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 -S
Digitally signed by Danielle Daly -S
Date: 2022.12.28 15:20:09 -05'00'

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 Monitoring Report Template 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.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (AD) (Version 3.0)

State: Arkansas

Demonstration Name: Arkansas Health and Opportunity for Me (ARHOME)

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

Standard information on CMS-provided metrics									
#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)
EXAMPLE: AD_33 ***(Do not delete or edit this row)***	*EXAMPLE: Preventive care and office visit utilization*	*EXAMPLE: Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period.*	*EXAMPLE: 1.1.7 Access to care*	*EXAMPLE: Claims and encounters and other administrative records*	*EXAMPLE: 90 days*	*EXAMPLE: Quarter*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*
AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement 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-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	1.1.1 Enrollment	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 disenrolled 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	Re-enrollments or re-instatements using defined pathways after disenrollment 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 disenrolled 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	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	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	Beneficiaries determined ineligible for Medicaid after state processes a beneficiary-reported change in circumstance	Number of beneficiaries who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they were determined ineligible 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 the demonstration due to transfer to another Medicaid eligibility group	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	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 disenrollment.	1.1.3 Enrollment duration at time of disenrollment	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 disenrollment.	1.1.3 Enrollment duration at time of disenrollment	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

#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)
AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process, but move from the demonstration to CHIP.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	N
AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	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 process.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y
AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y
AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Required	Y
AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices.	1.1.4 Renewal	Administrative records	30 days	Month	Quarterly	Recommended	N
AD_23	Beneficiaries who reached 5% limit	Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit on cost sharing and premiums during the month.	1.1.5 Cost sharing limit	Administrative records	30 days	Month	Quarterly	Required for states with cost-sharing or premiums	Y
AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	Y
AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	Y
AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	Y
AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	Y
AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal.	1.1.6 Appeals and grievances	Administrative records	None	Quarter	Quarterly	Recommended	Y
AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period.	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y
AD_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 and encounters	90 days	Quarter	Quarterly	Required	Y
AD_31	Specialist provider availability	Number of specialty physician and non-physician medical practitioners enrolled to deliver Medicaid services at the end of the measurement period.	1.1.7 Access to care	Provider enrollment databases	90 days	Quarter	Quarterly	Required	Y
AD_32	Specialist provider active participation	Number of specialty physician and non-physician medical practitioners 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 and encounters	90 days	Quarter	Quarterly	Required	Y
AD_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 administrative records	90 days	Quarter	Quarterly	Recommended	N
AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	N
AD_35	Emergency department utilization, all use	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	N
AD_36	Emergency department utilization, non-emergency	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-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended. Required for states with copayments for non-emergency use.	N
AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period.	1.1.7 Access to care	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Recommended	N

#	Metric name	Metric description	Reporting topic[a]	Data source	Calculation lag	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	1.1.8 Quality of care and health outcomes	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year	Annually	Required (AD_38A or AD_38B. States do not have to report both.)	N
AD_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
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 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 rates 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
AD_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 visit (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
AD_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. Percentage of beneficiaries who initiate treatment through an inpatient 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. Percentage of beneficiaries who initiate treatment and who were engaged 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
AD_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
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]	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
AD_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
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	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
AD_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
State-specific metrics									
[Insert row(s) for any additional state-specific metrics by right-clicking on row 58 and selecting "Insert"]									

[a] The reporting topics correspond to the prompts for the any demonstration (AD) reporting topic in Section 4 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.

[c] 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.

* 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.

Medicaid Section 1115 Eligibility and Coverage Demonstra

State: Arkansas

Demonstration Name: Arkansas Health and Opportunity fo

Table: Eligibility and Coverage Demonst

		Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	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.)[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
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*	*EXAMPLE:*	*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	01/01/2022-12/31/22	Decrease in 2023 due to the end of the PHE, then consistent	Decrease	Y		N		
AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	01/01/2022-12/31/22	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	01/01/2022-12/31/22	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								
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 consistent	Decrease	Y		N		
AD_16	Beneficiaries determined ineligible for the demonstration at 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_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		

#	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.)[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								
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								
AD_23	Beneficiaries who reached 5% limit	01/01/2022-12/31/22	Consistent	Consistent	Y		N		
AD_24	Appeals, eligibility	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	01/01/2022-12/31/22	Consistent	Consistent	N	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	Specialist provider active 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								

#	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.)[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_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]								
AD_38B	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 measure]								
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									
[Insert row(s) for any additional state-specific metrics by right									

[a] The reporting topics correspond to the prompts for the any de

[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
Coverage Demonstrations Monitoring Protocol Instructions.

* The rationale for these metrics was first described in Mathem
for Eligibility and Coverage Demonstrations That Include Prem
Engagement," dated June 21, 2018.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned metrics (PR) (Version 3.0)

State Arkansas
Demonstration Name Arkansas Health and Opportunity for Me (ARHOME)

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

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target		
#	Metric name	Metric description	Reporting topic[a]	Data source	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 demonstration target
EXAMPLE: PR_21 ***(Do not delete or edit this row)***	*EXAMPLE: Third-party premium payment*	*EXAMPLE: Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.*	*EXAMPLE: PR.Mod_1: Eligibility and payment amounts*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020 - 01/31/2020*	*EXAMPLE: Consistent*	*EXAMPLE: Consistent*
PR_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
PR_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 count of those exempt from owing premiums or other monthly payments, and therefore not required to make payments. For example, demonstration policies may exempt beneficiaries who 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	Y	01/01/2022-12/31/22	None	None
PR_3	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 this month.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Required	Y	01/01/2022-12/31/22	None	None
PR_4	Beneficiaries who were subject to premium policy but declare hardship for that 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 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			
PR_5	Beneficiaries in short-term arrears (grace period)	Among 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).	PR.Mod_5: Operationalize strategies for noncompliance	Administrative records	30 days	Month	Quarterly	Required if state has a grace period	N			
PR_6	Beneficiaries in long-term arrears	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who did not pay this month, and who remain enrolled even though they had exceeded the grace period, i.e., allowable period of noncompliance.	PR.Mod_5: Operationalize strategies for noncompliance	Administrative 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			
PR_7	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 noncompliance	Administrative records	30 days	Month	Quarterly	Required	N			
PR_8	Beneficiaries in enrollment duration tier 1	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 1 – the shortest enrollment duration, during which beneficiaries are subject to the first set of program rules and requirements. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Mod_1: Eligibility and 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 fo

Table: Eligibility and Coverage Demons

		Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	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.)[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
EXAMPLE: *PR_21* ***(Do not delete or edit this row)***	*EXAMPLE:* *Third-party premium payment*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *N*	*EXAMPLE:*	*EXAMPLE:*
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	Y		N		
PR_2	Beneficiaries who were exempt from premiums for that month	Y		N		
PR_3	Beneficiaries who paid a premium during the month	Y		N		
PR_4	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					

#	Metric name	Metric description	Reporting topic[a]	Data source	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 demonstration target
PR_9	Beneficiaries in enrollment duration tier 2	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 2 - the enrollment duration that follows tier 1, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 1. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended in states with time-variant premium policies	N			
PR_10	Beneficiaries in enrollment duration tiers 3+	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 3 – the enrollment duration that follows tier 2, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 2. Tiers are defined in terms of enrollment 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 enrollees within each additional tier.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended in states with time-variant premium policies	N			
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	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 enrolled in the demonstration.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
PR_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 payments did not change.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
PR_13	Premium increase following mid-year processing of 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 payments increased.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
PR_14	Premium decrease following mid-year processing of 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 payments decreased.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	Number of demonstration beneficiaries disenrolled from Medicaid as of the last day of 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 termination for failure to pay	N			
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	The number of prior demonstration beneficiaries who were disenrolled from Medicaid for failure to pay premiums and are in a non-eligibility period, meaning they 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	Administrative records	30 days	Month	Quarterly	Required if state has a non-eligibility period policy	N			
PR_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			
PR_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			
PR_19	Premium increase	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 monthly payments.	PR.Mod_1: Eligibility and payment amounts	Administrative records	30 days	Month	Quarterly	Recommended	N			
PR_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			
PR_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			
State-specific metrics												
[Insert row(s) for any additional state-specific metrics by right-clicking on row 32 and selecting "Insert"]												

[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.

[c] 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.

* 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.

#	Metric name	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.)[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
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						
[Insert row(s) for any additional state-specific metrics by right						

[a] The reporting topics correspond to the premiums or account pa

[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 f Coverage Demonstrations Monitoring Protocol Instructions.

* The rationale for these metrics was first described in Mathema Eligibility and Coverage Demonstrations That Include Premium Engagement," dated June 21, 2018.

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

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

Standard information on CMS-provided metrics										Baseline, annual goals, and demonstration target		
#	Metric name	Metric description	Reporting topic[a]	Data source	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 demonstration target
EXAMPLE: RW_1 ***(Do not delete or edit this row)***	*EXAMPLE: Beneficiaries who indicated that they had unpaid medical bills at the time of application*	*EXAMPLE: The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question.*	*EXAMPLE: RW.Mod_1: Retroactive eligibility and demonstration requirements*	*EXAMPLE: Administrative records*	*EXAMPLE: 30 days*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020 - 01/31/2020*	*EXAMPLE: Consistent*	*EXAMPLE: Consistent*
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months or other time period specified in the state's Medicaid application question.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	30 days	Month	Quarterly	Required	Y	07/01/2022-06/30/23	Consistent	Consistent
RW_2	Beneficiaries who had a coverage gap at renewal	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver 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 on time.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	Y	07/01/2022-06/30/23	Consistent	Consistent
RW_3	Beneficiaries who had a coverage gap at renewal and had claims denied	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver 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 during the period of disenrollment that were denied by the state.	RW.Mod_1: Retroactive eligibility and demonstration requirements	Administrative records	90 days	Quarter	Quarterly	Required	Y	07/01/2022-06/30/23	Consistent	Consistent
State-specific metrics												
[Insert row(s) for any additional state-specific metrics by right-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.

[c] 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

		Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	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.)[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
EXAMPLE: *RW_1* ***(Do not delete or edit this row)***	*EXAMPLE:* *Beneficiaries who indicated that they had unpaid medical bills at the time of application*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *N*	*EXAMPLE:*	*EXAMPLE:*
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	Y		N		
RW_2	Beneficiaries who had a coverage gap at renewal	N	CMS authorized a retroactive eligibility waiver, allowing for 30 days, rather than 90 days. DHS will calculate Step 3 of the calculation to 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		
RW_3	Beneficiaries who had a coverage gap at renewal and had claims denied	N	Step 2 will include beneficiaries for whom claims were submitted for services rendered during the coverage gap that were denied by the state or the qualified health plan	N		
State-specific metrics						
[Insert row(s) for any additional state-specific metrics by righ						

[a] The reporting topic corresponds to the retroactive eligibility w

[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) - Planned subpopulations (AD) (Version 3.0)

State: Arkansas

Demonstration Name: Arkansas Health and Opportunity for Me (ARHOME)

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

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-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" or grey), list the subpopulations state plans to report (Format comma separated)[b, c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), 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:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *AD_1 - AD_23, AD_33 - AD_44*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *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		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; AD_20; AD_21; AD_23; AD_24; AD_25
Exempt groups	Eligibility 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 exemptions, exemptions due to medical frailty*	Recommended	AD_1 - AD_11, AD_15 - AD_23, AD_33 - AD_37	State-specific	Y		Exempt from copays: AIAN, medically frail, < or =20% FPL; individuals in hospice, pregnant women, 19- and 20-year-olds		
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *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		

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[c] If the state is planning to phase in 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 category in column H.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (PR) (Version 3.0)

State: Arkansas
Demonstration Name: Arkansas Health and Opportunity for Me (ARHOME)

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

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category[a]	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-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" or grey), list the subpopulations state plans to report (Format comma separated)[c, d]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), 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:* *Less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *PR_1 - PR_21*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *Y*	*EXAMPLE:*	*EXAMPLE:* *Y*	*EXAMPLE:*
Income groups	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	0%-20% FPL; >20%-40% FPL; >40%-60% FPL; >60%-80% FPL; >80%-100% FPL; >100%-120% FPL; >120%-	N	PR_1; PR_2; PR_3
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	PR_15 - PR_17	CMS-provided	Y	Y		Y	
Specific eligibility groups	Medicaid eligibility groups included in the state's demonstration based on the STCs authorizing the demonstration *EXAMPLE:* *Section 1931 parents, the new adult group, transitional medical assistance beneficiaries*	Required	PR_1 - PR_21	State-specific	N				

[a] For definitions of subpopulations, see CMS-provided technical specifications on subpopulation categories.

[b] If applicable. See CMS-provided technical specifications on subpopulation categories.

[c] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[d] If the state is planning to phase in 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

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

State	Arkansas
Demonstration Name	Arkansas Health and Opportunity for Me (ARHOME)

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 MM/DD/YYYY 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 entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the eligibility 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 (Y/N)" column to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category, the state should describe 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 editing and should not be altered by the state.

Table 1. Eligibility and Coverage Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates		
	AD	PR	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)	DY1Q1	DY1Q1	DY1Q1
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)	DY1Q1	DY1Q1	DY1Q1
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

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (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	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	PR	RW	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) AD	PR	RW
01/01/2022	03/31/2022	05/31/2022	DY1Q1	None	Narrative information	DY1Q1	DY1Q1	DY1Q1					
				30 days	Month	DY1Q1	DY1Q1	DY1Q1					
				None	Quarter	DY1Q1							
				90 days	Quarter								
				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								
04/01/2022	06/30/2022	08/29/2022	DY1Q2	None	Narrative information	DY1Q2	DY1Q2	DY1Q2					
				30 days	Month	DY1Q2	DY1Q2	DY1Q2					
				None	Quarter	DY1Q2							
				90 days	Quarter	DY1Q1		DY1Q1					
				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								
07/01/2022	09/30/2022	11/29/2022	DY1Q3	None	Narrative information	DY1Q3	DY1Q3	DY1Q3					
				30 days	Month	DY1Q3	DY1Q3	DY1Q3					
				None	Quarter	DY1Q3							
				90 days	Quarter	DY1Q2		DY1Q2					
				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								
10/01/2022	12/31/2022	03/31/2023	DY1Q4	None	Narrative information	DY1Q4	DY1Q4	DY1Q4					
				30 days	Month	DY1Q4	DY1Q4	DY1Q4					
				None	Quarter	DY1Q4							
				90 days	Quarter	DY1Q3		DY1Q3					
				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	DY1							
01/01/2023	03/31/2023	05/30/2023	DY2Q1	None	Narrative information	DY2Q1	DY2Q1	DY2Q1					
				30 days	Month	DY2Q1	DY2Q1	DY2Q1					
				None	Quarter	DY2Q1							
				90 days	Quarter	DY1Q4		DY1Q4					
				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								
04/01/2023	06/30/2023	08/29/2023	DY2Q2	None	Narrative information	DY2Q2	DY2Q2	DY2Q2					
				30 days	Month	DY2Q2	DY2Q2	DY2Q2					
				None	Quarter	DY2Q2							
				90 days	Quarter	DY2Q1		DY2Q1					
				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								
07/01/2023	09/30/2023	11/29/2023	DY2Q3	None	Narrative information	DY2Q3	DY2Q3	DY2Q3					
				30 days	Month	DY2Q3	DY2Q3	DY2Q3					
				None	Quarter	DY2Q3							
				90 days	Quarter	DY2Q2		DY2Q2					
				90 days	Calendar year	CY2022			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								
10/01/2023	12/31/2023	03/30/2024	DY2Q4	None	Narrative information	DY2Q4	DY2Q4	DY2Q4					
				30 days	Month	DY2Q4	DY2Q4	DY2Q4					
				None	Quarter	DY2Q4							
				90 days	Quarter	DY2Q3		DY2Q3					

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (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	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] AD	PR	RW	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3) 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							
01/01/2024	03/31/2024	05/30/2024	DY3Q1	None	Narrative information	DY3Q1	DY3Q1	DY3Q1					
				30 days	Month	DY3Q1	DY3Q1	DY3Q1					
				None	Quarter	DY3Q1							
				90 days	Quarter	DY2Q4		DY2Q4					
				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								
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	Quarter	DY3Q1		DY3Q1					
				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								
07/01/2024	09/30/2024	11/29/2024	DY3Q3	None	Narrative information	DY3Q3	DY3Q3	DY3Q3					
				30 days	Month	DY3Q3	DY3Q3	DY3Q3					
				None	Quarter	DY3Q3							
				90 days	Quarter	DY3Q2		DY3Q2					
				90 days	Calendar year	CY2023			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	DY3Q4					
				30 days	Month	DY3Q4	DY3Q4	DY3Q4					
				None	Quarter	DY3Q4							
				90 days	Quarter	DY3Q3		DY3Q3					
				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	DY3							
01/01/2025	03/31/2025	05/30/2025	DY4Q1	None	Narrative information	DY4Q1	DY4Q1	DY4Q1					
				30 days	Month	DY4Q1	DY4Q1	DY4Q1					
				None	Quarter	DY4Q1							
				90 days	Quarter	DY3Q4		DY3Q4					
				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								
04/01/2025	06/30/2025	08/29/2025	DY4Q2	None	Narrative information	DY4Q2	DY4Q2	DY4Q2					
				30 days	Month	DY4Q2	DY4Q2	DY4Q2					
				None	Quarter	DY4Q2							
				90 days	Quarter	DY4Q1		DY4Q1					
				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								

Reporting quarter start date (MM/DD/YYYY)	Reporting quarter end date (MM/DD/YYYY)	Monitoring report due (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	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b]			Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations	Proposed deviation in measurement period from standard reporting schedule (Format DY#Q#; e.g., DY1Q3)		
						AD	PR	RW			AD	PR	RW
07/01/2025	09/30/2025	11/29/2025	DY4Q3	None	Narrative information	DY4Q3	DY4Q3	DY4Q3					
				30 days	Month	DY4Q3	DY4Q3	DY4Q3					
				None	Quarter	DY4Q3							
				90 days	Quarter	DY4Q2		DY4Q2					
				90 days	Calendar year	CY2024			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								
10/01/2025	12/31/2025	03/31/2026	DY4Q4	None	Narrative information	DY4Q4	DY4Q4	DY4Q4					
				30 days	Month	DY4Q4	DY4Q4	DY4Q4					
				None	Quarter	DY4Q4							
				90 days	Quarter	DY4Q3		DY4Q3					
				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	DY4							
01/01/2026	03/31/2026	05/30/2026	DY5Q1	None	Narrative information	DY5Q1	DY5Q1	DY5Q1					
				30 days	Month	DY5Q1	DY5Q1	DY5Q1					
				None	Quarter	DY5Q1							
				90 days	Quarter	DY4Q4		DY4Q4					
				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								
04/01/2026	06/30/2026	08/29/2026	DY5Q2	None	Narrative information	DY5Q2	DY5Q2	DY5Q2					
				30 days	Month	DY5Q2	DY5Q2	DY5Q2					
				None	Quarter	DY5Q2							
				90 days	Quarter	DY5Q1		DY5Q1					
				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								
07/01/2026	09/30/2026	11/29/2026	DY5Q3	None	Narrative information	DY5Q3	DY5Q3	DY5Q3					
				30 days	Month	DY5Q3	DY5Q3	DY5Q3					
				None	Quarter	DY5Q3							
				90 days	Quarter	DY5Q2		DY5Q2					
				90 days	Calendar year	CY2025			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								
10/01/2026	12/31/2026	03/31/2027	DY5Q4	None	Narrative information	DY5Q4	DY5Q4	DY5Q4					
				30 days	Month	DY5Q4	DY5Q4	DY5Q4					
				None	Quarter	DY5Q4							
				90 days	Quarter	DY5Q3		DY5Q3					
				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	DY5							
[Add rows for all additional demonstration reporting quarters]													

[a] **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. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "EandC reporting schedule tab" should align with the first day of a month. If a state's eligibility and coverage demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "EandC reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[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.