume of claims during CY2018 and CY2019. This was in both groups of the TEFRA-like and Medicaid non-TEFRA-like populations.

For **Question 2.3b**, the top five primary diagnosis conditions/codes and condition types for TEFRA-like beneficiaries were determined. Also, based on the number of DME claims, the beneficiaries that have durable medical equipment (DME) coverage are presented in **Table 4**.

Table 4. TEFRA-Like and Non-TEFRA-Like Populations - Measure 2.3a (Durable Medically Equipment (DME) coverage): Top Five Primary Diagnosis Conditions for CY2018 and CY2019.

Top Five Primary Diagnosis Conditions for TEFRA-Like Beneficiaries	TEFRA-Like: Number of DME Claims		Top Five Primary Diagnosis Conditions for Non-TEFRA-Like Beneficiaries	Non-TEFRA-Like: Number of DME Claims	
	CY2018	CY2019		CY2018	CY2019
Genitourinary Symptoms	5,584	5,332	Genitourinary Symptoms	25,510	24,941
Nutrition Endocrine and Metabolic Disorders	2,211	1,935	Nutrition Endocrine and Metabolic Disorders	25,095	23,598
Other GI Disorders	1,514	1,414	Child/ Adolescent Emotional Disorders	9,980	10,939
Other Congenital Anomalies	1,046	969	Other GI Disorders	7,584	7,220
Nervous System Disorders	968	867	Other Congenital Anomalies (in CY2018) / Diabetes (in CY2019)	2,902	3,370

In summary for **Hypothesis 2.3**, DME coverage for the Arkansas TEFRA-like population had higher rates for appropriate preventive care when compared to Medicaid Non-TEFRA-like population (in both 2018 and 2019).

Hypothesis 3.1

For **Hypothesis 3.1**, the IE evaluated the beneficiary's experience regarding quality of care and access to health care services received in the Arkansas TEFRA-like demonstration. It was determined beneficiary experience has remained the same or improved over time.

For **Question 3.1a**, the IE addressed if TEFRA-like beneficiaries' experience scores regarding getting care quickly improved or stayed the same over time. The results show the following:

- The TEFRA Beneficiary Satisfaction Survey individual scores for "Getting care quickly" displayed no significant difference between 2019 and 2018.
- TEFRA-like beneficiaries' experience scores for "Getting care quickly" have slightly increased over time when comparing 2019 to 2018 (see **Figure 11**).
- The 2019 TEFRA "Getting care quickly" scores were very similar to the 2019 ARKids First A and B Beneficiary Satisfaction Survey composite scores (all three scores approx. 95%). There was no significant difference.

For **Question 3.1b**, the IE reported if TEFRA-like beneficiaries' have confidence in how well doctors communicate. The results show the following:

- On average, 94.9% of survey respondents from the TEFRA Beneficiary Satisfaction Survey received favorable "How well doctors communicate" feedback in 2019.
- In comparison to 2018's composite score, the TEFRA-like population had a slightly lower composite score of 93.3% for how well doctors communicate (see **Figure 12**).
- Similar findings were found when comparing this to the ARKids First A Beneficiary Satisfaction Survey 2019 composite score of 94.1%. When comparing TEFRA Beneficiary Satisfaction Survey scores to ARKids First B Beneficiary Satisfaction Survey scores for how well doctors communicate, the ARKids First B Satisfaction Survey had a slightly higher score at 96.1% (see **Figure 12**).

Figure 11. Measure 3.1a (Survey-based getting care quickly): The percentage of survey responses marked "Usually" or "Always" (i.e., favorably) for domain of Getting care quickly (i.e., receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed) for 2017/2018 and 2019.

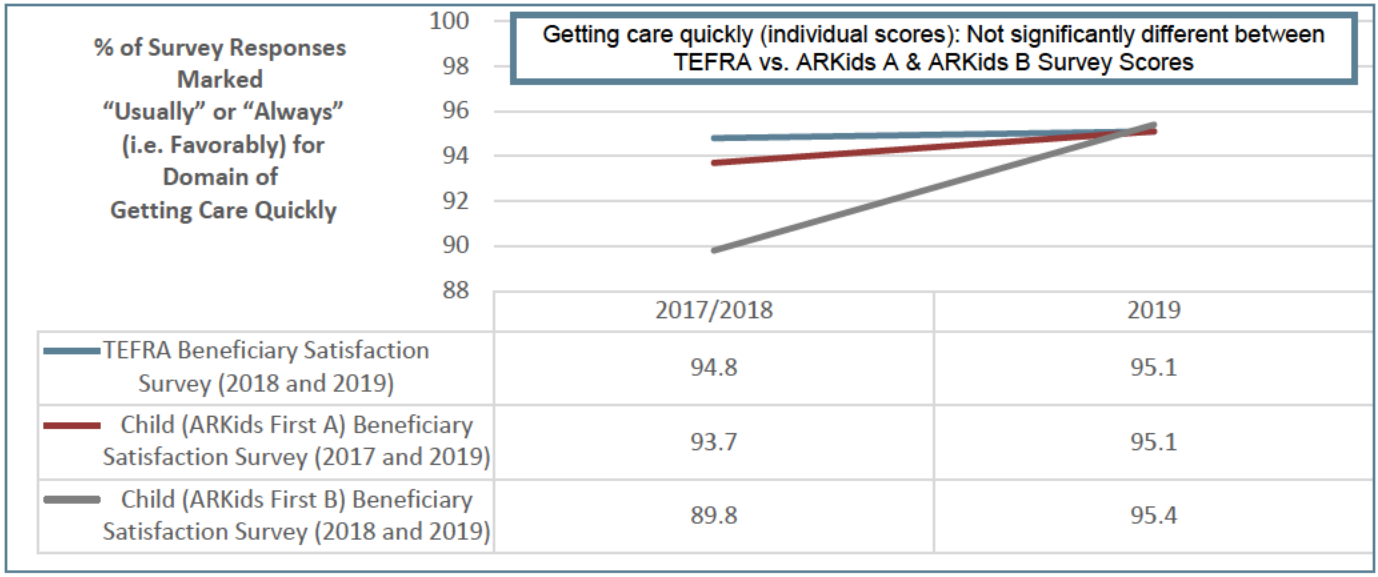
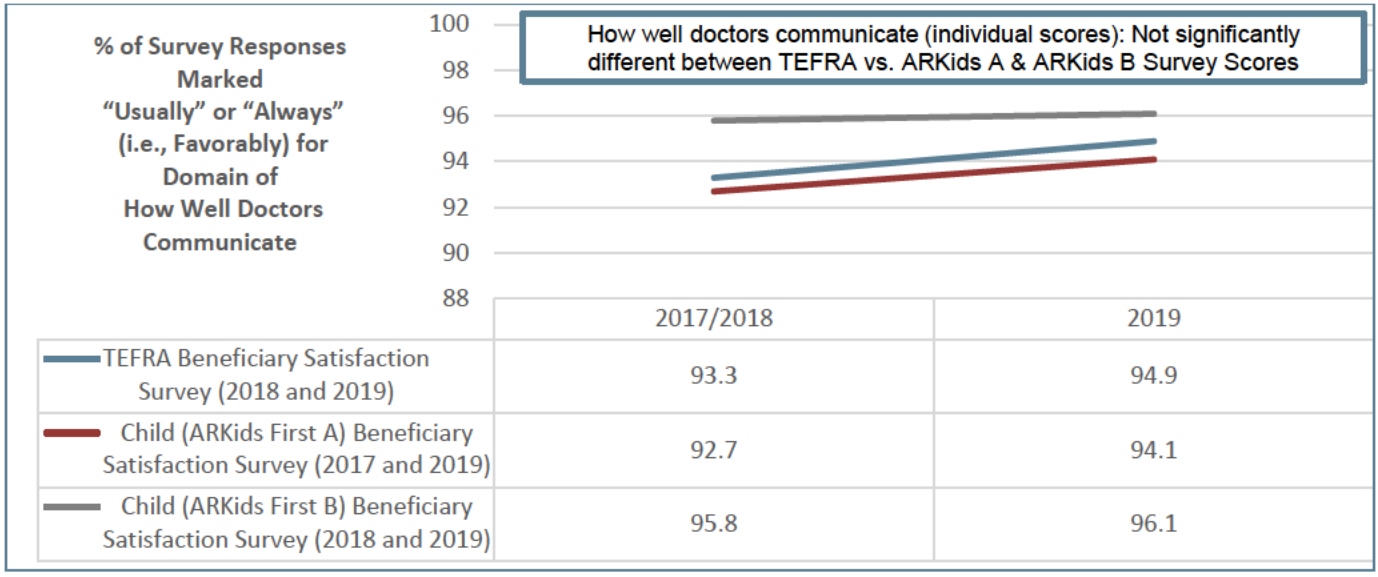


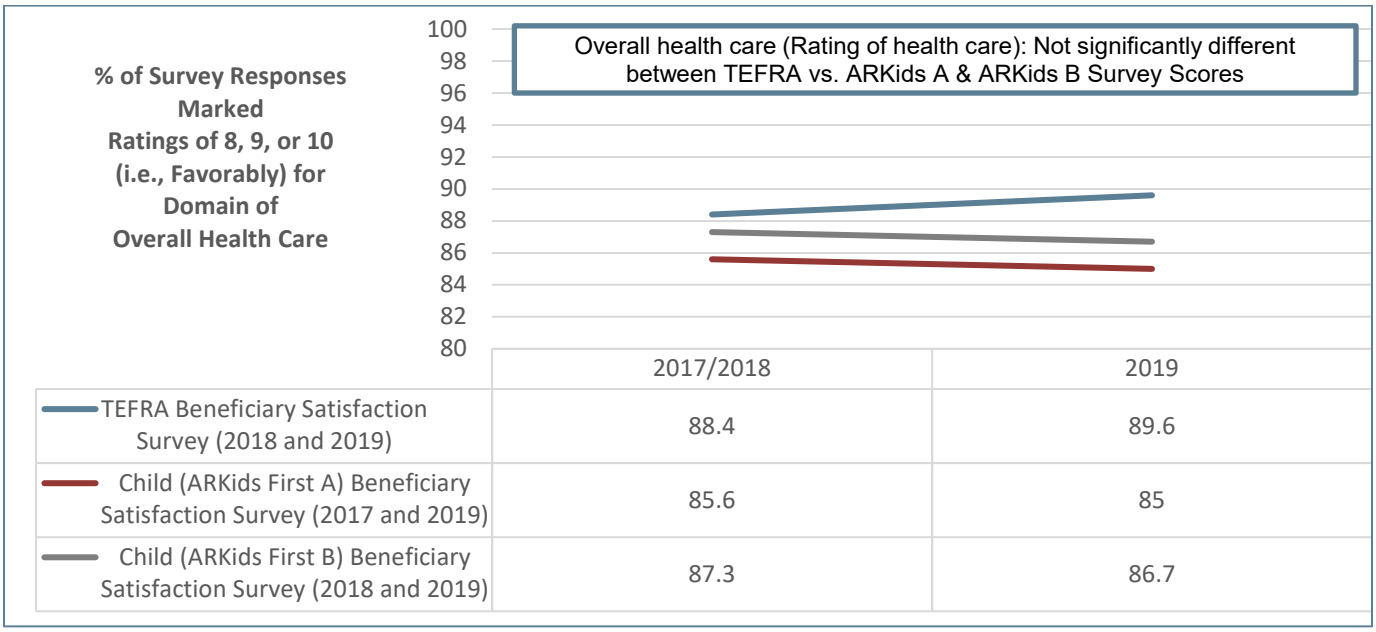
Figure 12. Measure 3.1b (Survey-based how well doctors communicate): The percentage of survey responses marked "Usually" or "Always" (i.e., favorably) for domain of How well doctors communicate (i.e., Doctors explaining things in an understandable way, Doctors listening carefully to you, Doctors showing respect for what you had to say, AND Doctors spending enough time with you for 2017/2018 and 2019.



For **Question 3.1c**, the IE determined that the overall health care rating showed improvement over time. The results showed the following:

- During 2019, the percentage of TEFRA-like survey responses (89.6%) that marked ratings of 8, 9, or 10 (i.e., favorably) for overall health care was higher than the ARKids A population (85.0%) and ARKids B population (86.7%).
- As shown in **Figure 13**, there were similar findings when the 2018 TEFRA-like overall health care rate was compared to the 2017 ARKids First A Beneficiary Satisfaction Survey rate (85.6%) and the 2018 ARKids First B Beneficiary Satisfaction Survey (87.3%).

Figure 13. Measure 3.1c (Survey-based overall health care): The percentage of survey responses marked ratings of 8, 9, or 10 (i.e., favorably) for Overall health care for 2017/2018 and 2019 .



In summary for **Hypothesis 3.1**, when compared to ARKids First A or ARKids First B beneficiary experience, Arkansas TEFRA-like beneficiary experience regarding quality of care and access to health care services has remained the same or improved over time (i.e., no significant difference).

Hypothesis 3.2

For **Hypothesis 3.2**, the IE reviewed if patient experience with access to health care services improve with enrollment into the TEFRA-like program.

For **Question 3.2a**, the IE identified if TEFRA-like beneficiaries experience better access to health care when seeing a personal doctor or nurse. The results show the following:

- As shown in **Figure 14**, when comparing health care for a "personal doctor or nurse," before and after enrolling in TEFRA, the 2019 and 2018 survey scores had similar findings in the decreased number of respondents with a problem seeing a personal doctor (i.e., respectively between 2019 and 2018 pre-TEFRA of 24.7% and 23.4%, respectively vs. 2019 and 2018 post-TEFRA of 7.2% and 5.6%).

- A similar absolute percentage difference was found between pre and post 2019 and 2018 survey results for TEFRA-like beneficiaries with a problem seeing a personal doctor or nurse.

For **Question 3.2b**, the IE reported if TEFRA-like beneficiaries experience better pharmacy access for prescription medications with enrollment into TEFRA-like program. The results show the following:

- In the 2019 and 2018 surveys, before and after enrolling in TEFRA, the results were similar in the decreased number of respondents with a problem getting prescription medicine (i.e., respectively between 2019 and 2018 pre-TEFRA of 32.1% and 29.0% vs. 2019 and 2018 post-TEFRA of 15.5% and 16.1%, as displayed in **Figure 14**).

- A substantial absolute percentage difference of 16.6% (2019 survey) and 12.9% (2018 survey) was identified between pre and post results for TEFRA-like beneficiaries with a problem getting prescription medicine.

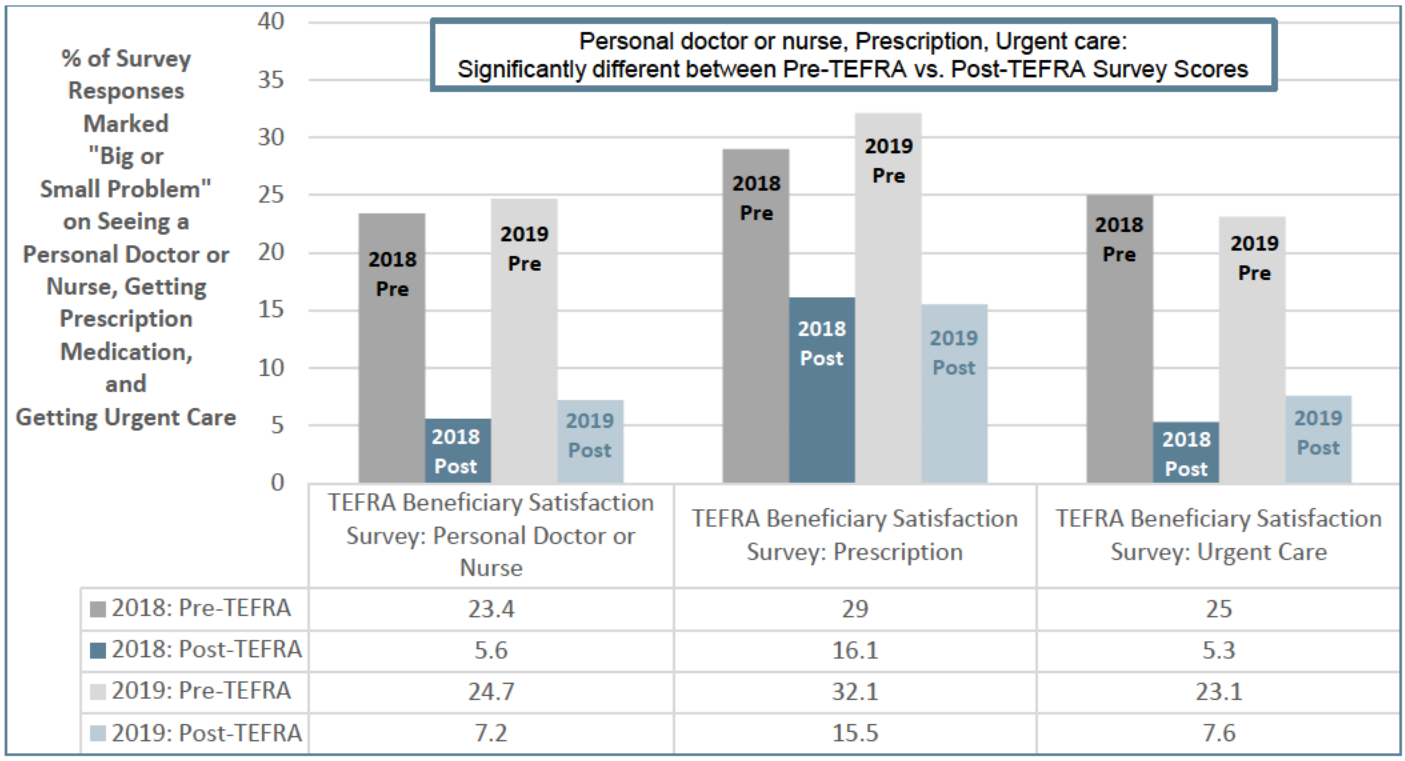
For **Question 3.2c**, the IE determined if beneficiaries experience problems when needing urgent care access with enrollment into TEFRA-like program. The results show the following:

- When comparing urgent care before and since enrolling in TEFRA, it was determined that 2018 had a higher percentage difference between pre and post surveys as compared to 2019 (i.e., respectively between 2019 and 2018 pre-TEFRA of 23.1% and 25.0% vs. 2019 and 2018 post-TEFRA of 7.6% and 5.3%, as displayed in **Figure 14**).

- This absolute percentage difference between pre and post survey results (for TEFRA-like beneficiaries with a problem getting the needed urgent care from a doctor's office or the emergency room) was 19.7% in 2018 as compared to 15.5% in 2019.

- During both 2018 and 2019, all three survey-based measures for pre-TEFRA vs. post-TEFRA were significantly different.

Figure 14. Measure 3.2a (Survey-based of Pre-TEFRA vs. Post-TEFRA: Personal doctor or nurse): The percentage of survey responses marked "Big or small problem" on “How much of a problem, if any, was it for your child to see a personal doctor or nurse?”, Measure 3.2b (Survey-based of Pre-TEFRA vs. Post-TEFRA: Prescription): The percentage of survey responses marked "Big or small problem" on “How much of a problem, if any, was it to get your child’s prescription medication?”, and Measure 3.2c (Survey-based of Pre-TEFRA vs. Post-TEFRA: Urgent care): The percentage of survey responses marked "Big or small problem" on “How much of a problem, if any, was it for your child to get urgent care?” for 2017/2018 and 2019.



	TEFRA Beneficiary Satisfaction Survey: Personal Doctor or Nurse	TEFRA Beneficiary Satisfaction Survey: Prescription	TEFRA Beneficiary Satisfaction Survey: Urgent Care
2018: Pre-TEFRA	23.4	29	25
2018: Post-TEFRA	5.6	16.1	5.3
2019: Pre-TEFRA	24.7	32.1	23.1
2019: Post-TEFRA	7.2	15.5	7.6

In summary for **Hypothesis 3.2**, the results show beneficiary’s experience regarding access to health care services in personal doctor or nurse, prescriptions, and urgent care improve with enrollment into the Arkansas TEFRA-like program.

Hypothesis 4.1

For **Hypothesis 4.1**, the IE determined if the premium barriers for TEFRA-like beneficiaries remained stable over time.

For **Question 4.1a.**, the IE addressed the percentage of TEFRA-like beneficiaries that experienced a premium barrier. While comparing 2018 and 2019 survey scores for how much of a financial burden it was to

pay TEFRA premiums in the last six months, it was determined the scores decreased from 11.2% in 2018 to 8.7% in 2019 (not significantly different).

For **Question 4.1b**, the IE identified how the premium range differs for those experiencing a premium barrier. The results show the following:

- In comparing 2018 and 2019 survey results for TEFRA premium ranges and "a big financial burden," $52 - $78 showed the most respondents across both years, with scores of 10.0% and 12.0%, respectively (see **Table 5**).
- The highest percentage of survey responses, 25.9%, marked "A big financial burden" and was for the $281–$328 TEFRA premium range during 2018. However, this shifted during 2019 to the $364–$416 TEFRA premium range, with a survey response rate of 21.1%.

Table 5. Measure 4.1b (Survey-based premium ranges for premium barriers): A cross-table of the survey responses marked "A big financial burden" on "In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?" by the premium ranges survey responses marked on "A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?" for 2018 and 2019.

	% of Survey Responses Who Answered the Financial Burden as "A Big Financial Burden"	
	2018 TEFRA Beneficiary	2019 TEFRA Beneficiary
$0	1.9% (1/53)	0.0% (0/47)
$20–$41	7.0% (6/86)	6.7% (5/75)
$52–$78	10.0% (17/170)	12.0% (16/133)
$93–$125	6.8% (9/132)	6.7% (8/120)
$145–$182	18.8% (16/85)	5.9% (4/68)
$208–$250	19.1% (9/47)	18.2% (6/33)
$281–$328	25.9% (7/27)	5.3% (1/19)
$364–$416	25.0% (5/20)	21.1% (4/19)
$458	13.7% (7/51)	11.1% (5/45)

In summary for **Hypothesis 4.1**, findings for **Questions 4.1.a** indicate premium barriers for TEFRA-like beneficiaries remained stable over time between 2018 and 2019.

Hypothesis 4.2

For **Hypothesis 4.2**, the IE's focus was to reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed (due to program barriers of health care access if the premium barriers for TEFRA-like beneficiaries remain stable over time). Results were used from the TEFRA Disenrollee Beneficiary Survey, an additional TEFRA survey conducted by the survey vendor for 2018 only and not conducted in 2019.

For **Question 4.2a**, the IE evaluated the top five reasons why Arkansas TEFRA-like beneficiaries' cases were closed. TEFRA disenrollee beneficiary survey respondents were asked who closed their child's TEFRA case, where a majority (69.9%) reported closure by DHS/Medicaid. The top five reasons for closure of a child's TEFRA case include the following:

1. "No longer eligible" (40 respondents),
2. "Other" (39 respondents),
3. "Could not afford premium payment" (17 respondents),
4. "TEFRA services no longer needed" (14 respondents),
5. "Could not complete paperwork on time", and "Obtained other coverage" (tie with 8 respondents each).

For **Question 4.2b**, the IE gauged how patient perception of 'getting care quickly' during lockout periods compared with similar perceptions among enrolled patients. The TEFRA Disenrollee Beneficiary Survey's total composite score for "Getting care quickly" during 2018 was lower, at 84.0%, as compared to other beneficiary satisfaction survey scores of 94.8% (TEFRA survey), 93.7% (ARKids First A survey), and 89.8% (ARKids First B survey).

For **Question 4.2c**, the IE determined how difficult it is to get speech, occupational, and physical therapy during a lockout period. This was found by comparing the "Special therapies" composite score of 54.8% (from the TEFRA Disenrollee Beneficiary Survey) to the composite score of 89.6% (from the TEFRA Beneficiary Satisfaction Survey). Out of all three therapies, speech had the highest score of 62.2% for "Not a problem." This was for the child to get the speech therapy needed while the TEFRA case was closed during 2018 (see **Table 6**).

Table 6. Measure 4.2c (Survey-based getting care quickly for disenrollees): Survey-based therapy services (i.e. special therapies) for disenrollees: Percentage of survey responses marked "Not a problem" by a) speech, b) occupational, and c) physical therapy services for 2018.

Therapy Services (Survey-Based)	Scores (Percentage) "Not a problem"		Statistically Significance Testing (p < 0.05)
	2018 TEFRA Beneficiary Satisfaction	2018 TEFRA Disenrollee Beneficiary	
Getting speech therapy	88.5%	62.2%	Not significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA Survey Scores
Getting occupational therapy	89.1%	50.0%	Significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA Survey Scores
Getting physical therapy	91.2%	52.2%	Not significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA Survey Scores
Total (Composite) (Special therapies)	**89.6%**	**54.8%**	N/A

For **Question 4.2d**, the IE explored 1) what types of medical services were not met for patients experiencing a lockout period and 2) how patients' experiences varied by common diagnosis. **Table 7** displays the types of medical services beneficiaries were not able to receive because they were not enrolled in the TEFRA program. Also, this table displays the top five primary diagnosis conditions, as listed in the evaluation design. Question 13, from the 2018 Disenrollee Beneficiary Survey, asks disenrollees what types of medical services

they could not receive when not enrolled in TEFRA. “Special therapy” was the second highest response, at 22.8%, and “Other" was the top response, at 31.5%.

- Some reasons listed in the “Other” field included the following (listed in alphabetical order):
    - Advanced family eye care
    - Developmental preschool services
    - Enteral supplies
    - Home health
    - Mental health
    - Referrals to adult specialists
    - Sleep clinic
    - Supplies
    - Therapist and psychiatrist

Table 7. Measure 4.2d (Survey-based medical services not received for disenrollees): Responses to survey question: What types of medical services could you not get for your child because your child was not enrolled in the TEFRA program for 2018.

Responses for Medical Services Not Received for Disenrollees	2018 TEFRA Disenrollee Beneficiary Survey		Top Five Primary Diagnosis Conditions for TEFRA-Like Beneficiaries*
	# of Reponses	% of Responses	
Regular physician visits	8	8.7%	1) Attention Deficit Hyperactivity Disorders, 2) Mood Disorders, 3) Anxiety/ Nonpsychotic Disorders, 4) Adjustment Disorders, and 5) Child/ Adolescent Emotional Disorders
Visits to a specialist	10	10.9%	
Emergency room visits	1	1.1%	
Dental visits	6	6.5%	
Prescription medicine	11	12.0%	
Special therapy	21	22.8%	
Medical equipment	6	6.5%	
Other	29	31.5%	

*Based off the top 5 highest volume of TEFRA-like beneficiaries during CY2018.

In summary for **Hypothesis 4.2**, due to the TEFRA Disenrollee Survey only being provided during 2018, the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed could not be reviewed over time. The IE did compare survey scores between TEFRA disenrollee to TEFRA enrollee, as well as ARKids First A and ARKids First B, and found no significant difference on access to health care services of "Getting care quickly" and "Special therapies of speech and physical therapies."

VII. Conclusions

Claims-Based Conclusions

Of the nine claims-based measures for comparison between the TEFRA-like population vs. the non-TEFRA-like population, the TEFRA-like population outperformed the non-TEFRA-like population on the following measures:

- Therapy services (Measure 1.1a)
- Proportion of days covered (PDC), threshold of 50% (Measure 1.2a)
- Anti-seizure prescription (Measure 1.2d)
- Third Party Liability (TPL) coverage (Measure 2.2a)
- Durable Medical Equipment (DME) coverage (Measure 2.2c)

Of the three claims-based measures, where comparison between performance periods was completed on the TEFRA-like population only, the TEFRA-like population showed a growth in performance over 2018 and 2019 in the following measures:

- First health care visit to PCP within 60 days (Measure 2.1a)
- Average length (in months) of TEFRA-like segments proportion of days covered (PDC), threshold of 50% (Measure 2.1c)

See **Appendix D** for claims-based measure specific results for statistically significant results.

In the final evaluation, the IE would like to explore additional claims data to be included within the measures. The initial analysis included only Fee for Service (FFS) claims. Therefore, the inclusion of additional data will ensure that the IE has explored all information to be used in the measure calculations. The two data sources are Provider-Led Arkansas Shared Savings Entity (PASSE) encounter claims and medical claims from other insurance carriers. The PASSE encounter claims for those beneficiaries that were enrolled in a new Medicaid program (launched March 1, 2019) and any other insurance provider for TPL medical claims.

Survey-Based Conclusions

Of the eight survey-based measures for comparison between the TEFRA Beneficiary Satisfaction Survey, the ARKids First A and ARKids First B Beneficiary Satisfaction Surveys, and the TEFRA Disenrollee Beneficiary Survey, the TEFRA-like satisfaction scores outperformed or were not significantly different than the comparison surveys on the following measures:

- Getting care quickly (Measure 3.1a)

- How well doctors communicate (Measure 3.1b)
- Overall health care (Measure 3.1c)
- Pre-TEFRA vs. post-TEFRA of personal doctor or nurse (Measure 3.2a)
- Pre-TEFRA vs. post-TEFRA of prescription (Measure 3.2b)
- Pre-TEFRA vs. post-TEFRA of urgent care (Measure 3.2c)

Of the two survey-based measures, where comparison between performance periods was completed on TEFRA surveys only, the TEFRA scores showed no significant difference between 2019 vs. 2018 TEFRA surveys as favorable performance, except for physical therapy services, in the following measures:

- Therapy services (Measure 1.1a)
- Premium barriers (a big financial burden) (Measure 4.1a)

See **Appendix D** for survey-based measure specific results and statistically significance testing.

Results presented in the interim evaluation show that the demonstration was effective in achieving the majority of goals and objectives established at the beginning of the current TEFRA-like demonstration. Impacts to **Hypothesis 4.2** will need to be reviewed due to the TEFRA Disenrollee Beneficiary Survey only being performed in 2018 and not during 2019. More details are provided in the "Lessons Learned and Recommendations" section of this report.

VIII. Interpretations, Policy Implications and Interactions with Other State Initiatives

The TEFRA-like demonstration continues to show success providing the needed care to enrolled beneficiaries. The program is considered well established, well known to the community, and stable. Benchmarking survey scores calculated by NCBD reflected only the most positive response. Therefore, the ARKids First A and ARKids First B composites and ratings were not able to be used for comparison purposes. NCQA's State of Healthcare Quality Report was also reviewed for national Medicaid HMO CAP rates for children and young adults, 12 months to 19 years of age, for comparison. NCQA's national Medicaid HMO CAP (CY2018 and CY2019), CMS's Quality of Care for Children in Medicaid and CHIP 2019 Child Core Set Chart Pack (CY2018 only) CAP, and Arkansas Medicaid CAP (CY2018 only) rates were compared to TEFRA-like CAP rates. TEFRA-like CAP rates were above in all but one age group compared to the CAP rates for national Medicaid HMO, the Child Core Set Chart Pack, and Arkansas Medicaid. For more detailed

information, refer to **Hypothesis 1.1** results.

Due to longevity of the demonstration, interpretation for a non-TEFRA-like population is difficult to measure. Furthermore, the IE outlined the challenges surrounding the selection of a non-TEFRA-like population. In other words, this refers to the challenges of identifying a comparison population with similar medical conditions or diagnoses. (This is displayed in **Table 4**, in the section labeled **Hypotheses 2.3**. This compares the top five diagnoses between the TEFRA-like and non-TEFRA-like populations.) Despite these limitations, conclusions can be drawn from this analysis.

To further advance beneficiary/guardian satisfaction, a business operation review resulted in the planned implementation of enhancements to decrease ambiguity in the TEFRA invoice, ensure DMS receives timely TEFRA premium payments, provide notice of past due account balances, and provide awareness concerning TEFRA policy changes (by creating easier to read statements and improved notification of rate changes and late premiums). In addition, a process is in place to forgive premium payments in arrears for 12 months or more, based on specific past TEFRA eligibility closure reasons. As previously mentioned, comparisons within Arkansas and with other states continues to be pursued, although challenging.

IX. Lessons Learned and Recommendations

TEFRA Disenrollee Beneficiary Survey

Due to the TEFRA Disenrollee Beneficiary Survey only being performed in 2018, and not during 2019, re-evaluation of **Hypothesis 4.2** is recommended. Originally, the focus was to reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access. Also, to assess whether the premium barriers for TEFRA-like beneficiaries remain stable over time. Consideration is being given as to the cost and benefit of commissioning this survey again in the future. Before administering this kind of survey again, a review and restructuring of the survey instrument may be warranted. A resolution to the ambiguity of responses that fell into the "Other" category should be examined as well. In addition, revisiting the general survey configuration, including the selected population of the survey, should be considered.

We suggest monitoring the reasons why TEFRA-like beneficiaries were closed due to potential program barriers of health care access by evaluating the Division of County Operation's (DCO) closure list. This information allows the ability to identify broader reasons why enrollees left the TEFRA-like program and to track over time and pinpoint closure reasons due to health care access. Our recommendation is to update the survey structure or explore another source for this type of information such as the DCO.

PCP Visits and Special Therapy Services

For **Measure 1.1c**[8], the TEFRA-like population had lower percentage of beneficiaries 12 months –18 years of age who had a visit with a PCP at 92.7% compared to non-TEFRA-like population at 98.2% during CY2019. Ages 25 months – 6 years had a much lower rate of lower percentage of TEFRA-like beneficiaries who had a visit with a PCP compared to non-TEFRA-like population during CY2019 (90.4% vs. 97.4%). Although the TEFRA-like population is seeing their PCP at a high rate, it is not as high as the non-TEFRA-like population. Therefore, our recommendation is to provide more education regarding the proper coordination of care through their PCP.

Measure 2.1b[9] is another measure we suggest observing for the newly enrolled TEFRA-like beneficiaries. This is because special therapy services are a major reason for this population to enroll. The 5 - 8 age group had a decrease in the rate of beneficiaries receiving their first health care visit for speech, occupational, or physical therapy services within 60 days of enrollment at 53.0% during CY2018 and 37.8% in CY2019. The overall total dropped from 43.9% in CY2018 to 38.7% in CY2019. The southern part of the state of southeast and southwest regions showed lower percentage of newly enrolled TEFRA-like beneficiaries receiving first health care visit for speech, occupational, or physical therapy services within 60 days of enrollment as compared to central, northeast, and northwest regions of the state during CY2019. Since therapy is a major part of the care that is received by the TEFRA-like population, and considering these declining rates from CY2018 to CY2019, our recommendation is to provide additional education to newly enrolled TEFRA-like beneficiaries. This education will help them learn of available special therapy services in their area.

[8] Children and Adolescents' Access to Primary Care Practitioners (CAP): The percentage of beneficiaries 12 months – 18 years of age who had a visit with a PCP.
[9] First health care visit for therapy services w/in 60 days: The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit for speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period.

X. Attachments

Appendix A. Driver Diagram

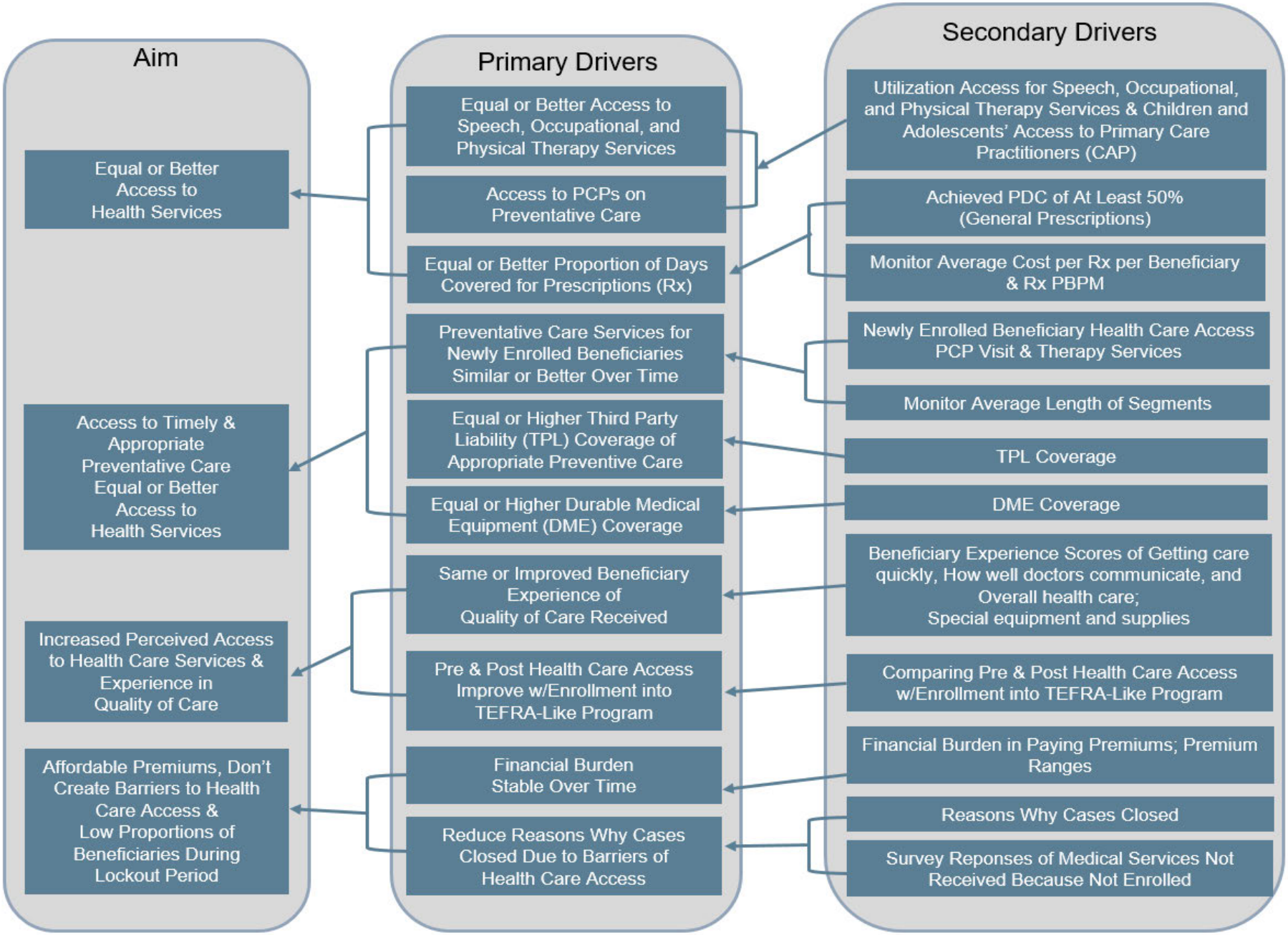
Appendix B. Four Goals with Evaluation Hypotheses and Drivers

Appendix C. Research Questions, Evaluation Outcome and Measures, Comparison Populations, Data Sources, and Analytic Methods Summary Table

Appendix D. Evaluation Outcome and Measure Results

Appendix E. CMS-approved Evaluation Design

Appendix A. Driver Diagram



Appendix B. Four Goals with Evaluation Hypotheses and Drivers

#	Goal	Hypotheses	Drivers
1	Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population	Hypothesis 1.1: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Hypothesis 1.2: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).	Utilizing claims-based & beneficiary's experience of therapy services. Examining PCP visits, Rx proportion of days covered, Rx costs and usage of seizure medications.
2	Ensuring demonstration enrollees have access to timely and appropriate preventive care	Hypothesis 2.1: Preventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar or better over time. Hypothesis 2.2: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Hypothesis 2.3: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).	Examining TEFRA-like coverage. Reviewing PCP visits and therapy services access on newly enrolled TEFRA-like beneficiaries. Utilizing beneficiary's experience of access to health care. Investigating TPL and DME coverage.
3	Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received	Hypothesis 3.1: Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration has remained the same or improved over time. Hypothesis 3.2: Patient's experience with access to health care services improve with enrollment into TEFRA-like program.	Utilizing beneficiary's experience of doctor communication and overall health care. Impacts on health care access pre and post.
4	Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low	Hypothesis 4.1: Premium barriers for TEFRA-like beneficiaries will remain stable over time. Hypothesis 4.2: Reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access.	Examining percent of TEFRA-like lockouts and financial burden. Utilizing disenrollees experience of therapy services. Investing reasons why cases were closed.

Appendix C. Research Questions, Evaluation Design Outcome and Measures, Comparison Populations, Data Sources, and Analytic Methods Summary Table

For *Goal 1: Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population,* Measures 1.1a – 1.1c and 1.2a – 1.2d is used.

Hypothesis 1.1 and 1.2 uses a chi-squared test to evaluate statistically significant differences between the TEFRA-like demonstration population and the Medicaid non-TEFRA- like population for beneficiary level measures and survey-based measures. Wilcoxon-Mann-Whitney test is used for event level measures, which is a non-parametric analog to the t-test, as the data are not normally distributed. The analysis tested using a significance level of $p < 0.05$.

Hypothesis 1.1: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Measure 1.1a	Claims-based therapy services
Description:	The percentage of beneficiaries < 19 years of age who are utilizing therapy services during the measurement period (By a) speech, b) occupational, and c) physical therapy services)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Numerator is number of beneficiaries < 19 years of age that were continuously enrolled utilizing therapy services during the measurement period (By a) speech, b) occupational, and c) physical therapy services). Therapy Service: Identify beneficiaries who received at least one therapy visit from value set codes as defined below for Occupational Therapy Value Set, Occupational/Physical Therapy Value Set, Physical Therapy Value Set, Speech Therapy Value Set, and Therapy Assistant Modifiers Value Set during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.1a & 1.1b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State."
Measure Steward:	DMS Homegrown

Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test

Measure 1.1b	**Survey-based therapy services (i.e. special therapies)**
Description:	Scores of the TEFRA beneficiary satisfaction survey questions of "In the last 6 months, how much of a problem, if any, was it to get the therapy services your child needed through TEFRA?" (By a) speech, b) occupational, and c) physical therapy services) (Domain: *Special therapies*)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator is number of respondents who answered "Not a problem," in the last 6 months to get therapy your child needed through TEFRA. (By a) speech, b) occupational, and c) physical therapy services). "In the last 6 months, how much of a problem, if any, was it to get the speech therapy your child needed through TEFRA?", "In the last 6 months, how much of a problem, if any, was it to get the occupational therapy your child needed through TEFRA?" and "In the last 6 months, how much of a problem, if any, was it to get the physical therapy your child needed through TEFRA?". (Domain: *Special therapies*).
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	1.1b
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Therapy claims-based service rates compare to TEFRA satisfaction survey scores of getting speech, occupational, and physical therapies, where applicable. Trend over time of TEFRA satisfaction survey scores.
Comparison Method(s):	Chi-squared test

Measure 1.1c	Children and Adolescents' Access to Primary Care Practitioners (CAP)
Description:	The percentage of beneficiaries 12 months–18 years of age who had a visit with a PCP. Report four age stratifications. • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–18 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries for a) 12 months – 6 years of age that were continuously enrolled during the measurement period and b) 7 – 18 years of age that were continuously enrolled during the measurement period and year prior to the measurement period. Numerator(s): For 12–24 months, 25 months–6 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period. For 7–11 years, 12–18 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period or the year prior to the measurement period. Count all beneficiaries who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits. In addition, similar check was applied as used for Core Set CAP measure implementation of header billing provider type in ('01' '02' '03' '04' '05' '24' '29' '49' '58' '62' '69' '81'). Numerator is the number of beneficiaries a) 12 months – 6 years of age who had one or more visits with a PCP during the measurement period and b) 7 – 18 years of age who had one or more visits with a PCP during the measurement period or the year prior to the measurement period.
Continuous Enrollment:	For 12–24 months, 25 months–6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For 7–11 years, 12–18 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.1c
Measure Steward:	NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	CMS Core Set Mean Rate Across Reported States by CMS[10]; NCQA's State of Health Report Card (Medicaid HMO)[11]

[10] CMS annually releases information on state progress in reporting the Child Core Set measures and assesses state-specific performance for measures that are reported by at least 25 states and which met internal standards of data quality. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

[11] NCQA's State of Health Care Quality Report. NCQA produces every year to focus on major quality issues the U.S. faces and to support the spread of evidence-based

Hypothesis 1.2: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Measure 1.2a	Proportion of days covered (PDC) threshold of 50%
Description:	The percentage of beneficiaries < 19 years of age who met the proportion of days covered (PDC) threshold of 50% during the measurement period (General Prescriptions)
Technical Specifications:	Denominator: The eligible population. Denominator is number of beneficiaries < 19 years of age who were dispensed at least two prescriptions on two unique dates of service during the measurement period. Numerator(s): Numerator is number of beneficiaries who met the 50% PDC threshold (from Index Prescription Start Date (IPSD) to the end of the measurement period) during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2a & 1.2b
Sub-group:	By parts of the state with low and high access. By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State".
Measure Steward:	PQA-Like/DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test

Measure 1.2b	Average cost per prescription (Rx) per beneficiary
Description:	The average cost per prescription (Rx) per beneficiary for < 19 years of age that were continuously enrolled during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the total number of prescriptions dispensed for beneficiaries < 19 years of age that were continuously enrolled during the measurement period. If multiple prescriptions are dispensed on the same day, calculate number of unique ICNs. Numerator(s): Calculate the total cost of prescriptions dispensed during the measurement period. Sum across claims on header paid amount for total cost of prescriptions. Numerator is the total prescription costs during the measurement period.

care. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/.

Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2c
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By gender: Female, Male, and Unknown. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State". Identify the top five prescriptions based upon average cost per prescription (Rx) per beneficiary (or number of beneficiaries). To review the top five prescriptions based upon number of beneficiaries who qualified for the denominator.
Measure Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Wilcoxon-Mann-Whitney test

Measure 1.2c	**Prescriptions (Rx) per beneficiary per month (PBPM)**
Description:	The prescriptions (Rx) per beneficiary per month (PBPM) for < 19 years of age during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiary months. Beneficiary months are a beneficiary's contribution to the total 12-month enrollment. Beneficiary months are calculated by summing the total number of months each beneficiary is enrolled in the program during the measurement period. Numerator(s): Calculate the total number of prescriptions dispensed during the measurement period. Numerator is the number of general prescriptions filled for beneficiaries during the measurement period. If multiple prescriptions are dispensed on the same day, calculate number of unique ICNs.
Beneficiary Months:	Verify Medicaid enrollment on the last day of each month during the measurement period. Count the month if the beneficiary is enrolled and < 19 years of age.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2d
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Measure Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)

Comparison Method(s):	Two-group t-test; Chi-squared test

Measure 1.2d	**Anti-Seizure**
Description:	The percentage of beneficiaries < 19 years of age taking at least two seizure medications during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Numerator is the number of beneficiaries who have at least two seizure prescriptions during the measurement period. Anti-seizure medications may be dispensed on the same day. 1. At least two medications from Anticonvulsants Medications Value Set (i.e. H4A or H4B). 2. Or one medication from Anticonvulsants Medications Value Set (i.e. H4A or H4B) and at least one medication from Benzodiazepines Medications Value Set (i.e.H8R).
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2e
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Measure Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test

For *Goal 2: Ensuring demonstration enrollees have access to timely and appropriate preventive care*, Measures 2.1a – 2.1c, 2.2a – 2.2b, and 2.3a will be used.

Hypothesis 2.2 - 2.3 uses a chi-squared test to evaluate statistically significant differences between the TEFRA-like demonstration population and the Medicaid non-TEFRA- like population for beneficiary level measures and survey-based measures. Wilcoxon-Mann-Whitney test is used for event level measures, which is a non-parametric analog to the t-test, as the data are not normally distributed. The analysis tested using a significance level of $p < 0.05$.

Hypothesis 2.1: ***Preventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar or better over time.***

Measure 2.1a	First health care visit to PCP w/in 60 days
Description:	The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit to PCP within 60 days of enrollment during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of newly enrolled TEFRA-like beneficiaries < 19 years of having an enrollment start date of at least 60 days before the end of the measurement period. Numerator(s): Numerator is the number of newly enrolled TEFRA-like beneficiaries for which the TEFRA-like beneficiary received first health care visit to PCP within 60 days of enrollment during the measurement period.
Newly Enrolled:	Identify newly enrolled TEFRA-like beneficiaries where an enrollment start date is at least 60 days before the end of the measurement period
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1a
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Measure Steward:	DMS Homegrown; CAP Portion: NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Trend over time of TEFRA-like coverage
Comparison Method(s):	Longitudinal data analysis; Chi-squared test

Measure 2.1b	First health care visit for therapy services w/in 60 days
Description:	The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit for speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of newly enrolled TEFRA-like beneficiaries < 19 years of having an enrollment start date of at least 60 days before the end of the measurement period. Numerator(s): Numerator is the number of newly enrolled TEFRA-like beneficiaries for which the TEFRA-like beneficiary received first health care visit to speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period. Therapy Service: Identify beneficiaries who received at least one therapy visit from value set codes as defined below for Occupational Therapy Value Set, Occupational/Physical Therapy Value Set, Physical Therapy Value Set, Speech Therapy Value Set, and Therapy Assistant Modifiers Value Set during the measurement period.

Newly Enrolled:	Identify newly enrolled TEFRA-like beneficiaries where an enrollment start date is at least 60 days before the end of the measurement period
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State".
Measure Steward:	DMS Homegrown; CAP Portion: NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test

Measure 2.1c	**Average length of TEFRA-like segments**
Description:	The average length (in months) of TEFRA-like segments for beneficiaries <19 years of age during the measurement period.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of TEFRA-like beneficiaries < 19 years of age enrolled during the measurement period. Numerator(s): Calculate the total number of days each TEFRA-like beneficiary is enrolled during the measurement period. Sum across all TEFRA-like beneficiaries for overall total number of days. Numerator is the total number of days across all enrolled TEFRA-like beneficiaries during the measurement period. Average Length in Months: Calculate the average length in months as ((total number of days each TEFRA-like beneficiary is enrolled during the measurement period divided by number of TEFRA-like beneficiaries < 19 years of age enrolled during the measurement period) then divided by 30 calendar days. Outcome is total number of months each TEFRA-like beneficiary is enrolled during the measurement period.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1c
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Measure Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Trend over time of TEFRA-like coverage
Comparison Method(s):	Longitudinal data analysis; Wilcoxon-Mann-Whitney test

Hypothesis 2.2 ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Measure 2.2a	Third Party Liability (TPL) coverage
Description:	The percentage of beneficiaries <19 years of age who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) that were continuously enrolled during the measurement period. TPL coverage represents where a beneficiary had a TPL claim within the measurement period.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Count all beneficiaries where private insurance amount (header) is > $0 or had a crossover claim (Medicare coverage) during the measurement period. Numerator is the number of beneficiaries who had at least one TPL claim during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.2a & 2.2c
Sub-group:	By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State".
Measure Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test

Measure 2.2b	Third Party Liability (TPL) coverage & CAP
Description:	The percentage of beneficiaries 12 months–18 years of age who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP. Report four age stratifications. • Children 12–24 months and 25 months–6 years who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–18 years who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) for a) 12 months – 6 years of age that were continuously enrolled during the measurement period and b) 7 – 18 years of age that were continuously enrolled during the measurement period and year prior to the measurement period. Numerator(s): For 12–24 months, 25 months–6 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period. For 7–11 years, 12–18 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period or the year prior to the measurement period. Count all beneficiaries who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits. In addition, similar check was applied as used for Core Set CAP measure implementation of header billing provider type in ('01' '02' '03' '04' '05' '24' '29' '49' '58' '62' '69' '81'). Numerator is the number of beneficiaries who had a visit with a PCP a) 12 months – 6 years of age who had one or more visits with a PCP during the measurement period and b) 7 – 18 years of age who had one or more visits with a PCP during the measurement period or the year prior to the measurement period.
Continuous Enrollment:	For 12–24 months, 25 months–6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For 7–11 years, 12–18 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.2b
Measure Steward:	DMS Homegrown; NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test

Hypothesis 2.3 ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Measure 2.3a	Durable Medically Equipment (DME) coverage
Description:	The percentage of beneficiaries <19 years of age who had at least one DME coverage claim that were continuously enrolled during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period.

	Numerator(s): Numerator is the number of beneficiaries who had at least one DME coverage claim during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.3a & 2.3b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. Identify top primary dx conditions and condition types on number of claims and beneficiaries <19 years of age who have DME coverage for beneficiaries who qualified for the numerator during the measurement period. To review the top 10 primary diagnosis conditions and condition types (i.e. groupings) by number of claims for beneficiaries who qualified for the numerator. In addition, to review number of beneficiaries for each top 10 primary diagnosis condition. Number of claims and beneficiaries for the top 10 primary diagnosis conditions (based on the total number of distinct claims from the beneficiaries who have DME coverage).
Measure Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test; Chi-squared test

For *Goal 3: Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received*, Measures 3.1a – 3.1c and 3.2a – 3.2c are used.

TEFRA Beneficiary Satisfaction Survey questions related to access to health care services and quality of care received will be organized into three domains and records beneficiary's experience for each domain. Individual questions are used from each of the three domains. Composite scores were not used for the significance testing due to beneficiary level satisfaction survey data not being available to the evaluation contractor. A composite score domain combines the responses of two or more questions, except for "Overall health care" domain, to obtain a single score. The individual questions and composite domains represent the percentage of beneficiaries that responded favorably. For example, questions scaled as "Never," "Sometimes," "Usually" and "Always," a favorable response represents the proportion of beneficiaries who selected "Usually" or "Always."

- ***Domain 1 - Getting care quickly:***
  - *Obtaining care right away for an illness/injury/condition*
  - *Obtaining care when wanted, but not needed right away*

- ***Domain 2 - How well doctors communicate:***
  - *Doctors explaining things in an understandable way to your child*
  - *Doctors listening carefully to you*
  - *Doctors showing respect for what you had to say*
  - *Doctors spending enough time with the child*
- ***Domain 3 - Overall health care:***
  - *Rating of health care*

Sequential trend analyses are used to assess whether beneficiary experience has improved over time or remained the same. The scores, where available, is compared to both ARKids First A and First B beneficiary satisfaction survey data. A chi-square goodness of fit test will be used to test whether the observed proportions for a categorical variable differ from assumed proportions. The analysis tested using a significance level of $p < 0.05$.

Hypothesis 3.1 ***Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration has remained the same or improved over time.***

Measure 3.1a	Survey-based getting care quickly
Description:	The percentage of survey responses marked "Usually" or "Always" (i.e. favorably) for domain of Getting care quickly (i.e. receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed). (Domain: *Getting care quickly*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 2) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed (for each survey question). Questions on Obtaining care right away for an illness/injury/condition ("In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?") and Obtaining care when wanted, but not needed right away ("In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or

	clinic as soon as your child needed?") (Domain: *Getting care quickly*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1a
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report)
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey. Questions on Obtaining care right away for an illness/injury/condition ("In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?") and Obtaining care when wanted, when not needed right away ("In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?"). Trend over time of satisfaction survey scores.
Comparison Method(s):	Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Measure 3.1b	**Survey-based how well doctors communicate**
Description:	The percentage of survey responses marked "Usually" or "Always" (i.e. favorably) for domain of How well doctors communicate (i.e. Doctors explaining things in an understandable way, Doctors listening carefully to you, Doctors showing respect for what you had to say, AND Doctors spending enough time with you. (Domain: *How well doctors communicate*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 4) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" on Doctors explaining things in an understandable way to your child AND Doctors listening carefully to you AND Doctors showing respect for what you had to say AND Doctors spending enough time with your child (for each survey question). Questions on Doctors explaining things in an understandable way to your child ("In the last 6 months, how often did doctors or other health providers explain things in a way your child could understand?"), Doctors

	listening carefully to you ("In the last 6 months, how often did your child's doctors or other health providers listen carefully to you?"), and Doctors showing respect for what you had to say ("In the last 6 months, how often did your child's health care professional show respect for what you had to say?"), and Doctors spending enough time with your child ("In the last 6 months, how often did doctors or other health providers spend enough time with your child?"). (Domain: *How well doctors communicate*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1b
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report)
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey. Questions on Doctors listening carefully to you ("In the last 6 months, how often did your child's personal doctor listen carefully to you?"), Doctors showing respect for what you had to say ("In the last 6 months, how often did your child's personal doctor show respect for what you had to say?"), Doctors explaining things in an understandable way to your child ("In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?"), and Doctors spending enough time with your child ("In the last 6 months, how often did your child's personal doctor spend enough time with your child?"). Trend over time of satisfaction survey scores.
Comparison Method(s):	Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Measure 3.1c	**Survey-based overall health care**
Description:	The percentage of survey responses marked ratings of 8, 9, or 10 (i.e. favorably) for Overall health care. (Domain: *Overall health care*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of 8, 9 or 10. Question on rating of health care, ("We want to know your rating of all your child's health care in the last 6

	months from all doctors and other health providers. How would you rate all your child's health care?"). (Domain: *Overall health care*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1c
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report);
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey. Question on rating of health care, where numerator represents responses of 8, 9 or 10, ("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 child's health care in the last 6 months?"). Trend over time of satisfaction survey scores.
Comparison Method(s):	Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Hypothesis 3.2 ***Patient's experience with access to health care services improve with enrollment into TEFRA-like program.***

Measure 3.2a	**Survey-based of Pre-TEFRA vs. Post-TEFRA: Personal doctor or nurse**
Description:	The percentage of survey responses marked "Big or small problem" on "How much of a problem, if any, was it for your child to see a personal doctor or nurse?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on "How much of a problem, if any, was it for your child to see a personal doctor or nurse?".
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable

	gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2a
Sub-group:	Pre-TEFRA vs. Post-TEFRA
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Chi-squared test

Measure 3.2b	**Survey-based of Pre-TEFRA vs. Post-TEFRA: Prescription**
Description:	The percentage of survey responses marked "Big or small problem" on “How much of a problem, if any, was it to get your child’s prescription medication?”
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on “How much of a problem, if any, was it to get your child’s prescription medication?”.
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2b
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores.
Comparison Method(s):	Chi-squared test

Measure 3.2c	**Survey-based of Pre-TEFRA vs. Post-TEFRA: Urgent care**

Description:	The percentage of survey responses marked "Big or small problem" on "How much of a problem, if any, was it for your child to get urgent care?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on "How much of a problem, if any, was it for your child to get urgent care?".
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2c
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Chi-squared test

For *Goal 4: Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low*, Measures 4.1a – 4.1b and 4.2a – 4.2d are used.

The evaluator reviewed the top five reasons why TEFRA-like beneficiary cases were closed. This will aid in understanding the reasons for disenrollment and if a child is receiving health care during a closed case. The state investigated barriers of therapy services during the patient's lockout period. The three survey questions related to getting special therapies for a) speech, b) occupational, and c) physical therapy will be utilized between TEFRA Disenrollee Beneficiary Survey data and TEFRA Beneficiary Satisfaction Survey data, where applicable for measurement periods. Lastly, the state will compare the common medical services a patient could not get when not enrolled in TEFRA-like program (i.e. regular physician visits, visits to a specialist, emergency room visits, dental visits, prescription medicine, special therapy, and medical equipment) and determine if any overlap exists with the top common diagnosis conditions for the TEFRA-like beneficiaries.

Hypothesis 4.1: ***Premium barriers for TEFRA-like beneficiaries will remain stable over time.***

Measure 4.1a	Survey-based premium barriers

Description:	The percentage of survey responses marked “A big financial burden" on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?”.
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of “A big financial burden". Question on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?”.
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	4.1a
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Chi-squared test

Measure 4.1b	**Survey-based premium ranges for premium barriers**
Description:	A cross-table of the survey responses marked "A big financial burden" on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” by the premium ranges survey responses marked on “A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?”
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question of "A big financial burden" on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” Numerator(s): Numerator is the number of survey responses for each premium range. Questions on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” and “A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?”
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.

Research Question(s):	4.1b
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Chi-squared test

Hypothesis 4.2: Reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access.

Measure 4.2a	**Survey-based reasons why cases closed**
Description:	Identify the top five reasons why TEFRA-like beneficiary cases were closed from beneficiary satisfaction survey.
Technical Specifications:	Question on "What was the reason that your child's TEFRA case was closed? (Check all that apply)?".
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2a
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	Trend over time of top five reasons why TEFRA-like beneficiary cases were closed

Measure 4.2b	**Survey-based getting care quickly for disenrollees**
Description:	The percentage of survey (Disenrollee) responses marked "Usually" or "Always" (i.e. favorably) for domain of Getting care quickly (i.e. receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed). (Domain: *Getting care quickly*)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 2) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered

	"Usually" or "Always" receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed (for each survey question). Questions on Obtaining care right away for an illness/injury/condition ("During the period your child's TEFRA was closed, when your child needed care right away, how often did your child get care as soon as he or she needed?"). and Obtaining care when wanted, but not needed right away ("During the time your child's TEFRA case was closed, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as soon as your child needed?"). (Domain: *Getting care quickly*)
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2b
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	TEFRA Beneficiary Survey, Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey, where applicable. Trend over time of satisfaction survey scores.
Comparison Method(s):	Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Measure 4.2c	**Survey-based therapy services (i.e. special therapies) for disenrollees**
Description:	Percentage of survey responses marked "Not a problem" by a) speech, b) occupational, and c) physical therapy services
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question (for each survey question). If reviewing composite score, denominator is the number of survey questions (n = 3). Numerator(s): Number of respondents who answered "Not a problem", to get therapy your child needed. (By a) speech, b) occupational, and c) physical therapy services) (for each survey question). Combined scores (percentage) of not a problem of Getting Special therapies for a) speech, b) occupational, and c) physical therapy services divided by number of survey questions (n = 3). Questions on not a problem of Getting speech therapy ("During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the speech therapy your child needed?"), Not a problem of

	Getting occupational therapy ("During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the occupational therapy your child needed?"), and Not a problem of Getting physical therapy ("During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the physical therapy your child needed?").
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2c
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	TEFRA Beneficiary Satisfaction Survey, Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey, where applicable. Trend over time of satisfaction survey scores.
Comparison Method(s):	Chi-squared test

Measure 4.2d	**Survey-based medical services not received for disenrollees**
Description:	Responses to survey question: What types of medical services could you not get for your child because your child was not enrolled in the TEFRA program?
Technical Specifications:	List the top medical services of beneficiaries not enrolled in TEFRA-like program. Question on "What types of medical services could you not get for your child because your child was not enrolled in the TEFRA program? (Check all that apply)?".
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2d
Measure Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.

Comparison Group:	Trend over time of top medical services of beneficiaries not enrolled in TEFRA-like program. Review the types of medical services related to the top common diagnosis conditions/codes for TEFRA-like beneficiaries.

Appendix D. Evaluation Outcome and Measure Results

Measure Number	Measure Name	Year 1 Measurement Period		Year 2 Measurement Period		Statistically Significance Testing (p < 0.05)	
		TEFRA-Like Results	Non-TEFRA-Like Results	TEFRA-Like Results	Non-TEFRA-Like Results	Year 1 Measurement Period	Year 2 Measurement Period
Measure 1.1a	Claims-based therapy services: Speech	59.0%	15.5%	59.6%	15.6%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
	Claims-based therapy services: Occupational	49.2%	9.5%	44.6%	9.0%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
	Claims-based therapy services: Physical	64.9%	13.6%	64.4%	13.7%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 1.1b	Survey-based therapy services: Speech	88.5%	N/A	89.5%	N/A	Not significantly different between 2018 vs. 2019 TEFRA Survey Scores	
	Survey-based therapy services: Occupational	89.1%	N/A	90.4%	N/A		
	Survey-based therapy services: Physical	91.2%	N/A	89.4%	N/A		
Measure 1.1c	Claims-based: Children and Adolescents' Access to Primary Care Practitioners (CAP) for Ages 12 Months – 6 Years (Child)	89.3%	97.8%	90.8%	97.7%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
	Claims-based: Children and Adolescents' Access to Primary Care Practitioners (CAP) for Ages 7 Years – 18 Years (Adolescent)	93.0%	98.7%	94.3%	98.4%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Not significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 1.2a	Claims-based: Proportion of days covered (PDC) threshold of 50%	59.9%	56.0%	57.4%	56.1%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Not significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019

Measure 1.2b	Claims-based: Average cost per prescription (Rx) per beneficiary	$159.98	$99.82	$140.29	$69.86	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	ATTACHMENT 5 Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 1.2c	Claims-based: Prescriptions (Rx) per beneficiary per month (PBPM)	1.0	1.1	0.9	1.1	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 1.2d	Claims-based: Anti-Seizure	8.3%	5.9%	7.6%	5.7%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 2.1a	Claims-based: First health care visit to PCP w/in 60 days	31.7%	N/A	36.7%	N/A	Not significantly different between CY2018 vs. CY2019 TEFRA-like	
Measure 2.1b	Claims-based: First health care visit for therapy services w/in 60 days	43.9%	N/A	38.7%	N/A	Not significantly different between CY2018 vs. CY2019 TEFRA-like	
Measure 2.1c	Claims-based: Average length of TEFRA-like segments	9.8	N/A	10.0	N/A	Significantly different between CY2018 vs. CY2019 TEFRA-like	
Measure 2.2a	Claims-based: Third Party Liability (TPL) coverage	69.7%	8.6%	74.3%	22.6%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 2.2b	Claims-based: Third Party Liability (TPL) coverage & Children and Adolescents' Access to Primary Care Practitioners (CAP) for Ages 12 Months – 6 Years (Child)	91.0%	96.1%	91.9%	96.5%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
	Claims-based: Third Party Liability (TPL) coverage & Children and Adolescents' Access to Primary Care Practitioners (CAP) for Ages 7 – 18 Years (Adolescent)	93.7%	95.6%	94.7%	98.1%	Not significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Not significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 2.2c	Claims-based: Durable Medically Equipment (DME) coverage	40.8%	13.3%	38.0%	12.9%	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2018	Significantly different between TEFRA-like vs. Non-TEFRA-like during CY2019
Measure 3.1a	Survey-based: Getting care quickly (Obtaining care right away for an illness/injury/condition)	97.0%	97.1% (ARKids A) 92.2% (ARKids B)	97.9%	96.3% (ARKids A) 97.0% (ARKids B)	Not significantly different between 2018 TEFRA vs. 2017 ARKids A & 2018 ARKids B Survey Scores	Not significantly different between 2019 TEFRA vs. 2019 ARKids A & 2019 ARKids B Survey Scores

							ATTACHMENT 5
	Survey-based: Getting care quickly (Obtaining care when wanted, but not needed right away)	92.6%	90.2% (ARKids A) 87.5% (ARKids B)	92.3%	94.0% (ARKids A) 93.7% (ARKids B)	Not significantly different between 2018 TEFRA vs. 2017 ARKids A & 2018 ARKids B Survey Scores	Not significantly different between 2019 TEFRA vs. 2019 ARKids A & 2019 ARKids B Survey Scores
Measure 3.1b	Survey-based: How well doctors communicate (Doctors listening carefully to you)	97.3%	94.9% (ARKids A) 97.0% (ARKids B)	97.9%	96.4% (ARKids A) 97.2% (ARKids B)	Not significantly different between 2018 TEFRA vs. 2017 ARKids A & 2018 ARKids B Survey Scores	Not significantly different between 2019 TEFRA vs. 2019 ARKids A & 2019 ARKids B Survey Scores
	Survey-based: How well doctors communicate (Doctors showing respect for what you had to say)	98.4%	96.7% (ARKids A) 97.4% (ARKids B)	97.9%	96.6% (ARKids A) 98.2% (ARKids B)	Not significantly different between 2018 TEFRA vs. 2017 ARKids A & 2018 ARKids B Survey Scores	Not significantly different between 2019 TEFRA vs. 2019 ARKids A & 2019 ARKids B Survey Scores
	Survey-based: How well doctors communicate (Doctors explaining things in an understandable way to your child)	83.9%	89.2% (ARKids A) 93.0% (ARKids B)	89.3%	92.5% (ARKids A) 95.5% (ARKids B)	Not significantly different between 2018 TEFRA vs. 2017 ARKids A & 2018 ARKids B Survey Scores	Not significantly different between 2019 TEFRA vs. 2019 ARKids A & 2019 ARKids B Survey Scores
	Survey-based: How well doctors communicate (Doctors spending enough time with your child)	93.7%	90.0% (ARKids A) 95.8% (ARKids B)	94.5%	91.0% (ARKids A) 93.5% (ARKids B)	Not significantly different between 2018 TEFRA vs. 2017 ARKids A & 2018 ARKids B Survey Scores	Not significantly different between 2019 TEFRA vs. 2019 ARKids A & 2019 ARKids B Survey Scores
Measure 3.1c	Survey-based: Overall health care (Rating of health care)	88.4%	85.6% (ARKids A) 87.3% (ARKids B)	89.6%	85.0% (ARKids A) 86.7% (ARKids B)	Not significantly different between 2018 TEFRA vs. 2017 ARKids A & 2018 ARKids B Survey Scores	Not significantly different between 2019 TEFRA vs. 2019 ARKids A & 2019 ARKids B Survey Scores
Measure 3.2a	Survey-based of Pre-TEFRA vs. Post-TEFRA: Personal doctor or nurse (Comparing health care before and since enrolling in TEFRA)	5.6%	23.4%	7.2%	24.7%	Significantly different between Pre-TEFRA vs. Post-TEFRA 2018 TEFRA Survey Scores	Significantly different between Pre-TEFRA vs. Post-TEFRA 2019 TEFRA Survey Scores
Measure 3.2b	Survey-based of Pre-TEFRA vs.	16.1%		15.5%	32.1%	Significantly different	Significantly different

	Post-TEFRA: Prescription (Comparing health care before and since enrolling in TEFRA)		29.0%			between Pre-TEFRA vs. Post-TEFRA 2018 TEFRA Survey Scores	between Pre-TEFRA vs. Post-TEFRA 2019 TEFRA Survey Scores
Measure 3.2c	Survey-based of Pre-TEFRA vs. Post-TEFRA: Urgent care (Comparing health care before and since enrolling in TEFRA)	5.3%	25.0%	7.6%	23.1%	Significantly different between Pre-TEFRA vs. Post-TEFRA 2018 TEFRA Survey Scores	Significantly different between Pre-TEFRA vs. Post-TEFRA 2019 TEFRA Survey Scores
Measure 4.1a	Survey-based: Premium barriers (A big financial burden)	11.2%	N/A	8.7%	N/A	Not significantly different between 2018 vs. 2019 TEFRA Survey Scores	
Measure 4.1b	Survey-based: Premium ranges for premium barriers (A big financial burden by monthly TEFRA premium)	Due to small number of responses, reporting descriptive statistics for highest percentage of survey responses, 25.9%, marked "A big financial burden", with $281–$328 TEFRA premium range during 2018 and shifted during 2019 to $364–$416 TEFRA premium range of 21.1% survey response rate.					
Measure 4.2a	Survey-based: Reasons why cases closed	From the 2018 TEFRA Disenrollee Survey, the top five reasons for closure of a child's TEFRA case were: 1) "No longer eligible" (40 respondents), 2) "Other" (39 respondents), 3) "Could not afford premium payment" (17 respondents), 4) "TEFRA services no longer needed" (14 respondents), 5) "Could not complete paperwork on time", and "Obtained other coverage" (tie with 8 respondents each)					
Measure 4.2b	Survey-based: Getting care quickly for disenrollees (Obtaining care right away for an illness/injury/condition)	83.3% (TEFRA Disenrollee)		97.0% (TEFRA) 97.1% (ARKids A) 92.2% (ARKids B)		Not significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA, 2017 ARKids A & 2018 ARKids B Survey Scores	
	Survey-based: Getting care quickly for disenrollees (Obtaining care when wanted, but not needed right away)	84.6% (TEFRA Disenrollee)		92.6% (TEFRA) 90.2% (ARKids A) 87.5% (ARKids B)		Not significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA, 2017 ARKids A & 2018 ARKids B Survey Scores	
Measure 4.2c	Survey-based therapy services: Speech	62.2% (TEFRA Disenrollee)		88.5% (TEFRA)		Not significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA Survey Scores	
	Survey-based therapy services: Occupational	50.0% (TEFRA Disenrollee)		89.1% (TEFRA)		Significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA Survey Scores	
	Survey-based therapy services: Physical	52.2% (TEFRA Disenrollee)		91.2% (TEFRA)		Not significantly different between 2018 TEFRA Disenrollee vs. 2018 TEFRA Survey Scores	
Measure 4.2d	Survey-based: Medical services not received for disenrollees	From the 2018 TEFRA Disenrollee Survey, the top responses for medical services not received for disenrollee were: 1) "Other" (31.5%), 2) "Special therapy" (22.8%), 3) "Prescription medicine" (12.0%), and 4) "Visits to a specialist" (10.9%)					

ARKANSAS TEFRA-LIKE
Section 1115
Project Number 11W001636

Evaluation Design

July 26, 2019

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Table of Contents

I. General Background Information

Demonstration Overview

History

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave individual states the option to provide health care benefits to children living with disabilities, and whose family income was too high to qualify for traditional Medicaid. Sometimes called the Katie Beckett Option 1, this program is associated with a child whose experience with viral encephalitis at a young age left her family in financial hardship. If Katie continued receiving treatment at the hospital, she qualified for Supplemental Security Income (SSI) through Medicaid. However, if she were treated at home, her parents' income would make her ineligible for Medicaid. Interestingly, the hospital-based care was six times more than the cost of home-based care. To address the issues associated with this act, President Ronald Reagan and the Secretary of Health and Human Services created a committee to review the regulations and ensure that children with disabilities could receive home-based treatment (the Katie Beckett option), which then recommended Section 134 of the TEFRA.

Before 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to transition the disabled children from traditional Medicaid to a TEFRA-like, 1115 Demonstration Waiver program. Arkansas' 1115 TEFRA-like Demonstration Waiver was originally approved on October 17, 2002 and implemented on January 1, 2003. Following the initial five-year demonstration period, the program has continued to be renewed. The TEFRA Waiver is a cost sharing Medicaid program that enables certain children with a disability to have care in their homes rather than in an institution. Using the flexibility available within a Demonstration Waiver, Arkansas was able to develop and implement a sliding scale premium fee structure based on the family's income, effectively passing a portion of the cost to the eligible child's family. Families with annual incomes of less than $25,000 were exempted from the premium requirement; program eligibility was determined solely on the assets and resources of the child.

Current

Original renewal request was provided to Centers for Medicare & Medicaid Services (CMS) on June 30, 2017 for a three-year extension renewal for the TEFRA Demonstration Waiver with no program changes. Initially, as the review/approval process for the extension renewal application had not been completed by the December 31, 2017 end date of the May 12, 2015 – December 31, 2017 demonstration period, CMS first approved through April 30, 2018 an extension of the demonstration. This allowed the state additional time to complete the review/renewal process, and the Special Terms & Conditions (STC) for the new renewal period to be finalized. Thus, on October 18, 2017, Arkansas submitted a follow-up request to extend the demonstration for a three-year period with no program changes. Lastly, CMS approved on May 9, 2018 the demonstration extension request for a period of five years, through the December 31, 2022. Since the initial TEFRA Demonstration Waiver approval in 2003, the state was given the option of only three year renewal periods until the last renewal request when the state was given a five-year renewal option, which the state opted to accept. Overall, the TEFRA extension renewal was approved on May 9, 2018 for a demonstration period from May 9, 2018 – December 31, 2022.

In accordance with CMS' demonstration requirement, the Arkansas Division of Medical Services (DMS) must develop an evaluation design for the TEFRA-like demonstration no later than 120 days following demonstration approval from CMS (STC 47). The draft evaluation design is built on exploratory analysis performance metrics using latest claims-based data available during January 1, 2016 – December 31, 2016 and satisfaction survey outcomes.

Demonstration Goals

The purpose of the evaluation design is to assess the impact of the demonstration on the quality and affordability of health care for all children eligible for the program. The evaluation design will explore and evaluate the effectiveness of the demonstration for each research hypothesis, as approved by CMS. Arkansas will continue to test the following four goals during the demonstration, which CMS and Arkansas expects will continue to promote Medicaid program objectives.

- ***Goal 1:*** *Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population.*
- ***Goal 2:*** *Ensuring demonstration enrollees have access to timely and appropriate preventive care.*
- ***Goal 3:*** *Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received.*
- ***Goal 4:*** *Ensuring premium contributions are affordable, do not create a barrier to health*

care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low.

As illustrated in the "Methodology" section, each research hypothesis includes one or more evaluation design metrics. Included in the evaluation design will be examinations of the demonstration's performance on a set of outcome and satisfaction metrics over time and relative to a comparable population in the Arkansas Medicaid program, where applicable. Each metric will be described and include a description of the numerator and denominator, the sources of data, and the analytic method used to test the hypotheses. Both cross-sectional and sequential trend analyses will be used, depending on whether the metric is across one point in time or multiple points in time, along with the specific research hypothesis being addressed.

Target Population

The target population will include all beneficiaries covered under Title XIX of the Social Security Act in the State of Arkansas, ages 18 or younger, who meet the medical necessity requirement for institutional care, have income that is less than the long-term care Medicaid limit, and do not have countable assets greater than $2,000.

The target population will include enrolled TEFRA-like beneficiaries meeting all of the following eligibility criteria:

a) Child must be age 18 or younger,
b) Child must meet the Social Security Administration's definition of disability,
c) Child must be a U.S. citizen or qualified alien,
d) Child must have established residency in the state of Arkansas,
e) Child must have a Social Security Number or have applied for one,
f) Child's annual gross countable income must be less than the current Medicaid State Plan income limit established for long-term care services, in accordance with section 1902(a)(10)(A)(ii)(V) of the Act (i.e., the child would be Medicaid eligible if institutionalized),
g) Child's countable assets do not exceed $2,000 (parent(s) assets are not considered),
h) Child meets the medical necessity requirement for institutional placement, or level of care, or be at risk, in the future, for institutional placement, and
i) If eligibility criteria a – h is met, the child must also have access to medical care in the home, it must be deemed appropriate to provide such care outside an institution, and the estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

Due to the TEFRA-like program characteristics, Medicaid may serve as a secondary payer for some of the covered beneficiaries in the target population, which could include cases of third-party liability (TPL). The evaluation design will explore which proportion of the target population is TPL and the range of impact throughout the state.

Comparison Populations

A comparison population for select evaluation design metrics on claims-based outcomes and metrics will consist of Medicaid non-TEFRA-like program beneficiaries. This comparison population will include similar age and beneficiary diagnosis characteristics, as described under criteria (g) below, as TEFRA-like population. Analyses were conducted for the claims-based comparison population to focus on program level, similar beneficiary primary diagnosis conditions and ages. Under DMS Medical Director's guidance, clinical review was performed on the selection of primary diagnosis conditions of five behavioral health conditions[1] and four medical conditions[2]. The purpose of the selection was to identify TEFRA-like beneficiaries primary diagnosis conditions of characteristics beneficiary primary diagnosis conditions and apply to Medicaid fee-for-service population to include as non-TEFRA-like population. The claims-based comparison population of enrolled Medicaid non-TEFRA-like will include beneficiaries who meet the following criteria:

a) Child must be age 18 or younger,

b) Child must be a U.S. citizen or qualified alien,

c) Child must have established residency in the state of Arkansas,

d) Child must have a Social Security Number or have applied for one,

e) Child must have continuous enrollment of Medicaid non-TEFRA-like program,

f) Not enrolled in TEFRA-like program 12 months prior/post evaluation measurement periods, and

g) Child must be identified in at least one of the nine selected primary diagnosis conditions of the following: *Child/ Adolescent Emotional Disorders, Other Congenital Anomalies, Attention Deficit Hyperactivity Disorders, Anxiety/ Nonpsychotic Disorders, Mood Disorders, Nervous System Congenital Anomalies, Cardiac and Circulatory Congenital Anomalies, Adjustment Disorders, and Hereditary and Degenerative Nervous System Conditions*

[1] Child/ Adolescent Emotional Disorders, Attention Deficit Hyperactivity Disorders, Mood Disorders, Anxiety/ Nonpsychotic Disorders, and Adjustment Disorders.

[2] Other Congenital Anomalies, Nervous System Congenital Anomalies, Cardiac and Circulatory Congenital Anomalies, and Hereditary and Degenerative Nervous Sys Conditions.

In researching comparison populations, the Developmental Disabilities Services (DDS) program was studied but there was evidence to indicate DDS beneficiaries were also included in TEFRA-like program. DDS has no age limit on services provided. It was concluded that DDS population would have overlap of beneficiaries between the TEFRA-like population and DDS population, thus would lead to confounding comparisons between the two populations. In the state's previous demonstration evaluation design ARKids A population was used as the comparison population. Since ARKids A provides health insurance to children who qualify based on family income level and would not have similar beneficiary diagnosis characteristics as the TEFRA-like population, we have determined to no longer consider this group as a reasonable comparison group for this evaluation design. Instead, DMS wants to determine if the TEFRA-like population have equal or better access to health services compared to beneficiaries with similar diagnosis beneficiary characteristics from Medicaid fee-for-service population.

Exploratory Analysis of Target and Comparison Populations

DMS contracted with a vendor to gather and analyze exploratory data to help formalize the TEFRA-like evaluation design. Calendar year 2016 (January 1, 2016 – December 31, 2016) constitutes the measurement period for the exploratory analysis of this evaluation design. This analysis was vital in determining relevant hypotheses, research questions, and development of Arkansas specific homegrown metrics in the evaluation design process for the TEFRA-like population.

Target Population

Descriptive findings on the demographic and eligibility characteristics of the TEFRA-like population help understand not only the demonstration population more fully but also provides useful contextual information that will facilitate interpretation of evaluation design findings. A total of 5,588 beneficiaries were identified having at least one TEFRA-like segment during the measurement period of CY2016. Of the TEFRA-like beneficiaries, 99% had at least one TEFRA segment during the measurement period. Almost 70% of population were enrolled for at least 11 months out of the year (n = 3,841 beneficiaries) in TEFRA-like coverage. Over 50% of the TEFRA-like population were between the ages of two and ten as of December 31, 2016. Almost two-thirds of the TEFRA-like population were male. An examination of additional demographic characteristics among the TEFRA-like population revealed that the majority were white (75%; n = 4,166), and nearly 74% lived in the Northwest and Central regions. The median number of TEFRA-like beneficiaries that have been enrolled for less than 12 months is 162 during the CY2016 measurement period.

Using CY2016 Arkansas claims from the TEFRA-like population on primary ICD-10 diagnosis codes, the clinical characteristics of the target group were explored. Primary diagnosis codes were grouped together by level of condition such as *Other Congenital Anomalies,* then characterized by either a

medical or behavioral health condition type. Primary diagnosis groups of 253 medical conditions and 15 behavioral health conditions of administrative claims were analyzed to assess the appropriateness of similar beneficiary comparison group options. This exploratory analysis further aided in the development of the next section, Evaluation Hypotheses and Research Questions of the evaluation design.

Twelve medical and six behavioral health conditions were selected based on the top volume of primary diagnosis conditions from the TEFRA-like population. An analytical review on the number and percentage of claims for these 12 medical and six behavioral health conditions were calculated to obtain a majority of claims from both medical and behavioral health condition types. Per DMS Medical Director's guidance, this list of conditions was narrowed to five behavioral health conditions (see **footnote 1**) and four medical conditions (see **footnote 2**). Over 57% of claims from the non-TEFRA-like beneficiaries account for the five selected behavioral health conditions and four selected medical conditions.

This comparison group will be used on relevant claims-based settings for selected hypotheses under the next section. This will allow the state on specific evaluation design outcomes and metrics to compare TEFRA-like population to non-TEFRA-like population with similar beneficiary primary diagnosis conditions.

Table 1 displays beneficiary counts for the four medical and five behavioral health conditions described above based for selected primary diagnosis conditions. Some beneficiaries could have more than one primary diagnosis condition assigned but almost 1,000 (n = 990) of the TEFRA-like population have *Child/Adolescent Emotional Disorders* and almost 800 (n = 793) have *Other Congenital Anomalies.* The behavioral health condition of *Attention Deficit Hyperactivity Disorders* accounts for 14% of the primary diagnoses in the target group and over 50% in the comparison group. Ranked second on primary diagnosis groupings for the non-TEFRA-like beneficiaries is *Mood Disorders* affecting 27% of the population, which on the other hand affects only 5% of the TEFRA-like population.

Also, the two behavioral health conditions of *Anxiety/ Nonpsychotic Disorders* and *Adjustment Disorders* affects 18% and 17% of the non-TEFRA-like population, respectively.

Table 1. Number and Percentage of Beneficiaries on Selected Primary Diagnosis Conditions

Selected Primary Diagnosis Condition	Condition Type	# of TEFRA-Like Beneficiaries	% of TEFRA-Like Beneficiaries	# of Non-TEFRA-Like Beneficiaries	% of Non-TEFRA-Like Beneficiaries
Child/ Adolescent Emotional Disorders	Behavioral Health Condition	990	17.72	6,779	7.27
Other Congenital Anomalies	Medical Condition	793	14.19	7,527	8.08
Attention Deficit Hyperactivity Disorders	Behavioral Health Condition	772	13.82	46,937	50.37
Anxiety/ Nonpsychotic Disorders	Behavioral Health Condition	388	6.94	16,419	17.62
Mood Disorders	Behavioral Health Condition	298	5.33	24,861	26.68
Cardiac and Circulatory Congenital Anomalies	Medical Condition	283	5.06	3,466	3.72
Nervous System Congenital Anomalies	Medical Condition	192	3.44	997	1.07
Adjustment Disorders	Behavioral Health Condition	102	1.83	15,500	16.63
Hereditary and Degenerative Nervous Sys Conditions	Medical Condition	59	1.06	489	0.52

In addition, the volume of TEFRA-like beneficiaries receiving occupational, physical and speech-language pathology therapy services during CY2016 was examined. Findings show that at most 54% of TEFRA-like population had at least one therapy service and majority of beneficiaries were between three to 11 years of age (see **Table 2**). Beneficiaries covered by the TEFRA-like demonstration are eligible because of their significant health conditions; therefore, analyzing the distributions of characteristics related to health conditions types and selected diagnosis groupings helps frame the therapy utilization characteristics already presented, as well as other aspects of the evaluation design.

Table 2. TEFRA-Like Beneficiary Frequency by Age for Therapy Services

Therapy Services	1 – 2 Years of Age	3 – 6 Years of Age	7 – 11 Years of Age	12 – 15 Years of Age	16 – 18 Years of Age	Total # of TEFRA-Like Beneficiaries (%)
Occupational Therapy	324	1,348	925	334	126	**3,057 (54%)**
Physical Therapy	305	1,085	692	281	131	**2,494 (44%)**
Speech Therapy	306	1,311	792	300	105	**2,814 (50%)**

Comparison Population

For an accurate comparison to the TEFRA-like population on claims-based outcomes (as described in **Table 1**), beneficiaries who are not enrolled in TEFRA-like services but are enrolled in Medicaid with similar medical and behavioral health conditions (selected primary diagnosis conditions) will be used as a comparison population. Additionally, this comparison population will capture those beneficiaries enrolled in Medicaid not responsible for paying TEFRA premiums for their Medicaid coverage. Ninety-seven percent of non-TEFRA-like population had at least one Medicaid segment during January 1, 2016 - December 31, 2016 measurement period. Equivalent findings for the non-TEFRA-like population of children ages 19 and under were observed on the length of Medicaid segments. The majority of the population had 12-month enrollment during the year on Medicaid segments. With respect to demographic characteristics, 42% of non-TEFRA-like population were females and the majority were between the ages of 5 and 16, 48% were white[3], and 74% resided in the Northwest and Central parts of the state.

II. Evaluation Hypotheses and Research Questions

Driver Diagram

In order to effectively assess if the demonstration is achieving each of the state's four goals, we need to develop a strong evaluation design. An important part of that process is to develop a driver diagram to help depict clearly the fundamental relationship between the primary drivers, secondary drivers, and ultimate aims of the demonstration. In order to provide a visual display of DMS's theory of what "drives" or contributes to the achievement of the demonstration goals, a driver diagram is provided in **Appendix A**. One of the primary drivers contributing directly to achieving *Goal 1 of Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population* is proportion of days covered for prescriptions, which in turn

[3] And another 29% unknown, 15% black/African American, and 8% other.

might be driven by factors such as average cost per prescription per beneficiary and prescription per beneficiary per month (PBPM) – regarded as the secondary drivers for the ultimate aim in this depiction. One moderating factor to examine is third-party liability (TPL) coverage of enrolled TEFRA-like beneficiaries. Based upon exploratory analysis, over 67% of the TEFRA-like beneficiaries have TPL coverage during CY2016 measurement period. This is vastly different compared to the corresponding rate for the Medicaid non-TEFRA-like beneficiaries at 6% in CY2016. TPL coverage could have an impact on metric calculations and when comparing to Medicaid non-TEFRA-like beneficiaries.

Evaluation Hypotheses and Research Questions

The TEFRA-like demonstration's four goals showcase the Centers for Medicare & Medicaid Services' (CMS) three-part aim of better care for individuals, better health for population and lower costs. The ultimate success of those goals will be evaluated through the deploying the evaluation design, which is organized around nine hypotheses and 28 research questions.

Goal 1: Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population

DMS's mission statement is, "To ensure that high-quality and accessible healthcare services are provided to citizens of Arkansas who are eligible for Medicaid or Nursing Home Care." This statement aligns with the intent of evaluating the success of the demonstration by analyzing health services used by the TEFRA-like beneficiaries compared to the non-TEFRA-like beneficiaries. Primarily, under Goal 1 the evaluation will assess the utilization rates of speech, occupational, and physical therapy services of TEFRA-like beneficiaries, on how these rates are similar or better compared to those for non-TEFRA-like beneficiaries. Goal 1 has two hypotheses and eight research questions.

Hypothesis 1.1: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for Hypothesis 1.1

1.1a. What are the claim-based rates of TEFRA-like beneficiaries for speech, occupational, and physical therapy services? Does demographics have an impact on the access to health services for speech, occupational, and physical therapy services?

1.1b. How do claims-based utilization rates for therapy service compare to TEFRA Satisfaction Survey scores of getting speech, occupational, and physical therapies?

1.1c. How does PCP access look for TEFRA-like beneficiaries? What age group is the lowest and highest utilizers to preventive care?

Hypothesis 1.2: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for Hypothesis 1.2

1.2a. How does TEFRA-like beneficiaries prescriptions coverage change over time?

1.2b. What geographic regions of the state for TEFRA-like beneficiaries have both low and high access to health services on at least two prescriptions and who achieved a PDC of at least 50%?

1.2c. Are TEFRA-like beneficiaries seeing a change in the level of cost based on the average cost of prescription (Rx) per beneficiary over time?

1.2d. Are TEFRA-like beneficiaries receiving similar or better (Rx) per beneficiary per month (PBPM)?

1.2e. Do TEFRA-like beneficiaries maintain refills on seizure medications over time?

Goal 2: Ensuring demonstration enrollees have access to timely and appropriate preventive care

Under goal 2, frequency of gaps in TEFRA-like coverage and the average length (in months) a TEFRA-like beneficiary is enrolled will be examined. An incentive for a patient to enroll under the TEFRA-like program is to receive the services of speech, occupational, and physical therapy. The state will review the percent of newly enrolled TEFRA-like beneficiaries receiving therapy services within 60 days of enrollment. A marker for timely preventative care will be beneficiary's experience of obtaining care right away. As described in the "Driver Diagram" section, the majority of TEFRA-like beneficiaries have third-party liability coverage, and therefore, the state will research what parts of the state have high and low percentages of TPL coverage. Another indicator for appropriate preventative care is to examine the percent of TEFRA-like beneficiaries who have durable medical equipment coverage. Goal 2 has three hypotheses and eight research questions.

Hypothesis 2.1: **P*reventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar or better over time.***

Research Questions for Hypothesis 2.1

2.1a. How soon after enrollment are newly enrolled TEFRA-like beneficiaries getting access to first health care PCP visit?

2.1b. What is the rate of newly enrolled TEFRA-like beneficiaries receiving speech, occupational, and physical therapies within a certain number of days from enrollment?

2.1c. What is the average length (in months) of TEFRA-like segments within the measurement period?

Hypothesis 2.2: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for Hypothesis 2.2

2.2a. What are the rates of third-party liability (TPL) coverage?

2.2b. Are TEFRA-like beneficiaries who have TPL receiving preventive care with a PCP visit?

2.2c. What geographic regions of the state have high percentages of TPL coverage? What geographic regions of the state have low percentages of TPL coverage?

Hypothesis 2.3: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Research Questions for Hypothesis 2.3

2.3a. Do TEFRA-like beneficiaries have equal or higher rates of durable medical equipment (DME) coverage?

2.3b. What are the top five primary diagnosis conditions/codes and condition types for TEFRA-like beneficiaries who have durable medical equipment (DME) coverage?

Goal 3: Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received

Patient experience with the TEFRA-like demonstration program over time will be assessed by analyzing responses from the TEFRA Beneficiary Satisfaction Survey domains of “Getting care quickly”, “How well doctors communicate”, and “Overall health care”. In addition, the percentage of TEFRA-like beneficiaries who have DME will be compared to Consumer Assessment of Health Care Providers and Systems (CAHPS®)-like survey domain score of “Special equipment and supplies”. An indicator of comparing the TEFRA-like plan with other health plans, will be used to investigate the impact on patient experiences on health care services. This will be determined by comparing responses pre enrollment of six months to post enrollment in the TEFRA-like program.

Goal 3 has two hypotheses and six research questions.

Hypothesis 3.1: ***Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration has remained the same or improved over time.***

Research Questions for Hypothesis 3.1

3.1a. Have TEFRA-like beneficiaries' experience scores of getting care quickly improved or stayed the same over time?

3.1b. Do TEFRA-like beneficiaries have confidence in how well doctors communicate?

3.1c. Is the overall health care rating showing improvement over time?

Hypothesis 3.2: ***Patient's experience with access to health care services improve with enrollment into TEFRA-like program.***

Research Questions for Hypothesis 3.2

3.2a. Are TEFRA-like beneficiaries' experiencing better access to health care when seeing a personal doctor or nurse with enrollment into TEFRA-like program?

3.2b. Are TEFRA-like beneficiaries' experiencing better pharmacy access on prescription medications with enrollment into TEFRA-like program?

3.2c. Are TEFRA-like beneficiaries' experiencing any problems when needing urgent care access with enrollment into TEFRA-like program?

Goal 4: Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low

How much of a financial burden of the TEFRA-like premiums will be is an important way to gauge beneficiaries experience on health care access and financial impact. This will be analyzed from respondents perceiving premiums as a financial burden from the TEFRA Beneficiary Satisfaction Survey. Also, the reported TEFRA-like premium range will be studied over time to access the differences for respondents paying the program premiums as a financial burden. Goal 4 has two hypotheses and six research questions.

Hypothesis 4.1: ***Premium barriers for TEFRA-like beneficiaries will remain stable over time.***

Research Questions for Hypothesis 4.1

4.1a. What is the percentage of TEFRA-like beneficiaries experiencing a premium barrier?

4.1b. How does the premium range differ of those experiencing a premium barrier?

Hypothesis 4.2: ***Reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access.***

Research Questions for Hypothesis 4.2

4.2a. What are the top five reasons why Arkansas TEFRA-like beneficiaries' cases were closed?

4.2b. How does patient perception of 'getting care quickly' during lockout periods compare with similar perceptions among enrolled patients?

4.2c. How difficult it is to get speech, occupational, and physical therapy during lock-out period?

4.2d. What are the types of medical services that were not met for patients experiencing a lockout period? How does this patients experience vary by common diagnosis?

III. Methodology

Evaluation Design Summary

Arkansas will analyze the hypotheses and drivers described in **Appendix B** to address the four goals as listed in the approved Special Terms and Conditions (STCs) document. By examining the hypotheses and research questions listed in the "Evaluation Hypotheses and Research Questions", we will assess the performance of the demonstration and its potential effect on TEFRA-like population. As illustrated in **Appendix C**, each hypothesis includes two or more research questions which then help assess the desired evaluation outcome and metric. Wherever feasible, survey-based outcomes (more on surveys discussed below) will be in a standardized form comparable to and compared against national values. The evaluation design will exam demonstration's performance on a set of outcomes and metrics along with beneficiary's experience scores over accessibility, therapy services, overall health care, financial burden on TEFRA-like premiums and other relevant scores. DMS and the evaluation contractor will use multiple sources of data for the nine hypotheses and 28 research questions. The evaluation design will provide details of data sources on collected data for both administrative and CAHPS or CAHPS-like survey-based data. The analytic methods will offer quantitative or qualitative approaches to answer the research questions. Both cross-sectional and sequential trend analyses will be used depending on whether the outcome or metric is observed across one point in time or multiple points in time.

Target and Comparison Populations

The target population will include all beneficiaries covered under Title XIX of the Social Security Act in the State of Arkansas, ages 18 or younger, who meet the medical necessity requirement for institutional care, have income that is less than the long-term care Medicaid limit, and do not have countable assets greater than $2,000. The comparison population will include similar age and beneficiary diagnosis characteristics as the TEFRA-like population, which will be used for selected claims-based outcomes and metrics. For additional information of the target and comparison populations, please refer to the "General Background Information" section. A consideration for establishing a comparison group with TEFRA or TEFRA-like programs is to pull relevant material from other states. This material will be reviewed regularly and included within the subsequent evaluation report as a reference list, which will serve as background information.

Evaluation Period

The interim evaluation report will be submitted to CMS on June 30, 2021 and summative evaluation report will be provided by June 30, 2024. The observation period of interest will include the years 2018 – 2022 for both claims-based and survey reporting timeframes with the time origin representing over five months prior to the demonstration renewal on May 9, 2018. The measurement period for the interim evaluation report will be years 2018 – 2019 and summative (final) evaluation report will be years 2018 – 2022. **Appendix C** includes more information on dates of service to be included in both the interim and summative evaluations reports as listed on "Measurement Period" row for each metric table.

Data Sources

The Arkansas Division of Medical Services (DMS) and its contractor will use multiple sources of data to assess the research hypotheses. The evaluation design will leverage claims-based administrative data, enrollment data and survey-based scores, as applicable. Administrative data sources include information extracted from DMS' Medicaid Management Information System (MMIS). Accurate and timely data reporting is essential in order for the TEFRA-like evaluation to be successful in achieving its goals of accessibility to health services, beneficiary experience in program and affordable premiums. In order to meet this requirement, the contractor will use its own Arkansas Medicaid Data Warehouse, vendor approved priority warehouse system. Data analytics will be performed without direct engagement from the State, as to avoid biased opinion or skewed results. The data evaluator will run the analytics and provide data as necessary for the analysis. Data from administrative claims will be used and will not alter input data or the output of results.

Administrative Data

The Medicaid Management Information System (MMIS) data source is used to collect, manage, and maintain Medicaid beneficiary files (i.e., eligibility, enrollment, and demographics) and fee-for-service (FFS) claims. Use of FFS claims will be limited to final, paid status claims. Interim transaction and voided records will be excluded from all evaluations, because these types of records introduce a level of uncertainty that can impact reported rates. The contractor will use raw, full sets of Medicaid data, which is provided on a weekly basis consisting of claims, provider, beneficiary, and pharmacy data subject areas. To ensure accurate and complete data, the contractor's Arkansas Medicaid Data Warehouse will utilize the pre-snapshot data claims process and will require a minimum three-month lag to allow time for the majority of claims to be processed through the MMIS. The contractor will use fee-for-service claims and follow Healthcare Effectiveness Data and Information Set (HEDIS®) or CMS Core Set national specifications for national metrics. Applicable claim types, such as institutional, professional, and pharmacy claims will be used to calculate the various evaluation design metrics while beneficiary demographic files will be used to assess beneficiary age, gender, and other demographic information. Eligibility files will be used to verify a beneficiary's enrollment in the State's Medicaid programs. Each metric (see **Appendix C**) associated with each research hypothesis lists the data source(s) used in addressing it.

Survey Data

TEFRA Beneficiary Satisfaction Survey

The TEFRA Beneficiary Satisfaction Survey is designed and based on the CAHPS® 5.0H Medicaid Child survey and covers topics such as getting care quickly, how well doctors communicate, and access to care, among others. This instrument can include specific survey items designed to elicit information that addresses research hypotheses regarding the financial burden of the program and access to medical equipment and medical therapies. On an annual basis, the TEFRA Beneficiary Satisfaction Survey (TEFRA survey) has been conducted by the Arkansas Division of Medical Services (DMS) in collaboration with the Arkansas Foundation for Medical Care (AFMC), a National Committee for Quality Assurance (NCQA) Certified Healthcare Effectiveness Data and Information Set (HEDIS®) survey vendor. All beneficiaries in the TEFRA-like demonstration will be included in the analyses. The TEFRA survey will follow a traditional NCQA sampling strategy—1,650 beneficiaries will be randomly selected from the Medicaid Management Information System (MMIS). To be eligible for the study, beneficiaries must be enrolled in the program for at least six months, with no more than one 30-day gap in enrollment.

TEFRA Disenrollee Beneficiary Survey

The survey vendor also conducted a TEFRA Disenrollee Beneficiary Survey, which is administered on as needed basis and is a CAHPS-like survey. Survey was modeled after the CAHPS® 5.0H Medicaid Child survey. This additional survey was first conducted in 2018 by AFMC and used to assess the impact of premium contributions by asking additional questions of beneficiaries who were disenrolled from the program. Results provided important information about TEFRA premiums and the experiences of those who lost TEFRA coverage. The disenrollee survey looks at the reasons TEFRA beneficiaries were disenrolled and if disenrollment was voluntary. Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by one beneficiary per household where the youngest beneficiary was utilized for survey purposes.

Medicaid ARKids A and ARKids B Beneficiary Surveys

For additional survey outcomes, two other surveys overseen by the survey vendor will be used as potential sources of data for plausible comparison groups. The ARKids First A and ARKids First B beneficiary survey results and applicable national rates will be addressed.

The ARKids First A beneficiary survey is a CAHPS® 5.0H Medicaid Child survey and is currently conducted every two years. Thus, monitoring results provided during the year ARKids First A not being conducted will include previous survey year's results. The CAHPS 5.0H Medicaid child survey has included five composite measures, four rating questions, two question summary rates and five effectiveness of care measures. NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Due to the state's enrollment data being reported monthly, the survey vendor set the criteria at 30 days. The sampling frame for children consisted of all ARKids First A Arkansas Medicaid primary care case management (PCCM) enrollees who were 17 years old or younger as of the end of the reported calendar year. The child beneficiaries' six-month continuous enrollment began six months prior to the reported calendar year. Beneficiaries selected within the last 24 months were excluded from the population and only one beneficiary per household was selected.

The beneficiary satisfaction survey for the ARKids First B is a CAHPS-like survey and is currently conducted on an annual basis. The survey was adopted using HEDIS/CAHPS® guidelines and protocol, from the CAHPS 5.0H survey to assess beneficiaries' experiences with their health plans.

The ARKids First B beneficiary survey has included five composite measures, six rating questions and two summary rates. Survey vendor used a systematic sampling method as provided by NCQA's protocol for administering HEDIS/CAHPS surveys. Similar to ARKids First A, the criteria at 30 days was used because the enrollment data are reported monthly. The sampling frame consisted of all ARKids First B PCCM enrollees ages 17 and younger as of the end of the reported calendar year. The beneficiaries' six-month continuous enrollment began six months prior to the reported calendar year. Beneficiaries selected for other surveys within the last 12 months were excluded from the population this year, and only one beneficiary per household was selected.

Medicaid Survey Comparison

A comparison group for selected metric on the survey-based questions (i.e. timely and appropriate preventive care) will use a variety of state driven beneficiary satisfaction surveys. As an example, selected composite (i.e. *Getting care quickly* and *How well doctors communicate*) and individual scores (i.e. *Rating of health care*) from TEFRA beneficiary survey results if applicable will be compared to ARKids First A and First B beneficiary survey results. Also, TEFRA disenrollee beneficiary survey results, if available, will be compared to TEFRA beneficiary survey results in the domain of *Special equipment and supplies*. When possible, evaluation survey results will incorporate national survey results provided by National CAHPS Benchmarking Database (NCBD) for comparison purposes (see **Appendix C**, under "National Benchmark" row for applicable metrics). The NCBD is a national repository funded by Agency for Healthcare Research and Quality (AHRQ) containing data from the CAHPS health plan survey to provide comparative data on health plans.

Analytic Methods

The evaluation design will use univariate and bivariate analyses to test the hypotheses associated with the goals of the TEFRA-like program and related research questions. Univariate analyses will be used to compute metrics such as central tendency (i.e., mean, mode, and median), spread (i.e., range, variance, max, min, quartiles and standard deviation) and frequency distributions. The evaluation design will discuss the generalization of results in the context of data limitations. Statistical testing such as t-tests, chi-square testing with 95% confidence intervals will be utilized and regressions analysis will be reviewed in the evaluation design to determine differences and correlations, as feasible. **Appendix C** specifies the comparison strategies, descriptions of outcomes and metrics, high-level technical specifications, data sources, and analytical approaches for each hypothesis. Appropriate statistical analyses will be selected for each hypothesis.

The two main analytic methods used to determine whether the beneficiaries in the TEFRA-like population are doing as well or better than non-TEFRA-like Medicaid beneficiaries in the traditional Medicaid program with the selected primary diagnosis conditions on the various metrics in the evaluation are cross-sectional analysis, such as the t-test and longitudinal data analysis, such as linear mixed models. The t-test will be used for TEFRA-like vs. non-TEFRA-like single group methods of assessment as well as for cross-sectional comparisons of two groups at one point in time. A chi-squared test will be used to compare the proportion of respondents' experience on selected questions from TEFRA Beneficiary Satisfaction Survey compared to similar questions from Medicaid ARKids A and ARKids B Beneficiary Surveys. The longitudinal nature of the data will be exploited to establish trends in outcomes for the TEFRA-like population trend.

Evaluation Outcomes and Metrics

Appendix C exhibits the evaluation design outcome and metric description names along with numerator and denominator descriptions. If applicable for benchmarking, analysis will use data from publicly available national surveys. Outcomes such as quality of care, access to health care, health outcomes, and beneficiary experience will be examined. In learning from previous evaluation design results and experience of state specific data, Arkansas has value-added components to its current evaluation design. For example, Arkansas included specific TEFRA-like DMS homegrown metrics for evaluation design approach (see **Appendix C** Metric 2.2a as an example). TEFRA-like population homegrown metrics were developed with oversight from Arkansas' Medical Director and driven from exploratory analysis of CY2016 findings. Also, Arkansas will use national selected evaluation design metrics as provided in CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP[4] and Pharmacy Quality Alliance (PQA-like)[5] sources.

IV. Special Methodological Considerations

The demonstration evaluation from the perspective of beneficiaries provides an opportunity to understand the impact of services that improve or maintain a child's health, or prevent a child's health from getting worse. Two methodological considerations that have impacted our choice of evaluation approaches include: 1) the long standing nature of the TEFRA-like program with a lack of baseline data, and 2) the difficulty of identifying a comparison group for the specificities of the target population. Since the program was launched many years ago, a true baseline in which a similar group can be compared year over year is difficult to establish. Additionally, since the program has a

[4] Centers for Medicare & Medicaid Services, Children's Health Care Quality Measures. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[5] Pharmacy Quality Alliance. https://www.pqaalliance.org/pqa-measures.

very specific population of TEFRA-like beneficiaries, the complexity of determining a true comparison population is challenging. The target population consists of a small sample size of less than 6,000 beneficiaries. As such, the comparative methods are descriptive and will include survey comparisons of TEFRA beneficiary survey results to ARKids First A and First B beneficiary survey results. If feasible, evaluation survey results will incorporate national survey results provided by the National CAHPS Benchmarking Database (NCBD) for comparison purposes.

Methodological Limitations

The evaluation design has limitations on the lack of a truly comparative TEFRA-like population for selected metrics. TEFRA-like enrollees may not have prior Medicaid coverage, thus there are limitations around baseline values for the evaluation design metrics. The design will treat Year 1 of the current demonstration period of performance, 2018, as a baseline from which to measure changes over the course of the demonstration, and will analyze survey scores on patient's health care plan experience in the six months before enrolling in TEFRA (pre-TEFRA) compared to post enrollment in the TEFRA health plan (post-TEFRA). The evaluation will also conduct an in-state analysis comparing TEFRA-like population to a group with similar primary diagnosis conditions as a "comparison population". Another drawback related to surveys is getting scores on an annual basis for comparison from the ARKids First A beneficiary survey. A comparison will be evaluated every two years due to the survey being conducted every two years to address this challenge.

Attachments

Appendix A. Driver Diagram

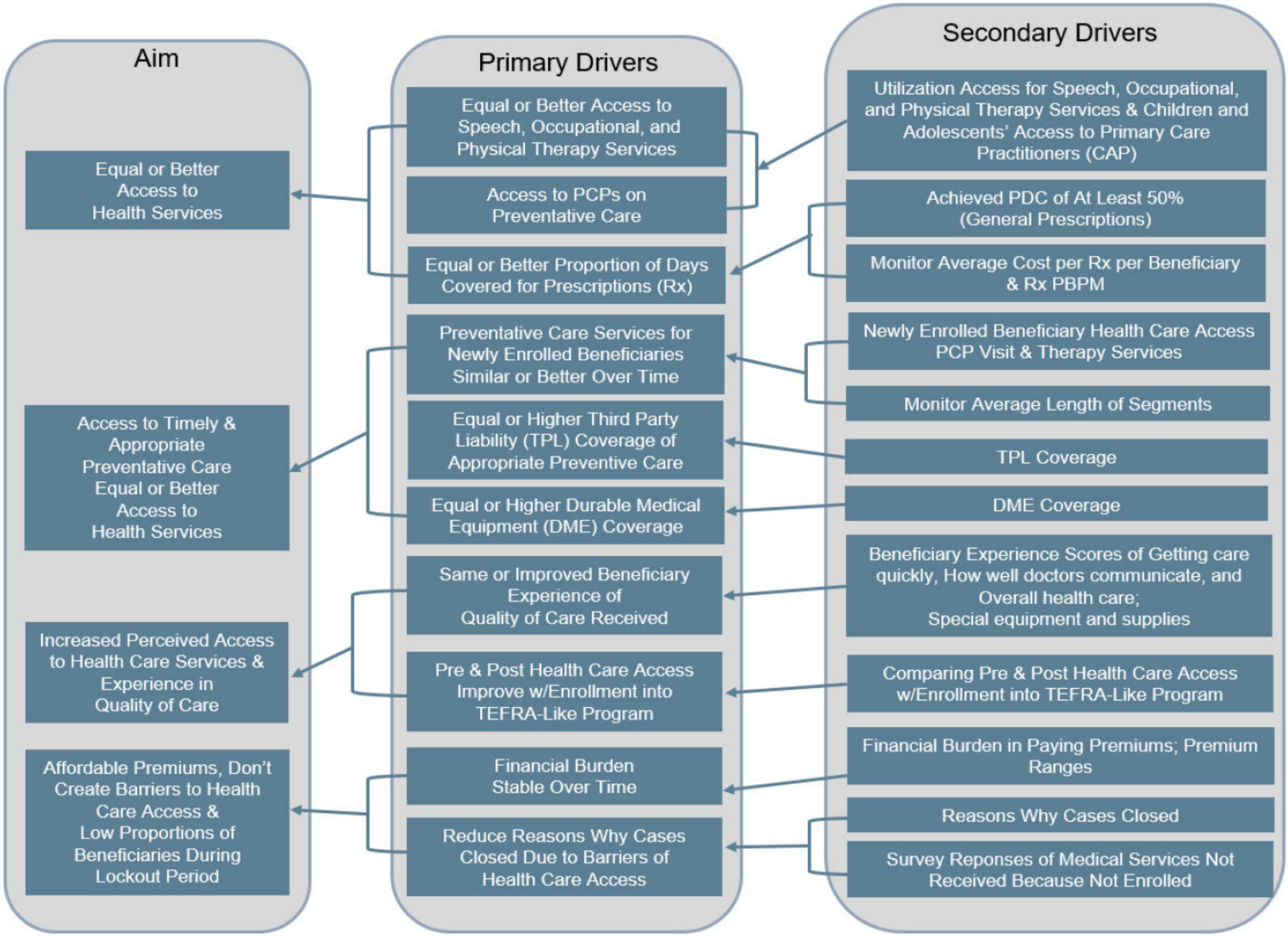
Appendix B. Four Goals with Evaluation Hypotheses and Drivers

Appendix C. Research Questions, Evaluation Design Outcome and Metrics, Comparison Populations, Data Sources, and Analytic Methods Summary Table

Appendix D. Independent Evaluator

Appendix E. Evaluation Budget

Appendix A. Driver Diagram



#	Goal	Hypotheses	Drivers
1	Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population	Hypothesis 1.1: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Hypothesis 1.2: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).	Utilizing claims-based & beneficiary's experience of therapy services. Examining PCP visits, Rx proportion of days covered, Rx costs and usage of seizure medications.
2	Ensuring demonstration enrollees have access to timely and appropriate preventive care	Hypothesis 2.1: Preventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar or better over time. Hypothesis 2.2: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Hypothesis 2.3: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).	Examining TEFRA-like coverage. Reviewing PCP visits and therapy services access on newly enrolled TEFRA-like beneficiaries. Utilizing beneficiary's experience of access to health care. Investigating TPL and DME coverage.
3	Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received	Hypothesis 3.1: Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration has remained the same or improved over time. Hypothesis 3.2: Patient's experience with access to health care services improve with enrollment into TEFRA-like program.	Utilizing beneficiary's experience of doctor communication and overall health care. Impacts on health care access pre and post.
4	Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low	Hypothesis 4.1: Premium barriers for TEFRA-like beneficiaries will remain stable over time. Hypothesis 4.2: Reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access.	Examining percent of TEFRA-like lockouts and financial burden. Utilizing disenrollees experience of therapy services. Investing reasons why cases were closed.

Appendix C. Research Questions, Evaluation Design Outcome and Metrics, Comparison Populations, Data Sources, and Analytic Methods Summary Table

The nine research hypotheses are grouped according to the four demonstration goals as described in **Appendix B**. The descriptions presented below under each hypotheses specify outcomes and metrics, comparison methods, data sources for the research questions to assess the evaluation design.

For *Goal 1: Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population*, Metrics 1.1a – 1.1c and 1.2a – 1.2d will be used.

Hypothesis 1.1 will compare the access to therapy health care services for beneficiaries in the TEFRA- like demonstration to the beneficiaries in the Medicaid non-TEFRA-like population based on similar beneficiary characteristics. In order to evaluate access to health services across all age groups, comparisons will be made using a HEDIS metric, Children and Adolescents' Access to Primary Care Practitioners (CAP). This metric measures the percentage of beneficiaries who had a visit with a PCP during the measurement year. In exploratory research, results were calculated and reviewed over several national metrics under the Child Core Set and HEDIS metrics such as Well-Child Visits in the First 15-Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, Annual Dental Visit (ADV), and Medication Management for People with Asthma (MMA) but small denominator sizes were not always valid under the TEFRA-like population for comparison to Medicaid non-TEFRA-like population. Contractor will examine access to health services by analyzing survey questions from the TEFRA beneficiary satisfaction survey "In the last 6 months, how much of a problem, if any, was it to get the therapy services your child needed through TEFRA?" Results will be broken down by a) speech, b) occupational, and c) physical therapy services and also a composite score as needed. For comparison between the TEFRA-like and non-TEFRA-like populations, the percentage of beneficiaries who are utilizing each or combination of therapy services will be analyzed using administrative claims during similar performance periods. Hypothesis 1.2 will assess if the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Specifically for Pharmacy Quality Alliance (PQA-like) and home-grown metric of proportion of days covered (PDC) on general prescriptions, the percentage of TEFRA beneficiaries with at least two prescriptions and who achieved a PDC of at least 50% was developed. Seizure medications were analyzed during initial research on the study group. Results showed almost 10% of TEFRA-like beneficiaries had at least two seizure medications filled during CY2016. In addition, the state will analyze the average cost per prescription (Rx) per beneficiary and prescriptions (Rx) per beneficiary per month (PBPM) for the

TEFRA-like population. Hypothesis 1.1 and 1.2 will use a t-test or other applicable bivariate testing to evaluate statistically significant differences between the TEFRA-like demonstration population and the Medicaid non-TEFRA- like population. The analysis will be tested using a significance level of $p < 0.05$.

Hypothesis 1.1: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Metric 1.1a	Claims-based therapy services
Description:	The percentage of beneficiaries < 19 years of age who are utilizing therapy services during the measurement period (By a) speech, b) occupational, and c) physical therapy services)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Numerator is number of beneficiaries < 19 years of age that were continuously enrolled utilizing therapy services during the measurement period (By a) speech, b) occupational, and c) physical therapy services). Therapy Service: Identify beneficiaries who received at least one therapy visit from value set codes as defined below for Occupational Therapy Value Set, Occupational/Physical Therapy Value Set, Physical Therapy Value Set, Speech Therapy Value Set, and Therapy Assistant Modifiers Value Set during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.1a & 1.1b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State."
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.1b	Survey-based therapy services (i.e. special therapies)
Description:	Scores of the TEFRA beneficiary satisfaction survey questions of "In the last 6 months, how much of a problem, if any, was it to get the therapy services your child needed through TEFRA?" (By a) speech, b) occupational, and c) physical therapy services) (Domain: *Special therapies*)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator is number of respondents who answered "Not a problem," in the last 6 months to get therapy your child needed through TEFRA. (By a) speech, b) occupational, and c) physical therapy services). "In the last 6 months, how much of a problem, if any, was it to get the speech therapy your child needed through TEFRA?", "In the last 6 months, how much of a problem, if any, was it to get the occupational therapy your child needed through TEFRA?" and "In the last 6 months, how much of a problem, if any, was it to get the physical therapy your child needed through TEFRA?". (Domain: *Special therapies*).
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	1.1b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Therapy claims-based service rates compare to TEFRA satisfaction survey scores of getting speech, occupational, and physical therapies, where applicable. Trend over time of TEFRA satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 1.1c	Children and Adolescents' Access to Primary Care Practitioners (CAP)
Description:	The percentage of beneficiaries 12 months–18 years of age who had a visit with a PCP. Report four age stratifications. • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–18 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries for a) 12 months – 6 years of age that were continuously enrolled during the measurement period and b) 7 – 18 years of age that were continuously enrolled during the measurement period and year prior to the measurement period. Numerator(s): For 12–24 months, 25 months–6 years: One or more visits with a PCP (Ambulatory Visits

	Value Set) during the measurement period. For 7–11 years, 12–18 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period or the year prior to the measurement period. Count all beneficiaries who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits. In addition, similar check was applied as used for Core Set CAP metric implementation of header billing provider type in ('01' '02' '03' '04' '05' '24' '29' '49' '58' '62' '69' '81'). Numerator is the number of beneficiaries a) 12 months – 6 years of age who had one or more visits with a PCP during the measurement period and b) 7 – 18 years of age who had one or more visits with a PCP during the measurement period or the year prior to the measurement period.
Continuous Enrollment:	For 12–24 months, 25 months–6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For 7–11 years, 12–18 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.1c
Metric Steward:	NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test
National Benchmark:	CMS Core Set Mean Rate Across Reported States by CMS[6]; NCQA's State of Health Report Card (Medicaid HMO)[7]

Hypothesis 1.2: ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Metric 1.2a	Proportion of days covered (PDC) threshold of 50%
Description:	The percentage of beneficiaries < 19 years of age who met the proportion of days covered (PDC) threshold of 50% during the measurement period (General Prescriptions)

[6] CMS annually releases information on state progress in reporting the Child Core Set measures and assesses state-specific performance for measures that are reported by at least 25 states and which met internal standards of data quality. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

[7] NCQA's State of Health Care Quality Report. NCQA produces every year to focus on major quality issues the U.S. faces and to support the spread of evidence-based care. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/.

Technical Specifications:	Denominator: The eligible population. Denominator is number of beneficiaries < 19 years of age who were dispensed at least two prescriptions on two unique dates of service during the measurement period. Numerator(s): Numerator is number of beneficiaries who met the 50% PDC threshold (from Index Prescription Start Date (IPSD) to the end of the measurement period) during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2a & 1.2b
Sub-group:	By parts of the state with low and high access. By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State".
Metric Steward:	PQA-Like/DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.2b	**Average cost per prescription (Rx) per beneficiary**
Description:	The average cost per prescription (Rx) per beneficiary for < 19 years of age that were continuously enrolled during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the total number of prescriptions dispensed for beneficiaries < 19 years of age that were continuously enrolled during the measurement period. If multiple prescriptions are dispensed on the same day, calculate number of unique ICNs. Numerator(s): Calculate the total cost of prescriptions dispensed during the measurement period. Sum across claims on header paid amount for total cost of prescriptions. Numerator is the total prescription costs during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2c
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By gender: Female, Male, and Unknown. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State". Identify the top five prescriptions based upon average cost per prescription (Rx) per beneficiary (or number of beneficiaries). To review the top five prescriptions based upon number of beneficiaries who qualified for

	the denominator.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.2c	**Prescriptions (Rx) per beneficiary per month (PBPM)**
Description:	The prescriptions (Rx) per beneficiary per month (PBPM) for < 19 years of age during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiary months. Beneficiary months are a beneficiary's contribution to the total 12-month enrollment. Beneficiary months are calculated by summing the total number of months each beneficiary is enrolled in the program during the measurement period. Numerator(s): Calculate the total number of prescriptions dispensed during the measurement period. Numerator is the number of general prescriptions filled for beneficiaries during the measurement period. If multiple prescriptions are dispensed on the same day, calculate number of unique ICNs.
Beneficiary Months:	Verify Medicaid enrollment on the last day of each month during the measurement period. Count the month if the beneficiary is enrolled and < 19 years of age.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2d
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.2d	**Anti-Seizure**
Description:	The percentage of beneficiaries < 19 years of age taking at least two seizure medications during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period.

	Numerator(s): Numerator is the number of beneficiaries who have at least two seizure prescriptions during the measurement period. Anti-seizure medications may be dispensed on the same day. 1. At least two medications from Anticonvulsants Medications Value Set (i.e. H4A or H4B). 2. Or one medication from Anticonvulsants Medications Value Set (i.e. H4A or H4B) and at least one medication from Benzodiazepines Medications Value Set (i.e.H8R).
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2e
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

For *Goal 2: Ensuring demonstration enrollees have access to timely and appropriate preventive care*, Metrics 2.1a – 2.1c, 2.2a – 2.2b, and 2.3a will be used.

Hypothesis 2.1 will identify the newly enrolled TEFRA-like beneficiaries and determine the rate of beneficiaries receiving first health care visit to PCP within 60 days of enrollment. Similar analysis on newly enrolled TEFRA-like beneficiaries will calculate the rate of beneficiaries receiving first health care visit to speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period. Exploratory analysis for CY2016 showed that TEFRA-like beneficiaries are enrolled for the vast part of the year (i.e. average length of over 11 months out of a calendar year). Under this hypothesis a trend will evaluate of this a continued pattern or fluctuates year by year.

Under hypothesis 2.2, the percentage of TEFRA-like beneficiaries who have third-party liability (TPL) coverage will be calculated to compare if rates are equal to or higher than the Medicaid Non-TEFRA-like group. The state will determine which geographic regions have low percentages and high percentages of TPL coverage for both target and comparison populations. Lastly, the contractor will investigate if there is a difference between rates of beneficiaries who had at least one Medicaid claim paid by TPL coverage and who had a visit with a PCP during measurement period.

Similar to 2.2, hypothesis 2.3 will study TEFRA-like beneficiaries who have durable medical equipment (DME) services. TEFRA-like beneficiary's primary care physician involvement is important in determining if DME services are medically necessary and prescribed on a

regular basis. Another indication to analyze DME services was found in exploratory analysis of TEFRA-like beneficiaries primary diagnosis groupings. Based on exploratory analysis during CY2016 of selected primary diagnosis group for medical conditions, *Other Congenital Anomalies* was affecting slightly over 14% for the TEFRA-like population. Hypothesis 2.2 - 2.3 will use a t-test or other applicable bivariate testing to evaluate statistically significant differences between the TEFRA-like demonstration population and the Medicaid non-TEFRA- like population. The analysis will be tested using a significance level of $p < 0.05$.

Hypothesis 2.1: ***Preventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar or better over time.***

Metric 2.1a	First health care visit to PCP w/in 60 days
Description:	The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit to PCP within 60 days of enrollment during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of newly enrolled TEFRA-like beneficiaries < 19 years of having an enrollment start date of at least 60 days before the end of the measurement period. Numerator(s): Numerator is the number of newly enrolled TEFRA-like beneficiaries for which the TEFRA-like beneficiary received first health care visit to PCP within 60 days of enrollment during the measurement period.
Newly Enrolled:	Identify newly enrolled TEFRA-like beneficiaries where an enrollment start date is at least 60 days before the end of the measurement period
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1a
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown; CAP Portion: NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Trend over time of TEFRA-like coverage
Comparison Method(s):	Longitudinal data analysis

Metric 2.1b	First health care visit for therapy services w/in 60 days
Description:	The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit for speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of newly enrolled TEFRA-like beneficiaries < 19 years of having an enrollment start date of at least 60 days before the end of the measurement period. Numerator(s): Numerator is the number of newly enrolled TEFRA-like beneficiaries for which the TEFRA-like beneficiary received first health care visit to speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period. Therapy Service: Identify beneficiaries who received at least one therapy visit from value set codes as defined below for Occupational Therapy Value Set, Occupational/Physical Therapy Value Set, Physical Therapy Value Set, Speech Therapy Value Set, and Therapy Assistant Modifiers Value Set during the measurement period.
Newly Enrolled:	Identify newly enrolled TEFRA-like beneficiaries where an enrollment start date is at least 60 days before the end of the measurement period
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as “Out-of-State”.
Metric Steward:	DMS Homegrown; CAP Portion: NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 2.1c	Average length of TEFRA-like segments
Description:	The average length (in months) of TEFRA-like segments for beneficiaries <19 years of age during the measurement period.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of TEFRA-like beneficiaries < 19 years of age enrolled during the measurement period.

	Numerator(s): Calculate the total number of days each TEFRA-like beneficiary is enrolled during the measurement period. Sum across all TEFRA-like beneficiaries for overall total number of days. Numerator is the total number of days across all enrolled TEFRA-like beneficiaries during the measurement period. Average Length in Months: Calculate the average length in months as ((total number of days each TEFRA-like beneficiary is enrolled during the measurement period divided by number of TEFRA-like beneficiaries < 19 years of age enrolled during the measurement period) then divided by 30 calendar days. Outcome is total number of months each TEFRA-like beneficiary is enrolled during the measurement period.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1c
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Trend over time of TEFRA-like coverage
Comparison Method(s):	Longitudinal data analysis

Hypothesis 2.2 ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Metric 2.2a	Third Party Liability (TPL) coverage
Description:	The percentage of beneficiaries <19 years of age who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) that were continuously enrolled during the measurement period. TPL coverage represents where a beneficiary had a TPL claim within the measurement period.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Count all beneficiaries where private insurance amount (header) is > $0 or had a crossover claim (Medicare coverage) during the measurement period. Numerator is the number of beneficiaries who had at least one TPL claim during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.2a & 2.2c
Sub-group:	By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as “Out-of-State”.
Metric Steward:	DMS Homegrown

Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 2.2b	**Third Party Liability (TPL) coverage & CAP**
Description:	The percentage of beneficiaries 12 months–18 years of age who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP. Report four age stratifications. • Children 12–24 months and 25 months–6 years who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–18 years who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) for a) 12 months – 6 years of age that were continuously enrolled during the measurement period and b) 7 – 18 years of age that were continuously enrolled during the measurement period and year prior to the measurement period. Numerator(s): For 12–24 months, 25 months–6 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period. For 7–11 years, 12–18 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period or the year prior to the measurement period. Count all beneficiaries who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits. In addition, similar check was applied as used for Core Set CAP metric implementation of header billing provider type in ('01' '02' '03' '04' '05' '24' '29' '49' '58' '62' '69' '81'). Numerator is the number of beneficiaries who had a visit with a PCP a) 12 months – 6 years of age who had one or more visits with a PCP during the measurement period and b) 7 – 18 years of age who had one or more visits with a PCP during the measurement period or the year prior to the measurement period.
Continuous Enrollment:	For 12–24 months, 25 months–6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For 7–11 years, 12–18 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.2b
Metric Steward:	DMS Homegrown; NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)

Comparison Method(s):	Two-group t-test

Hypothesis 2.3 ***The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).***

Metric 2.3a	Durable Medically Equipment (DME) coverage
Description:	The percentage of beneficiaries <19 years of age who had at least one DME coverage claim that were continuously enrolled during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Numerator is the number of beneficiaries who had at least one DME coverage claim during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.3a & 2.3b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. Identify top primary dx conditions and conditions types on number of claims and beneficiaries <19 years of age who have DME coverage for beneficiaries who qualified for the numerator during the measurement period. To review the top 10 primary diagnosis conditions and condition types (i.e. groupings) by number of claims for beneficiaries who qualified for the numerator. In addition, to review number of beneficiaries for each top 10 primary diagnosis condition. Number of claims and beneficiaries for the top 10 primary diagnosis conditions (based on the total number of distinct claims from the beneficiaries who have DME coverage).
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

For *Goal 3: Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received*, Metrics 3.1a – 3.1c and 3.2a – 3.2c will be used.

TEFRA Beneficiary Satisfaction Survey questions related to access to health care services and quality of care received will be organized into three domains and records beneficiary's experience for each domain. A composite score will be used from each of the three domains.

A composite score domain combines the responses of two or more questions, except for "Overall health care" domain, to obtain a single score. The composite domains represent the percentage of beneficiaries who responded favorably. For example, questions scaled as "Never," "Sometimes," "Usually" and "Always," a favorable response represents the proportion of beneficiaries who selected "Usually" or "Always."

- ***Domain 1 - Getting care quickly:***
  - *Obtaining care right away for an illness/injury/condition*
  - *Obtaining care when wanted, but not needed right away*
- ***Domain 2 - How well doctors communicate:***
  - *Doctors explaining things in an understandable way to your child*
  - *Doctors listening carefully to you*
  - *Doctors showing respect for what you had to say*
  - *Doctors spending enough time with the child*
- ***Domain 3 - Overall health care:***
  - *Rating of health care*

Sequential trend analyses will be used to assess whether beneficiary experience has improved over time or remained the same. The scores, if available, will be compared to both ARKids First A and First B beneficiary survey data. TEFRA Beneficiary Satisfaction Survey asked patients to compare certain aspects of the health care plan their child had in the six months before enrolling in TEFRA (pre-TEFRA) with post enrollment in the TEFRA health plan (post-TEFRA). The three survey questions will be evaluated to determine the impact of patient experience on access to health care services after receipt of enrollment into TEFRA-like program (i.e. questions of "How much of a problem, if any, was it for your child to see a personal doctor or nurse?", "How much of a problem, if any, was it to get your child's prescription medication?", and "How much of a problem, if any, was it for your child to get urgent care?"). A chi-square goodness of fit test will be used to test whether the observed proportions for a categorical variable differ from assumed proportions. The analysis will be tested using a significance level of $p < 0.05$.

Hypothesis 3.1 ***Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration has remained the same or improved over time.***

Metric 3.1a	Survey-based getting care quickly
Description:	The percentage of survey responses marked "Usually" or "Always" (i.e. favorably) for domain of Getting care quickly (i.e. receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed). (Domain: *Getting care quickly*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 2) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed (for each survey question). Questions on Obtaining care right away for an illness/injury/condition ("In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?") and Obtaining care when wanted, but not needed right away ("In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as your child needed?") (Domain: *Getting care quickly*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1a
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report)
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey. Questions on Obtaining care right away for an illness/injury/condition ("In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?") and Obtaining care when wanted, when not needed right away ("In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?").

	Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Metric 3.1b	**Survey-based how well doctors communicate**
Description:	The percentage of survey responses marked "Usually" or "Always" (i.e. favorably) for domain of How well doctors communicate (i.e. Doctors explaining things in an understandable way, Doctors listening carefully to you, Doctors showing respect for what you had to say, AND Doctors spending enough time with you. (Domain: *How well doctors communicate*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 4) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" on Doctors explaining things in an understandable way to your child AND Doctors listening carefully to you AND Doctors showing respect for what you had to say AND Doctors spending enough time with your child (for each survey question). Questions on Doctors explaining things in an understandable way to your child ("In the last 6 months, how often did doctors or other health providers explain things in a way your child could understand?"), Doctors listening carefully to you ("In the last 6 months, how often did your child's doctors or other health providers listen carefully to you?"), and Doctors showing respect for what you had to say ("In the last 6 months, how often did your child's health care professional show respect for what you had to say?"), and Doctors spending enough time with your child ("In the last 6 months, how often did doctors or other health providers spend enough time with your child?"). (Domain: *How well doctors communicate*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report)
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey.

	Questions on Doctors listening carefully to you ("In the last 6 months, how often did your child's personal doctor listen carefully to you?"), Doctors showing respect for what you had to say ("In the last 6 months, how often did your child's personal doctor show respect for what you had to say?"), Doctors explaining things in an understandable way to your child ("In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?"), and Doctors spending enough time with your child ("In the last 6 months, how often did your child's personal doctor spend enough time with your child?"). Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Metric 3.1c	**Survey-based overall health care**
Description:	The percentage of survey responses marked ratings of 8, 9, or 10 (i.e. favorably) for Overall health care. (Domain: *Overall health care*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of 8, 9 or 10. Question on rating of health care, ("We want to know your rating of all your child's health care in the last 6 months from all doctors and other health providers. How would you rate all your child's health care?"). (Domain: *Overall health care*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1c
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report);
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey. Question on rating of health care, where numerator represents responses of 8, 9 or 10, ("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 child's health care in the last 6 months?"). Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Hypothesis 3.2 ***Patient's experience with access to health care services improve with enrollment into TEFRA-like program.***

Metric 3.2a	**Survey-based of Pre-TEFRA vs. Post-TEFRA: Personal doctor or nurse**
Description:	The percentage of survey responses marked "Big or small problem" on "How much of a problem, if any, was it for your child to see a personal doctor or nurse?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on "How much of a problem, if any, was it for your child to see a personal doctor or nurse?".
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2a
Sub-group:	Pre-TEFRA vs. Post-TEFRA
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 3.2b	**Survey-based of Pre-TEFRA vs. Post-TEFRA: Prescription**
Description:	The percentage of survey responses marked "Big or small problem" on "How much of a problem, if any, was it to get your child's prescription medication?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question.

	Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on “How much of a problem, if any, was it to get your child’s prescription medication?”.
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 3.2c	**Survey-based of Pre-TEFRA vs. Post-TEFRA: Urgent care**
Description:	The percentage of survey responses marked "Big or small problem" on “How much of a problem, if any, was it for your child to get urgent care?”.
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on “How much of a problem, if any, was it for your child to get urgent care?”.
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2c
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

For *Goal 4: Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low*, Metrics 4.1a – 4.1b and 4.2a – 4.2d will be used.

Families of children determined eligible for the TEFRA-like program whose annual income after allowable deduction exceeds 150 percent of the federal poverty level are required to pay a monthly premium to participate in the program. Monthly premiums are based on a family's household size, the number of people living in the household, and the annual income as reported to the Internal Revenue Service. Families can deduct $600 for each dependent child living in the home, along with excess medical and dental expenses as shown on Schedule A of the parents' federal tax returns[8]. The beneficiary's experience on TEFRA-like premiums in view of financial burdensome will be evaluated to determine affordability of premiums. Along with testing the stability if the caretaker's experience on TEFRA-like premiums are a financial burden, the premium range (i.e. $20–$41 vs. $208–$250) can provide information on how much these ranges differ. The contractor will review the top five reasons why TEFRA-like beneficiary cases were closed. This will aid in understanding reasons why disenrollment and if child is receiving health care during a closed case. The state will also investigate barriers of therapy services during the patient's lockout period. The three survey questions related to getting special therapies for a) speech, b) occupational, and c) physical therapy will be utilized between TEFRA Disenrollee Beneficiary Survey data and TEFRA Beneficiary Survey data, where applicable for measurement periods. Lastly, the state will compare the common medical services a patient could not get will not enrolled in TEFRA-like program (i.e. regular physician visits, visits to a specialist, emergency room visits, dental visits, prescription medicine, special therapy, and medical equipment) and determine if any overlap exists with the top common diagnosis conditions for the TEFRA-like beneficiaries.

Hypothesis 4.1: ***Premium barriers for TEFRA-like beneficiaries will remain stable over time.***

Metric 4.1a	Survey-based premium barriers
Description:	The percentage of survey responses marked "A big financial burden" on "In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "A big financial burden". Question on "In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?".
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one

[8] https://humanservices.arkansas.gov/about-dhs/dms/tefra/cost.

	gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	4.1a
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 4.1b	**Survey-based premium ranges for premium barriers**
Description:	A cross-table of the survey responses marked "A big financial burden" on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” by the premium ranges survey responses marked on “A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?”
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question of "A big financial burden" on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” Numerator(s): Numerator is the number of survey responses for each premium range. Questions on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” and “A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?”
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	4.1b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

Hypothesis 4.2: Reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access.

Metric 4.2a	Survey-based reasons why cases closed
Description:	Identify the top five reasons why TEFRA-like beneficiary cases were closed from beneficiary satisfaction survey.
Technical Specifications:	Question on "What was the reason that your child's TEFRA case was closed? (Check all that apply)?".
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2a
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	Trend over time of top five reasons why TEFRA-like beneficiary cases were closed

Metric 4.2b	Survey-based getting care quickly for disenrollees
Description:	The percentage of survey (Disenrollee) responses marked "Usually" or "Always" (i.e. favorably) for domain of Getting care quickly (i.e. receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed). (Domain: *Getting care quickly*)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 2) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed (for each survey question). Questions on Obtaining care right away for an illness/injury/condition ("During the period your child's TEFRA was closed, when your child needed care right away, how often did your child get care as soon as he or she needed?"). and Obtaining care when wanted, but not needed right away ("During the time your child's TEFRA case was closed, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as soon as your child needed?"). (Domain: *Getting care quickly*)
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified.

	This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	TEFRA Beneficiary Survey, Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey, where applicable. Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Metric 4.2c	**Survey-based therapy services (i.e. special therapies) for disenrollees**
Description:	Percentage of survey responses marked “Not a problem” by a) speech, b) occupational, and c) physical therapy services
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question (for each survey question). If reviewing composite score, denominator is the number of survey questions (n = 3). Numerator(s): Number of respondents who answered "Not a problem", to get therapy your child needed. (By a) speech, b) occupational, and c) physical therapy services) (for each survey question). Combined scores (percentage) of not a problem of Getting Special therapies for a) speech, b) occupational, and c) physical therapy services divided by number of survey questions (n = 3). Questions on not a problem of Getting speech therapy (“During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the speech therapy your child needed?”), Not a problem of Getting occupational therapy (“During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the occupational therapy your child needed?”), and Not a problem of Getting physical therapy (“During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the physical therapy your child needed?”).
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year’s premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.

Research Question(s):	4.2c
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	TEFRA Beneficiary Survey, where applicable. Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 4.2d	**Survey-based medical services not received for disenrollees**
Description:	Responses to survey question: What types of medical services could you not get for your child because your child was not enrolled in the TEFRA program?
Technical Specifications:	List the top medical services of beneficiaries not enrolled in TEFRA-like program. Question on "What types of medical services could you not get for your child because your child was not enrolled in the TEFRA program? (Check all that apply)?".
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2d
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	Trend over time of top medical services of beneficiaries not enrolled in TEFRA-like program. Review the types of medical services related to the top common diagnosis conditions/codes for TEFRA-like beneficiaries.

Appendix D. Independent Evaluator

Based on State protocols, DMS did follow established policies and procedures to acquire an independent entity or entities to conduct the TEFRA-like demonstration evaluation. The State did either undertake a competitive procurement for the evaluator or did contract with entities that had an existing contractual relationship with the State. An assessment of potential contractors' experience, knowledge of State programs and populations, and resource requirements was determined during selection of the final candidate, including steps to identify and/or mitigate any conflicts of interest.

The contractor evaluator hired to conduct the analysis and write the valuation report is ensured to have no actual or potential conflicts of interests. The state hires a contractor independent from DHS and Arkansas Medicaid. The evaluation design includes a "No Conflict of Interest" signed confirmation statement from the independent evaluator. The federal approval of the TEFRA-like demonstration is prepared upon compliance with a set of Special Terms and Conditions. Specific to the program evaluation, the Special Terms and Conditions outline four goals that the State must investigate. DMS and the evaluator develop multiple hypotheses and research questions around these terms and conditions. The evaluation design includes a discussion of the goals, objectives, hypotheses, and research questions, including those that focus specifically on target and comparison populations, and more generally on beneficiaries and beneficiary's experience of services. The evaluator will continue to maintain separation throughout the demonstration evaluation to avoid potential conflicts of interest.

Appendix E. Evaluation Budget

An estimated total cost for the development and production of the TEFRA-like evaluation design and the resulting TEFRA-like evaluation reports are included in **Table 3.** This includes a breakdown of the estimated cost for staff and administration work, an approximation of cost and overall price to complete the five-year TEFRA-like evaluation. Cost includes data cleaning, analyses and the actual production of the evaluation design and evaluation report deliverables.

Table 3. Total TEFRA-Like Analysis Estimated Costs for Five Year Evaluation

Staff/ Work performed	Costs
Evaluation design/protocol	$9,977.73
Data preparation/cleaning	$21,635.37
Data analysis	$74,686.68
Report production	$12,046.21
Project Planning/Management	$5,647.29
Administration	$58,732.92
Estimated total cost	**$182,726.19**

ABBREVIATED NOTICE FOR PUBLIC COMMENT PERIOD FOR PROPOSED TEFRA SECTION 1115 DEMONSTRATION PROJECT

Pursuant to 42 C.F.R. § 431.408, the Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) issues the following abbreviated notice for the Section 1115 Demonstration Project waiver for the TEFRA program.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave individual states the option to provide health care benefits to children living with disabilities whose family income was too high to qualify for traditional Medicaid. Prior to 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to use the flexibility available within a Section 1115 demonstration waiver to develop and implement a sliding scale premium fee structure based on the family's income, effectively passing a portion of the cost to the eligible child's family.

Today the TEFRA program allows children who require an institutional level of care to remain in their homes and receive the treatment they need in a process that is cost effective and sustainable. Families with annual incomes at or below 150% of the federal poverty level (FPL) are exempted from the premium requirement, and program eligibility is determined solely on the assets and resources of the child. The State's current objective is to continue providing medical services to disabled children eligible for Medicaid under the TEFRA-like 1115 demonstration waiver.

To be eligible for the TEFRA-like demonstration, a child must meet the requirements for medical necessity, appropriateness of care, and financial need. During the current demonstration period, enrollment started at just under 5,000 TEFRA enrollees and peaked at just under 6,000 enrollees by June of 2021.

Individuals enrolled in the TEFRA-like demonstration waiver receive the full range of State Medicaid benefits and services. Services provided under the TEFRA-like demonstration waiver are delivered through the State's existing network of Medicaid providers.

The TEFRA-like demonstration waiver allows the State to require a sliding-scale premium for eligible children based upon the income of the custodial parent(s). A monthly premium can be assessed only if the family income is above 150% of the FPL and more than $25,000. There are no co-payments charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed 5% of the family's gross income. Most clients (between 60% and 70% each year of the demonstration) pay premiums between $20 and $182 per month. In the 2021 TEFRA Beneficiary Survey, just 7% of respondents said the premiums were "a big financial burden." The other 93% said it was only a small financial burden or not a burden at all. The premium payments continue to provide an important offset to the cost of providing this care under the TEFRA program.

During the current demonstration period, the Arkansas TEFRA-like program has consistently operated under the budget neutrality levels set by the program's Special Terms and Conditions. The total expenditures have increased 5% on average each year during the period, while the number of member months increased an average of 4% each year.

Arkansas proposes extending the current TEFRA demonstration with an expected 4.1% annual increase in member months. The per member per month cost will not exceed a 1% annual increase.

The state proposes to continue the TEFRA demonstration with only the following minor changes:

- Enhance the TEFRA program's evaluation methodology by expanding the comparison population, exploring data from the state's All Payer Claims Database and adding a longitudinal analysis.
- Allowing clients with long-term or chronic conditions to obtain a medical redetermination every three years, rather than every year.

The TEFRA full notice is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the full notice and this notice on the DHS website at https://humanservices.arkansas.gov/rules/arkansas-tefra-waiver/

Public comments may be submitted in writing at the above mailing address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 20, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Two public hearings will be held for public comment:

1) The *Task Force on Autism* will meet in Room B of the Mac Building, 1 Capitol Mall, Little Rock, AR 72201 on May 24, 2022, at 1:30 PM. Comments may be submitted at the hearing by the public by sign-up with the Task Force on Autism procedures. If you would like the electronic link, please send request to ORP at ORP@dhs.arkansas.gov.

2) A second public hearing by remote access through a Zoom webinar will be held on June 2, 2022, at 2:30 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/83750606618. The webinar ID is 837 5060 6618. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

Elizabeth Pitman, Director
Division of Medical Services

Probate Notices 1220

admitted to probate as the last Will of the above-named decedent. Contest of the probate of the will can be effected only by filing a petition within the time provided by law. All persons having claims against the estate must exhibit them, duly verified, to the undersigned within six (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate. This notice first published on May 22nd, 2022. Brandon Perry, by Dustin Duke, 415 North McKinley, Ste. 830, Little Rock, AR 72205.

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IN THE CIRCUIT COURT OF SALINE COUNTY, ARKANSAS PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF JAMES ROBERT VINCENT, DECEASED

NO. 63PR-22-169-4

NOTICE OF OPENING ESTATE AND FILING OF CLAIMS

Last known address of decedent: 12834 Yacht Club Circle, Fort Myers, Florida

Date of Death: August 23, 2021

An instrument dated September 3, 2009, and codicil dated June 16, 2011 was on April 22, 2022, admitted to probate as the last will of the above named decedent and the undersigned has been appointed personal representative thereunder. Contest of the probate of the will can be effected only by filing a petition within the time provided by law.

All persons having claims against the estate must exhibit them, duly verified, to the undersigned within six (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate.

This notice first published 15th day of May, 2022.

The name and address of the Representative and his attorney are stated below:

Frank E. Vincent,
Representative of the Estate of
James Robert Vincent,
Deceased
By: Bethany A. Pike, Ark. Bar
No. 2009114
The Elrod Firm
Landers Corp. Plaza, Bldg. 100,
22461 Interstate 30
Bryant, Arkansas 72022
501-847-1311

75552433z

IN THE CIRCUIT COURT OF SALINE COUNTY, ARKANSAS PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF DOUGLAS WILSON, DECEASED

CASE NO. 63PR-22-1

NOTICE OF AFFIDAVIT FOR COLLECTION OF SMALL ESTATE

Name of decedent: Douglas Wilson

Last known address of decedent:3005 Ward Drive, Benton, AR 72019

Date of Death: September 28, 2021

On May 17, 2022, an amended affidavit for collection of small estate by distribute was filed with respect to the estate of Douglas Wilson, deceased, with the clerk of the probate division of the circuit court of Saline County, Arkansas, under Ark. Code Ann. § 28-41-101.

All persons having claims against the estate must exhibit them, properly verified, to the distribute or his or her attorney within three (3) months from the date of the first publication of this notice or they shall be forever barred and precluded from any benefit of the estate.

The name, mailing address, and telephone number of the distribute or the distributee's attorney is:

Carol Wilson
c/o Chasey J. Cox
Newland & Associates, PLLC
2228 Cottondale Lane, Suite 220
Little Rock, AR 72202

This notice first published the 22nd day of May, 2022.

Respectfully submitted,
CAROL WILSON
By and through:
NEWLAND & ASSOCIATES, PLLC
2228 Cottondale Lane Suite 220
Little Rock, AR 72202
(501) 221-9393 telephone
(501) 221-7058 facsimile
/s/Chasey J. Cox
Chasey J. Cox, Ark. Bar # 2009135

75556088f

IN THE CIRCUIT COURT OF YELL COUNTY, ARKANSAS DARDANELLE DISTRICT PROBATE DIVISION II

IN THE MATTER OF THE ESTATE OF BOBBY WOODS, DECEASED

NO. 75NPR-22-35

NOTICE OF APPOINTMENT AS ADMINISTRATRIX

Last known address: 1112 North 6th Street, Dardanelle, AR 72834

Date of Death: July 23, 2019

The undersigned was appointed administratrix of the estate of Bobby Woods, deceased, on May 3, 2022.

All persons having claims against the estate must exhibit them, duly verified, to the undersigned within six (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate.

This notice first published on May 15th, 2022.

Brandie Silva
ADMINISTRATRIX
C/O PAUL A. EDDY
Attorney at Law
P. O. Box 1144
805 West 2nd Court
Russellville, AR 72801
(479) 968-5557

75552155f

IN THE COUNTY COURT OF PULASKI COUNTY, ARKANSAS PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF JENNIFER DAWN HENDERSON, Deceased

CASE NO. 60PR-2022-998-IX

NOTICE OF PROBATE AND FILING OF CLAIMS

Last known address 17723 Bradshaw Rd., Little Rock, AR 72206-6365

Date of Death March 3, 2022

The undersigned was appointed Administrator of the Estate of the above-named Decedent by Order of the Court on the 10th day of May, 2022.

All persons having claims against the estate must exhibit them, duly verified, to the undersigned within six (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate.

Brandon Henderson,
Administrator
c/o Jonathan J. Martin, P.A.
Attorney at Law
PO Box 6421
Hot Springs, AR 71902

75555289z

IN THE PROBATE COURT OF JEFFERSON COUNTY, ARKANSAS PROBATE DIVISION I

IN THE MATTER OF THE ESTATE OF LEODUS FRANKLIN QUALLS, Deceased

NO. 35PR-2022- 148

NOTICE TO INTERESTED PERSONS

Last known address of decedent: 31 Cypress Drive, Pine Bluff, Arkansas 71603

Date of death: March 14, 2022.

An instrument dated July 30, 2020, was, on the 21st day of April 2022, admitted to probate as the Last Will and Testament of the above-named decedent, and the undersigned, OLIVIA SUE BATES, has been appointed personal representative under the Will. Any contest of the probate of the Will can be effected only by filing a petition within the time provided by law.

All persons having claims against the estate shall properly verify such claims and present all such claims to the personal representative or file them with court within three (3) months from the date of the first publication of this Notice, or they shall be forever barred and precluded from any benefit in decedent's estate. However, claims for injury or death caused by the negligence of the decedent shall be filed within six (6) months from the date of the first publication of this Notice, or they shall be forever barred and precluded from any benefit in the estate.

This Notice first published the 15th day of MAY 2022

OLIVIA SUE BATES,
Personal Representative
c/o Jesse L. Kearney #76062
CROSS & KEARNEY, PLLC
Post Office Box 6606
Pine Bluff, Arkansas 71611

75552457f

IN THE PROBATE COURT OF JEFFERSON COUNTY, ARKANSAS FOURTH DIVISION - PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF TRICIA LEIGH SEVIER McCOOL, DECEASED

No. 35PR-22-201

Last known address of decedent: 1507 Dixon Lane Pine Bluff, AR 71603

Date of death: March 23, 2022

The undersigned was appointed Administratrix of the Estate of the above named decedent on the 16th day of May, 2022.

All persons having claims against the Estate must exhibit them, duly verified, to the undersigned within six (6) months from the date of the first publication of this Notice, or they shall be forever barred and precluded from any benefit in the Estate. Claims for injury or death caused by the negligence of the decedent shall also be filed within six (6) months from the date of the first publication of this Notice, or they shall be forever barred and precluded from any benefit in the Estate.

This notice first published the 22nd day of May, 2022

/s/Karen L. Sevier
Karen L. Sevier, Administratrix
22 Hillsboro Drive
Austin, AR 72007

Prepared By:
Ed Daniel IV
Ed Daniel IV Attorney at Law, PLLC Attorney for the Estate
10310 West Markham,
Suite 203 Little Rock, AR 72205-1579
(501) 228-4488
(501) 228-4485 (Fax)

75555947f

IN THE PULASKI COUNTY CIRCUIT COURT PROBATE DIVISION

IN THE MATTER OF THE ESTATE OF FRED T KELTNER, Deceased

CAUSE NO. 60PR-22-951

NOTICE

Last known address of decedent: 100 Audubon Drive-Apt 1008, Maumelle, AR 72113 Date of Death:July 9, 2020

An instrument dated July 27, 2017, was on the day of May 3, 2022, admitted to probate as the Last Will of the above named decedent and the undersigned has been appointed Executrix thereunder. Contest of the probate of the will can be effected only by filing a petition within the time provided by law.

All persons having claims against the estate must exhibit them, duly verified, to the undersigned within three (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate. Provided that claims for injury or death caused by the negligence of the decedent shall be filed within six (6) months from the date of the first publication of the notice, or they shall forever be barred and precluded from any benefit in such estate.

This notice first published the 15th day of May, 2022.

Kristy Sims, Petitioner
c/o Charles L. Carpenter, Jr.
2800 Percy Machin Drive
North Little Rock, AR 72114
501.231.5996
Attorney for Estate

75553067f

NOTICE

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS PROBATE DIVISION

IN THE MATTER OF THE ESTATE OFNO. 60PR-22-957

JERRY WILLIAM SPEARS, DECEASED

Last known address of decedent: 21300 Colonel Glenn Road, Little Rock, AR 72210.

Date of death: December 2, 2020

The undersigned was appointed Administrator of the estate of the above-named decedent on the 9th day of May, 2022.

All persons having claims against the estate, including claims for injury or death caused by the negligence of the decedent, must exhibit them, duly verified, to the undersigned within six (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate.

This notice first published: May 15, 2022.

Brenda Spears, Administrator
21300 Colonel Glenn Road
Little Rock, AR 72210
RMP LLP Attn: Trae Norton
Attorney for Estate
PO Box 1788
Fayetteville, AR 72702

75551981 May 15 & 22, 2022

NOTICE

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS 15th DIVISION

IN THE MATTER OF THE ESTATE OF DOROTHY JEAN HOLLAND, DECEASED

NO. 60PR-22-1024

Last Known Address of Decedent:3203 IMPERIAL VALLEY DRIVE, Little Rock, AR 72212

Date of Death: July 24, 2021

An instrument dated July 27, 1995 was on the 16th day of May, 2022, admitted to probate as the last will of the above named decedent, and the undersigned has been appointed Executor. A contest of the probate of the will can be effected only by filing a petition within the time provided by law.

All persons having claims against the estate must exhibit them, duly verified, to the undersigned within three (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate. Provided, that claims for injury or death caused by the negligence of the decedent shall be filed within six (6) months from the date of the first publication of the notice, or they shall be forever barred and precluded from any benefit in the estate.

This notice first published 22nd day of May, 2022.

Keith Holland
1818 N. Taylor #181
Little Rock, AR 72207

75555067z

NOTICE

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS 15th DIVISION

IN THE MATTER OF THE ESTATE OF OSCAR LEWIS HOLLAND, DECEASED

NO. 60PR-22-1023

Last Known Address of Decedent:3203 IMPERIAL VALLEY DRIVE, Little Rock, AR 72212

Date of Death: January 1, 2021

An instrument dated July 27, 1995 was on the 16th day of May, 2022, admitted to probate as the last will of the above named decedent, and the undersigned has been appointed Executor. A contest of the probate of the will can be effected only by filing a petition within the time provided by law.

All persons having claims against the estate must exhibit them, duly verified, to the undersigned within three (6) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate. Provided, that claims for injury or death caused by the negligence of the decedent shall be filed within six (6) months from the date of the first publication of the notice, or they shall be forever barred and precluded from any benefit in the estate.

This notice first published 22nd day of May, 2022.

Keith Holland
1818 N. Taylor #181
Little Rock, AR 72207

75555069z

THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS, PROBATE DIVISION IN THE MATTER OF THE ESTATE OF ANNETTE M. MERRILL, deceased. Case No.: 60PR-22-955 NOTICE: Last known address of decedent: 3123 W. 11th Street, Little Rock, AR 72204. Date of Death: May 12, 2021. An Affidavit for Collection of Small Estate by Distributee was filed with respect to the estate of ANNETTE M. MERRILL, deceased, with the Circuit Court of Pulaski County, Arkansas, pursuant to Ark. Code Ann. §28-41-101. The legal description of the real property listed in the affidavit is as follows: Lot 7 Block 5 Jones & Worthen Addition also known as 3123 W. 11th Street, Little Rock, AR, Pulaski County, Arkansas. All persons having claims against the estate must exhibit them, properly verified to the distributee or their attorney within three (3) months from the date of the first publication of this notice, or they shall be forever barred and precluded from any benefit in the estate. The name, mailing address, and phone number of the distributee's attorney and affiant are as follows: Adrian Reeder, 108 Spruce Street, Jacksonville, AR 72076. Pamela R. Abrams, AR Bar No.: 2017149, 14500 Wimbledon Loop, Little Rock, AR 72210; (501) 247-8435.

75553914f

Meetings/Hearings 1230

ABBREVIATED NOTICE FOR PUBLIC COMMENT PERIOD FOR PROPOSED TEFRA SECTION 1115 DEMONSTRATION PROJECT

Pursuant to 42 C.F.R. § 431.408, the Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) issues the following abbreviated notice for the Section 1115 Demonstration Project waiver for the TEFRA program.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave individual states the option to provide health care benefits to children living with disabilities whose family income was too high to qualify for traditional Medicaid. Prior to 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to use the flexibility available within a Section 1115 demonstration waiver to develop and implement a sliding scale premium fee structure based on the family's income, effectively passing a portion of the cost to the eligible child's family.

Today the TEFRA program allows children who require an institutional level of care to remain in their homes and receive the treatment they need in a process that is cost effective and sustainable. Families with annual incomes at or below 150% of the federal poverty level (FPL) are exempted from the premium requirement, and program eligibility is determined solely on the assets and resources of the child.

The State's current objective is to continue providing medical services to disabled children eligible for Medicaid under the TEFRA-like 1115 demonstration waiver.

To be eligible for the TEFRA-like demonstration, a child must meet the requirements for medical necessity, appropriateness of care, and financial need. During the current demonstration period, enrollment started at just under 5,000 TEFRA enrollees and peaked at just under 6,000 enrollees by June of 2021.

Individuals enrolled in the TEFRA-like demonstration waiver receive the full range of State Medicaid benefits and services. Services provided under the TEFRA-like demonstration waiver are delivered through the State's existing network of Medicaid providers.

The TEFRA-like demonstration waiver allows the State to require a sliding-scale premium for eligible children based upon the income of the custodial parent(s). A monthly premium can be assessed only if the family income is above 150% of the FPL and more than $25,000. There are no co-payments charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed 5% of the family's gross income. Most clients (between 60% and 70% each year of the demonstration) pay premiums between $20 and $182 per month. In the 2021 TEFRA Beneficiary Survey, just 7% of respondents said the premiums were "a big financial burden." The other 93% said it was only a small financial burden or not a burden at all. The premium payments continue to provide an important offset to the cost of providing this care under the TEFRA program.

During the current demonstration period, the Arkansas TEFRA-like program has consistently operated under the budget neutrality levels set by the program's Special Terms and Conditions. The total expenditures have increased 5% on average each year during the period, while the number of member months increased an average of 4% each year.

Arkansas proposes extending the current TEFRA demonstration with an expected 4.1% annual increase in member months. The per member per month cost will not exceed a 1% annual increase.

The state proposes to continue the TEFRA demonstration with only the following minor changes:

- Enhance the TEFRA program's evaluation methodology by expanding the comparison population, exploring data from the state's All Payer Claims Database and adding a longitudinal analysis.
- Allowing clients with long-term or chronic conditions to obtain a medical redetermination every three years, rather than every year.

The TEFRA full notice is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the full notice and this notice on the DHS website at https://humanservices.arkansas.gov/rules/arkansas-tefra-waiver/

Public comments may be submitted in writing at the above mailing address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 20, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Two public hearings will be held for public comment:

1) The Task Force on Autism will meet in Room B of the Mac Building, 1 Capitol Mall, Little Rock, AR 72201 on May 24, 2022, at 1:30 PM. Comments may be submitted at the hearing by the public by sign-up with the Task Force on Autism procedures. If you would like the electronic link, please send request to ORP at ORP@dhs.arkansas.gov.

2) A second public hearing by remote access through a Zoom webinar will be held on June 2, 2022, at 2:30 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/83750606618. The webinar ID is 837 5060 6618. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

/s/S. Elizabeth Pitman
Elizabeth Pitman, Director
Division of Medical Services

75556757f

AEDD will be having a Board of Director's meeting on Tuesday, June 21st at 11:30 a.m. at AEDD Central Office at 105 East Roosevelt Road, Little Rock.

75556133f

IN THE CIRCUIT COURT OF CHICOT COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES ,PETITIONER

VS.

CASE NO. 09JV-22-54

LASONYA MILLER, PARENTet al, DEFENDANTS

ORDER FOR SERVICE BY WARNING ORDER ON LASONYA MILLER

On this 16th day of May 2022, the above entitled cause of action is presented to the Court upon a Motion for Service as Directed by Court. Based upon the verified motion, the Court, noting the best interests, welfare, health and safety, case plan and appropriate statutory provisions, does hereby FIND, ORDER, ADJUDGE AND DECREE:

1.This Court possesses jurisdiction of the parties and the subject matter before it.

2.Pursuant to paragraph (g)(4) of Rule 4 of the Arkansas Rules of Civil Procedure, service shall be made by publication of this order, published weekly for two consecutive weeks in a newspaper having general circulation in the county where the action is filed. Additionally, the clerk shall conspicuously post this order for a continuous period of 30-days at the courthouse of the county where the action is filed. Proof of service shall be had as set out in of paragraphs (g)(3)(A)-(D) of Rule 4 of the Arkansas Rules of Civil Procedure.

3.Lasonya Miller shall take notice that on May 2, 2022, a petition was filed by the Arkansas Department of Human Services in seeking to adjudicate dependent-neglect to you as to J.F. DOB: 01/11/2005.

4.A hearing on the relief sought by the Arkansas Department of Human Services is scheduled for June 22,2022 at 12:00pm via Zoom teleconference. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services at 1-800-950-5817 or requesting the Court appoint you an attorney.

5.If a last known address is known, the Arkansas Department of Human Services shall mail a copy of the petition or motion and a copy of this order to LaSonya Miller by certified mail, addressed to the person to be served with a return receipt requested and delivery restricted to the addressee or the agent of the addressee.

6.LaSonya Miller shall take notice that unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted or you may be otherwise barred from asserting your interest in this matter.

IT IS SO ORDERED.

HONORABLE TERESA FRENCH
CIRCUIT JUDGE
JUVENILE DIVISION

Prepared by
/s/Gerald Hartley
Gerald Hartley, Bar # 2005107
Attorney for the Petitioner
Arkansas Department of Human Services
PO Box 1350,
Monticello, AR 71657
Phone: (870) 367-6835
ext. 1333
Fax: (870) 367-0916

75555732f

IN THE CIRCUIT COURT OF CONWAY COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PETITIONER

VS.

CASE NO. 15JV-22-20

KIMBERLY WALLACE, PARENT,ZACHARY RUBLE, PARENT, DEFENDANTS

SERENITY RUBLE, FEMALE, DOB: 02-18-2018, JUVENILE, RESPONDENT

WARNING ORDER

TO: KIMBERLY WALLACE, AND TO ALL WHOM IT MAY CONCERN

Take notice that on April 28, 2022 a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Conway County, Arkansas, to have S.R., DOB: 02-18-2018 declared dependent. Such declaration could result in the juveniles' continued removal from your custody and placement in the care of some suitable person, agency or institution.

An adjudication hearing on this matter is scheduled for June 23, 2022 at 10:30 a.m. at the Conway County Courthouse, 117 South Moose Street, Morrilton, AR 72110. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

Circuit Clerk
By: Deputy Clerk

75555945f

IN THE CIRCUIT COURT OF DALLAS COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PETITIONER

VS.

CASE NO. 20JV-22-11

BRITTANY MCDONALD, PARENT, TAMMY RAY, CUSTODIAN, DAVID RAY, CUSTODIAN, BILLY JOE WALTHALL, III, PARENT OF, DEFENDANTS

H. W., DOB: 12/17/2010, FEMALE, RESPONDENT, S. M., DOB: 11/21/2012, FEMALE, RESPONDENT, JUVENILES

ADJUDICATION WARNING ORDER FOR BRITTANY MCDONALD

TO: BRITTANY MCDONALD and all other known and putative fathers.

Take notice that on April 7, 2022, a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Dallas County, Arkansas, to have H. W., DOB: 12/17/2010 and S.M., DOB: 11/21/2012 declared dependent. Such declaration could result in the juveniles' continued removal from your custody and placement in the care of some suitable person, agency or institution.

An adjudication hearing will be held on July 20, 2022 at 1:30 p.m. at the Dallas County Courthouse, Fordyce, Arkansas 71742. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

Putative parents take notice that pursuant to Arkansas state law, you have the right to:

(A) Know the methods of establishing paternity. You can establish paternity by: 1. Proving that you were married to the mother of the child at the time the child was born; 2. Presenting an Acknowledgment of Paternity that has been properly signed and filed with the Arkansas Department of Health, Office of Vital Records; or 3. Proving that a court of competent jurisdiction has entered an order declaring that you are the child's legal father.

(B) Prove that you have had significant contacts with the herein child.

(C) Be heard by the Court.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

/s/Pam Barnes
Circuit Clerk
By: /s/Deputy Clerk
Date: 5-9-2022

75552507z

IN THE CIRCUIT COURT OF GARLAND COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PETITIONER

VS.

CASE NO. 26JV-21-162

MEGAN BERKHEIMER, PARENT, ROMAN LUDACKA, PARENT OF: DEFENDANTS

X.L., FEMALE, DOB: 06/28/2021, JUVENILE, RESPONDENT

WARNING ORDER

TO: ROMAN LUDACKA

Take notice that on April 29, 2022, a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Garland County, Arkansas, to terminate your parental rights to the juveniles, X.L., DOB: 06/28/202. Such declaration could result in termination of your parental rights.

A termination of parental rights hearing on this matter is scheduled for June 22, 2022, at 11:30 a.m., at the Garland County Courthouse, 501 Ouachita Avenue, Room 203, Hot Springs, Arkansas 71901. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and your attorney may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

/s/Jeannie Pike
Circuit Clerk
By: /s/L. M. Johnson
Deputy Clerk
Date: May 10, 2022

75553029z

IN THE CIRCUIT COURT OF GARLAND COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PETITIONER

VS.

CASE NO. 26JV-22-133

AMBER MONTGOMERY, PARENT OF: DEFENDANT

A.B., FEMALE, DOB: 10/06/2014, B.B., MALE, DOB: 05/23/2012, JUVENILES, RESPONDENTS

WARNING ORDER

TO: AMBER MONTGOMERY, AND ANY AND ALL PUTATIVE FATHERS

Take notice that on April 29, 2022. a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Garland County, Arkansas, to have A.B. (DOB: 10/06/2014) and B.B. (DOB: 05/23/2012), declared dependent-neglected. Such declaration could result in the juveniles' continued removal from your custody and placement in the care of some suitable person, agency or institution.

An adjudication hearing on this matter is scheduled for June 22, 2022, at 3:00 p.m. at the Garland County Courthouse, 501 Ouachita Avenue, Room 203, Hot Springs, Arkansas 71901. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

/s/Jeannie Pike,
Circuit Clerk
By: /s/Greta Bates
Deputy Clerk
Date: May 6, 2022

75551960z

IN THE CIRCUIT COURT OF GARLAND COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PETITIONER

VS.

CASE NO. 26JV-22-138

SUMMER PARKER, PARENT, JERRY WAYNE FANT, PUTATIVE PARENT OF: DEFENDANTS

A.P., FEMALE, DOB: 09/05/2019, N.F., FEMALE, DOB: 12/15/2020, JUVENILES, RESPONDENTS

WARNING ORDER

TO: JERRY WAYNE FANT, AND ANY AND ALL PUTATIVE FATHERS

Take notice that on May 2, 2022. a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Garland County, Arkansas, to have A.P. (DOB: 09/05/2019) and N.F. (DOB: 12/15/2020), declared dependent-neglected. Such declaration could result in the juveniles' continued removal from your custody and placement in the care of some suitable person, agency or institution.

An adjudication hearing on this matter is scheduled for June 29, 2022, at 10:00 a.m. at the Garland County Courthouse, 501 Ouachita Avenue, Room 203, Hot Springs, Arkansas 71901. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

/s/Jeannie Pike
Circuit Clerk
By: /s/Greta Bates
Deputy Clerk
Date: May 6, 2022

75551956z

IN THE CIRCUIT COURT OF MILLER COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PLAINTIFF

VS.

NO. 46JV-22-41-2

ROSEMARY BROWN, MOTHER, DEFENDANT

D. B., DOB 12/24/07, B/M, JUVENILE, RESPONDENT

DATRAN JONES, PARENT ,DEFENDANT

S. B., DOB: 12/10/08, B/F, JUVENILE, RESPONDENT

A. B., DOB: 08/23/13, B/F, M. B., DOB: 12/13/14, B/F, C. B., DOB: 04/27/16, B/M, C. B., DOB: 04/02/18, B/M, JUVENILES, RESPONDENTS

ADJUDICATION WARNING ORDER

TO: DATRAN JONES; TORIANO WASHINGTON; ANY AND ALL PUTATIVE FATHERS

Take notice that on April 11, 2022 a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Miller County, Arkansas, to have D.B., DOB: December 24, 2007; S.B., DOB: December 10, 2008; A.B., DOB: August 23, 2013; M.B., DOB: December 13, 2014; C.B., DOB: April 27, 2016; C.B., DOB: April 2, 2018 declared dependent-neglected. Such declaration could result in the juvenile's continued removal from your custody and placement in the care of some suitable person, agency or institution.

An adjudication hearing on this matter is scheduled for June 1, 2022 at 9:00 a.m. at the Hazel Street Courthouse, 305 East 5th St., Texarkana, Arkansas. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

Putative parents take notice that pursuant to Arkansas state law, you have the right to:

(A) Know the methods of establishing paternity. You can establish paternity by: 1. Proving that you were married to the mother of the child at the time the child was born; 2. Presenting an Acknowledgment of Paternity that has been properly signed and filed with the Arkansas Department of Health, Office of Vital Records; or 3. Proving that a court of competent jurisdiction has entered an order declaring that you are the child's legal father.

(B) Prove that you have had significant contacts with the herein child.

(C) Be heard by the Court.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

/s/Mary Pankey
Circuit Clerk
By: /s/Deputy Clerk
Date: May 12, 2022

75553519z

IN THE CIRCUIT COURT OF MISSISSIPPI COUNTY, ARKANSAS OSCEOLA DISTRICT JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PLAINTIFF

VS.

NO. 470 JV-2022-32

LANESHIA WILLIAMS, PARENT, ALFRED THOMAS, PUTATIVE FATHER, TYRONE HALL, PUTATIVE FATHER, DEFENDANTS

PROMISE THOMAS, DOB: 06-24-2020, FEMALE, TYLER HALL, DOB: 09-13-2010, MALE, JUVENILES, RESPONDENTS

ADJUDICATION WARNING ORDER

TO: Laneshia Williams, mother, Alfred Thomas and Tyrone Hall, and all other biological/legal/putative fathers

Take notice that on May 2, 2022, a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Mississippi County, Osceola District, Arkansas, to have Promise Thomas, DOB: 06-27-2020; and Tyler Hall, DOB: 09-13-2010 declared dependent-neglected.

A hearing on the petition to adjudicate is scheduled for June 13, 2022 at 9:30 a.m. at the Mississippi County Courthouse, 200 W. Hale Ave., Osceola, AR. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court appoint you an attorney.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

Leslie Mason, Circuit Clerk
By: /s/DC
Date: 5-9-22 @ 10:30 a.m.

75552304f

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS 8th JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PLAINTIFF

vs.

NO. 60JV-22-71

JADA LATIMER, 10/29/1991, PARENT, DEFENDANTS

S. L.B., MALE, DOB: 01/28/2022 JUVENILE, RESPONDENT

TERMINATION OF PARENTAL RIGHTS WARNING ORDER

TO: ROBERT BAILEY, ANY AND ALL OTHER UNKNOWN LEGAUPUTATIVE FATHERS AND TO ALL WHOM IT MAY CONCERN

Take notice that on May 12, 2022, a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Pulaski County, Arkansas, to terminate parental rights as to the following juvenile: S. L.B., DOB: January 28, 2022.

A hearing on the petition to terminate parental rights is scheduled for June 30, 2022 at 10:45 a.m. at the Juvenile Justice Center, 8th Division, 3001 W. Roosevelt Road, Little Rock, AR., 72204, phone: 340-6700. The hearing will also be heard via Zoom.

Putative parents take notice that pursuant to Arkansas state law, you have the right to:

(A) Know the methods of establishing paternity. You can establish paternity by:

1. Proving that you were married to the mother of the child at the time the child was born;

2. Presenting an Acknowledgment of Paternity that has been properly signed and filed with the Arkansas Department of Health, Office of Vital Records; or

3. Proving that a court of competent jurisdiction has entered an order declaring that you are the child's legal father.

(B) Prove that you have had significant contacts with the herein child.

(C) Be heard by the Court.

/s/Terri Hollingsworth
Circuit Clerk
By: /s/Betty Stewart
Deputy Clerk
Date: May 12, 2022

PREPARED BY:
Kevin Jones, Bar #2014179
Arkansas Dept. of Human Services Office of Chief Counsel
P.O. Box 1437-Slot S280 Little Rock, AR 72203-1437 (501) 320-6322

75553498f

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS 8TH JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PLAINTIFF

VS.

60JV-22-279

CASSANDRA ARMENTO, DOB: 07/12/1979, PARENT, ANDRE' HILL, PARENT, DEFENDANTS

D. H., DOB: 05/14/2007, MALE ,F. C., DOB: 08/27/2018, FEMALE, JUVENILES, RESPONDENTS

ANDRE' HILL, PARENT, ALLEN CONAWAY, PARENT ,DEFENDANTS

D. C., DOB: 08/07/2010, MALE, JUVENILE, RESPONDENT

ANDRE'HILL, PARENT, WENDELL FERGUSON, PARENT, DEFENDANTS

D. F., DOB: 10/09/2013, MALE, JUVENILE, RESPONDENT

ADJUDICATION WARNING ORDER

TO: ANDRE' HILL, WENDELL FERGUSON , ANY AND ALL OTHER UNKNOWN LEGAL/PUTATIVE FATHERS AND TO ALL WHOM IT MAY CONCERN

Take notice that on May 2, 2022 a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Pulaski County, Arkansas, for Ex Parte Emergency Custody as to the following juveniles: D. H., DOB: 05/14/2007; F. C., DOB: 08/27/2018; D. C., DOB: 08/07/2010; and D. F., DOB: 10/09/2013. An Ex Parte Order for Emergency Custody was granted on May 2, 2022.

An adjudication hearing is scheduled for June 21, 2022 at 10:45 a.m. at the Juvenile Justice Center, 8th Division, 3001 W. Roosevelt Road, Little Rock, AR., 72204, phone: 501-340-6668. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court appoint you an attorney.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

/s/Terri Hollingsworth
Circuit Clerk
By: /s/Betty Stewart
Deputy Clerk

Date: May 20, 2022
PREPARED BY:
Kevin Jones, Bar #2014179
Arkansas Dept. of Human Services
Office of Chief Counsel
P.O. Box 1437-Slot S280
Little Rock, AR 72203-1437
(501) 320-6309

75556699f

IN THE CIRCUIT COURT OF WASHINGTON COUNTY, ARKANSAS JUVENILE DIVISION III

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PETITIONER

VS.

CASE NO. 72JV-22-146-3

KELSEY BOWLIN, PARENT, MARK NORRIS, PARENT, DEFENDANTS

E.N., DOB: 01/24/2009, FEMALE

RICHARD CROUCH, DOB: PUTATIVE PARENT, DEFENDANT

A.C., DOB: 08/15/2014, FEMALE, JUVENILES, RESPONDENTS

ADJUDICATION WARNING ORDER

TO: RICHARD CROUCH, AND ANY AND ALL UNKNOWN PARENTS OR PUTATIVE PARENTS

Take notice that on April 8, 2022, a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of Washington County, Arkansas, to have A.C., DOB: 08/15/2014 declared dependent-neglected. Such declaration could result in the juvenile's continued removal from your custody and placement in the care of some suitable person, agency or institution.

An Adjudication & Disposition Hearing this matter is scheduled for June 2, 2022 at 11:00 a.m. with the Washington County Circuit Court, Juvenile Division III, 885 W. Clydesdale, Fayetteville, AR 72701. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

Putative parents take notice that pursuant to Arkansas state law, you have the right to:

(A) Know the methods of establishing paternity. You can establish paternity by: 1. Proving that you were married to the mother of the child at the time the child was born; 2. Presenting an Acknowledgment of Paternity that has been properly signed and filed with the Arkansas Department of Health, Office of Vital Records; or 3. Proving that a court of competent jurisdiction has entered an order declaring that you are the child's legal father.

(B) Prove that you have had significant contacts with the herein child.

(C) Be heard by the Court.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

KYLE SYLVESTER, CIRCUIT CLERK
Washington County Circuit Court
280 N. College Avenue
Fayetteville, AR 72701
By: /s/Ember McIntosh
Deputy Clerk
Date: May 10, 2022

75552632f

IN THE CIRCUIT COURT OF WHITE COUNTY, ARKANSAS JUVENILE DIVISION

ARKANSAS DEPARTMENT OF HUMAN SERVICES, PETITIONER

VS.

73JV-22-64

JENNIFER OTERO,MOTHER, DAVID GRAY, PUTATIVE FATHER OF J.G. AND K.G., JUAN MUNSON, PUTATIVE FATHER OF L.O., DEFENDANTS

J.G., FEMALE, DOB: 12-15-2005, K.G.,FEMALE, DOB: 2-6-2008, L.O., FEMALE, DOB: 1-7-2012, JUVENILES, RESPONDENTS

WARNING ORDER

TO: David Gray and all others claiming parental rights

Take notice that on March 21, 2022 a petition was filed by the Arkansas Department of Human Services in the Circuit Court, Juvenile Division, of White County, Arkansas, to have J.G., DOB: December 15, 2005 and K.G., DOB: February 6, 2008; declared dependent-neglected. Such declaration could result in the juvenile's continued removal from your custody and placement in the care of some suitable person, agency or institution.

A review hearing on this matter is scheduled for July 21, 2022 at 9:00 a.m. at Judge Pate's Courtroom, White County Law Enforement Courts Building, 1600 E. Booth Rd., Searcy, AR 72143. If you desire to be represented by an attorney, you should immediately contact your attorney so that an answer can be filed for you and he may appear with you at any hearing. If you cannot afford an attorney, you may obtain one by contacting Legal Services or requesting the Court to determine if you qualify for appointed counsel.

Putative parents take notice that pursuant to Arkansas state law, you have the right to:

(A) Know the methods of establishing paternity. You can establish paternity by: 1. Proving that you were married to the mother of the children at the time the children were born; 2. Presenting an Acknowledgment of Paternity that has been properly signed and filed with the Arkansas Department of Health, Office of Vital Records; or 3. Proving that a court of competent jurisdiction has entered an order declaring that you are the children's legal father.

(B) Prove that you have had significant contacts with the herein children.

(C) Be heard by the Court.

NOW, unless you appear and defend or otherwise respond within thirty days from the first date of publication of this notice, the Petition may be taken as confessed, and a decree entered and granted.

Tami King
Circuit Clerk
By: Michelle Bui
Deputy Clerk
Date: 5-19-2022

75556325f

Notice of Proposed State Implementation Plan Revision, Public Hearing, and Comment Period

The Division of Environmental Quality (DEQ) is proposing a revision to the Arkansas state implementation plan (SIP). This revision is intended to address a SIP call issued by the United States Environmental Protection Agency (EPA) with respect to a provision in the Arkansas SIP, Arkansas Pollution Control and Ecology Commission Rule 19.602, that provides for an affirmative defense for non-compliance with a technology-based emission limitation during emergency conditions if certain criteria are met. In this SIP revision, DEQ is proposing to remove Rule 19.602 from the federally-enforceable Arkansas SIP. Although this provision would be removed from the federally-enforceable Arkansas SIP, no changes to Rule 19.602 are proposed and the provision will remain in effect as a State-only provision.

Pursuant to Ark. Code Ann. § 8-4-317, DEQ by this notice solicits comments of any interested party to the proposed SIP revision by submitting comments in writing on or before the end of the public comment period, which is June 22, 2022. All comments should be directed to Erika Droke at the electronic mail or physical mail addresses listed below.

Full and complete copies of the proposed SIP revision are available for inspection and review after making an appointment during regular business hours at the DEQ headquarters building, 5301 Northshore Drive, North Little Rock, AR 72118.

A public hearing on the proposed SIP revision will be held on June 22, 2022, beginning at 2:00 p.m. Central Time to accept comments. The hearing will be held in the Commission Room at the E&E headquarters building at 5301 Northshore Drive, North Little Rock, AR 72118. The public hearing may be viewed via live broadcast on the E&E YouTube channel at https://www.youtube.com/channel/UCMr_txlSHivnxRjg3dmOZ0A. If the hearing is postponed and rescheduled, a new legal notice will be published to announce the details of the new hearing date.

Participation may be in person or through the Zoom virtual meetings platform. Written and oral statements may be submitted regarding the proposed SIP for consideration at the Public Hearing. Persons wishing to be recognized to make an oral comment through the Zoom virtual meetings platform during the public hearing must be placed on a "virtual sign-in list" by leaving a voicemail at 501-682-0542 or emailing droke@adeq.state.ar.us before 4:00 p.m., Central Time on the day before the hearing. Persons attending via the Zoom virtual meetings platform may participate using a telephone or internet audio. The Zoom information will be provided to those persons on the virtual sign-in list. A request to be included on the list of commenters must include the name and mailing address of the individual requestor or commenter and, for those wishing to comment via Zoom using telephone access, the commenter's phone number.

Oral and written comments regarding the proposed SIP revision will be accepted at the hearing, but written comments are preferred in the interest of accuracy. In addition, written and electronic mail comments will be considered if received no later than 4:30 p.m., Central Time, June 22, 2022. Written comments should be delivered or mailed to: Erika Droke, Department of Energy and Environment, 5301 Northshore Drive, North Little Rock, AR 72118. Submit electronic comments on the proposed state plan to: airplancomments@adeq.state.ar.us.

The proposed SIP revision is posted to E&E's website at http://www.adeq.state.ar.us/air/planning/sip/.

The deadline for submitting written comments on the proposed SIP revision is 4:30 p.m., Central Time, June 22, 2022.

Published May 22, 2022

Julie Linck, Chief Administrator of Environment,
Division of Environmental Quality

75556121f

NOTICE OF PUBLIC HEARING

North Little Rock Historic District Commission
506 Main Street
North Little Rock, AR 72114
501.371.0755

A meeting of the NORTH LITTLE ROCK HISTORIC DISTRICT COMMISSION will be held at 5:30 P.M. on Thursday, June 9, 2022 at 506 Main Street, North Little Rock, Arkansas.

Public Hearing will be held on the following:

1) 315A Main Street – Construct 36' by 19' outdoor patio in back of the building, with fencing of a 42' high black rod iron picket railing and two 48' wide gates, one close to the building's alley entrance and the other for access to a concrete grease trap.

Sandra Taylor Smith, Director
North Little Rock Historic District Commission
506 Main Street
North Little Rock, AR 72114

75556640z

NOTICE OF RULEMAKING AND PUBLIC HEARING

In accordance with Ark. Code Ann. § 23-2-305, the Arkansas Public Service Commission has set a public hearing in Docket No. 19-069-R to begin at 9:30 a.m. on July 28, 2022, in the Hearing Room of the Arkansas Public Service Commission Building, 1000 Center Street, Little Rock, Arkansas 72201. This docket was initiated for the sole purpose of revising the Arkansas Gas Pipeline Code. The purpose of this hearing is to consider the proposed draft rules and all comments submitted thereon. A copy of the proposed rules may be viewed on the Commission website, located at www.arkansas.gov/psc.

Interested persons who desire to submit written comments in response to Staff's Petition prior to the hearing shall do so no later than noon (12:00 p.m.) on June 22, 2022. Any such written comments shall be submitted to the Office of the Secretary of the Arkansas Public Service Commission for inclusion in this docket to the address listed below or by submitting them electronically via the Commission's website. Any person or entity may offer public comments orally at the hearing.

If you plan to attend the public hearing and need special facilities or assistance relating to a disability, please contact the Secretary of the Commission at (501) 682-5782 no later than three (3) days prior to the hearing.

Further information may be obtained by viewing the Commission's web site at www.arkansas.gov/psc, or by contacting Mary Loos, Secretary of the Commission, at 1000 Center Street, P.O. Box 400, Little Rock, Arkansas 72203-0400, by phone (501) 682-5782, or by e-mail at Mary.Loos@Arkansas.gov.

75553951f

The Sherwood Planning Commission will meet for their regularly scheduled meeting on Tuesday, June 14th, 2022 at 5:00 p.m. in the City Council Chambers at 2201 E. Kiehl Avenue, Sherwood Arkansas. Interested persons should check the City of Sherwood web page at https://www.cityofsherwood.net/AgendaCenter for meeting updates. This is a request for a Rezoning at:

Approximately 1.460 acres of land described as PT LT 1 BEG 50'E OF NE COR LT 1 S0*51'W305.22' S89*59'W212' N0*51'E305.28' E212' TO POB AKA LT 1A of Lot 1, Block 10, Sylvan Hills Addition to the City of Sherwood, Arkansas.

Located at 200 Hillcrest in the City of Sherwood, from R-1 to C-3.

Arkansas Code 14-55-208 has been amended to require that publications made in a newspaper shall have the following statement:

"This publication was paid for by City of Sherwood, Arkansas. The amount to be paid for this publication is $53.32."

75556488z

The Sherwood Planning Commission will meet for their regularly scheduled meeting on Tuesday, June 14th, 2022 at 5:00 p.m. in the City Council Chambers at 2201 E. Kiehl Avenue, Sherwood, Arkansas, to hold two public hearings for Site Plan Review for two Commercial Developments in Sherwood, Arkansas. Interested persons should check the City of Sherwood web page https://www.cityofsherwood.net/AgendaCenter for meeting updates.

Arkansas Code 14-55-208 has been amended to require that publications made in a newspaper shall have the following statement:

"This publication was paid for by City of Sherwood, Arkansas. The amount to be paid for this publication is $38.44."

75556494z

The Sherwood Planning Commission will meet for their regularly scheduled meeting on Tuesday, June 14th, 2022 at 5:00 p.m. in the City Council Chambers at 2201 E. Kiehl Avenue, Sherwood Arkansas. Interested persons should check the City of Sherwood web page at https://www.cityofsherwood.net/AgendaCenter for meeting updates. This is a request for a Rezoning at:

PART OF THE NORTH HALF (N 1/2) OF SECTION 31, T-3-N R-11-W, SHERWOOD, PULASKI COUNTY, ARKANSAS, MORE PARTICULARLY DESCRIBED AS FOLLOWS:

BEGINNING AT THE SOUTHWEST CORNER OF LOT 1, MILLERS VALLEY ADDITION, PHASE I, TO THE CITY OF SHERWOOD, PULASKI COUNTY, ARKANSAS AND THE NORTH RIGHT-OF-WAY OF JOHNSON ROAD, THENCE ALONG SAID NORTH RIGHT-OF WAY N36°00'49"W, 325.91 FEET; THENCE ALONG A CURVE TO THE LEFT HAVING A RADIUS OF 430 FEET AND A CHORD BEARING AND DISTANCE OF N55°48'21"W, 291.20 FEET; THENCE N75°35'52"W, 67.66 FEET; THENCE LEAVING SAID NORTH RIGHT-OF-WAY N16°02'11"E, 428.47 FEET; THENCE S69°39'34"E, 663.31 FEET TO THE ANGLE POINT OF LOT 9, MILLERS VALLEY ADDITION, PHASE 2, TO THE CITY OF SHERWOOD, PULASKI COUNTY, ARKANSAS; THENCE ALONG THE WEST LINE OF MILLERS VALLEY ADDITION, PHASE 2, S47°26'23"W, 120.90 FEET; THENCE S00°50'00"E, 229.54 FEET TO THE NORTHWEST CORNER OF LOT 5, MILLERS VALLEY ADDITION, PHASE I, TO THE CITY OF SHERWOOD, PULASKI COUNTY, ARKANSAS; THENCE ALONG THE WEST LINE OF MILLERS VALLEY ADDITION, PHASE I, S00°50'01"E, 198.16 FEET; THENCE S53°59'11"W, 197.13 FEET TO THE POINT OF BEGINNING, CONTAINING 7.72 ACRES, MORE OR LESS.

Located off of Johnson Road in the City of Sherwood, from R-3 to R-1.

Arkansas Code 14-55-208 has been amended to require that publications made in a newspaper shall have the following statement:

"This publication was paid for by City of Sherwood, Arkansas. The amount to be paid for this publication is $114.08."

75556492z

Alcohol Permits 1240

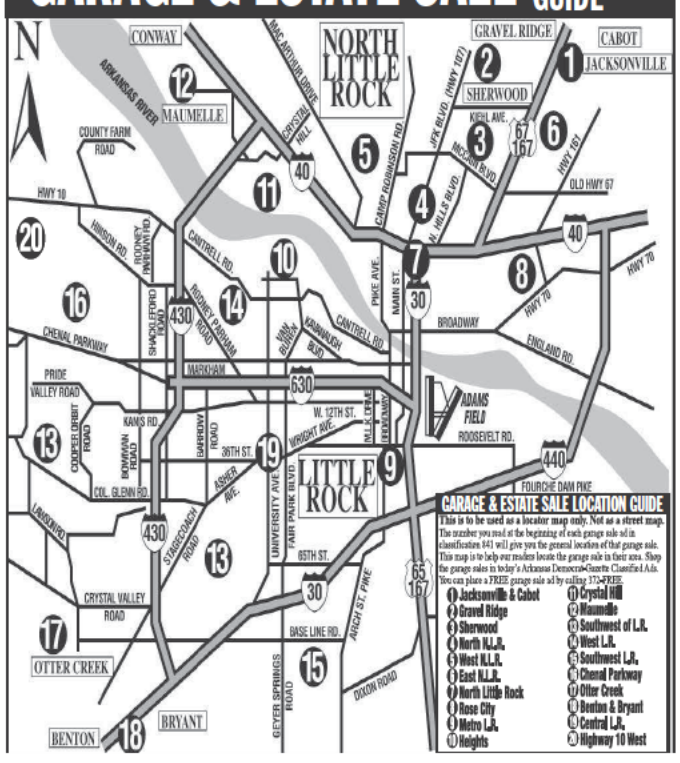
NOTICE OF FILING APPLICATION FOR GROCERY STORE WINE & SMALL FARM WINE, RETAIL PERMITS

Notice is hereby given that the undersigned has filed an application with the Alcoholic Beverage Control Division of the State of Arkansas for permits to sell wines produced at Small Farm Wineries and Grocery Store Wine at retail to be carried out and not consumed on the premises described as: 3100 S. Olive Street, Pine Bluff, Jefferson County.

Said application was filed on April 13, 2022. The undersigned states that he is a resident of Arkansas, of good moral character; that he has never been convicted of a felony or other crime involving moral turpitude; that no license to sell alcoholic beverages by the undersigned has been revoked within five (5) years past; and, that the undersigned has never been convicted of violating the laws of this State, or any other State, relative to the sale of

ATTACHMENT 7

GARAGE & ESTATE SALE LOCATION GUIDE

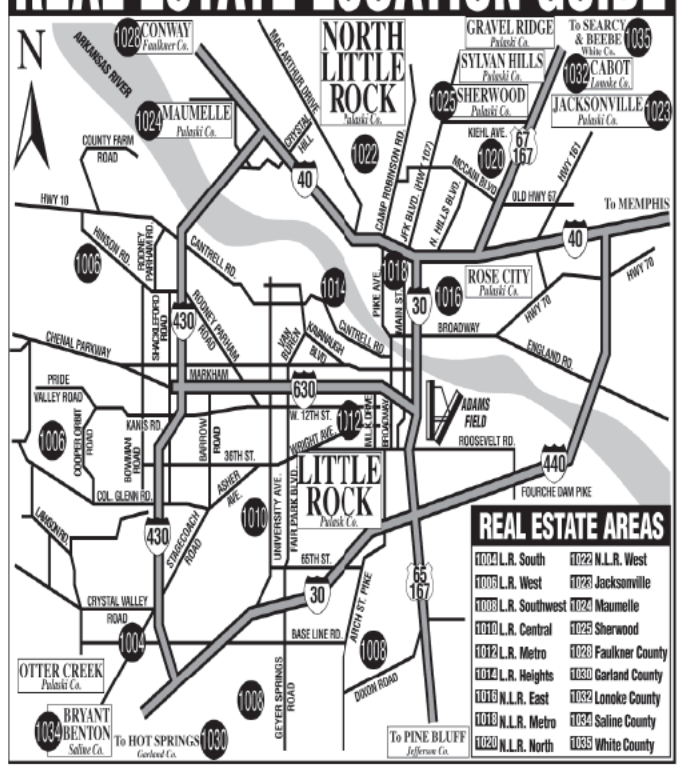


GARAGE & ESTATE SALE LOCATION GUIDE

This is to be used as a locator map only. Not as a street map. The number you read at the beginning of each garage sale ad in classification 843 will give you the general location of that garage sale. This map is to help our readers locate the garage sale in their area. Shop the garage sales in today's Arkansas Democrat•Gazette Classified Ads. You can place a FREE garage sale ad by calling 372-FREE.

1. Jacksonville & Cabot
2. Gravel Ridge
3. Sherwood
4. North N.L.R.
5. West N.L.R.
6. East N.L.R.
7. North Little Rock
8. Rose City
9. Metro L.R.
10. Heights
11. Crystal Hill
12. Maumelle
13. Southwest of L.R.
14. West L.R.
15. Southwest L.R.
16. Chenal Parkway
17. Otter Creek
18. Benton & Bryant
19. Central L.R.
20. Highway 10 West

REAL ESTATE LOCATION GUIDE



REAL ESTATE AREAS

1004 L.R. South	1022 N.L.R. West
1006 L.R. West	1023 Jacksonville
1008 L.R. Southwest	1024 Maumelle
1010 L.R. Central	1025 Sherwood
1012 L.R. Heights	1028 Faulkner County
1014 N.L.R. East	1030 Garland County
1016 N.L.R. Metro	1032 Lonoke County
1018 N.L.R. North	1034 Saline County
	1035 White County

Dogs 710

AUGGIE. 16 week old, UTD on shots and worming. one blue meral, one red meral. $500. 5015933441

AUSTRALIAN SHEPHARDS. REG. UTD ON SHOTS/WORMER TXT OR CALL $250. 870-262-9080

Great DEAL

BEAGLE PUPPIES, AKC w/papers, (3) Tris/9 Lemons, 1st shot, $200 ea. 870-490-1040

BLUE HEELER. Full 1F/4M Royal Call before 8:30 pm DOB 1/15/22 OBO $75. 870-334-2675

BOSTON TERRIER. Black/white, registered ACA, shots/wormed. June 11. $800. 8708307903

BOSTON TERRIER, Toy & Std. Poodle, Fuzzy Mixes, German Shepherd, Terrier Mix, Chiweenie, pottytr & spoilt , $195+ 501-961-1910 NLR

John found Marsha through a personal ad in Classified.

BULL TERRIER. 8 PUPPIES - WHITE & BRINDLE TEXT FOR INFO : NOT REGISTERED $1000. 501-350-1763

CHIHUAHUA . Puppies. ACA registered various ages & colors $500- $600. 501-733-5268

CHIHUAHUA TEACUP PUPPIES, Call 479-264-2664

CHIHUAHUA TEACUP VALENTINE PUPPIES, Blues, Call 479-264-2664

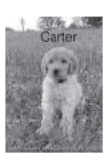
DACHSHUND . Miniature. ACA registered Puppies. Damascus AR $500. 501-733-5268

DOG HOUSE . New Dog Houses, 2'x2'-$50,,2'x3'-$80,,3'x4'-$140. 501-224-6451

F1BB GOLDENDOODLE. Black with markings. 2 Males, 1 Female. call or text $500. 501-286-9095

F1B GOLDENDOODLE. females, ready June 5, vet checked, utd shots. $1200. 8704040127

F1B GOLDENDOODLES . males, ready 6/5/22. Vet checked, utd shots $1000. 8704040127



F1 GOLDENDOODLES . Standard size, ready now, utd shots, vet checked $1000. 8704040127

GERMAN SHEPHERD Pups. AKC, blk/tan, sable. Grt. temperments, Ive VM. $500. 479-244-5070

GERMAN SHEPHERD Pups AKC 8 males, 1 females, Full Reg. $750, AKC pet reg. $550. 479-313-3202

LABRADOR RETRIEVER. Labrador puppies for sale, Russellville area. Two males two females. Both parents are AKC registered and proven hunting retrievers. Ready to go for training for the fall duck season. Vet checked. $950. 479-264-0841 479-747-5298, leave message

MALTIPOO PUPS, Non shedding, hypo allergenic. Red Toy Poodles. Fayetteville 918-649-7004 fishermountainpuppies.com

SIBERIAN HUSKY Puppies For Sale. Black & White, Blue Eyes, $250 each . Call 501-920-8101.

STANDARD POODLE. Brown Merle, parti, abstract and cream. Ready now $700. 8705779628

Dogs 710

LOOK

WESTIE PUP, (F), $1,200. Dachshund Pup, (M), $800. Reg, S&W. Call 870-408-1607

YORKIPOO PUPPIES. Precious first generation babies! Pics/Info on KellyPup.com $750. -$1250

Antiques & Collectibles 808

MUST See!

BEANIE BABIES, 56, selling cheap. Odd features, mint. cond. Under $500. 501-258-6591

Farm Equipment 837

Great DEAL

HAY EQUIPMENT: Hay Baler New Holland, $800. Mower, New Holland, 7', $600. Rake, New Holland, 8 wheels, $1,200. Hay Hauler, holds 5 bales, $750. Call 501-849-2977

Guns & Ammunition 843

18 GUN Steel Security Cabinet . $170. 5015511715

True Life Classified Story: John & Marsha met through a personal ad. After a short courtship, they found their wedding rings and Marsha's bridal gown advertised in the Democrat-Gazette Classified. Once the knot was tied, Marsha found the perfect apartment in town & they lived happily ever after.

44 TAURUS tracker . $825. 5017128006

MUST See!

COLLECTORS FACTORY Engraved Astro Constable 380 $1,550. Call 501-808-8240.

Home Appliances 846

WASHER & DRYER Sets, $375. 3 Large Upright Freezers, $650 & Up. 501-618-1948

Lawn, Garden Supplies 850

2019 JOHN DEERE Z345R Z-TRAK 42-in ZERO TURN MOWER. $850. 870-205-6430

Great DEAL

RIDING LAWN Mowers, have (2), in working cond. $250 each. Call 501-416-6329

Apartments, Furnished 903

CABOT AREA, Large Garage Apt., furn. utilities paid, $650 mo+ $300 dep. 22' Camper, furn., utilities paid, $500 mo. + $300 dep. 501-606-2615

Houses, Unfurnished 931

3205 CENTER St. - 2BR HOME, remodeled, all new appl., w/d, stove, fridge. $900 dep. Rent $900. 501-218-4917, LR 72206.

Rooms / Board 980

ALEXANDER: Room For Rent, 1224 Midland Road. 3BR, 1BA, rural area, close to shopping, big yard, $400 a month. Call 501-617-3535.

Let a Service Professional do it for you. Use Classified to connect you with an expert who'll do the jobs you hate. Air conditioning and heating; appliance repairs; brick, stone and concrete work; excavating; care giving; carpet cleaning; child care; cleaning; drywall repair; electrical; garden and lawn service; home repairs and remodeling; interior decorating, moving and hauling, painting and papering, plumbing, power washing, roofing repairs, security systems, and more. Democrat-Gazette Classified connects people to people!

LR, UTILS pd. $130 wk. + $130 dep. 1715 S. Summit & 2008 West 22nd St. 501-960-7009

Little Rock West 1006

WLR, BRICK 3 BR., 2 Full BA, LR, DR., Kitc. 6601 Sherry Dr. $1,100 mo. $500 dep. 501-407-1447.

Out of Area Real Estate 1036

HUNT, FISH, Canoe Buffalo River. No neighbors, can sleep 10, 2 BA, small but unique, sprayed foam insulation, 2 car gar. w/elec. roll-up door, tongue & groove yellow pine in ceiling, walls, floors, cabinets. Put in dash get-out Buffalo River, 4 mi. from Buffalo Point Park. Solid concrete gar. floor & walls. Solid doors. 3-$1,500 ceiling fans. Will leave one gun safe. Hunt from den, deck, or under waterproof deck. Insured for $360,000. 11+ acres. Selling at $11,000 per acre. White oak, red oak, pine & hickory uncut. Year round spring comes up on my land with waterfall. Shooting lanes or viewing. Room for cabines. New side by side refrigerator, freezer hidden under island, new washing machine, 2 yr old elec. dryer, propane water heater & wall heater in bath, heat pump. Electric, $80-$100 per month. Propane, $400-$600 per year. Cathderal ceiling-all glass front toward East. One piece commercial sink and running boards, ss sink in garage, rustic decor, many error heads, bows, errors & leather. New wood heater. Disabled, 30 years with Entergy Mississippi. Must move back home for help. Lots of closets. Basement could be mancave. Much more. Must sell quickly-medical bills. Third home I've built. Less than 2 hours from Branson, 16 miles to Yellville. Age 72, live alone. Cell 601-896-7930.

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WEEKEND GETAWAY in Witts Springs Area of Searcy Co. Secluded 8.80 acres with Cabin. Close proximity to National Forest. Owner Financing Available. Call or Text 870-448-7664

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or the Secretary of State's website at:

http://www.sos.arkansas.gov/rules_and_regs/index.php/rules/search/new

Ralph T. Hudson, Director
Division of Labor
Department of Labor and Licensing
75556126f

Legal Notices 1201

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75555667f

Bids/Requests 1210

NOTICE TO BIDDERS
BID #22-3775

Notice is hereby given that the City of North Little Rock's Commerce Department will receive sealed bids until, Tuesday, June 7, 2099 at 10:00 a.m. on the following:

Transformers for the North Little Rock Electric Department

Specifications and required bid forms may be secured from the City of North Little Rock, Commerce Department, 120 Main Street in North Little Rock or www.nlr.ar.gov. The right is reserved by the City of North Little Rock to reject any or all bids, in whole or part, or award items separately, or to waive informalities in bids received.

The City of North Little Rock encourages participation from MBE/DBE/WBE and SBA vendors.

Amy Smith
Assistant Director for Procurement
75556496f

Request for Qualification
ASUTR 22-001 Architect

Arkansas State University Three Rivers is requesting Qualification Submissions from individuals or firms interested in providing professional, technical and advisory Architect services for a construction and renovation project.

Submission Deadline Date/Time: June 10, 2022 @ 4:00 p.m. Local Time

Review of submissions will begin June 13, 2022, with an anticipated selection date of July 14, 2022.

Submit Proposals in accordance with the Request for Qualification document located at: www.asutr.edu/pages/purchasing.
75553457f

Request for Qualifications (RFQ) for Architectural Services

Pine Bluff Urban Renewal Agency, Pine Bluff Arkansas, is seeking services of a qualified architect for a 65–75-unit mixed housing development in downtown Pine Bluff. The project is proposed to be funded by a public private partnership. Procedures for selection of an architect will be in accordance with procurement requirements of State Law. Interested parties are invited to secure a Request for Qualification package by email only at chandra@cityofpinebluff-ar.gov . Responses must be submitted no later than 1:30pm, June 1, 2022, at 417 W 6th Ave Pine Bluff, AR 71601.

Pine Bluff Urban Renewal is an Equal Opportunity/Affirmative Action Employer.
75555082f

Meetings/ Hearings 1230

ABBREVIATED NOTICE FOR PUBLIC COMMENT PERIOD FOR PROPOSED TEFRA SECTION 1115 DEMONSTRATION PROJECT

Pursuant to 42 C.F.R. § 431.408, the Director of the Division of Medical Services (DMS) of the Department of Human Services (DHS) issues the following abbreviated notice for the Section 1115 Demonstration Project waiver for the TEFRA program.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave individual states the option to provide health care benefits to children living with disabilities whose family income was too high to qualify for traditional Medicaid. Prior to 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to use the flexibility available within a Section 1115 demonstration waiver to develop and implement a sliding scale premium fee structure based on the family's income, effectively passing a portion of the cost to the eligible child's family.

Today the TEFRA program allows children who require an institutional level of care to remain in their homes and receive the treatment they need in a process that is cost effective and sustainable. Families with annual incomes at or below 150% of the federal poverty level (FPL) are exempted from the premium requirement, and program eligibility is determined solely on the assets and resources of the child.

The State's current objective is to continue providing medical services to disabled children eligible for Medicaid under the TEFRA-like 1115 demonstration waiver.

To be eligible for the TEFRA-like demonstration, a child must meet the requirements for medical necessity, appropriateness of care, and financial need. During the current demonstration period, enrollment started at just under 5,000 TEFRA enrollees and peaked at just under 6,000 enrollees by June of 2021.

Individuals enrolled in the TEFRA-like demonstration waiver receive the full range of State Medicaid benefits and services. Services provided under the TEFRA-like demonstration waiver are delivered through the State's existing network of Medicaid providers.

The TEFRA-like demonstration waiver allows the State to require a sliding-scale premium for eligible children based upon the income of the custodial parent(s). A monthly premium can be assessed only if the family income is above 150% of the FPL and more than $25,000. There are no co-payments charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed 5% of the family's gross income. Most clients (between 60% and 70% each year of the demonstration) pay premiums between $20 and $182 per month. In the 2021 TEFRA Beneficiary Survey, just 7% of respondents said the premiums were "a big financial burden." The other 93% said it was only a small financial burden or not a burden at all. The premium payments continue to provide an important offset to the cost of providing this care under the TEFRA program.

During the current demonstration period, the Arkansas TEFRA-like program has consistently operated under the budget neutrality levels set by the program's Special Terms and Conditions. The total expenditures have increased 5% on average each year during the period, while the number of member months increased an average of 4% each year.

Arkansas proposes extending the current TEFRA demonstration with an expected 4.1% annual increase in member months. The per member per month cost will not exceed a 1% annual increase.

The state proposes to continue the TEFRA demonstration with only the following minor changes:

• Enhance the TEFRA program's evaluation methodology by expanding the comparison population, exploring data from the state's All Payer Claims Database and adding a longitudinal analysis.

• Allowing clients with long-term or chronic conditions to obtain a medical redetermination every three years, rather than every year.

The TEFRA full notice is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the full notice and this notice on the DHS website at https://humanservices.arkansas.gov/rules/arkansas-tefra-waiver/

Public comments may be submitted in writing at the above mailing address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 20, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Two public hearings will be held for public comment:

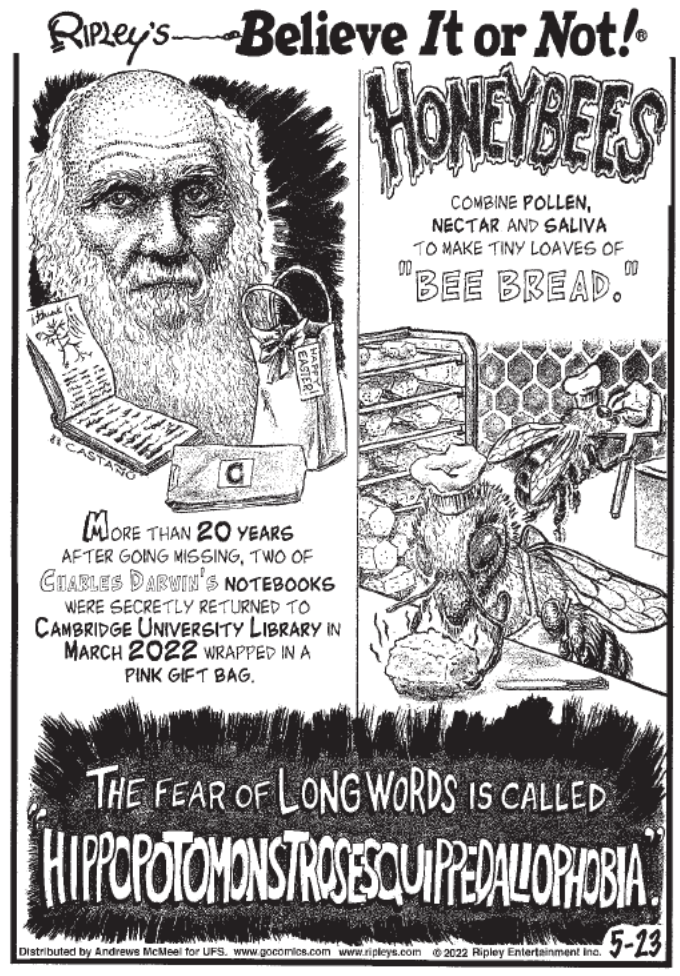
1) The Task Force on Autism will meet in Room B of the Mac Building, 1 Capitol Mall, Little Rock, AR 72201 on May 24, 2022, at 1:30 PM. Comments may be submitted at the hearing by the public by sign-up with the Task Force on Autism procedures. If you would like the electronic link, please send request to ORP at ORP@dhs.arkansas.gov.

2) A second public hearing by remote access through a Zoom webinar will be held on June 2, 2022, at 2:30 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/83750606618. The webinar ID is 837 5060 6618. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

/s/S. Elizabeth Pitman
Elizabeth Pitman, Director
Division of Medical Services
75556757f



Classified Ad Information

To Place Your Ad

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PAID ADS CALL:
Weekdays from 8 a.m. to 5 p.m.
LR METRO: 501-372-3733
FAX: 501-378-3591
VISIT: 9 a.m. to 4 p.m. weekdays at
121 E. Capitol Ave. at Scott Street
Little Rock, AR
MAIL: Classified Arkansas
Arkansas Democrat-Gazette
121 E. Capitol Ave. Scott Street
Little Rock, AR 72201
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Liner and Display ads
Call **501-378-3434**

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FREE AD EXCLUDES:
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- Heavy Equipment
- Garage Sales
- Dogs
- Rental & Real Estate
- Statewide Ads

UPGRADE YOUR FREE AD:
Attention Getter, Gray Screens, Box Ad, Extra Days in print, Add Photo.
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For Monday & Tuesday.....5 p.m. Friday
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SUNDAY REAL ESTATE

1 p.m. Wednesday

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For Sunday-Tuesday.....Noon Friday
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LEGAL FAX: 501-918-4547

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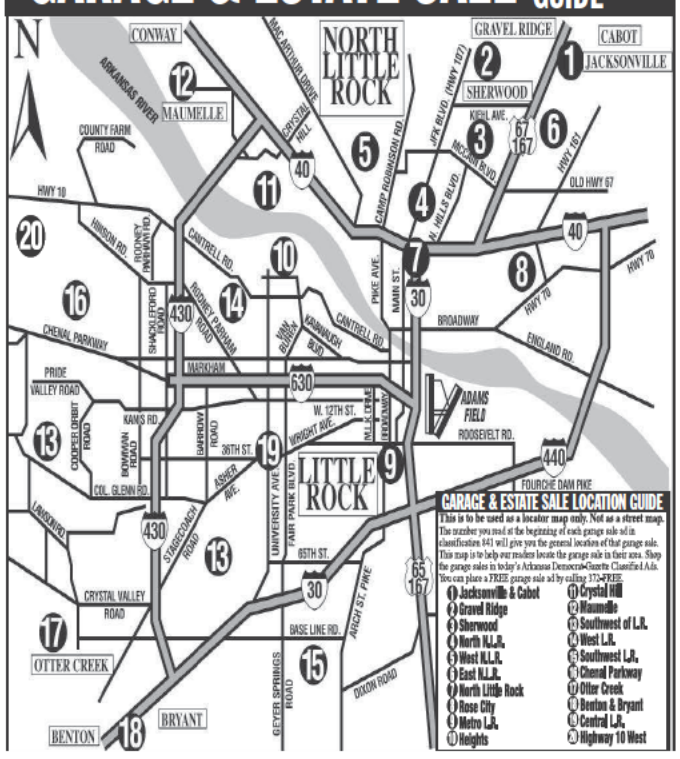
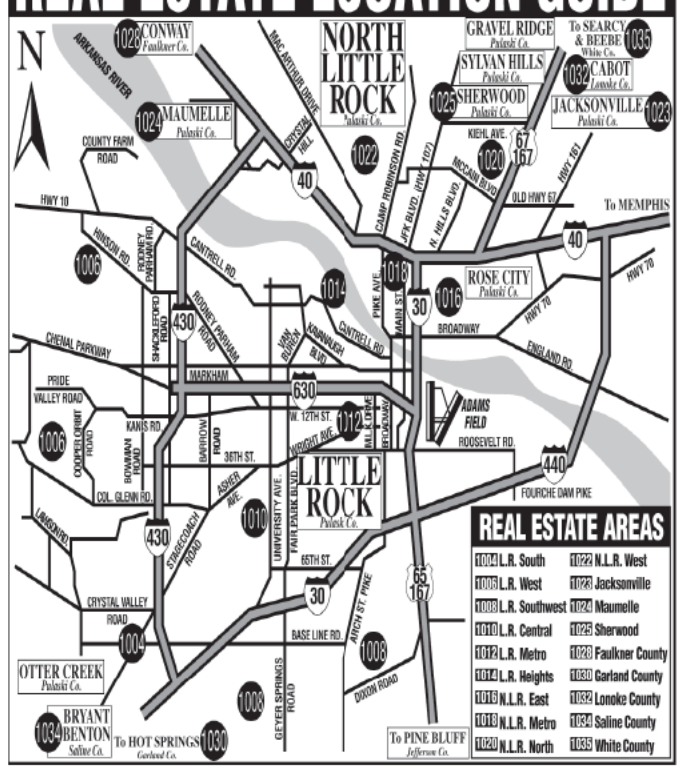
GARAGE & ESTATE SALE LOCATION GUIDE



REAL ESTATE LOCATION GUIDE



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Division of Labor
Department of Labor and Licensing
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75555667f

Bids/Requests 1210

ADVERTISEMENT FOR BID
Creekside Community Center
Harrison Parks & Recreation Renovation
Owner:City of Harrison
P.O. Box 1715
Harrison, Arkansas 72602
Architect: Cromwell Architects Engineers
1300 East 6th Street
Little Rock, Arkansas 72202
Construction Manager: Butch May Contracting, Inc
701 N. Walnut Street, Suite A
Harrison, Arkansas 72601
TIME & PLACE:
Bids will be received for individual trade packages on the Harrison Parks & Recreation Renovation project. Sealed bids will be received until 2:00 p.m. on Thursday, June 9th, 2022, at the City of Harrison, Public Works located at 303 North 3rd Street, Harrison, Arkansas. Electronic bids can be submitted to Wade Phillips, Director of Public Works, publicworks@cityofharrison.com. Bids will be received and publicly opened with the architect and owner's representatives. The owner reserves the right to reject any or all bids.
MANDITORY PRE-BID MEETING
A mandatory pre-bid meeting will be held at 2:00 p.m. on May 24th, 2022 at the project site, 515 South Pine Street, Harrison, Arkansas.
EXAMINATION & PROCUREMENT OF DOCUMENTS:
Construction documents (which includes Bid Package descriptions) can be obtained electronically at no cost by qualified bidders at Butch May Contracting, Inc, 701 North Walnut Street, Harrison, Arkansas. Contact Kara Morris at 870-741-9637 or by email kmorris@bmccontractors.net. Hard copies can be viewed at Butch May Contracting, Inc. office.
BID REQUIREMENTS:
Bid security in the amount of five percent (5%) of the bid amount must accompany each bid over $100,000.00 in accordance with the Instructions to Bidders. The owner reserves the right to reject any or all bids and to waive any formalities. The bid proposal and work of the proposed contract shall be in accordance with all applicable federal, state, county and local laws ordinance and regulations.
BID GUARANTEE: Bids must be firm for a period of ten (10) days after the scheduled time of opening.
PERFORMANCE-PAYMENT BOND: A one hundred percent (100%) Performance- Payment Bond issued by a surety company authorized to do business in the State of Arkansas will be required within ten (10) working days after the successful bidder has been notified of the award of the contract to him. Only applicable to bids over $100,000.00.
75553494f

ADVERTISEMENT FOR BID
Creekside Community Center Gymnasium Building
Owner:City of Harrison
P.O. Box 1715
Harrison, Arkansas 72602
Architect: ETC Engineers & Architects, Inc
1510 South Broadway
Little Rock, Arkansas 72202
Construction Manager:Butch May Contracting, Inc
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Harrison, Arkansas 72601
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Meetings/ Hearings 1230

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- Enhance the TEFRA program's evaluation methodology by expanding the comparison population, exploring data from the state's All Payer Claims Database and adding a longitudinal analysis.
- Allowing clients with long-term or chronic conditions to obtain a medical redetermination every three years, rather than every year.

The TEFRA full notice is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the full notice and this notice on the DHS website at https://humanservices.arkansas.gov/rules/arkansas-tefra-waiver/

Public comments may be submitted in writing at the above mailing address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 20, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Two public hearings will be held for public comment:

1) The Task Force on Autism will meet in Room B of the Mac Building, 1 Capitol Mall, Little Rock, AR 72201 on May 24, 2022, at 1:30 PM. Comments may be submitted at the hearing by the public by sign-up with the Task Force on Autism procedures. If you would like the electronic link, please send request to ORP at ORP@dhs.arkansas.gov.

2) A second public hearing by remote access through a Zoom webinar will be held on June 2, 2022, at 2:30 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/83750606618. The webinar ID is 837 5060 6618. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-534-4138.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528
/s/S. Elizabeth Pitman
Elizabeth Pitman, Director
Division of Medical Services
75556757f

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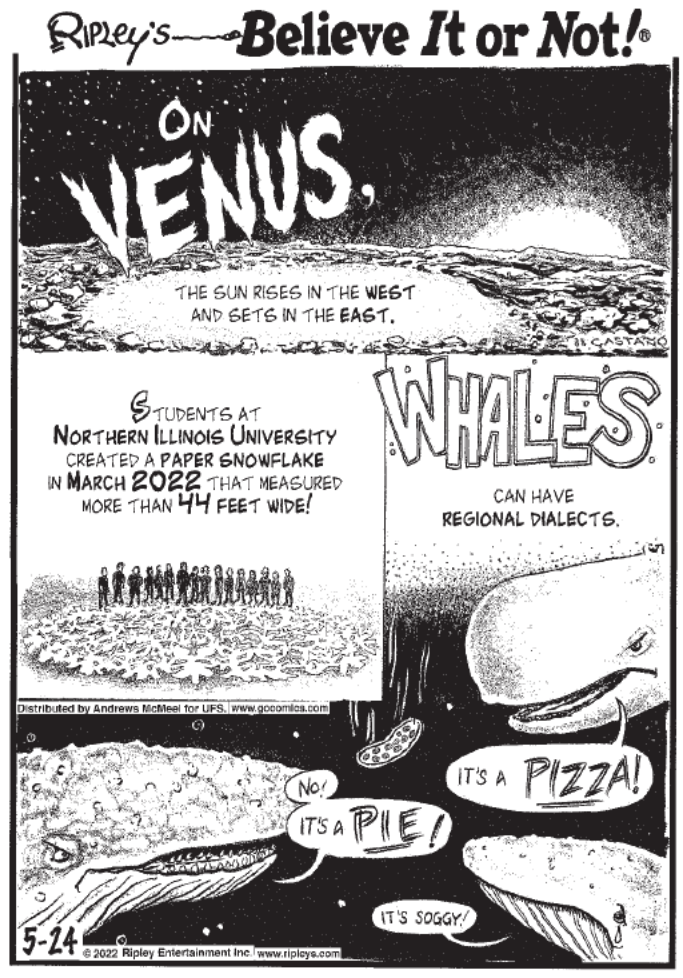

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Arkansas Democrat Gazette

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TEFRA

Mac Golden: Welcome everyone to the public hearing on the Tax Equity and Fiscal Responsibility Act section 11-15 demonstration project. Neil Smith, Assistant Director of the Division of Medical Services will be announcing the notice and presenting some information and then we will open the floor for public comments. Please utilize the raise hand, the chat or the Q&A feature within Zoom to make a comment and you'll be recognized to give a public comment on the record. All official responses to public comments will appear on the DHS Proposed Rules and Notices website after the public comment period concludes.

If you have questions or need a copy of the notice or any other information about TEFRA or any other information, please email orp@dhs.arkansas.gov or call 501-534-4138.

Mrs. Smith will now read the notice.

Nell Smith: Good afternoon everyone, we are applying to renew our TEFRA waiver for another five years, and this process is the public comment process for that application. Our temporary Medicaid program allows children who require an institutional level of care to remain in their homes and receive the treatment that they need in a process that's cost effective and sustainable for families and the state of Arkansas. To be eligible for the TEFRA like demonstration the child must meet the requirements for medical necessity for appropriateness of care and financial need during the current demonstration period. Enrollment started at just under 5000 TEFRA enrollees and peaked at just under 6000 enrollees by June of 2021. Individuals enrolled in the TEFRA like demonstration waiver receive a full range of state Medicaid benefits and services, and services provided under the TEFRA like demonstration waiver are delivered through the state's existing network of Medicaid providers. The temporary waiver allows the state to require a sliding scale monthly premium for eligible children, based on the income of the custodial parent. A monthly premium can be assessed only if the income is above 150% of the federal poverty level and more than $25,000 annually. There are no co-payment charges for services to TEFRA children, and families total out-of-pocket costs sharing can't exceed 5% of the family's gross income. So, we're planning to continue all of those elements of the program and the waiver allows us to charge that premium, but we are proposing to continue the same way, but with a few minor changes, and those are where we want to enhance the type of programs evaluation methodology by expanding the comparison population that we use.

We want to explore data from the States all pair claims database and we'd like to add a longitudinal analysis and we think all of those things will make a more robust evaluation. The second change that we are proposing is to allow clients, with certain long term or chronic conditions to obtain a medical redetermination every three years rather than the current annual requirement. The TEFRA notice is available for review at, and this is in the chat, at the at the DHS Office of Rules Promulgation, Second Floor, Donaghey Plaza South Building, 7th and Main Streets, P.O. Box 1437 Slot 295, Little Rock Arkansas 72203

and you can also access and download the full notice on the DHS website and at the link that they provided in the chat. Public comments may be submitted in writing at the mailing address that I just mentioned, or at the following email address which Mac mentioned earlier, orp@dhs.arkansas.gov. All public comments must be received by DHS no later than June 20 2022. It's important to note that public comments as submitted in response to this Notice are considered public documents and public comments, including the commenters name and any personal information contained within the public comments will be made publicly available.

If you need this material in a different format, such as large print please contact the Office of Rules Promulgation at 501-534-4138.

And just one last note the Arkansas Department of Human Services is in compliance with Title Six and Seven of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin. And I'll stop there, and let Mac take over.

Mac Golden: Thank you, Miss Smith. Please let the record reflect we have four attendees for today's public hearing. If any attendee would like to make a public comment at this time, please utilize the chat the raise hand or the Q&A feature. Barry, do you see anyone indicating I do not see any indication.

DHS Zoom: No, sir.

Mac Golden: Very well, if no one would like to make a public comment today and you wish to later, please utilize the email address in the chat or, as mentioned earlier, orp@dhs.arkansas.gov.

And upon that we will consider this public hearing closed. Thank you for attending today

Notice for Extended Public Comment Period

Arkansas's Tax Equity and Fiscal Responsibility Act (TEFRA-like)

Section 1115 Demonstration Project Application for Five-Year Period

January 2023-December 2027

Program Description

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave individual states the option to provide health care benefits to children living with disabilities whose family income was too high to qualify for traditional Medicaid. Prior to 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to transition the disabled children from traditional Medicaid to a TEFRA-like, Section 1115 demonstration waiver program.

Using the flexibility available within a demonstration waiver, Arkansas was able to develop and implement a sliding scale premium fee structure based on the family's income, effectively passing a portion of the cost to the eligible child's family. Families with annual incomes at or below 150% of the federal poverty level (FPL) are exempted from the premium requirement, and program eligibility is determined solely on the assets and resources of the child.

Waiver and Expenditure Authorities

Under the authority of section 1115(a) (2) of the Social Security Act (the Act), Arkansas was granted the following expenditure authority to enable Arkansas to operate the program.

1. Demonstration Waiver Population – Expenditures for services provided to children ages 18 and under, who require an institutional level of care, and would otherwise be Medicaid-eligible under a TEFRA state plan option.

Additionally, the following provision is considered not applicable to the TEFRA program

1. Cost Sharing Section 1902(a)(14) Insofar as it incorporates Section 1916—To enable Arkansas to charge a sliding scale monthly premium to custodial parent(s) of eligible children with annual family income above $25,000, except that no premium may be charged to families with incomes less than 150 percent of the federal poverty level.

Arkansas's 1115 TEFRA-like demonstration waiver was originally approved in October 2002 and implemented January 1, 2003. Following the initial five-year demonstration period (October 1, 2002 – December 31, 2007) , the waiver was twice renewed with three-year extensions (January 1, 2008 – December 31, 2010 and January 1, 2011 – December 31, 2013) and once for a one 1-year extension (January 1, 2014 – December 31, 2014) when CMS was unable to give states' extension renewal applications the attention needed for thorough reviews due to the number of 1115 demonstration

waiver extension renewal applications submitted to CMS at the end of 2013. CMS renewed all affected demonstration waivers for an additional 12-month period (January 1, 2014 – December 31, 2014). Then, because not all could be reviewed/approved in that 12-month period, some states' demonstrations, including Arkansas's TEFRA-like demonstration, were renewed for additional months to complete the review/approval process. Arkansas's TEFRA-like demonstration's renewal was extended for an additional 4 months (January 1, 2015 – May 11, 2015) until the review/approval process was completed. CMS approved a three-year extension for the period May 12, 2015 – December 31, 2017, and another extension through December 31, 2022. With this application, Arkansas is requesting a five-year extension of the state's TEFRA-like demonstration.

Goals and Objectives

The State's original objective was to replace the Medicaid state plan optional TEFRA aid category with a TEFRA-like demonstration. The State, with its budgetary limitations, wanted to continue to provide services to this population of children but needed to reduce the State's financial obligations. The State chose to reduce its financial obligations by requiring a sliding-scale family premium. If the TEFRA child's family had health insurance coverage for the child from another source, the family was, and still is, required to retain that insurance.

The State's current objective is to continue providing medical services to disabled children eligible for Medicaid under Section 134 of the Tax Equity and Fiscal Responsibility Act through the TEFRA-like Section 1115 demonstration waiver. Additionally, the State would like to continue to achieve the following four goals, established in its current demonstration evaluation:

Goal 1: *Ensure demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population.*

Goal 2: *Ensure demonstration enrollees have access to timely and appropriate preventive care.*

Goal 3: *Ensure enrollment in the demonstration increases clients' perceived access to health care services and experience in the quality of care received.*

Goal 4: *Ensure premium contributions are affordable, that they do not create a barrier to health care access, and that the proportion of clients who experience a lockout period for nonpayment of premiums is relatively low.*

Eligibility

To be eligible for the TEFRA-like demonstration, a child must meet the requirements for medical necessity, appropriateness of care, and financial need.

Medical necessity: The TEFRA-like demonstration waiver provides coverage to children ages 18 and under with substantial disabilities. The child must be disabled according to the SSI definition of disability. If disability has not been established by SSA, it must be determined by the State's Medical Review Team. The child(ren) of families applying to participate in the TEFRA-like demonstration waiver are also evaluated for likely eligibility in Arkansas's title XIX Medicaid state plan programs.

Appropriateness of care: Clients must meet the medical necessity requirement for institutional placement, but their needed medical services must be appropriate to provide outside an institution.

Financial need: Clients must have income and resources that do not exceed established limits. The income limit for TEFRA applicants/clients is three times the SSI/SPA (which calculates to $2,523 per month). Only the child's income is considered. Parental income in not considered in the eligibility determination but is considered for the purpose of calculating monthly premium. The resource limit is $2,000. A child can enroll in TEFRA and must retain any other creditable health insurance coverage he or she has.

Client Enrollment

Throughout the current demonstration period, the TEFRA program has served an increasing number of enrollees, allowing Medicaid to serve more clients who would otherwise require institutional care. During the current demonstration period, enrollment started at just under 5,000 TEFRA enrollees. Enrollment rose by more than 20%, peaking at just under 6,000 enrollees by June of 2021

Proposed Change

DHS is proposing a change to the current program to require less frequent medical redeterminations for clients with certain conditions. Some TEFRA clients have long-term or chronic conditions that do not need to be reidentified every year. DHS would like to establish a list of long-term or chronic conditions and require TEFRA clients with these conditions to obtain a medical redetermination only every three years, rather than the current annual process. These TEFRA clients still would reapply and meet financial requirements annually, but they would no longer need to be medically redetermined every year. Reducing the frequency of medical redeterminations would eliminate unnecessary paperwork and reduce some of the burden of renewals on these families, providers and DHS staff processing renewals.

Cost Sharing

The TEFRA-like demonstration waiver allows the State to require a sliding-scale premium for eligible children based on the income of the custodial parent(s). A monthly premium can be assessed only if the family income is above 150% of the FPL and more than $25,000. There are no co-payments charged for services to TEFRA children, and a family's total annual out-of-pocket cost sharing cannot exceed 5% of the family's gross income.

A premium is assessed only if the family has income (after allowable deductions) above 150% of the FPL. The maximum premium assessed is $5,500 per year for incomes above $200,000 annually. Families are not charged additional premium if they have more than one child in the TEFRA program. And a family's total annual out of pocket cost sharing cannot exceed 5 percent of the family's gross income.

The majority of clients (between 60% and 70% each year of the demonstration) pay premiums between $20 and $182 per month. In the 2021 TEFRA Beneficiary Survey, just 7% of respondents said the premiums were "a big financial burden." The other 93% said it was only a small financial burden or not a burden at all. The premiums collected from clients ranged from $5.3 million in 2018 to $6.5 million in 2021. The premium payments continue to provide an important offset to the cost of providing this care under the TEFRA program. In 2021, the premiums collected reduced program expenditures by 8%.

Arkansas is not requesting changes to the current demonstration's cost sharing requirements.

Benefit Coverage and Health Care Delivery System

Individuals enrolled in the TEFRA-like demonstration waiver receive the full range of State Medicaid benefits and services. Services provided under the TEFRA-like demonstration waiver are delivered through the State's existing network of Medicaid providers. Demonstration waiver clients must select a primary care physician.

Arkansas is not requesting changes to the current demonstration's benefit or health care delivery requirements.

Expenditures and Budget Neutrality

During the current demonstration period, the Arkansas TEFRA-like program has consistently operated under the budget neutrality levels set by #43 of the Special Terms and Conditions. The total expenditures have increased 5% on average each year during the period, while the number of member months increased an average of 4% each year.

	CY2017	CY 2018	CY 2019	CY 2020	CY 2021
	DY15	DY16	DY17	DY18	DY19
TOTAL EXPENDITURES	$67,168,894	$64,101,606	$75,331,470	$74,432,259	$82,324,145
TOTAL PREMIUMS COLLECTED	$(3,700,729)	$(5,302,962)	$(5,595,945)	$(5,448,201)	$(6,503,116)
ELIGIBLE MEMBER MONTHS	59,623	60,427	63,443	65,986	70,106
PMPM COST	$1,126.56	$1,060.81	$1,187.39	$1,128.00	$1,174.28
BUDGET NEUTRALITY LIMITS	$1,935.26	$1,143.87	$1,181.39	$1,220.14	$1,260.16

Arkansas proposes extending the current TEFRA demonstration with an expected 4.1% annual increase in member months. The per member per month cost will not exceed a 1% annual increase, provided in the table below.

	CY 2022		CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
			DEMONSTRATION YEARS (DY)				
	DY 00	DEMO TREND RATE	DY 01	DY 02	DY 03	DY 04	DY 05
Eligible Member Months	73,001	4.1%	76,016	79,156	82,425	85,829	89,374
PMPM Cost	$1,186.49	1.0%	$1,198.83	$1,211.30	$1,223.90	$1,236.63	$1,249.49
Total Expenditure			$91,130,665	$95,881,435	$100,879,892	$106,138,836	$111,671,718

Evaluation

The four goals of the TEFRA program will continue to be examined through the following evaluation hypotheses:

- The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population.

- The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population.
- Preventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar to or better than before enrollment.
- The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population.
- The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population.
- Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration remains the same or improves over time.
- Patient experience with access to health care services improve with enrollment into TEFRA-like program.
- Premium barriers for TEFRA-like beneficiaries remain stable over time.
- TEFRA-like beneficiary case closures due to program barriers to health care access reduce or stay the same over time.

Proposed Change

For the summative evaluation of the current TEFRA-like demonstration and the evaluation of the requested extension period, DHS is considering changes to its TEFRA evaluation design to enhance its methodology, if approved by CMS. The potential changes include:

1) Changing the comparison population to include the Provider-Led Arkansas Shared Savings Entity (PASSE) population if the primary medical and behavioral health conditions are similar to the TEFRA-like population. The current evaluation uses a comparison group that consists of patients of similar age and diagnosis characteristics as the TEFRA-like population, but DHS believes the comparison population could be a better match if PASSE clients were included in the analysis.
2) Exploring other data sources including other payors' medical claims from the Arkansas All-Payer Claims Database (APCD) for the TEFRA-like population. Nearly three-quarters of TEFRA clients have additional health insurance coverage. Because the analysis for the interim evaluation included only Fee for Service (FFS) claims, the evaluation did not consider health services TEFRA clients received that were covered by third party liability. The inclusion of additional data will ensure the evaluation explores a broader array of information in the measure calculations. The two data sources are Provider-Led Arkansas Shared Savings Entity (PASSE) encounter claims for clients enrolled in the new Medicaid program (launched March 1, 2019) and medical claims from other insurance carriers for individuals with TPL medical claims.
3) Adding a longitudinal analysis by trending the TEFRA-like population over time. Since the TEFRA demonstration waiver has been successful in serving a population with high treatment needs

and the population medical needs are unique, DHS would like to explore a longitudinal design for future evaluations.

Public Notice Availability

The application for a Section 1115 Demonstration Project for the TEFRA was posted online May 22, 2022. A copy of DHS's proposed waiver application is available for review at: Arkansas TEFRA Waiver - Arkansas Department of Human Services. The Department of Human Services will hold the following public hearings:

As part of a meeting of The Task Force on Autism, Room B of the MAC Building, 1 Capitol Mall, Little Rock, AR 72201 on May 24, 2022, at 1:30 PM.

By remote access through a Zoom webinar on June 2, 2022, at 2:30 p.m. Public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/83750606618. The webinar ID is 837 5060 6618.

The public may comment on the proposed demonstration application during the 30-day public comment period beginning May 22, 2022, through June 20, 2022. Public comments may be submitted in writing to the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437 or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 20, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

Centers for Medicare & Medicaid Services

Section 1115 Demonstration
FAST TRACK Extension Template for Program Changes

Proposed Demonstration Changes for the Extension Period

A. General Description. Provide an overall description of the changes the state proposes for the extension of the demonstration. Specifically, include information on the expected impact these proposed program changes will have on populations covered by the demonstration and how it furthers the approved objectives and goals of the demonstration.

Arkansas proposes two changes to its current program.

- Reduce the frequency that TEFRA clients with long-term or chronic conditions must be medically redetermined—from the current annual requirement to every three years. These TEFRA clients would still reapply and meet financial requirements annually, but they would no longer need to be medically redetermined every year.
- Enhance the TEFRA program evaluation design with a more robust comparison group, a more complete picture of the health services TEFRA clients receive, and an analysis of improvements in the TEFRA program over time.

B. Expenditure Authorities. List any proposed modifications, additions to, or removal of currently approved expenditure authorities. Indicate how each new expenditure authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

C. Waiver Authorities. List any proposed modifications, additions to, or removal of currently approved waiver authorities. Indicate how each new waiver authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

D. Eligibility. List any proposed changes to the population(s) currently being served under the demonstration.

If the state is proposing to add populations, please refer to the list of Medicaid Eligibility Groups at: 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 a plain language description of the group(s) that is sufficiently descriptive to explain to the public.

If the state is proposing to remove any demonstration populations, please include in the justification how the state intends to transition affected beneficiaries into other eligible coverage as outlined in the Special Terms and Conditions (STCs).

Some TEFRA clients have long-term or chronic conditions that do not need to be reidentified every year. DHS is proposing to establish a list of long-term or chronic conditions and require

TEFRA clients with these conditions to obtain a medical redetermination only every three years, rather than the current annual process. These TEFRA clients would still reapply and meet financial requirements annually, but they would no longer need to be medically redetermined every year. Reducing the frequency of medical redeterminations would eliminate unnecessary paperwork and reduce some of the burden of renewals on these families, providers and DHS staff processing renewals.

E. Benefits and Cost Sharing. Describe any proposed changes to the benefits currently provided under the demonstration and any applicable cost sharing requirements. The justification should include any expected impact these changes will have on current and future demonstration enrollment.

F. Delivery System. Describe any proposed changes to the healthcare delivery system by which benefits will be provided to demonstration enrollees. The justification should include how the state intends a seamless transition for demonstration enrollees and any expected impact on current and future demonstration enrollment.

G. Budget/Allotment Neutrality. Describe any proposed changes to state demonstration financing (i.e., sources of state share) and/or any proposed changes to the overall approved budget/allotment neutrality methodology for determining federal expenditure limits (other than routine updates based on best estimate of federal rates of change in expenditures at the time of extension).

H. Evaluation. Describe any proposed changes to the overall demonstration evaluation design, research questions or hypotheses being tested, data sources, statistical methods, and/or outcome measures. Justification should include how these changes furthers and does not substantially alter the currently approved goals and objectives for the demonstration.

For the summative evaluation of the current TEFRA-like demonstration and the evaluation of the requested extension period, DHS is proposing changes to its TEFRA evaluation design to enhance its methodology, if approved by CMS. The potential changes include:

1) Changing the comparison population to include the Provider-Led Arkansas Shared Savings Entity (PASSE) population if the primary medical and behavioral health conditions are similar to the TEFRA-like population. The current evaluation uses a comparison group that consists of patients of similar age and diagnosis characteristics as the TEFRA-like population, but DHS believes the comparison population could be a better match if PASSE clients were included in the analysis.
2) Exploring other data sources including other payors' medical claims from the Arkansas All-Payer Claims Database (APCD) for the TEFRA-like population. Nearly three-quarters of TEFRA clients have additional health insurance coverage. Because the analysis for the interim evaluation included only Fee for Service (FFS) claims, the

evaluation did not consider health services TEFRA clients received that were covered by third party liability. The inclusion of additional data will ensure the evaluation explores a broader array of information in the measure calculations. The two data sources are Provider-Led Arkansas Shared Savings Entity (PASSE) encounter claims for clients enrolled in the new Medicaid program (launched March 1, 2019) and medical claims from other insurance carriers for individuals with TPL medical claims.

3) Adding a longitudinal analysis by trending the TEFRA-like population over time. Since the TEFRA demonstration waiver has been successful in serving a population with high treatment needs and the population medical needs are unique, DHS would like to explore a longitudinal design for future evaluations.

I. Other. Describe proposed changes to any other demonstration program feature that does not fit within the above program categories. Describe how these change(s) furthers the state's intended goals and objectives for the requested extension period.

State Contact Person(s)

Please provide the contact information for the state's point of contact for this demonstration extension application.

Name: Nell Smith
Title: Assistant Director, Population Health, Division of Medical Services
Agency: Arkansas Department of Human Services
Address: 700 Main Street
City/State/Zip: Little Rock, AR 72203
Telephone Number: 501/320-6277
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City/State/Zip: Little Rock, AR 72203
Telephone Number: 501/682-8257
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