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 DY1Q1-3 report*
Reporting period	*01/01/2022-09/30/2022*
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 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 in 2022.

The state implemented other program provisions aimed at improving beneficiaries' health outcomes. In 2022, QHPs were required to provide at least one health improvement incentive to encourage the use of preventive care and one health improvement incentive 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 were also required to offer one economic independence incentive 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.

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.		PR_1	The number of beneficiaries required to pay a premium dropped in April. This is likely due to the annual increase in the FPL levels, which take effect annually in April. The increase in the FPL incomes causes fewer existing beneficiaries to qualify as ≥100% FPL, resulting in fewer people subject to a premium.
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.		*PR_3*	*The number of beneficiaries reported having paid their premium (PR_3) dropped each month during the first three quarters of 2022. This was likely due to the fact that the QHPs apply premium payments to the last month owed. That means if a beneficiary is three months behind in premium payments and makes a payment in April, that payment will be applied to the January premium owed. This causes the most recent months to have the least premiums paid.*

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.	NA		
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	NX		
1.2.1.c Process for claiming financial hardship	NA		
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			To determine the total cost sharing beneficiaries were subject to, the state combined the total monthly ARHOME premium beneficiaries or beneficiaries in their household were charged, any TEFRA premiums beneficiaries or beneficiaries in their household were charged, and any copay charged to beneficiaries or beneficiaries in their household as recorded in QHP claims data. This total was compared with 5% of the beneficiary's household income.
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).			The state stopped allowing premiums for beneficiaries in Q1 2023.
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.			The state stopped allowing premiums for beneficiaries in Q1 2023.

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).			The state stopped allowing premiums for beneficiaries in Q1 2023.

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	X		
5.2.1.c Process for providing advance notice to beneficiaries at risk of suspension or disenrollment for noncompliance	X		

	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)			In 2022, with the transition to ARHOME, beneficiaries' failure to pay their premium shifted from being a debt to the state to being a debt to the health insurer. This ended the state's effort to collect unpaid premiums by intercepting the debt from beneficiaries' state tax return. Still state statute prevented insurers from disenrolling beneficiaries from whom they could not collect premium.
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)	X		
6.2.1.d Processes for reporting changes in income, making hardship claims, and filing appeals	X		
6.2.1.e Consequences of nonpayment			In 2022, with the transition to ARHOME, beneficiaries' failure to pay their premium shifted from being a debt to the state to being a debt to the health insurer. This ended the state's effort to collect unpaid premiums by intercepting the debt from beneficiaries' state tax return. Still, state statute prevented insurers from disenrolling beneficiaries from whom they could not collect premium.
6.2.1.f Non-eligibility periods	NA		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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		
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)	X		
7.2.2 Describe any additional systems modifications that the state is planning to implement.			In 2022, the state paid the QHPs one premium rate for beneficiaries who were not subject to a premium and that same rate, less $13/month for beneficiaries who were subject to a beneficiary premium. Beginning in 2023, the premiums the state pays to the QHPs do not have that $13 deduction for any beneficiaries.

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.		RW_1	The state's waiver of retroactive eligibility requirements was operationalized beginning July 1, 2022. Ten people were subject to the waiver in that first quarter of operations (Q3). The values for RW_2 and RW_3 are 0 because we do not have a waiver of the 90-day retroactive eligibility *at renewal*. The limited 30-day retroactive eligibility applies 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.	NA		

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 <u>all beneficiaries in the demonstration</u>, 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	*New enrollment dipped in February, a typical trend following open enrollment and a regular increase in January enrollees. The dip in February is followed by an increase in March to normal monthly levels.*

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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_10*	The number of beneficiaries who were determined ineligible for Medicaid significantly increased in June 2022. In July 2022, there was a spike in ARHOME closures primarily due to beneficiaries' failure to respond to request for information (RFI) notices. All of these are valid closures, as the RFIs were related to Reasonable Opportunity Period (ROP) verifications required to evaluate eligibility. Most of these RFIs were sent in March 2022 with a due date 90 days later (June 2022). In March 2022, a larger than usual number of ROP RFIs were sent by workers, and most of these were sent by individuals working on the Maximus Surge Support team. At that time, DHS was working to clear a backlog of Medicaid tasks, and that may have resulted in the "spike" in the number of RFIs that were sent. This in turn could have resulted in a higher number of closures. Beneficiaries whose ARHOME eligibility closed because they transferred to another Medicaid eligibility group increased significantly in March. This resulted from the federal poverty level guideline changes that are implemented in April each year. The FPL income change causes all beneficiaries' eligibility to be assessed for changes to more appropriate eligibility groups. The beneficiaries in AD_10 reduced in April in a return to regular levels.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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_13, AD_14	The numbers for AD_13 and AD_14 increased significantly in June 2022. This increase is related to the increase in overall closures described for AD_7 above. After considerable inquiry, we are unable to determine a specific reason for the increase.
1.1.4 Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.		AD_15	Beneficiaries due for renewal significantly increased in April. This is a routine April increase which is likely due to the federal poverty level guideline changes that are implemented in April each year. The FPL income change causes all beneficiaries' eligibility to be assessed for changes to more appropriate eligibility groups. Individuals whose Medicaid eligibility changes due to the FPL change will have their redetermination date reset, causing a higher number of renewals due in April each year.
1.1.5 Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.		*AD_23*	In 2022, the demonstration 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 enrolled in a QHP. The numbers for AD_23 increased each of the first three quarters of 2022 due to data issues resulting in some people appearing to have paid more cost sharing than 5% of their household income. We believe these results stem 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 began decreasing after Q3 2022 due to several steps the state has taken to address these issues. See monitoring report for Q1 2023.

	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_24-AD_28*	AD_25 increased in Q3. One of the QHPs indicated that the primary driver is step therapy legislation that went into effect in 2022. Additionally the QHP's utilization management team staffing and training resources increased throughout 2022.
1.1.7	Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.	X	*AD_31*	The number of specialists in the ARHOME networks increased in Q3 likely due to including in-network providers who are within a 50 mile radius of Arkansas.
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		
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.			During Q1 2023, the state planned to implement changes to the state's cost sharing structure, effective January 1, 2023. The state eliminated the $13 per month premium (previously charged to beneficiaries above 100% FPL). The program increased the service-specific copays to $4.70/$9.40, depending on the service and began charging copays to non-exempt individuals between 20% and 100% FPL. Previously, copays were charged only to beneficiaries above 100% FPL. Additionally quarterly copay limits were changed from $60 per quarter, to a quarterly limit based on the beneficiary's FPL. The new limits range from $27 per quarter to $163 per quarter.

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 monthly PMPM cost ranging from $658.44 to $705.06, the state remained under the budget neutrality limit of $717.25. This does not include the final annual cost settlement reconciliation the state has with the carriers to adjust for actual cost share reduction payments.
1.2	**Implementation update**		
1.2.1	Describe any anticipated program changes that may impact financial/budget neutrality.	X	

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.		In March 2022, DHS hired General Dynamics Information Technology (GDIT) to provide an independent evaluation of the ARHOME program, in accordance with Section XIII of the Special Terms and Conditions. GDIT submitted a draft evaluation design to DHS on April 29, and the final draft was submitted to CMS on June 17, 2022. The evaluation will examine four demonstration goals: 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 The evaluation will use data from eligibility, claims, surveys, interviews, focus groups, commercial insurance, and cost reporting. DHS asked GDIT to develop a consulting committee of Arkansas subject-matter experts with experience with ARHOME, the population and program evaluation to guide GDIT's work and provide real world context and perspective to guide the evaluation calculations. Current committee members are a licensed University of Arkansas Medical Sciences (UAMS) physician with experience in health services performance measurement, a Ph.D. prepared UAMS faculty with experience in economic evaluation of health services and research experience with Arkansas' healthcare delivery/finance system, and a Ph.D. prepared researcher at Oregon Health and Science University with experience in administration of Arkansas Medicaid expansion program and healthcare performance measurement. The committee met several times in May to review and provide recommendations on the ARHOME evaluation design. The advisors also supported GDIT's presentation of the evaluation design to DHS leadership. In June 2022, GDIT drafted and reviewed the client satisfaction surveys with the advisory committee and DHS. The client surveys are based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Medicaid clients, but GDIT has developed additional ARHOME program questions to measure client's awareness of the QHP incentives to improve health and economic independence outcomes and client's participation in the incentives.

Prompt	State has no update to report (place an X)	State response
		In the third quarter of 2022, GDIT and DHS received and reviewed CMS' feedback on the draft evaluation design. GDIT reconvened the advisory committee to review this feedback and obtain their recommendations on revisions to the original design. DHS submitted its revised evaluation design on November 4, 2022. GDIT also finalized the client satisfaction surveys with input from the committee and DHS. The surveys were mailed out starting in the last month of the third quarter 2022. Surveys will be received until enough responses are received, or the last month of quarter four 2022. The client surveys are based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Medicaid clients, but GDIT has developed additional ARHOME program questions to measure client's awareness of the QHP incentives to improve health and economic independence outcomes and client's participation in the incentives.
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.		GDIT submitted a draft evaluation design to DHS on April 29, and the final draft was submitted to CMS on June 17, 2022. In the third quarter of 2022, GDIT and DHS received and reviewed CMS' feedback on the draft evaluation design. DHS submitted its revised evaluation design on November 4, 2022.
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 continued to work with CMS on the Life360 HOME components of the original ARHOME application. The addition of the Life360 HOME program would require changes to the ARHOME STCs.
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 state continued to work with CMS on the Life360 HOME components of the original ARHOME application. The addition of the Life360 HOME program would require changes to the ARHOME STCs. The state also requested to change its cost sharing structure. The program applied to increase the service-specific copays to $4.70/$9.40, depending on the service and charge copays to non-exempt individuals between 20% and 100% FPL In 2022, copays were charged only to beneficiaries above 100% FPL. Additionally, the state requested to change quarterly copay limits from $60 per quarter, to a quarterly limit based on the beneficiary's FPL. The proposed limits range from $27 per quarter to $163 per quarter.
3.1.2.b The content or completeness of submitted monitoring reports and or future monitoring reports		*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.*
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.	*X*	

Prompt	State has no update to report (place an X)	State response
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	*X*	
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 13, 2022, 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. No members of the public attended. The public forum provided the following information:
		• Overview of ARHOME and implementation timeline
		• Examples of ARHOME health measures, QHP performance on those measures and target performance levels for 2022
		• Updates on pending program changes
		  • Life360 HOME program
		  • Changes to the cost sharing structure
		• Updates on plan changes to be implemented July 1, 2022
		  • Allowing ARHOME members to be enrolled in a Provider-led Shared Savings Entity (PASSE)
		  • Retroactive eligibility reduced from 90 days to 30 days

	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).	*X*	

*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:

Measures MSC-AD, FUA-AD, FUM-AD, and IET_AD (metrics AD_38A, AD_39, and AD_40) are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.

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it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."

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