Overview: The Monitoring Report for the section 1115 eligibility and coverage demonstrations consists of a Monitoring Report Workbook (Part A), Monitoring Report Template (Part B), and a Budget Neutrality Workbook (Part C). Each state with an approved eligibility and coverage policy in its section 1115 demonstration shall complete only one Monitoring Report 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. If the eligibility and coverage policies are part of a broader section 1115 demonstration, the state should report on the entire demonstration in the sections that apply to all eligibility and coverage demonstrations. CMS will work with the state to ensure there is no duplication in the reporting requirements for different components of the demonstration. For more information and any questions, the state should contact the section 1115 demonstration team.

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Report Template

Note: PRA Disclosure Statement to be added here

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

This section collects information on the approval features of the state's section 1115 demonstration overall, followed by information for each eligibility and coverage policy. Definitions for certain rows are provided below the table. The title page is a brief form that the state completed as part of its monitoring protocol. The title page will be populated with the information from the state's approved monitoring protocol. The state should complete the remaining two rows.

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*
Demonstration year and quarter	*EandC DY3Q4 report*
Reporting period	*10/01/2024-12/31/2024*
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 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. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information only. The recommended word count is 500 words or less.

ARHOME is Arkansas's Medicaid Expansion program serving adults between the ages of 19 and 64 with income below 138% of the federal poverty level. The program operates as a Section 1115 demonstration project, which allows the state to use Medicaid funding to purchase coverage through private Qualified Health Plans (QHPs) for eligible individuals. The program's goals include the following:

1. Providing continuity of coverage for individuals
2. Improving access to providers
3. Improving continuity of care across the continuum of coverage
4. Furthering quality improvement and delivery system reform initiatives that are successful across population groups

As part of the demonstration, Arkansas requested and received permission to shorten the allowable retroactive eligibility period at initial enrollment from 90 days to 30. The demonstration also included beneficiary premiums of $13 per month and copays of $4/$8, up to a maximum of $60 per quarter for individuals above 100% of the federal poverty level. The program would stop requiring beneficiaries from paying the $13 premium beginning January 1, 2023.

The state implemented other program provisions aimed at improving beneficiaries' health outcomes. QHPs are required to provide at least two health improvement incentives to encourage the use of preventive care and two health improvement incentives for each of the following populations:

- Pregnant women, particularly those with high-risk pregnancies
- Individuals with mental illness
- Individuals with substance use disorder
- Individuals with two or more chronic conditions

QHPs are also required to offer two economic independence incentives to encourage advances in beneficiaries' economic status or employment prospects.

CMS approved the new five-year waiver (January 1, 2022, through December 31, 2026) on December 21, 2021.

CMS approved an amendment to the ARHOME demonstration on November 21, 2022, to allow the state to implement the Life360 HOME program and to change the client copay structure. The Life360 HOME program seeks to provide supplemental care coordination services to address health-related social needs for individuals at high risk of long-term poverty. The amendment also

allowed the state to begin charging copays of $4.70/$9.40 for most beneficiaries above 20% of the federal poverty level. Quarterly copay limits were set to six different levels depending on the beneficiary's federal poverty level.

During 2024, DHS made significant progress in implementing the Life360 HOME program. So far, DHS received 11 letters of intent (the first step in the application process) from hospitals interested in becoming Life360 HOMEs. Ten were for Maternal Life360 and one was for Rural Life360. (Two hospitals later withdrew their letters of intent.) DHS has received six full applications (the second step in the application process) from hospitals interested in becoming Maternal Life360s. DHS has approved four applications and executed a Life360 HOME startup agreement with all four.

Readiness visits were conducted with four hospitals in 2024 and DHS executed full provider agreements for four hospitals to begin providing services.

In December 2024, CMS approved an amendment under the ARHOME Waiver for the state to provide non-medical transportation to transport Life360 HOME beneficiaries to community resources such as food or housing services when identified by the Life360 programs. The state will work with the Life360 hospitals on implementing the benefit for eligible beneficiaries.

There were no unexpected changes affecting the ARHOME program in 2024.

3. Narrative information on implementation, by eligibility and coverage policy and reporting topic

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Premiums and account payments (PR)			
PR.Mod_1. Eligibility and payment amounts			
PR.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to beneficiaries subject to premiums or account payments. Describe and explain changes (+ or -) greater than two percent.	X		The state stopped allowing premiums for beneficiaries in Q1 2023.
1.1.2 Discuss any data trends related to changes in premium amounts after mid-year change in circumstance or renewal.	X		
1.1.3 Discuss any data trends related to beneficiaries who are granted exemptions from premiums or account payments. Describe and explain changes (+ or -) greater than two percent.	X		
1.1.4 Discuss any data trends related to beneficiaries who paid a premium or account payment during that month. Describe and explain changes (+ or -) greater than two percent.	X		
1.1.5 Discuss any data trends related to beneficiaries who were subject to premiums or account payments but declared hardship. Describe and explain changes (+ or -) greater than two percent.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_1.2 Implementation update			
1.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state defines:	X		
1.2.1.a Beneficiaries exempt from premiums or account payments			
1.2.1.b Beneficiaries subject to premiums or account payments but exempt from compliance actions	X		
1.2.1.c Process for claiming financial hardship	X		
1.2.1.d Process for determining premium or account contribution amounts beneficiaries will pay	X		
1.2.1.e Process for determining that beneficiaries have reached the aggregate spending cap specified in the STCs	X		
1.2.1.f Other policy changes	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_2. Beneficiary account operations			
PR.Mod_2.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_2.2 Implementation update			
2.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how beneficiary health accounts are administered, including the role of vendors.	NA		
2.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how beneficiary health accounts work, including state contributions, use of account funds to pay for services, and rules for account rollovers and balances.	NA		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_3. Invoicing and payments			
PR.Mod_3.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_3.2 Implementation update			
3.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to invoicing and payment processes (including invoicing, beneficiary payments, grace periods, and deadlines for reporting a change in circumstance that would affect premium liability, and compliance actions).	X		
3.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to procedures for beneficiaries to pay premiums or account payments, or for third parties to pay premiums or account payments on behalf of beneficiaries.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_4. Reduction to premiums for non-income related reasons			
PR.Mod_4.1 Metric trends -- ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_4.2 Implementation update			
4.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to incentives or rewards related to premium or account payments (if applicable).	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_5. Operationalize strategies for noncompliance			
PR.Mod_5.1 Metric trends			
5.1.1 Discuss any data trends related to the number of beneficiaries who have experienced the below. Describe and explain changes (+ or -) greater than two percent. 5.1.1.i New disenrollments	NA		
5.1.1.ii New suspensions	NA		
5.1.2 Discuss any data trends related to beneficiaries in grace periods, non-eligibility periods, and/or other statuses. Describe and explain changes (+ or -) greater than two percent.	NA		
5.1.3 Discuss any data trends related to the number of beneficiaries who had collectible debt. Describe and explain changes (+ or -) greater than two percent.	NA		
PR.Mod_5.2 Implementation update			
5.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to: 5.2.1.a Implementation of compliance actions	X		
5.2.1.b Processes for identifying and tracking beneficiaries at risk of noncompliance	NA		
5.2.1.c Process for providing advance notice to beneficiaries at risk of suspension or disenrollment for noncompliance	NA		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1.d	Processes for tracking and pursuing collectible debts (if applicable)	NA		
5.2.1.e	Processes for screening those at risk of disenrollment for other Medicaid eligibility groups or exemptions	NA		
5.2.1.f	Appeals processes for beneficiaries subject to premium requirements	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_6. Develop comprehensive communications strategy			
PR.Mod_6.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_6.2 Implementation update			
6.2.1 Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's strategy to communicate with beneficiaries about:	X		
6.2.1.a Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's strategy to communicate with beneficiaries about:			
6.2.1.b Payment process	X		
6.2.1.c Rewards for payment (if any)	NA		
6.2.1.d Processes for reporting changes in income, making hardship claims, and filing appeals	X		
6.2.1.e Consequences of nonpayment	NA		
6.2.1.f Non-eligibility periods	NA		
6.2.2 Compared to the details outlined in the implementation plan, describe any change or expected changes to the information provided on beneficiary invoices.	X		
6.2.3 Describe any communication or outreach that was conducted with partners, such as managed care organizations or other contractors, during this reporting period.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2.4 Compared to the details outlined in the implementation plan, describe any changes or challenges with how materials or communications were accessible to beneficiaries with limited English proficiency, with low literacy, and in rural areas, and other diverse groups.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_7. Develop and modify systems			
PR.Mod_7.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_7.2 Implementation update			
7.2.1 Describe whether the state has developed or enhanced its systems capabilities as described in the implementation plan for: 7.2.1.a Accepting premiums or account payments	X		
7.2.1.b Tracking premiums or account payments	X		
7.2.1.c Establishing beneficiary accounts (if applicable)	NA		
7.2.1.d Operationalizing compliance actions (if applicable)	NA		
7.2.2 Describe any additional systems modifications that the state is planning to implement.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_8. State-specific metrics			
PR.Mod_8.1 Metric trends			
8.1.1 Discuss any data trends related to state-specific metrics. Describe and explain changes (+ or -) greater than two percent.	NA		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Retroactive eligibility waiver (RW)			
RW.Mod_1. Retroactive eligibility waiver and demonstration requirements			
RW.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to beneficiaries subject to retroactive eligibility waivers. Describe and explain changes (+ or -) greater than two percent.	X		The state does not have a waiver of retroactive eligibility at renewal (RW_2 and RW_3), only at application
RW.Mod_1.2 Implementation update			
1.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state will determine whether beneficiaries are exempt from the retroactive eligibility waiver.	X		
1.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any modifications or expected modifications to Medicaid applications to reflect the retroactive eligibility waiver.	X		
1.2.3 Report any modifications to the appeals processes for beneficiaries subject to retroactive eligibility waivers.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
RW.Mod_2. Develop comprehensive communications strategy			
RW.Mod_2.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
RW.Mod_2.2 Implementation update			
2.2.1 Compared to the details outlined in the implementation plan, describe any change or expected changes to the state's strategy for communicating to beneficiaries about changes to retroactive eligibility policies.	X		
2.2.2 Describe any communication or outreach that was conducted with partner organizations, including managed care organizations and community organizations.	X		
2.2.3 Describe any communication or outreach that was conducted with providers.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
RW.Mod_3. State-specific metrics			
RW.Mod_3.1 Metric trends			
3.1.1 Discuss any data trends related to state-specific metrics. Describe and explain changes (+ or -) greater than two percent.	X		.

4. Narrative information on implementation for any demonstration with eligibility and coverage policies

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_1 Metrics and operations for any demonstrations with eligibility and coverage policies (Any demonstration topics are applicable for reporting on the state's broader section 1115 demonstration. In support of CMS's efforts to simplify data collection and support analysis across states, report for all beneficiaries in the demonstration, not only those subject to eligibility and coverage policies.)			
AD.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to overall enrollment in the demonstration. Describe and explain changes (+ or -) greater than two percent.		AD_4	The number of new ARHOME enrollees increased in October and November, but then decreased in December. The fluctuations are likely due to a backlog of applications that began in October, peaked in November and was resolved by December. This caused what appeared to be a large increase in November from processing some October applications, and the apparent drop in applications in December as the backlog was resolved.
1.1.2 Discuss any data trends related to mid-year loss of demonstration eligibility. At a minimum, changes (+ or -) greater than two percent should be described.		AD_7, AD_8, AD_9, AD_10	In all four categories, the program saw a small variance in October, a large increase in November, and then a large decrease in December. The fluctuations are likely due to a reported processing backlog that began in October, peaked in November and was resolved by December. This caused what appeared to be a large increase in November from processing some October items, and the apparent reduction in December as the backlog was resolved.
1.1.3 Discuss any data trends related to enrollment duration at time of disenrollment. Describe and explain changes (+ or -) greater than two percent.		*AD_12, AD_13, AD_14*	The increase in disenrollments described above similarly affected the three duration measures.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.4 Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.		*AD_15-AD_22*	The number of beneficiaries due for renewal increased in October, decreased in November, and had a large increase in December. The fluctuations are likely due to a reported processing backlog of renewals that began in October, peaked in November and was resolved by December. This caused what appeared to be a large change in November and the apparent rise in renewals in December as the backlog was resolved.
1.1.5 Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.		*AD_23*	The number of beneficiaries whose copay obligation exceeded 5% of their household income (AD_23) decreased by 24% from Q3, reflecting efforts (described below) to address this issue. We believe the problem with allowing clients to be charged more than 5% of their household income stems from retroactive changes affecting beneficiaries' FPL after a copay has been charged, misalignment of the household income used to determine FPL for eligibility and household income used to determine copays, and QHPs unintentionally overcharging client copays. AD_23 decreased during Q4 due to several steps the state has taken to address these issues. Eligibility caseworkers have received additional training to ensure the household income used to determine FPL is the same household income entered and later used to determine cost sharing limits. Additionally, DHS has worked with ARHOME QHPs to identify and avoid charging excessive copays (for example, reporting back to them the beneficiaries who were charged more than the highest quarterly limit and requiring beneficiary repayment).

	Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.6	Discuss any data trends related to appeals and grievances. Describe and explain changes (+ or -) greater than two percent.		*AD_25; AD_28*	The number of benefit-denial appeals (AD_25) 14.25%. While the percentage change is higher than 2%, the numbers remain within the regular monthly range. The number of grievances (AD_28) decreased 5.88%. However, the numbers are within the normal monthly range and follow decreases from Q2.
1.1.7	Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.	X	*AD_29-AD_32*	The QHPs that participate in the ARHOME program have separate provider networks and categorize those providers' specialties differently. To account for these differences, we use a provider taxonomy developed by the Arkansas Insurance Department to assign specialties uniformly to the providers in Arkansas carrier networks. In the past, the small number of providers who appeared the AID list with multiple specialties (e.g. general and also specialist) were eliminated for purposes of this ARHOME metric. This quarter, AID published a new list with a greater than usual number of NPIs applied to more than one category of provider. This resulted in a greater number of eliminated providers, which made it appear that fewer providers and specialists were available. ARHOME is working with AID and the QHPs to address this issue and to ensure appropriate reporting of provider networks.
1.1.8	Discuss any data trends related to quality of care and health outcomes. Describe and explain changes (+ or -) greater than two percent.	NA		
1.1.9	Discuss any data trends related to administrative costs. Describe and explain changes (+ or -) greater than two percent.	NA		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_1.2. Implementation update			
1.2.1 Highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, compliance with requirements, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.			In Q4, DHS conducted three readiness reviews in the Life360 HOME program. One hospital reviewed began enrolling patients in January 2025. The SPA allowing all Medicaid beneficiaries eligible for Maternal Life360 to enroll in the program became effective November 1, 2024.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_2. State-specific metrics			
AD.Mod_2.1 Metric trends			
2.1.1 Discuss any data trends related to state-specific metrics. Discuss each state-specific metric trend in a separate row. Describe and explain changes (+ or -) greater than two percent.	NA		

5. Narrative information on other reporting topics

	Prompt	State has no update to report (place an X)	State response
1.	**Budget neutrality**		
1.1	**Current status and analysis**		
1.1.1	Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the eligibility and coverage policy component is part of a comprehensive demonstration, the state should provide an analysis of the eligibility and coverage policy related budget neutrality and an analysis of budget neutrality as a whole.		With a PMPM cost of $759.85 for the year, the state is currently under the budget neutrality limit of $802.86. This does not include the final annual cost settlement reconciliation the state has with the carriers to adjust for actual cost share reduction payments. Some of the Life 360 HOME expenditures for CY 24 appear on the CMS 64 report as a CY 25 expenditure. The reporting team is aware of this issue and will correct it for the next quarter's report.
1.2	**Implementation update**		

Prompt	State has no update to report (place an X)	State response
1.2.1 Describe any anticipated program changes that may impact financial/budget neutrality.		With the implementation of the Life360 HOME component of the ARHOME waiver, the state anticipates increased expenditures in the coming quarters. Because these expenditures are reported separately from ARHOME's PMPM budget neutrality, the state expects no impact from the Life360 HOME program to its PMPM cost. In December 2024, CMS approved an amendment under the ARHOME Waiver for the state to provide non-medical transportation to transport Life360 HOME beneficiaries to community resources such as housing services or food when identified by the Life360 programs. This benefit is available for ARHOME beneficiaries who are receiving services through the Life360 HOME. The state will work with the Life360 hospitals on implementing the benefit for eligible beneficiaries. In January 2025, Governor Sanders announced Pathway to Prosperity, a new initiative that provides a bridge over the "benefits cliff" by providing focused care coordination and a personal development plan supported by success coaching. The incentive offers a personal development plan and access to success coaches with a consequence of suspension of eligibility and loss of benefits for those who decline to participate.

Prompt	State has no update to report (place an X)	State response
2. Eligibility and coverage demonstration evaluation update		
2.1 Narrative information		
2.1.1 Provide updates on eligibility and coverage policy evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual [monitoring] reports. See Monitoring Report Instructions for more details.	X	The Life360 HOME evaluation design was approved by CMS in January 2025.
2.1.2 Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.		Expected timelines are being met and there are no real or anticipated barriers in the timeframes listed in the STCs.
2.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates.		Draft ARHOME Interim Evaluation is due 12/31/25. Draft ARHOME Summative Evaluation is due 6/30/28.

Prompt	State has no update to report (place an X)	State response
3. Other eligibility and coverage demonstration reporting		
3.1 General reporting requirements		
3.1.1 Describe whether the state foresees the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.		The state withdrew its amendment request to implement an Opportunities for Success Initiative. The previously anticipated changes to the ARHOME STCs are no longer expected. In January 2025, Governor Sanders announced Pathway to Prosperity, a new initiative that provides a bridge over the "benefits cliff" by providing focused care coordination and a personal development plan supported by success coaching. The incentive offers a personal development plan and access to success coaches with a consequence of suspension of eligibility and loss of benefits for those who decline to participate.
3.1.2 Compared to the details outlined in the STCs and the monitoring protocol, describe whether the state has formally requested any changes or whether the state expects to formally request any changes to: 3.1.2.a The schedule for completing and submitting monitoring reports		The STCs call for the state to submit a monitoring protocol for the Life360 HOME program 150 days after the November 1, 2022 approval of the amended STCs. CMS has indicated it will not expect the state to submit the revised monitoring protocol until CMS has provided the monitoring metrics it expects the state to report.
3.1.2.b The content or completeness of submitted monitoring reports and or future monitoring reports		As reported in the July 2024 submission of the Q1-Q3 2022 report, the state identified the cause of an issue with AD_15 noted in the Q1 2024 submission. The identified issue will result in resubmission of some related measures. Additionally, the state identified an issue with the data submitted for AD_23 in the Q1 2024 submission that will require corrections.

Prompt	State has no update to report (place an X)	State response
3.1.3 Describe whether the state has identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.		The STCs call for the state to submit a monitoring protocol for the Life360 HOME program 150 days after the November 1, 2022, approval of the amended STCs. CMS has indicated it will not expect the state to submit the revised monitoring protocol until CMS has provided the monitoring metrics it expects the state to report.

3.1.4 Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR 431.428(a)5		As part of its evaluation requirement, DHS's independent evaluator conducted a survey of ARHOME beneficiaries and a comparison group of non-ARHOME Medicaid beneficiaries in March and April of 2024. The results were analyzed and presented to DHS in Q4 2024. Favorable ratings among ARHOME beneficiaries for their personal doctor and specialist increased from 2022 to 2024. ARHOME beneficiary awareness of non-emergency medical transportation increased from 2022 to 2024. ARHOME beneficiaries rated all categories of perception of care higher than the comparison group. • Getting care quickly: 6.8% higher for target (86.1%, n=550) than comparison (79.3%, n=502). • Getting needed care: 2.8% higher for target (82.9%, n=591) than comparison (80.1%, n=536). • Doctor communication: 1.4% higher for target (93.5%, n=1416) than comparison (92.1%, n=1202). • Health plan customer service: 11.9% higher for target (90.9%, n=286) than comparison (79.0%, n=228). Favorable ratings (8-10) and average ratings were all higher for the target group than the comparison group for health care, personal doctor, specialist, and health plan. Differences in health care and health plan were significant, whereas differences in personal doctor and specialist were not. • Favorable rating of health care: 12.1% higher for target (75.6%, n=348) than comparison (63.5%, n=329). Average rating was 0.62 higher for target (8.38) than comparison (7.76).

		• Favorable rating of personal doctor: 0.4% higher for target (82.4%, n=467) than comparison (82.0%, n=384). Average rating was 0.15 higher for target (8.79) than comparison (8.64). • Favorable rating of specialist: 4.9% higher for target (83.1%, n=231) than comparison (78.2%, n=193). Average rating was 0.23 higher for target (8.69) than comparison (8.46). • Favorable rating of health plan: 15.6% higher for target (76.3%, n=562) than comparison (60.7%, n=476). Average rating was 0.82 higher for target (8.38) than comparison (7.56). ARHOME beneficiaries reported knowing and understanding more about Medicaid in 2024 than in 2022: • Knowledge of Medicaid paying all/part of the monthly cost: 71.4% (=412/577) vs. 65.2% (=133/204) • Knowledge that some people pay copays due to their income: 85.7% (=496/579) vs. 80.8% (=164/203) • Knowledge that ARHome has a shorter retroactive eligibility period than other Medicaid programs: 22.2% (=127/572) vs. 21.8% (=44/202) • Shorter retroactive eligibility period keeping you from enrolling in ARHome: 10.8% (=13/120) vs. 14.0% (=6/43)* Beneficiaries also reported knowing and understanding more about the ARHOME program in 2024 compared to 2022: • Health plan offering reward for healthy behaviors or wellness screenings: 30.3% (=173/571) vs. 23.3% (=47/202) • Knowledge that rewards/credits are part of ARHOME program to improve member health: 71.7% (=124/173) vs. 65.2% (=30/46)* • Health plan offering information on programs to help you get a job: 18.9% (=106/562) vs. 12.5% (=25/200)

Prompt	State has no update to report (place an X)	State response
		• Health plan offering reward to join programs to help you get a job: 10.8% (=61/567) vs. 10.6% (=21/198) • Knowledge that health plan should promote programs to help you get a job as part of ARHOME program: 17.1% (=98/573) vs. 15.7% (=31/197) • HYBRID: Beneficiary economic independence initiative awareness: 23.9% [= hybrid of 18.9%, 10.8%, and 17.1%]; Num/Den = 138/578 = 23.9% vs. 40/201 = 19.9%

Prompt	State has no update to report (place an X)	State response
3.2 Post-award public forum		
3.2.1 If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held indicating any resulting action items or issues. A summary of the post-award public forum should be included here for the period during which the forum was held and in the annual monitoring report.		DHS held a post-award forum public forum on June 25, 2024, to meet the annual requirement of 42 CFR 431.420(c), and as required by #52 of the Special Terms and Conditions. The public forum was held in conjunction with the ARHOME Advisory Panel and included a Zoom option for individuals who could not attend in person. Thirty-nine members of the public and seventeen DHS employees/contractors attended. The public forum provided the following information: • Overview of the ARHOME program, including a description of eligibility and current participant demographics; • Overview of the end of the Public Health Emergency, including ARHOME post-PHE enrollment numbers; • An explanation of how to renew ARHOME eligibility and what to do to restore lost coverage; • An overview of ARHOME enrollment by QHP, including health plan requirements and an overview of 2022 QHP health quality metrics and results; • A Life360 HOME update, including a program overview and a map of service delivery and population areas; and Other Life360 HOME updates and approvals, including completion of a billing system to allow for hospital enrollment, creation of a webpage, and CMS approval of a State Plan amendment to allow other Medicaid programs to participate in Maternal Life360.

	Prompt	State has no update to report (place an X)	State response
4.	**Notable state achievements and/or innovations**		
4.1	**Narrative information**		
4.1.1	Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies (1) pursuant to the eligibility and coverage policy hypotheses (or if broader demonstration, then eligibility and coverage policy related) or (2) that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms (e.g., number of impacted beneficiaries).		ARHOME's end-of-year achievements include six metrics in which ARHOME outperformed the 2023 mean of reporting states for Medicaid: 1. Breast Cancer Screening (National: 48.3%; ARHOME 50.7%) 2. COPD or Asthma in Older Adults Admission Rate (National: 38.8; ARHOME 16.2); 3. Asthma in Younger Adults Admission Rate (National: 3.3; ARHOME: 2.2); 4. Plan All-Cause Readmissions, Observed/Expected Ratio (National: 1.0161; ARHOME: .9570); 5. Asthma Medication Ratio (National: 62%; ARHOME: 65.1%); and 6. Initiation of SUD Treatment-Total Use Disorder (National: 46%; ARHOME: 46.9%). ARHOME has been previously unable to report on these achievements in DY3 quarterly reports due to the gap between the performance year and the results.

*The state should remove all example text from the table prior to submission.

Note: States must prominently display the following notice on any display of measure rates based on NCQA technical specifications for 1115 eligibility and coverage demonstration monitoring metrics:

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