DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-25-26 Baltimore, Maryland 21244-1850



State Demonstrations Group

December 28, 2022

Dawn Stehle Deputy Director for Health & Medicaid Arkansas Department of Human Services P.O. Box 1437 Slot S201 Little Rock, AR 72203-1437

Dear Dr. Stehle:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Eligibility and Coverage Monitoring Protocol, which is required by the Special Terms and Conditions (STC) #63 of Arkansas' section 1115 demonstration "Arkansas Health and Opportunity for Me" (ARHOME, or the "demonstration") (Project Number 11-W-00365/4). CMS has determined that the Monitoring Protocol, which was submitted on September 16, 2022, meets the requirements set forth in the STCs, and thereby approves the Monitoring Protocol.

The Monitoring Protocol is approved for the demonstration period through December 31, 2026, and is hereby incorporated into the demonstration STCs as Attachment E (see attached). In accordance with STC #106 (Public Access), the approved Monitoring Protocol may now be posted to your state's Medicaid website.

We look forward to our continued partnership on the ARHOME section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly Director Division of Demonstration Monitoring and Evaluation



cc: Michala Walker, State Monitoring Lead, CMS Medicaid and CHIP Operations Group



Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage policy in its section 1115 demonstration should complete only one Monitoring Protocol Template (Part B) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STC). This state-specific Part B Template reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information and any questions, the state should contact the CMS section 1115 demonstration team.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's eligibility and coverage demonstrations or eligibility and coverage policy components of the broader demonstration

The state should complete this title page as part of its eligibility and coverage monitoring protocol.

This section collects information on the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. This form should be submitted as the title page for all eligibility and coverage monitoring reports. The content of this table should stay consistent over time. All approval periods should include a start date and an end date (MM/DD/YYYY - MM/DD/YYYY). The dates in this section should pertain to the current demonstration period. For a policy that the state implemented as part of a previous demonstration, the state should treat the approval period start date of the current demonstration as the implementation date unless the state has set a new date to implement a modified version of the policy.

	Overall section 1115 demonstration
State	Arkansas
Demonstration name	Arkansas Health and Opportunity for Me (ARHOME)
Approval period for section 1115 demonstration	01/01/22-12/31/26
	Premiums or account payments
Premiums or account payments start date	01/01/22
Implementation date if different from premiums or account payments start date	NA
	Retroactive eligibility waiver
Retroactive eligibility waiver start date	01/01/22
Implementation date, if different from retroactive eligibility waiver start date	07/01/22

Notes:

1. Eligibility and coverage demonstration start date: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at the time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state

may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

2. **Implementation date of policy:** The date of implementation for each eligibility and coverage policy in the state's demonstration.

2. Acknowledgement of narrative reporting requirements

The state has reviewed the narrative questions in the <u>Monitoring Report Template</u> provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will report the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

The state has reviewed the Budget Neutrality Workbook and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 eligibility and coverage demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first eligibility and coverage demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocol. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first eligibility and coverage DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 eligibility and coverage demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by eligibility and coverage policy). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics

data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing a decrease in beneficiaries who did not complete renewal and were disenrolled from Medicaid (metric AD_19) over the course of the retrospective reporting period. This state may decide to highlight this change for CMS in Part B of its monitoring report by briefly summarizing the trend and explaining that during this period the state conducted additional outreach to beneficiaries about the renewal process.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

- The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.
- □ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.



Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Version 3.0)

Overview: The Monitoring Protocol for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Protocol Workbook (Part A) and a Monitoring Protocol Template (Part B). Each state with an approved eligibility and coverage policy in its section 1115 demonstration should complete only one Monitoring Protocol Workbook (Part A) that encompasses all eligibility and coverage policies approved in its demonstration as well as the demonstration overall, in accordance with the demonstration's special terms and conditions (STCs). This state-specific Part A Workbook reflects the composition of the eligibility and coverage policies in the state's demonstration. For more information and any questions, the state should contact the CMS section 1115 demonstration team.

Fligibility and Coverage Demonstrations Monitoring Protocol (Part A) Planned metrics (AD) (Version 3.0)						
Arkansas Health and Opportunity for Me (ARHOME)						
y and Coverage Demonstration Planned Metrics - Any Demonstration (AD)						
Standard information	a CMS-provided metrics					
	y and Coverage Demonstration Planned Metrics - Any Demonstration (AD)	Arkansas Arkansas Health and Opportunity for Me (ARHOME)	Arkansas Arkansas Health and Opportunity for Me (ARHOME) y and Coverage Demonstration Planned Metrics - Any Demonstration (AD)	Arkansas Arkansas Health and Opportunity for Mc (ARHOME) y and Coverage Demonstration Planned Metrics - Any Demonstration (AD)	Arkansas Arkansas Health and Opportunity for Mc (ARHOME) y and Coverage Demonstration Planned Metrics - Any Demonstration (AD)	Arkansas Arkansas Health and Opportunity for Me (ARHOME) y and Coverage Demonstration Planned Metrics - Any Demonstration (AD)

	Metric name	Metric description	Reporting topic ^a	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)
EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:
AD_33 (Do not delete or edit this row)	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters and other administrative records	90 days	Quarter	Quarterly	Recommended	Y
AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the neasurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point inner count. It captures beneficiaries who were enrolled for at least one day during the measurement period.		Administrative records	30 days	Month	Quarterly	Required	Y
AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status (i.e., enrolled, but not actively receiving benefits) for noncompliance with demonstration policies as of the last day of the measurement period.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required if state has a suspension policy	N
AD_3	Beneficiaries in a non-eligibility period who are prevented from re- enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were discarolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required if state has a non- eligibility period policy	N
AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and were not using a state-specific pathway back to coverage.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	Y
AD_5	Rc-enrollments or re-instatements using defined pathways after diserrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits).	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required for states with a defined re- enrollment or re-instatement pathway	N
AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period, have had Medicaid coverage within the prior 3 months, and are not using a state-specific pathway back to coverage.	1.1.1 Enrollment	Administrative records	30 days	Month	Quarterly	Required	N
AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Total number of beneficiaries in the demonstration determined ineligible for Medicaid and discarolled during the measurement period (separate reasons reported in other indicators), other than at renewal.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	Y
AD_8		Number of beneficiaries enrolled in the demonstration and who lost eligibility for Medicaid during the measurement period due to failure to provide timely change in circumstance information.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	Y
AD_9		Number of beneficiaries who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they were determined incligible after the state processed a change in circumstance, such as income or family household.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	Y
AD_10	Beneficiaries no longer eligible for	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to a Medicaid eligibility group not included in the demonstration during the measurement period.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Required	Y
AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to CHIP during the measurement period.	1.1.2 Mid-year loss of demonstration eligibility	Administrative records	30 days	Month	Quarterly	Recommended	N
AD_12	Enrollment duration, 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment.	1.1.3 Enrollment duration at time of disenrollment	t Administrative records	30 days	Month	Quarterly	Recommended	Y
AD_13	Enrollment duration, 4-6 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of diserrollment.	1.1.3 Enrollment duration at time of disenrollment	t Administrative records	30 days	Month	Quarterly	Recommended	Y
AD_14	Enrollment duration 7-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 7 or more months (up to 12 months) at the time of disenvollment.	1.1.3 Enrollment duration at time of disenrollment	t Administrative records	30 days	Month	Quarterly	Recommended	Y
AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y
AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y
AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y
	transfer to another Medicaid	a Medicaid eligibility group not included in the demonstration.							

	Metric name	Metric description	Reporting topic ^a	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)
D 18		Number of beneficiaries enrolled in the demonstration and due for renewal during the	1.1.4 Renewal	Administrative	30 days	Month	Quarterly	Required	N
5_10	for the demonstration at renewal,	measurement period who complete the renewal process, but move from the demonstration to		records	50 days		Quarteriy	required	
	transferred to CHIP	CHIP.							
D_19	Beneficiaries who did not complete renewal, disenrolled from	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y
	Medicaid	process.		records					
D_20	Beneficiaries who had	Number of beneficiaries enrolled in the demonstration and due for renewal during the	1.1.4 Renewal	Administrative	30 days	Month	Quarterly	Required	Y
	were still enrolled	measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled.		records					
D_21	Beneficiaries who retained	Number of beneficiaries enrolled in the demonstration and due for renewal during the	1.1.4 Renewal	Administrative	30 days	Month	Quarterly	Required	Y
	eligibility for the demonstration	measurement period who remained enrolled in the demonstration after responding to renewal		records					
D 22	after completing renewal forms Beneficiaries who renewed ex	notices. Number of beneficiaries enrolled in the demonstration and due for renewal during the	1.1.4 Renewal	Administrative	30 days	Month	Quarterly	Recommended	N
	parte	measurement period who remained enrolled as determined by third-party data sources or		records			· · · · · · · ·		
		available information, rather than beneficiary response to renewal notices.							
AD 23	Beneficiaries who reached 5%	Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit	1.1.5 Cost sharing limit	Administrative	30 days	Month	Quarterly	Required for	Y
	limit	on cost sharing and premiums during the month.	-	records	-			states with cost-	
								sharing or premiums	
D 24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the	1.1.6 Appeals and	Administrative	None	Quarter	Quarterly	Recommended	v
5_21	represent, engineering	measurement period regarding Medicaid eligibility.	grievances	records		Quarter	Quarteriy	recconniciacu	
			-						
D 25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the		Administrative	None	Ouarter	Quarterly	Recommended	V
D_25	Appeals, denial of benefits	measurement period regarding denial of benefits.	1.1.6 Appeals and grievances	records	None	Quarter	Quarteriy	Recommended	Y
			Ŷ						
D_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the	1.1.6 Appeals and	Administrative	None	Quarter	Quarterly	Recommended	Y
D 27	Grievances, provider or managed	measurement period regarding the quality of care or services provided. Number of grievances filed by beneficiaries enrolled in the demonstration during the	grievances 1.1.6 Appeals and	records Administrative	None	Quarter	Quarterly	Recommended	V
ub_2/	care entities	measurement period regarding a provider or managed care entity. Managed care entities	grievances	records	IVOIR	Quarter	Quarteriy	Recommended	
		include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and	·						
D 28	Grievances, other	Prepaid Ambulatory Health Plans (PAHP). Number of grievances filed by beneficiaries enrolled in the demonstration during the	1.1.6 Appeals and	Administrative	None	Quarter	Quarterly	Recommended	v
10_20	Grievances, outer	measurement period regarding other matters that are not subject to appeal.	grievances	records	IVOIR	Quarter	Quarteriy	Recommended	
AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the	1.1.7 Access to care	Provider enrollment	90 days	Quarter	Quarterly	Required	Y
		measurement period.		databases					
.D_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period.	1.1.7 Access to care	Provider enrollment databases and claims	90 days	Quarter	Quarterly	Required	Y
	participation	for 5 or more demonstration beneficiaries during the measurement period.		and encounters					
D_31	Specialist provider availability	Number of specialty physician and non-physician medical practitioners enrolled to deliver	1.1.7 Access to care	Provider enrollment	90 days	Quarter	Quarterly	Required	Y
		Medicaid services at the end of the measurement period.		databases					
D_32	Specialist provider active	Number of specialty physician and non-physician medical practitioners enrolled to deliver	1.1.7 Access to care	Provider enrollment databases and claims	90 days	Quarter	Quarterly	Required	Y
	participation	Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period.		databases and claims and encounters					
		incustrement period.		und encounters					
								Recommended	N
D 22	Preventive care and office visit	Total utilization of preventive cars and office vicits per 1.000 demonstration banaficiary	117 Access to care	Claims and	90 days	Quarter	Quartarly	Recommended	
D_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters and other	90 days	Quarter	Quarterly		
D_33			1.1.7 Access to care	encounters and other administrative	90 days	Quarter	Quarterly		
D_33		months during the measurement period.	1.1.7 Access to care	encounters and other	90 days	Quarter	Quarterly		
_		months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in	1.1.7 Access to care	encounters and other administrative records Claims and	90 days 90 days	Quarter	Quarterly Quarterly	Recommended	N
-	utilization	months during the measurement period.		encounters and other administrative records Claims and encounters; other				Recommended	N
-	utilization	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in		encounters and other administrative records Claims and				Recommended	N
 D_34	utilization Prescription drug use	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records	90 days	Quarter	Quarterly		
 D_34	utilization Prescription drug use	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary		encounters and other administrative records Claims and encounters; other administrative records Claims and				Recommended	
 D_34	utilization Prescription drug use Emergency department utilization,	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative	90 days	Quarter	Quarterly		
 D_34	utilization Prescription drug use Emergency department utilization,	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary	1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other	90 days	Quarter	Quarterly		
D_33 D_34 D_35	utilization Prescription drug use Emergency department utilization, all use Emergency department utilization,	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary	1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other	90 days	Quarter	Quarterly	Recommended Recommended.	N
D_34	utilization Prescription drug use Emergency department utilization, all use	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit	1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other	90 days 90 days	Quarter	Quarterly Quarterly	Recommended Recommended. Required for	N
	utilization Prescription drug use Emergency department utilization, all use Emergency department utilization,	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergenthone-emergent visit should be attended to the state differentiates emergenthone-emergent visit consyments, then non-emergency visits should be identified for monitoring purposes uning the measurement period.	1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative administrative	90 days 90 days	Quarter	Quarterly Quarterly	Recommended Recommended. Required for states with	N
	utilization Prescription drug use Emergency department utilization, all use Emergency department utilization,	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergenthone-emergent visit coayarment, then non-emergency visits should be identified for monitoring purposes using the same enteria used to assess the differential copayment. If the state does not differentiate emergenthon-emergent coayarments, then non-emergency visits should be identified at monitoring visits hould be identified at monitoring therein at a state of the state does not differentiate	1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other	90 days 90 days	Quarter	Quarterly Quarterly	Recommended Recommended. Required for	N
D_34	utilization Prescription drug use Emergency department utilization, all use Emergency department utilization,	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergenthone-emergent visit should be attended to the state differentiates emergenthone-emergent visit consyments, then non-emergency visits should be identified for monitoring purposes uning the measurement period.	1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative administrative	90 days 90 days	Quarter	Quarterly Quarterly	Recommended Recommended. Required for states with copayments for	N
D_34	utilization Prescription drug use Emergency department utilization, all use Emergency department utilization, non-emergency	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergency visits should be identified as all visits not categorized as emergent using the method below.	1.1.7 Access to care 1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records	90 days 90 days 90 days	Quarter Quarter Quarter	Quarterly Quarterly Quarterly	Recommended Recommended. Required for states with copayments for non-emergency use.	N
D_34	utilization Prescription drug use Emergency department utilization, all use Emergency department utilization,	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state dot differentiate emergent/non-emergent organments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below. Total number of inpatient admissions per 1,000 demonstration beneficiary months during the	1.1.7 Access to care 1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records	90 days 90 days	Quarter	Quarterly Quarterly	Recommended Recommended. Required for states with copayments for non-emergency	N
	utilization Prescription drug use Emergency department utilization, all use Emergency department utilization, non-emergency	months during the measurement period. Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period. Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergency visits should be identified as all visits not categorized as emergent using the method below.	1.1.7 Access to care 1.1.7 Access to care 1.1.7 Access to care	encounters and other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records Claims and encounters; other administrative records	90 days 90 days 90 days	Quarter Quarter Quarter	Quarterly Quarterly Quarterly	Recommended Recommended. Required for states with copayments for non-emergency use.	N

						Measurement	Reporting	Reporting	State will report
# D_38A	Metric name Medical Assistance with Smoking and Tobacco Use Cessation (MSC- AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	Metric description This metric consists of the following components; each assesses different facets of providing medical assistance with smaking and tobacco use cessation: - Advising amedean and tobacco use cessation: - Discussing cessation medications - Discussing cessation medications - Discussing cessation strategies	Reporting topic ^a 1.1.8 Quality of care and health outcomes	Data source Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	Calculation lag	period Calendar year	frequency	priority Required (AD_38A or AD_38B. States do not have to report both.)	(Y/N) N
.D_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	N
D_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA: NQF # 3488; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two nates are reported: 1. Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) 2. Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N
D_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 3489; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visits (31 total days). 2. Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N
D_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Precentage of beneficiaries who initiate treatment through an impatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Precentage of beneficiaries who initiate treatment and who were engagened in ongoing AOD treatment within 34 days of the initiation visit	1.1.8 Quality of care and health outcomes	Claims and encounters or EHR	90 days	Calendar year	Annually	Required	N
D_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N
D_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Astman in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N
D_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N
D_44		Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39.	1.1.8 Quality of care and health outcomes	Claims and encounters	90 days	Calendar year	Annually	Required	N
D_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, healthy behavior incentives, premium assistance, and/or retroactive eligibility waivers.	1.1.9 Administrative cost	Administrative records	None	Demonstration year	Annually	Recommended	N
ate-specific metrics			1	T	1	1		1	
Insert row(s) for any ad	lditional state-specific metrics by righ	t-clicking on row 58 and selecting "Insert"]							
		monstration (AD) reporting topic in Section 4 of the monitoring report template.							
The state should use co overage Demonstration	lumn O to outline calculation methods as Monitoring Protocol Instructions.	"N"), enter explanation in corresponding row in column O. for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and atica's memo to CMS titled "Recommendations for Standardized Reporting and Monitoring							

Medicaid Section 1115	Eligibility and Coverage Demonstra	1							
State Demonstration Name	Arkansas Arkansas Health and Opportunity fo	1							
Table: Eligibilit	y and Coverage Demons	1							
			nnual goals, and demonst	ration target		with CMS-provided technical specifications manual		Ph	ased-in metrics reporting
#	Metric name	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	specifications manual (Y/N)	definitions, policies, codes, target populations, etc.) ^{0,c}		EandC monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3) Explanation of any plans to phase in reporting over time
EXAMPLE: AD_33 (Do not delete or edit this row)	EXAMPLE: Preventive care and office visit utilization	EXAMPLE: 10/01/2019 - 01/01/2020	EXAMPLE: Increase	EXAMPLE: Increase	EXAMPLE: Y	EXAME	EXAMPLE: N	EXAMPLE:	EXAMPLE
AD_1	Total enrollment in the demonstration	01/01/2022-12/31/22	Decrease in 2023 due to the end of the PHE, then increase	Decrease	Y		N		
AD_2	Beneficiaries in suspension status for noncompliance								
AD_3	Beneficiaries in a non-eligibility period who are prevented from re- enrolling for a defined period of time								
AD_4	New enrollees	01/01/2022-12/31/22	Consistent	Consistent	Y		N		
AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies								
AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance								
AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal		Decrease in 2023 due to the end of the PHE, then consistent		Y		N		
AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information		Decrease in 2023 due to the end of the PHE, then consistent	Decrease	Y		N		
AD_9	Beneficiaries determined ineligible for Medicaid after state processes a beneficiary-reported change in circumstance		Decrease in 2023 due to the end of the PHE, then consistent	Decrease	Y		N		
AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	01/01/2022-12/31/22	Consistent	Consistent	Y		N		
AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP			Consistent					
AD_12	Enrollment duration, 0-3 months	01/01/2022-12/31/22	Increase in 2023 due to the end of the PHE, then consistent	Increase	Y		N		
AD_13	Enrollment duration, 4-6 months	01/01/2022-12/31/22	Increase in 2023 due to the end of the PHE, then consistent	Increase	Y		N		
AD_14	Enrollment duration 7-12 months	01/01/2022-12/31/22	Increase in 2023 due to the end of the PHE, then consistent	Increase	Y		N		
AD_15	Beneficiaries due for renewal	01/01/2022-12/31/22	Decrease in 2023 due to the end of the PHE, then		Y		N		
AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	01/01/2022-12/31/22		Decrease	Y		N		
AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	01/01/2022-12/31/22	Consistent	Consistent	Y		N		

		Baseline reporting period (MM/DD/YYYY -			Attest that planned reporting matches the CMS-provided technical	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.) ^{bc}		EandC monitoring report in	
#	Metric name	(MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demonstration target	specifications manual (Y/N)	specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.) ^{b,c}	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP						(443)	(
AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	01/01/2022-12/31/22	Decrease in 2023 due to the end of the PHE, then consistent	Decrease	Y		N		
AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	01/01/2022-12/31/22	Decrease in 2023 due to the end of the PHE, then consistent	Decrease	Y		N		
AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	01/01/2022-12/31/22	Decrease in 2023 due to the end of the PHE, then consistent	Decrease	Y		N		
AD_22	Beneficiaries who renewed ex parte		CONSISTENT						
AD_23	Beneficiaries who reached 5% limit	01/01/2022-12/31/22	Consistent	Consistent	Y		N		
AD_24	Appeals, cligibility	01/01/2022-12/31/22	Consistent	Consistent	N	See attached.	N		
AD_25	Appeals, denial of benefits	01/01/2022-12/31/22	Decrease in 2023 due to the end of the PHE, then consistent	Decrease	N	See attached.	N		
AD_26	Grievances, care quality	01/01/2023-12/31/23	Decrease	Decrease	N	See attached.	Y	DY2Q1	DHS will develop a formalized grievance process for quality of care issue to begin in 2023
AD_27	Grievances, provider or managed care entities	01/01/2023-12/31/23	Decrease	Decrease	N	See attached.	Y	DY2Q1	DHS will develop a formalized grievance process for quality of care issue to begin in 2023
AD_28	Grievances, other	01/01/2023-12/31/23	Decrease	Decrease	N	See attached.	Y	DY2Q1	DHS will develop a formalized grievance process for quality of care issue to begin in 2023
AD_29	Primary care provider availability		Consistent	Consistent		See attached.	N		
AD_30	Primary care provider active participation	01/01/2022-12/31/22	Consistent	Consistent	N	See attached.	N		
AD_31	Specialist provider availability	01/01/2022-12/31/22	Consistent	Consistent	N	See attached.	N		
AD_32	participation	01/01/2022-12/31/22	Consistent	Consistent	N	See attached.	N		
AD_33	Preventive care and office visit utilization								
AD_34	Prescription drug use								
AD_35	Emergency department utilization, all use								
AD_36	Emergency department utilization, non-emergency								
AD_37	Inpatient admissions								

Ħ	Metric name	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY) Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.) ³⁶	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC- AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]							
AD_38B	measurej Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]							
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 3488; Medicaid adult Core Set; Adjusted HEDIS							
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 3489; Medicaid adult Core Set; Adjusted HEDIS measure]							
AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]							
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]							
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]							
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]							
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ: NQF #0283; Medicaid Adult Core Set]							
AD_45	Administrative cost of demonstration operation							
State-specific metrics	additional state-specific matrice by sinks							
[Insert row(s) for any	additional state-specific metrics by right	<u>ا</u>				۱ <u> </u>		
^b If the state is not repo ^c The state should use of Coverage Demonstration	correspond to the prompts for the any de orting a required metric (i.e., column $J =$ column O to outline calculation methods ons Monitoring Protocol Instructions.							
* The rationale for thes for Eligibility and Cov Engagement," dated Ju	se metrics was first described in Mathem erage Demonstrations That Include Pren ine 21, 2018.	1						

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (PR) (Version 3.0) State Arkanass Demonstration Name Arkanass Iealth and Opportunity for Me (ARHOME)

Table: Eligibility and Coverage Demonstration Planned Metrics - Premiums and Account Payments (PR)

		Station Flained Metrics - Freinfuns and Account Faynen Standard information on	MS-provided metrics							Baseline, annual goals, and demonstration target			
# XAMPLE:	Metric name	Metric description	Reporting topic [#]	Data source	Calculation lag	Measurement period <u>EXAMPLE:</u>	Reporting frequency EXAMPLE:	Reporting priority EXAMPLE:	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY) <u>EXAMPLE:</u>	Annual goal EXAMPLE:	Overall demonstrati target	
XAMPLE: R_21 Do not delete or edit is row) R_1	Third-party premium payment	Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2020 - 01/31/2020	Consistent	Consistent	
R_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), regardless of whether they paid or did not pay during the measurement period.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2022-12/31/22	None	None	
3_2	Beneficiaries who were exempt from premiums for that month	Among beneficiaries enrolled in the demonstration who were subject to the premium (or account contribution) policy on the basis of income or eligibility group, the court of those exempt from owing premium or other monthly payments, and therefore not required to make paymers. For example, demonstration policies may exempt beneficiaries would otherwise be subject to premiums as incentives for healthy behaviors or other activities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Ŷ	01/01/2022-12/31/22	None	None	
t <u>3</u>	Beneficiaries who paid a premium during the month	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who paid thi month.	PR.Mod 1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2022-12/31/22	None	None	
ξ_4	Beneficiaries who were subject to premium policy but declare hardship for that month	Among hereficiaries enrolled in the demonstration whose income and eligibility group were abiject to the premium (or account contribution) policy, number of beneficiaries who were able to claim temporary hardship and were therefore not required to make a payment in the measurement period.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required for states that allow beneficiaries to avoid paying premiums or other monthly payments by claiming temporary hardship	N				
2_5	Beneficiaries in short-term arrears (grace period)	Anong beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, the number of those who did not pay in the measurement period, but had not yet exceeded their grace period (i.e., allowable period of noncompliance).	strategies for noncompliant	Administrative e records	30 days	Month	Quarterly	Required if state has a grace period	N				
<u>t</u> 6	Beneficiaries in long-term arrears	Among beneficiaries enrolled in the demonstration whose income and eligibility group were adjuct to the premium (or account contribution) policy, number of beneficiances who did not policy and the presence of the second	strategies for noncompliant	Administrative e records	30 days	Month	Quarterly	Required if state has a grace period and allows continued enrollment for any income and eligibility groups otherwise subject to premiums once the grace period has been exceeded	N				
27	Beneficiaries with collectible debt	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), number of beneficiaries who had collectible debt.	PR.Mod_5: Operationalize strategies for noncomplianc	Administrative e records	30 days	Month	Quarterly	Required	N				
R_8	Beneficiaries in enrollment duration tier 1	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cannalative length of arcollumnt fell in iter 1 – the shortest encollment duration, during which beneficiaries are adject to the first set of program nites and requirements. These are defined in terms of routilnear periods that are distinguished by different premium or copayment liabilities.	payment amounts	Administrative records	30 days	Month	Quarterly	Recommended in states with time- variant premium policies	N				

Medicaid Section 1115 Eligibility and Coverage Demonstra State Arkansas Demonstration Name Arkansas Health and Opportunity for

Table: Eligibility and Coverage Demons

Table: Englounty	and Coverage Demon	5 Alignmer	at with CMS-provided technical specifications manual		Phased-in metrics	eporting
		Attest that planned reporting matches the CMS-provided technical specifications manual (V/N)				
		technical specifications	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific	State - Landa - Landis - Ingeneration	EandC monitoring report in	
#	Metric name		definitions, policies, codes, target populations, etc.)	State plans to phase in reporting (Y/N)	EandC monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: PR_21	EXAMPLE: Third-party premium payment	EXAMPLE: Y	EXAMPLE:	EXAMPLE: N	EXAMPLE: EXAMPLE:	
(Do not delete or edit this row) PR_1						
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	Y		N		
	during the month, not exempt					
PR_2	Beneficiaries who were exempt	Y		N		
	from premiums for that month					
PR_3	Beneficiaries who paid a premium	v		N		
112	during the month	•				
PR_4	Beneficiaries who were subject to					
-	Beneficiaries who were subject to premium policy but declare hardship for that month					
PR_5	Beneficiaries in short-term arrears					
	(grace period)					
PR_6	Beneficiaries in long-term arrears					
PR_7	Beneficiaries with collectible debt					
PR_8	Beneficiaries in enrollment					
	duration tier 1					
1	I					

	Metric name	Metric description	Reporting topic ^a		Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY - MM/DD/YYYY)	Annual goal	Overall demo targe
29	Beneficiaries in enrollment duration tier 2	Number of beneficiaries corrolled in the demonstration and subject to premium policies whose comandarie length of orcollment eff lin in e2 - the enrollment duration that follows lier 1, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 1. Tries are defined in terms of enrollment periods that are distinguished by different premium or copsyment liabilities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended in states with time- variant premium policies	N			
10	Beneficiaries in enrollment duration tiers 3+	Number of beardficiaries contolled in the demonstration and adopted to premium policies whose semantisvic length of oracliment G1 in its - 1 the contolment administ that follows for 2, during which beardficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tite 2. These sed-finesh in errors of confloant periods that are distinguished by different premium or copayment liabilities. A state with more than three tiers of program rules should calculate additional metrics to report enrollment counts for current enrollment within each additional tier.	payment amounts	Administrative records	30 days	Month	Quarterly	Recommended in states with time- variant premium policies	N			
_11	Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration	Among beneficiaries enrolled in the demonstration who were not in their renewal month, number of beneficiaries for whom the state processed a change in household size or income during the measurement period and who remained eurolled in the demonstration.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
_12	No premium change following mid- year processing of a change in household or income information	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly approximents did not change.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
_13	Premium increase following mid- year processing of change in household or income information	Comparement of their immung performance may be used as the strength of the second seco	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
_14	Premium decrease following mid- year processing of change in household or income information		PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
t_15		Number of demonstration beneficiaries disensolled from Medienid as of the last day of the dneasarement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance		30 days	Month	Quarterly	Required only for states with premiums or monthly payment with a policy of termination for failure to pay	N			
<u>t</u> 16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who were dissected from Medical for failure to pay prevented from the originality prior to meaning thy are prevented from re-enrolling for some defined period of time, including those prevented from re-enrolling until their redetermination date.	PR.Mod_5: Operationalize strategies for noncompliance		30 days	Month	Quarterly	Required if state has a non-eligibility period policy	N			
t_17	Beneficiaries whose benefits are suspended for failure to pay	Number of demonstration beneficiaries whose benefits were suspended during the measurement period for failure to pay premiums.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required only for states with premiums or monthly payment with a policy of suspending benefits (without disenrollment) for failure to pay	N			
t_18	No premium change	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who are redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with no change in premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
_19	Premium increase	Informing payments. Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with an increase in required premiums or other monthy payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
_20	Premium decrease	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remained in income and eligibility groups subject to the demonstration, with a decrease in required premiums or other monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
L_21	Third-party premium payment	Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	N			

^a The reporting topics correspond to the premiums or account payments (PR) reporting topics in Section 3 of the monitoring report template. ^b If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.

⁶ The state should use column 0 to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

The rationale for these metrics was first described in Mathematica's memo to CMS titled "Recommendations for Standardized Reporting and Monitoring for Eligibility and Coverage Demonstrations That Include Premiums, Marketplace-Focused Premium Assistance, Health Behavior Incentives, or Community Engagement," dated June 21, 2018.

		Attest that planned				
		reporting matches the CMS-provided technical specifications manual	Explanation of any deviations from the CMS-provided technical specifications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.) ⁵⁶	State plans to phase in reporting	EandC monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	
#	Metric name	(Y/N)	definitions, policies, codes, target populations, etc.) ^{b.c}	State plans to phase in reporting (Y/N)	(Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
PR_9	Beneficiaries in enrollment duration tier 2					
PR_10	Beneficiaries in enrollment duration tiers 3+					
PR_11	Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration					
PR_12	No premium change following mid- year processing of a change in household or income information					
PR_13	Premium increase following mid- year processing of change in household or income information					
PR_14	Premium decrease following mid- year processing of change in household or income information					
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid					
PR_16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time					
PR_17	Beneficiaries whose benefits are suspended for failure to pay					
PR_18	No premium change					
PR_19	Premium increase					
PR_20	Premium decrease					
PR_21	Third-party premium payment					
State-specific metrics	dditional state-specific metrics by right			1		
				4	1	
	orrespond to the premiums or account p ting a required metric (i.e., column J = *					

^b If the state is not reporting a required metric (i.e., column J = "

⁶ The state should use column to to outline calculation methods f Coverage Demonstrations Monitoring Protocol Instructions.
⁸ The rationale for these metrics was first described in Mathema Eligibility and Coverage Demonstrations That Include Premium Engagement," dated June 21, 2018.

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Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (RW) (Version 3.0) State Demonstration Name Arkanass Health and Opportunity for Me (ARHOME)

Table: Eligibility and Coverage Demonstration Planned Metrics - Retroactive Eligibility Waiver (RW)

a Note runs Note status Note	Standard information on CMS-provided metrics												Desilies and a desired desired at the			
at More area More description Date seture Outral and a point Description Operating and a point Operating and a point Operating and a point Operating and a point Description Operating and a point Operating and a point Operating and a point Description Description Operating and a point Description Description <thdescrin< th=""> <thdescription< th=""> <thdescr< th=""><th></th><th></th><th>Stationed information on CAN-</th><th>rovaed metrics</th><th></th><th></th><th>Measurement</th><th>Reporting</th><th></th><th>State will rep<u>ort</u></th><th>Baseline reporting period</th><th>mnuar goals, and demon</th><th>Overall demonstration</th></thdescr<></thdescription<></thdescrin<>			Stationed information on CAN-	rovaed metrics			Measurement	Reporting		State will rep <u>ort</u>	Baseline reporting period	mnuar goals, and demon	Overall demonstration			
Image: Solution with an additional matrix is the solution of the soluti		Metric name	Metric description	Reporting topic ^a	Data source	Calculation lag	period		Reporting priority		MM/DD/YYYY)	Annual goal	target			
be by had used within the left concerve defaulty policy, who began are combinent priorial the type defaunce priorial much value of the model with the model	EXAMPLE: RW_l (Do not delete or edit this row)	Beneficiaries who indicated that they had unpaid medical bills at	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who begun a new emillement period in the reporting month, and who indicated at the time of application for Medicated that they had unpaid medical bills from the past three	RW.Mod_1: Retroactive eligibility and demonstration	Administrative					EXAMPLE: Y	01/01/2020 - 01/31/2020	Consistent				
pp of reaces all point of retractive digibility points who re-enrolled in the demonstration within 90 days after a pervious on inne. In the enrollement point in the demonstration records on time. The number of demonstration beneficiaries in income and eligibility and demonstration records on time. The number of demonstration beneficiaries on the beneficiary did not comply with reases approaces and eligibility and demonstration records on time. The number of demonstration beneficiaries in income and eligibility and the ensure of the beneficiary did not comply with reases approaces and eligibility and demonstration records of the provide state of the provide state of the demonstration records of the demon	RW_1	they had unpaid medical bills at the time of application	of retroactive eligibility policy, who began a new errollment period in the reporting month, and who indicated at the time of projectation for Medicaid that they had using and medical bills from the past three months or other time period specified in the state's Medicaid application question.	eligibility and demonstration requirements	records			Quarterly		Y						
specific metrics	RW_2		of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended because the beneficiary did not comply with renewal processes	eligibility and demonstration		90 days	Quarter	Quarterly	Required	Y	07/01/2022-06/30/23	Consistent	Consistent			
	RW_3	gap at renewal and had claims	of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended, and for whom claims were submitted for services rendered	eligibility and demonstration		90 days	Quarter	Quarterly	Required	Y	07/01/2022-06/30/23	Consistent	Consistent			
	State-specific metrics	· · · · · · · · · · · · · · · · · · ·	·	·	<u> </u>		·		·		·	·	<u> </u>			
rt row(s) for any additional state-specific metrics by right-clicking on row 14 and selecting "Insert"]		ditional state-specific metrics by righ	t-clicking on row 14 and selecting "Insert"]													

^a The reporting topic corresponds to the retroactive eligibility waiver (RW) reporting topic in Section 3 of the monitoring report template. ^b If the state is not reporting a required metric (i.e., column J = "N"), enter explanation in corresponding row in column O.

⁶ The state should use column O to outline calculation methods for specific metrics as explained in Version 3.0 of the Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstrat State Arkansas Demonstration Name Arkansas Health and Opportunity fo

Table: Eligibility and Coverage Demons

		Alignmer	at with CMS-provided technical specifications manual	Pha	ased-in metrics reporting	
ii XAMPLE: W_1 Do not delete or edit tis row)	Metric annie EXAMPLE: Bengleiaries who indicated that they had unpaid medical bills at the time of application	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N) EXAMPLE: Y	Explanation of any deviations from the CMS-provided technical appellications manual (different data sources or state-specific definitions, policies, codes, target populations, etc.) ²⁷ 21/(1072)	State plans to phase in reporting (V/N) EXAMPLE: N	EandC monitoring report in which metric will be physical (Format DFV 600, e.g., DF102) EXCHIPTE	Explanation of any plans to phase in reporting over time XMPLE
W_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	Y		N		
W_2	Beneficiaries who had a coverage gap at renewal		CMS autorized a retroactive dipably waiver, allowing for 90 days, matter than 90 days, and 90 days and 90 days and 90 days and 90 days mean: Retain beneficiaries whose previous enrollment spell ended more than 30 days prior to the start of the current enrollment spell, but not more than 90 days.	N		
-W_3	Beneficiaries who had a coverage gap at renewal and had claims denied		Stop 2 will include beneficiansis for whom claims were submitted for service rendered during the coverage gap that were denied by the state or the qualified health plan	N		
ate-specific metrics	1			1		

 $^{\rm a}$ The reporting topic corresponds to the retroactive eligibility w $^{\rm b}$ If the state is not reporting a required metric (i.e., column J = '

^c The state should use column O to outline calculation methods Demonstrations Monitoring Protocol Instructions.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planaed subpopulations (AD) (Version 3.4) State Demonstration Name Advanues licelah and Opportunity for Me (AEHOME)

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Any Demonstration (AD)

	Planned subpopul	ation reporting	Alignment with CMS-provided technical specifications manual						
						Subpopulati			
Subpopulation category [#]	Subpopulations	Reporting priority		Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMSs provided technical specifications manual (Y/N)	For state-specific subpopulation categories, or if the planned reporting of subpopulations does not match (i.e., column $G = -N^{m}$ or grey), list the subpopulations state plans to report (Format comma separated) ^{5,4}	matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column 1 = ">"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: Income groups (Do not delete or edit this row)		EXAMPLE: Recommended	EXAMPLE: AD_1 - AD_23, AD_33 - AD_44	EXAMPLE: CMS-provided	EXAMPLE: Y	EXAMPLE: Y	EXAMPLE:	EX4MPLE: Y	EXAMPLE:
Income groups	Less than 50% of the federal poverty level (FPL), 50- 100% FPL, and greater than 100% FPL	Recommended	AD_1 - AD_23, AD_33 - AD_44	CMS-provided	Y	N	0%-20% FPL; >20%-40% FPL; >40%-60% FPL; >60%- 80% FPL; >80%-100% FPL; >100%-120% FPL; >120%-	N	AD_1; AD_4; AD_7; AD_8; AD_9; AD_10; AD_12; AD_13; AD_14; AD_15; AD_16; AD_17; AD_19;
Specific demographic groups	Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56- 64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	CMS-provided	Y	Y			AD_1; AD_4; AD_7; AD_8; AD_9; AD_10; AD_12; AD_13; AD_14; AD_15; AD_16; AD_17; AD_19; AD_20; AD_21; AD_23; AD_24; AD_25
Exempt groups	Eighäry and income groups that are enrolled in the demonstration but are not required to participate in elements of the demonstration (such as paying premiums) for reasons other than income EXAMPLE: Geographic exemptions, employer sponsored insurance ecomptions, ecomptions due to medical faulty.	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	State-specific	Y		Exempt from coppy: AIAN, modically frail, - or - 20% PPL; individuals in hospice, pregnant women, 19- and 20- year-old		
Specific eligibility groups	Medicaid eliphiby groups included in the state's demonstration based on the STC's authorizing the demonstration EXLMPLE: Section 1931 parents, the new adult group, transitional medical assistance beneficiaries	Required	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_44	State-specific	Y		Medically frail, enrolled in QHP, awaiting enrollment in QHP		

⁴ For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.
⁵ If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.
⁷ If the state is planning to phase is the reporting of any of the subpopulation categories, the state should provide an explanation and the report (DY and Q) in which it will begin reporting the subpopulation metric.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (PR) (Version 3.0) State Demonstration Name Arkanaas licelah and Opportunity for Me (AEHOME)

Table: Eligibility and Coverage Demonstration Planned Subpopulations - Premiums and Account Payments (PR)

Planned subpopul	lation reporting	Alignment with CMS-provided technical specifications manual							
Subpopulations	Reporting priority		Subpopulation type		the CMS-provided technical	(i.e., column G = "N" or grey), list the subpopulations	matches CMS-provided technical specifications	If the planned reporting of relevant metrics does not match (i.e., column 1 = "N"). Bit the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)	
EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	EXAMPLE:	
Less than 50% of the federal poverty level (FPL), 50- 100% FPL, and greater than 100% FPL	Recommended	PR_1 - PR_21	CMS-provided	Y	Y		Y		
Less than 50% of the federal poverty level (FPL), 50- 100% FPL, and greater than 100% FPL	Recommended	PR_1 - PR_21	CMS-provided	Y			N	PR_1; PR_2; PR_3	
Age (less than 19, 19-26, 27-35, 36-45, 46-55, or 56- 64), sex (male or female), race (White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown), and ethnicity (Hispanic, non-Hispanic, or unknown)	Recommended	PR_15 - PR_17	CMS-provided	Y	Ŷ		Y		
Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration <i>EXCMPLE</i> : Section 1931 parents, the new adult group, transitional medical assistance beneficiaries	Required	PR_1 - PR_21	State-specific	N					
	Subpopulations EXAMPL: Set of the folderal processy level (774), 50- 1009; FP, and proster has (1009; FP. Leon has 956 of the folderal provery hourd (774), 50- 1009; FP, and proster than (1009; FP. Leon has 1056; and the folderal provery hourd (774), 50- 1009; FP, and proster than (1009; FP. Leon has 1056; and 1052; 57:55; 58:45; 46:655; and 56- dia), act (mails or finals), nearce (100 hand or Aladam Statistic, direct on and and and and and and hand the folderal or galaxy proge include in the same demonstration based on the STCs authorizing the demonstration EXCMUPS:	EXAMPLE: EX	Subpopulations Reporting priority Relevant metrics EXAMPLE: EXAMPLE: PLATPLE: PLAT	Subopolations Reporting priority Relevant metrics Subpopulations type EXAMPLE: EXAMPLE:	Subopolations Reporting priority Relevant metrics Subopolation type State will EXAMPLE: EXAMPLE:	Subpopulation Subpopulation <th co<="" td=""><td>Subpopulations Subpopulations Subpopulations Subpopulations Attest that planned subpopulations contraptions, or if the matches the description Factor specific subpopulations contraptions, or if the matches the description EXAMPLE: EXAMPLE: EXAMPLE: EXAMPLE: Factor specific subpopulations Factor specific subpopulations contraptions, or if the matches the description Include the description EXAMPLE: EXAMPLE: EXAMPLE: Factor specific subpopulations Factor specific subpopulations Include the description Factor specific subpopulations PR_1 - PR_2/1 EXAMPLE: EXAMPLE:</td><td>Subpopulations Reporting priority Relevant metrics Subpopulations Control that planned subpopulations reporting mitches the Ascreption Faster specific subpopulation restructions, with the framework in the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Contrel Contrel Control of the Control of the Contrel Control of the C</td></th>	<td>Subpopulations Subpopulations Subpopulations Subpopulations Attest that planned subpopulations contraptions, or if the matches the description Factor specific subpopulations contraptions, or if the matches the description EXAMPLE: EXAMPLE: EXAMPLE: EXAMPLE: Factor specific subpopulations Factor specific subpopulations contraptions, or if the matches the description Include the description EXAMPLE: EXAMPLE: EXAMPLE: Factor specific subpopulations Factor specific subpopulations Include the description Factor specific subpopulations PR_1 - PR_2/1 EXAMPLE: EXAMPLE:</td> <td>Subpopulations Reporting priority Relevant metrics Subpopulations Control that planned subpopulations reporting mitches the Ascreption Faster specific subpopulation restructions, with the framework in the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Contrel Contrel Control of the Control of the Contrel Control of the C</td>	Subpopulations Subpopulations Subpopulations Subpopulations Attest that planned subpopulations contraptions, or if the matches the description Factor specific subpopulations contraptions, or if the matches the description EXAMPLE: EXAMPLE: EXAMPLE: EXAMPLE: Factor specific subpopulations Factor specific subpopulations contraptions, or if the matches the description Include the description EXAMPLE: EXAMPLE: EXAMPLE: Factor specific subpopulations Factor specific subpopulations Include the description Factor specific subpopulations PR_1 - PR_2/1 EXAMPLE: EXAMPLE:	Subpopulations Reporting priority Relevant metrics Subpopulations Control that planned subpopulations reporting mitches the Ascreption Faster specific subpopulation restructions, with the framework in the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Control of the Astro- porting of the Control of the Contrel Contrel Control of the Control of the Contrel Control of the C

⁴ For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.
¹⁴ If applicable. See CMS-provided technical specifications on subpopulation categories.
¹⁴ If the state is a reporting a required subpopulation category (i.e., column 1⁻ ~N^{*}), effer explanation in corresponding row in column II.
¹⁴ If the state is planning to phase in the reporting of any of the subpopulation categories, the state should provide m explanation and the report (DY and Q) in which it will begin

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 3.0) State Arkansse Demonstration Name Arkansse

Instructions:

(1) in the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MDD/YYY with no spaces in the cell. The information entered in these cells will auto-populate the eligibility and coverage demonstration reporting schedule in Table 2. All cells in the input table must be completed in entiry and in the correct format for the standard reporting schedule is be accurately use populate.

(2) Review the state's reporting schedule in the digibility and coverage demonstration reporting schedule table (Table 2). For each of the reporting categories listed in columns E and F, select Y or N in the "Deviation from standard reporting schedule (YN)" column to indicate whether the state plan to report according to the standard reporting schedule. If a state's planned reporting decould for any quarter and/or reporting category, the state should decorde these deviations in the "Explanation for deviations" column and use the "Proposed deviations from standard reporting schedule" column to indicate the measurement periods with which it wishes to overwrite the standard schedule. All other columns are locked for eding and should host be allowed by the state.

Table 1. Eligibility and Coverage Demonstration Reporting Periods Input Table

	Demonstration reporting periods/da	tes	
			RW
Dates of first demonstration year			
Start date (MM/DD/YYYY)	01/01/2022	01/01/2022	01/01/2022
End date (MM/DD/YYYY)	12/31/2022	12/31/2022	12/31/2022
Dates of first quarter of the baseline reporting period for CMS-constructed metrics			
Reporting period (EandC DY and Q) (Format DY#Q#; e.g. DY1Q1)	DYIQI	DY1Q1	DY1QI
Start date (MM/DD/YYYY) ^a	01/01/2022	01/01/2022	01/01/2022
End date (MM/DD/YYYY)	03/31/2022	03/31/2022	03/31/2022
Broader section 1115 demonstration reporting period corresponding with the first EandC reporting quarter, if applicable. If there is no broader demonstration, fill in the first eligibility and coverage policy reporting period. (Format DY/#Q/#; e.g. DY1Q3)	DYIQI	DYIQI	DYIQI
First monitoring report due date (per STCs) (MM/DD/YYYY)	05/31/2022	05/31/2022	05/31/2022
First monitoring report in which the state plans to report calendar year (CY) metrics with a 90 day lag			
Reporting period (Format CY#; e.g. CY2019)	CY2022		
DY and Q associated with monitoring report (Format DY#Q#; e.g. DY1Q1)	DY2Q3		
DY and Q start date (MM/DD/YYYY)	07/01/2023		
DY and Q end date (MM/DD/YYYY)	09/30/2023		
Dates of last reporting quarter:			
Start date (MM/DD/YYYY)	10/01/2026	10/01/2022	10/01/2026
End date (MM/DD/YYYY)	12/31/2026	12/31/2022	12/31/2026

Table 2. Eligibility and Coverage Demonstration Reporting Schedule

Table 2. Eligibility and C	overage Demonstration Rep	porting Schedule	1										
						For each reporting							
						ror cach reporting					1		
						category, measuremen period for which information is captured in monitoring report per standard reporting schedule (Format DY//Q/!; e.g.,	E				1		
						period for which					1		
						information is					1		
						captured in monitorin	g				1		
						report per standard					Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)		
			Broader section 1115 DY			reporting schedule					measurement period from		
			(if applicable, otherwise the first			(Format DY#Q#; e.g.,			Deviation from		standard reporting schedule		
		Monitoring report due	eligibility and coverage policy			DY1Q3) ^b			standard reporting		(Format DV#O#: e.g., DV103)		
Reporting quarter start date	Reporting quarter end date	(ner STCe)	reporting period)	Penorting category:	Penarting estagory:				schedule	Explanation for	(Format D1#Q#, C.g., D11QD)		
Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	(per STCs) (MM/DD/YYYY)	Broader section 1115 DY (if applicable, otherwise the first eligibility and coverage policy reporting period) (Format DY#Q#; e.g. DY1Q3)	Reporting category: Calculation lag	Reporting category: Measurement period	AD	PD		Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	AD		RW
01/01/2022	03/31/2022	05/31/2022	DY1Q1	None	Narrative information	DY1Q1	DY1Q1	DY1Q1	(1////)	deviations			
010112022	0515112022	03/3/12022	5.1.Q.	30 days	Month	DY1Q1	DY1Q1	DY1Q1			(
				None	Ouarter	DY1Q1	DIIQI	DIIQI			(
				90 days	Quarter	DTIQI	-	-			;		
				90 days	Quarter		-	-		ana	;		
										The state is not required	1		
										to submit any metrics in	i l		
				90 days	Calendar year				n.a.	this reporting category	i l		
					-					since the category does	1		
										not contain any CMS	i l		
					la i					priority metrics.	·		
				None	Demonstration year						4		
04/01/2022	06/30/2022	08/29/2022	DY1Q2	None	Narrative information	DY1Q2	DY1Q2	DY1Q2			,		
				30 days	Month	DY1Q2	DY1Q2	DY1Q2			ı – – – – – – – – – – – – – – – – – – –		
				None	Quarter	DY1Q2					ı		
				90 days	Quarter	DY1Q1		DY1Q1			ı		
										The state is not required	1		
										to submit any metrics in	1		1
				90 days	Calendar year					this reporting category	1		
				50 uays	carendar year				n.a.	since the category does	1		
										not contain any CMS	1		
										priority metrics.	1		
				None	Demonstration year	1	1	i —			í i		
07/01/2022	09/30/2022	11/29/2022	DY1Q3	None	Narrative information	DY1Q3	DY1Q3 DY1Q3	DY1Q3			1		_
				30 days	Month	DY1Q3	DY103	DY1Q3			1 1		
				None	Quarter	DY1Q3					1 1		
				90 days	Ouarter	DY1Q2	1	DY1Q2			(
				50 days	Quarter	DTIQ2	1	101102		The state is not required	· · · · · · · · · · · · · · · · · · ·		
										to submit any metrics in	1		
											1		
				90 days	Calendar year				n.a.	this reporting category since the category does	1		
										since the category does	i l		
										not contain any CMS priority metrics.	i l		
				Ni	Description		-	-		priority metrics.	;		
10/01/2022	12/21/2022	02/21/2022	DV104	None	Demonstration year	DVIOL	DV104	DVIO			1		
10/01/2022	12/31/2022	03/31/2023	DY1Q4	30 days	Narrative information Month	DY1Q4 DY1Q4	DY1Q4 DY1Q4	DY1Q4 DY1Q4			;		
						DTIQ	DTIQ4	DTIQ4			;		
				None	Quarter	DY1Q4		DILLOS			;		
				90 days	Quarter	DY1Q3		DY1Q3		-	;		
										The state is not required	1		
										to submit any metrics in	1		
				90 days	Calendar year				n.a.	this reporting category	1		
										since the category does	1		
										not contain any CMS	1		
								1		priority metrics.	,		
				None	Demonstration year	DY1							
01/01/2023	03/31/2023	05/30/2023	DY2Q1	None	Narrative information	DY2Q1	DY2Q1	DY2Q1			ı – – – – – – – – – – – – – – – – – – –		
				30 days	Month	DY2Q1	DY2Q1	DY2Q1			ı – – – – – – – – – – – – – – – – – – –		
				None	Quarter	DY2Q1					ı		
				90 days	Quarter	DY1Q4		DY1Q4			1		
										The state is not required	1		
										to submit any metrics in	1		
				00.1	Cil. January					this reporting category	1		
				90 days	Calendar year				n.a.	since the category does	1		
										not contain any CMS	1		
										priority metrics.	1		
				None	Demonstration year						j i		
04/01/2023	06/30/2023	08/29/2023	DY2Q2	None	Narrative information	DY2Q2	DY2Q2	DY2Q2			1		
				30 days	Month	DY2Q2	DY2Q2	DY2Q2			i i		
				None	Quarter	DY2Q2					i i		
				90 days	Quarter	DY2Q1		DY2Q1			i i		
				1	1					The state is not required	(t	-	<u> </u>
										to submit any metrics in	1		
										this reporting category	1		
				90 days	Calendar year				n.a.	since the category does	1		1
										not contain any CMS	1		
										priority metrics.	1		1
				None	Demonstration year			1	-	1	(
07/01/2023	09/30/2023	11/29/2023	DY2Q3	None	Narrative information	DY203	DY2Q3	DY2Q3			(
				30 days	Month	DY2Q3 DY2Q3	DY2Q3	DY203		1	(
				None	Quarter	DY2Q3				1	(
				90 days	Quarter	DY2Q2	-	DY2Q2		1	(
				70 mg/s	A num res	5.202	1	D 1 2Q2		The state is not required	·		
										The state is not required to submit any metrics in	1		
										to submit any metrics in this reporting category	1		
				90 days	Calendar year	CY2022			n.a.	this reporting category since the category does	1		
										since the category does not contain any CMS	1		
										priority metrics.	1		
				N	D		-			priority metrics.	,		
10/01/2023	12/31/2023	03/30/2024	DY2Q4	None	Demonstration year Narrative information	DV204	DV204	DV204			1		
10.01.2023	2.5.1.2023	0.5.50 2024		None 30 days	Month	DY2Q4 DY2Q4	DY2Q4 DY2Q4	DY2Q4 DY2Q4		1	(÷		
						DV204	Q4	0.204		1	(÷		
				None	Quarter	DY2Q4	1	DI IAGA		-	· · · · · · · · · · · · · · · · · · ·		
				90 days	Quarter	DY2Q3		DY2Q3		1	, I		1

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MMDDDYYY)	Munitoring report due (per SICs) (MMDDYXY)	Broader section 1115 DY (Fapilicable, otherwise the first eligibility and coverage policy (Formal DV 400-cc, D3103)	Reporting category: Calculation bug	Reporting category: Masaurement period	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DV40%; e.g., DY1Q3) ^b AD	PR	RW	Deviation from standard reporting schedule (V/Nin.a.)	Explanation for deviations	Proposed deviation in measurement period from sinadard reporting schedule (Format DV140); 20 U(2) AD	PR		RW
				90 days	Calendar year				n.a.	The state is not required to submit any metrics in this reporting category since the category does not contain any CMS priority metrics.				
				None	Demonstration year	DY2							ĺ	
01/01/2024	03/31/2024	05/30/2024	DY3Q1	None	Narrative information	DY3Q1	DY3Q1	DY3Q1						
				30 days	Month	DY3Q1	DY3Q1	DY3Q1					ĺ	
				None	Quarter	DY3Q1								
				90 days	Quarter	DY2Q4	Ì	DY2Q4					ĺ	
				90 days	Calendar year				n.ä.	The state is not required to submit any metrics in this reporting category since the category does not contain any CMS priority metrics.				
				None	Demonstration year									
04/01/2024	06/30/2024	08/29/2024	DY3Q2	None	Narrative information	DY3Q2	DY3Q2	DY3Q2						
				30 days	Month	DY3Q2	DY3Q2	DY3Q2						
				None	Quarter	DY3Q2								
				90 days 90 days None	Quarter Calendar year Demonstration year	DY3Q1		DY3Q1	n.a.	The state is not required to submit any metrics in this reporting category since the category does not contain any CMS priority metrics.				
07/01/2024	09/30/2024	11/29/2024	DY3Q3	None	Narrative information	DY3Q3	DY3Q3	DY3Q3						
07/01/2024	09/30/2024	11/29/2024	01505	30 days	Month		DY3Q3	DY3Q3						
				None	Quarter	DY3Q3	51505	51505						
				90 days	Quarter	DY3Q2		DY3Q2						
				90 days	Calendar year	CY2023		01302	n.a.	The state is not required to submit any metrics in this reporting category since the category does not contain any CMS priority metrics.				
				None	Demonstration year									
10/01/2024	12/31/2024	03/31/2025	DY3Q4	None	Narrative information		DY3Q4	DY3Q4						
				30 days	Month	DY3Q4	DY3Q4	DY3Q4						
				None	Quarter	DY3Q4		DY3Q3						
				90 days 90 days None	Quarter Calendar year Demonstration year	DY3Q3 DY3			n.a.	The state is not required to submit any metrics in this reporting category since the category does not contain any CMS priority metrics.				
01/01/2025	03/31/2025	05/30/2025	DY4Q1	None	Narrative information	DY4Q1	DY4Q1	DY4Q1						
				30 days	Month			DY4Q1						
				None	Quarter	DY4Q1		×.						
				90 days	Quarter	DY3Q4		DY3Q4					1	
				90 days None	Calendar year Demonstration year				n.a.	The state is not required to submit any metrics in this reporting category since the category does not contain any CMS priority metrics.				
04/01/2025	06/30/2025	08/29/2025	DY4Q2	None	Narrative information	DY4Q2	DY4Q2	DY4Q2						
				30 days	Month	DY4Q2	DY4Q2	DY4Q2						
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				90 days	Quarter Quarter	DY4Q2 DY4Q1		DY4Q1						
				20 mys	Norma (C)					The state is not required				
				90 days	Calendar year				n.a.	to submit any metrics in this reporting category since the category does not contain any CMS priority metrics.				
				None	Demonstration year									

Image: section of the sectio							For each reporting category, measurement period for which							
NUM NUM <th></th> <th></th> <th>Monitoring report due</th> <th>eligibility and coverage policy</th> <th></th> <th></th> <th>report per standard reporting schedule (Format DY#Q#; e.g.,</th> <th></th> <th></th> <th>Deviation from standard reporting</th> <th></th> <th>Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)</th> <th></th> <th></th>			Monitoring report due	eligibility and coverage policy			report per standard reporting schedule (Format DY#Q#; e.g.,			Deviation from standard reporting		Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)		
Phiname <	(MM/DD/VVVV)	(MM/DD/YVY)	(per STCs) (MM/DD/VVVV)	reporting period) (Format DV#O#: e.g. DV1O3)	Calculation lag	Reporting category: Measurement period	AD	PR	RW	(V/N/n.a.)	Explanation for deviations	AD	PR	RW
Normal		09/30/2025	11/29/2025	DY4Q3	None	Narrative information	DY4Q3	DY4Q3	DY4Q3	(*********)				
Image: state in the state interval interva				-	30 days	Month	DY4Q3	DY4Q3	DY4Q3			1		ĺ
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Number Numer Numer Numer <td></td> <td></td> <td></td> <td></td> <td>90 days</td> <td>Quarter</td> <td>DY4Q2</td> <td></td> <td>DY4Q2</td> <td></td> <td></td> <td></td> <td></td> <td></td>					90 days	Quarter	DY4Q2		DY4Q2					
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Normal	10/01/2025	12/31/2025	03/31/2026	DY4Q4	None	Narrative information	DY4Q4	DY4Q4	DY4Q4			1		
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^b The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.