DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Janet Mann
Deputy Secretary and Medicaid Director
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

Dear Director Mann:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Arkansas' Tax Equity and Fiscal Responsibility Act (TEFRA-like) (Project Number 11-W-00163/6) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, and in alignment with the TEFRA-like STCs, CMS is retaining the cadence of annual monitoring reporting for this demonstration (see also section 1115(d)(2)(D)-(E) of the Act). However, CMS is extending the

due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The next annual monitoring report for the TEFRA-like demonstration will be due on June 29, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting due date.

Structured Monitoring Report Template

As noted in STC 30, "Annual Monitoring Report," the Annual Monitoring Report "must follow the framework provided by CMS… which is subject to change as monitoring systems are developed and/or evolve, and will be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

Demonstration Monitoring Calls

As STC 29 "Quarterly Operational Progress Updates and Monitoring Calls" describes, CMS and the state may "participate in quarterly conference calls" and the calls are intended "to discuss any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs

will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Arkansas TEFRA-like Section 1115 Demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

Enclosure
cc: Lee Herko, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY LIST

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

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

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

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

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

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

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Arkansas TEFRA-like Demonstration**

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

I. PREFACE

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

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

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

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

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

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

of 1975.

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

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

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

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

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

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

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

the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. ELIGIBILITY AND ENROLLMENT

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

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

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

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

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

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

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

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

V. BENEFITS AND DELIVERY SYSTEMS

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

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

VI. COST SHARING

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

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

22. Payment of Premiums.

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

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

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

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

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

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

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

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

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

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

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

VII. GENERAL REPORTING REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VIII. GENERAL FINANCIAL REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

X. EVALUATION OF THE DEMONSTRATION

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

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

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

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

Forum (NQF).

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

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

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

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

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

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

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

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

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

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

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

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

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

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

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

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

ATTACHMENT A –
Annual Monitoring Report Template

1. Preface

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

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

2. Executive Summary

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

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

3. Enrollment

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

Enrollment Issues/Trends: New and Continued

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

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

Anticipated Changes to Enrollment

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

4. Benefits

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

Benefit Issues: New and Continued

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

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

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

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

Anticipated Changes to Benefits

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

5. Demonstration-related Appeals

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

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

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

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

Appeal-related Program Changes

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

6. Quality

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

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

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

Quality-related Program Changes

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

7. Financial/Budget Neutrality

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

Financial/Budget Neutrality Issues: New and Continued

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

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

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

Financial/Budget Neutrality related Program Changes

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

8. Demonstration Operations and Policy

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

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

Consideration 1:

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

9. Implementation Update

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

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

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

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

10. Demonstration Evaluation Update

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

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

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

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

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

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

11. Other Demonstration Reporting

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

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

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

12. Post Award Public Forum

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

13. Notable State Achievements and/or Innovations

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

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

ARKANSAS TEFRA-LIKE
Section 1115
Project Number 11W001636

Evaluation Design

Submitted July 26, 2019

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Table of Contents

I. General Background Information

Demonstration Overview

History

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

Before 2002, Arkansas opted to place eligible disabled children in traditional Medicaid by assigning them to a new aid category within its Medicaid State Plan. While this arrangement allowed the children to remain in their homes, it ultimately placed an unsustainable financial burden on the State during a time when budget limitations were becoming more restrictive. To address the financial viability of the program, the State chose to transition the disabled children from traditional Medicaid to a TEFRA-like, 1115 Demonstration Waiver program. Arkansas' 1115 TEFRA-like Demonstration Waiver was originally approved on October 17, 2002 and implemented on January 1, 2003. Following the initial five-year demonstration period, the program has continued to be renewed. The TEFRA Waiver is a cost sharing Medicaid program that enables certain children with a disability to have care in their homes rather than in an institution. Using the flexibility available within a Demonstration Waiver, Arkansas was able to develop and implement a sliding scale premium fee structure based on the family's income, effectively passing a portion of the cost to the eligible child's family. Families with annual incomes of less than $25,000 were exempted from the premium requirement; program eligibility was determined solely on the assets and resources of the child.

Current

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

In accordance with CMS' demonstration requirement, the Arkansas Division of Medical Services (DMS) must develop an evaluation design for the TEFRA-like demonstration no later than 120 days following demonstration approval from CMS (STC 47). The draft evaluation design is built on exploratory analysis performance metrics using latest claims-based data available during January 1, 2016 – December 31, 2016 and satisfaction survey outcomes.

Demonstration Goals

The purpose of the evaluation design is to assess the impact of the demonstration on the quality and affordability of health care for all children eligible for the program. The evaluation design will explore and evaluate the effectiveness of the demonstration for each research hypothesis, as approved by CMS. Arkansas will continue to test the following four goals during the demonstration, which CMS and Arkansas expects will continue to promote Medicaid program objectives.

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

care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low.

As illustrated in the "Methodology" section, each research hypothesis includes one or more evaluation design metrics. Included in the evaluation design will be examinations of the demonstration's performance on a set of outcome and satisfaction metrics over time and relative to a comparable population in the Arkansas Medicaid program, where applicable. Each metric will be described and include a description of the numerator and denominator, the sources of data, and the analytic method used to test the hypotheses. Both cross-sectional and sequential trend analyses will be used, depending on whether the metric is across one point in time or multiple points in time, along with the specific research hypothesis being addressed.

Target Population

The target population will include all beneficiaries covered under Title XIX of the Social Security Act in the State of Arkansas, ages 18 or younger, who meet the medical necessity requirement for institutional care, have income that is less than the long-term care Medicaid limit, and do not have countable assets greater than $2,000.

The target population will include enrolled TEFRA-like beneficiaries meeting all of the following eligibility criteria:

a) Child must be age 18 or younger,
b) Child must meet the Social Security Administration's definition of disability,
c) Child must be a U.S. citizen or qualified alien,
d) Child must have established residency in the state of Arkansas,
e) Child must have a Social Security Number or have applied for one,
f) Child's annual gross countable income must be less than the current Medicaid State Plan income limit established for long-term care services, in accordance with section 1902(a)(10)(A)(ii)(V) of the Act (i.e., the child would be Medicaid eligible if institutionalized),
g) Child's countable assets do not exceed $2,000 (parent(s) assets are not considered),
h) Child meets the medical necessity requirement for institutional placement, or level of care, or be at risk, in the future, for institutional placement, and
i) If eligibility criteria a – h is met, the child must also have access to medical care in the home, it must be deemed appropriate to provide such care outside an institution, and the estimated cost of care in the home must not exceed the estimated cost of care if the child were in an institution.

Due to the TEFRA-like program characteristics, Medicaid may serve as a secondary payer for some of the covered beneficiaries in the target population, which could include cases of third-party liability (TPL). The evaluation design will explore which proportion of the target population is TPL and the range of impact throughout the state.

Comparison Populations

A comparison population for select evaluation design metrics on claims-based outcomes and metrics will consist of Medicaid non-TEFRA-like program beneficiaries. This comparison population will include similar age and beneficiary diagnosis characteristics, as described under criteria (g) below, as TEFRA-like population. Analyses were conducted for the claims-based comparison population to focus on program level, similar beneficiary primary diagnosis conditions and ages. Under DMS Medical Director's guidance, clinical review was performed on the selection of primary diagnosis conditions of five behavioral health conditions[1] and four medical conditions[2]. The purpose of the selection was to identify TEFRA-like beneficiaries primary diagnosis conditions of characteristics beneficiary primary diagnosis conditions and apply to Medicaid fee-for-service population to include as non-TEFRA-like population. The claims-based comparison population of enrolled Medicaid non-TEFRA-like will include beneficiaries who meet the following criteria:

a) Child must be age 18 or younger,

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

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

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

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

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

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

[1] Child/ Adolescent Emotional Disorders, Attention Deficit Hyperactivity Disorders, Mood Disorders, Anxiety/ Nonpsychotic Disorders, and Adjustment Disorders.

[2] Other Congenital Anomalies, Nervous System Congenital Anomalies, Cardiac and Circulatory Congenital Anomalies, and Hereditary and Degenerative Nervous Sys Conditions.

In researching comparison populations, the Developmental Disabilities Services (DDS) program was studied but there was evidence to indicate DDS beneficiaries were also included in TEFRA-like program. DDS has no age limit on services provided. It was concluded that DDS population would have overlap of beneficiaries between the TEFRA-like population and DDS population, thus would lead to confounding comparisons between the two populations. In the state's previous demonstration evaluation design ARKids A population was used as the comparison population. Since ARKids A provides health insurance to children who qualify based on family income level and would not have similar beneficiary diagnosis characteristics as the TEFRA-like population, we have determined to no longer consider this group as a reasonable comparison group for this evaluation design. Instead, DMS wants to determine if the TEFRA-like population have equal or better access to health services compared to beneficiaries with similar diagnosis beneficiary characteristics from Medicaid fee-for-service population.

Exploratory Analysis of Target and Comparison Populations

DMS contracted with a vendor to gather and analyze exploratory data to help formalize the TEFRA-like evaluation design. Calendar year 2016 (January 1, 2016 – December 31, 2016) constitutes the measurement period for the exploratory analysis of this evaluation design. This analysis was vital in determining relevant hypotheses, research questions, and development of Arkansas specific homegrown metrics in the evaluation design process for the TEFRA-like population.

Target Population

Descriptive findings on the demographic and eligibility characteristics of the TEFRA-like population help understand not only the demonstration population more fully but also provides useful contextual information that will facilitate interpretation of evaluation design findings. A total of 5,588 beneficiaries were identified having at least one TEFRA-like segment during the measurement period of CY2016. Of the TEFRA-like beneficiaries, 99% had at least one TEFRA segment during the measurement period. Almost 70% of population were enrolled for at least 11 months out of the year (n = 3,841 beneficiaries) in TEFRA-like coverage. Over 50% of the TEFRA-like population were between the ages of two and ten as of December 31, 2016. Almost two-thirds of the TEFRA-like population were male. An examination of additional demographic characteristics among the TEFRA-like population revealed that the majority were white (75%; n = 4,166), and nearly 74% lived in the Northwest and Central regions. The median number of TEFRA-like beneficiaries that have been enrolled for less than 12 months is 162 during the CY2016 measurement period.

Using CY2016 Arkansas claims from the TEFRA-like population on primary ICD-10 diagnosis codes, the clinical characteristics of the target group were explored. Primary diagnosis codes were grouped together by level of condition such as *Other Congenital Anomalies,* then characterized by either a

medical or behavioral health condition type. Primary diagnosis groups of 253 medical conditions and 15 behavioral health conditions of administrative claims were analyzed to assess the appropriateness of similar beneficiary comparison group options. This exploratory analysis further aided in the development of the next section, Evaluation Hypotheses and Research Questions of the evaluation design.

Twelve medical and six behavioral health conditions were selected based on the top volume of primary diagnosis conditions from the TEFRA-like population. An analytical review on the number and percentage of claims for these 12 medical and six behavioral health conditions were calculated to obtain a majority of claims from both medical and behavioral health condition types. Per DMS Medical Director's guidance, this list of conditions was narrowed to five behavioral health conditions (see **footnote 1**) and four medical conditions (see **footnote 2**). Over 57% of claims from the non-TEFRA-like beneficiaries account for the five selected behavioral health conditions and four selected medical conditions.

This comparison group will be used on relevant claims-based settings for selected hypotheses under the next section. This will allow the state on specific evaluation design outcomes and metrics to compare TEFRA-like population to non-TEFRA-like population with similar beneficiary primary diagnosis conditions.

Table 1 displays beneficiary counts for the four medical and five behavioral health conditions described above based for selected primary diagnosis conditions. Some beneficiaries could have more than one primary diagnosis condition assigned but almost 1,000 (n = 990) of the TEFRA-like population have *Child/Adolescent Emotional Disorders* and almost 800 (n = 793) have *Other Congenital Anomalies.* The behavioral health condition of *Attention Deficit Hyperactivity Disorders* accounts for 14% of the primary diagnoses in the target group and over 50% in the comparison group. Ranked second on primary diagnosis groupings for the non-TEFRA-like beneficiaries is *Mood Disorders* affecting 27% of the population, which on the other hand affects only 5% of the TEFRA-like population.

Also, the two behavioral health conditions of *Anxiety/ Nonpsychotic Disorders* and *Adjustment Disorders* affects 18% and 17% of the non-TEFRA-like population, respectively.

Table 1. Number and Percentage of Beneficiaries on Selected Primary Diagnosis Conditions

Selected Primary Diagnosis Condition	Condition Type	# of TEFRA-Like Beneficiaries	% of TEFRA-Like Beneficiaries	# of Non-TEFRA-Like Beneficiaries	% of Non-TEFRA-Like Beneficiaries
Child/ Adolescent Emotional Disorders	Behavioral Health Condition	990	17.72	6,779	7.27
Other Congenital Anomalies	Medical Condition	793	14.19	7,527	8.08
Attention Deficit Hyperactivity Disorders	Behavioral Health Condition	772	13.82	46,937	50.37
Anxiety/ Nonpsychotic Disorders	Behavioral Health Condition	388	6.94	16,419	17.62
Mood Disorders	Behavioral Health Condition	298	5.33	24,861	26.68
Cardiac and Circulatory Congenital Anomalies	Medical Condition	283	5.06	3,466	3.72
Nervous System Congenital Anomalies	Medical Condition	192	3.44	997	1.07
Adjustment Disorders	Behavioral Health Condition	102	1.83	15,500	16.63
Hereditary and Degenerative Nervous Sys Conditions	Medical Condition	59	1.06	489	0.52

In addition, the volume of TEFRA-like beneficiaries receiving occupational, physical and speech-language pathology therapy services during CY2016 was examined. Findings show that at most 54% of TEFRA-like population had at least one therapy service and majority of beneficiaries were between three to 11 years of age (see **Table 2**). Beneficiaries covered by the TEFRA-like demonstration are eligible because of their significant health conditions; therefore, analyzing the distributions of characteristics related to health conditions types and selected diagnosis groupings helps frame the therapy utilization characteristics already presented, as well as other aspects of the evaluation design.

Table 2. TEFRA-Like Beneficiary Frequency by Age for Therapy Services

Therapy Services	1 – 2 Years of Age	3 – 6 Years of Age	7 – 11 Years of Age	12 – 15 Years of Age	16 – 18 Years of Age	Total # of TEFRA-Like Beneficiaries (%)
Occupational Therapy	324	1,348	925	334	126	**3,057 (54%)**
Physical Therapy	305	1,085	692	281	131	**2,494 (44%)**
Speech Therapy	306	1,311	792	300	105	**2,814 (50%)**

Comparison Population

For an accurate comparison to the TEFRA-like population on claims-based outcomes (as described in **Table 1**), beneficiaries who are not enrolled in TEFRA-like services but are enrolled in Medicaid with similar medical and behavioral health conditions (selected primary diagnosis conditions) will be used as a comparison population. Additionally, this comparison population will capture those beneficiaries enrolled in Medicaid not responsible for paying TEFRA premiums for their Medicaid coverage. Ninety-seven percent of non-TEFRA-like population had at least one Medicaid segment during January 1, 2016 - December 31, 2016 measurement period. Equivalent findings for the non-TEFRA-like population of children ages 19 and under were observed on the length of Medicaid segments. The majority of the population had 12-month enrollment during the year on Medicaid segments. With respect to demographic characteristics, 42% of non-TEFRA-like population were females and the majority were between the ages of 5 and 16, 48% were white[3], and 74% resided in the Northwest and Central parts of the state.

II. Evaluation Hypotheses and Research Questions

Driver Diagram

In order to effectively assess if the demonstration is achieving each of the state's four goals, we need to develop a strong evaluation design. An important part of that process is to develop a driver diagram to help depict clearly the fundamental relationship between the primary drivers, secondary drivers, and ultimate aims of the demonstration. In order to provide a visual display of DMS's theory of what "drives" or contributes to the achievement of the demonstration goals, a driver diagram is provided in **Appendix A**. One of the primary drivers contributing directly to achieving *Goal 1 of Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population* is proportion of days covered for prescriptions, which in turn

[3] And another 29% unknown, 15% black/African American, and 8% other.

might be driven by factors such as average cost per prescription per beneficiary and prescription per beneficiary per month (PBPM) – regarded as the secondary drivers for the ultimate aim in this depiction. One moderating factor to examine is third-party liability (TPL) coverage of enrolled TEFRA-like beneficiaries. Based upon exploratory analysis, over 67% of the TEFRA-like beneficiaries have TPL coverage during CY2016 measurement period. This is vastly different compared to the corresponding rate for the Medicaid non-TEFRA-like beneficiaries at 6% in CY2016. TPL coverage could have an impact on metric calculations and when comparing to Medicaid non-TEFRA-like beneficiaries.

Evaluation Hypotheses and Research Questions

The TEFRA-like demonstration's four goals showcase the Centers for Medicare & Medicaid Services' (CMS) three-part aim of better care for individuals, better health for population and lower costs. The ultimate success of those goals will be evaluated through the deploying the evaluation design, which is organized around nine hypotheses and 28 research questions.

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

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

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

Research Questions for Hypothesis 1.1

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

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

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

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

Research Questions for Hypothesis 1.2

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

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

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

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

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

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

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

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

Research Questions for Hypothesis 2.1

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

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

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

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

Research Questions for Hypothesis 2.2

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

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

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

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

Research Questions for Hypothesis 2.3

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

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

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

Patient experience with the TEFRA-like demonstration program over time will be assessed by analyzing responses from the TEFRA Beneficiary Satisfaction Survey domains of “Getting care quickly”, “How well doctors communicate”, and “Overall health care”. In addition, the percentage of TEFRA-like beneficiaries who have DME will be compared to Consumer Assessment of Health Care Providers and Systems (CAHPS®)-like survey domain score of “Special equipment and supplies”. An indicator of comparing the TEFRA-like plan with other health plans, will be used to investigate the impact on patient experiences on health care services. This will be determined by comparing responses pre enrollment of six months to post enrollment in the TEFRA-like program.

Goal 3 has two hypotheses and six research questions.

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

Research Questions for Hypothesis 3.1

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

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

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

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

Research Questions for Hypothesis 3.2

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

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

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

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

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

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

Research Questions for Hypothesis 4.1

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

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

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

Research Questions for Hypothesis 4.2

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

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

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

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

III. Methodology

Evaluation Design Summary

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

Target and Comparison Populations

The target population will include all beneficiaries covered under Title XIX of the Social Security Act in the State of Arkansas, ages 18 or younger, who meet the medical necessity requirement for institutional care, have income that is less than the long-term care Medicaid limit, and do not have countable assets greater than $2,000. The comparison population will include similar age and beneficiary diagnosis characteristics as the TEFRA-like population, which will be used for selected claims-based outcomes and metrics. For additional information of the target and comparison populations, please refer to the "General Background Information" section. A consideration for establishing a comparison group with TEFRA or TEFRA-like programs is to pull relevant material from other states. This material will be reviewed regularly and included within the subsequent evaluation report as a reference list, which will serve as background information.

Evaluation Period

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

Data Sources

The Arkansas Division of Medical Services (DMS) and its contractor will use multiple sources of data to assess the research hypotheses. The evaluation design will leverage claims-based administrative data, enrollment data and survey-based scores, as applicable. Administrative data sources include information extracted from DMS' Medicaid Management Information System (MMIS). Accurate and timely data reporting is essential in order for the TEFRA-like evaluation to be successful in achieving its goals of accessibility to health services, beneficiary experience in program and affordable premiums. In order to meet this requirement, the contractor will use its own Arkansas Medicaid Data Warehouse, vendor approved priority warehouse system. Data analytics will be performed without direct engagement from the State, as to avoid biased opinion or skewed results. The data evaluator will run the analytics and provide data as necessary for the analysis. Data from administrative claims will be used and will not alter input data or the output of results.

Administrative Data

The Medicaid Management Information System (MMIS) data source is used to collect, manage, and maintain Medicaid beneficiary files (i.e., eligibility, enrollment, and demographics) and fee-for-service (FFS) claims. Use of FFS claims will be limited to final, paid status claims. Interim transaction and voided records will be excluded from all evaluations, because these types of records introduce a level of uncertainty that can impact reported rates. The contractor will use raw, full sets of Medicaid data, which is provided on a weekly basis consisting of claims, provider, beneficiary, and pharmacy data subject areas. To ensure accurate and complete data, the contractor's Arkansas Medicaid Data Warehouse will utilize the pre-snapshot data claims process and will require a minimum three-month lag to allow time for the majority of claims to be processed through the MMIS. The contractor will use fee-for-service claims and follow Healthcare Effectiveness Data and Information Set (HEDIS®) or CMS Core Set national specifications for national metrics. Applicable claim types, such as institutional, professional, and pharmacy claims will be used to calculate the various evaluation design metrics while beneficiary demographic files will be used to assess beneficiary age, gender, and other demographic information. Eligibility files will be used to verify a beneficiary's enrollment in the State's Medicaid programs. Each metric (see **Appendix C**) associated with each research hypothesis lists the data source(s) used in addressing it.

Survey Data

TEFRA Beneficiary Satisfaction Survey

The TEFRA Beneficiary Satisfaction Survey is designed and based on the CAHPS® 5.0H Medicaid Child survey and covers topics such as getting care quickly, how well doctors communicate, and access to care, among others. This instrument can include specific survey items designed to elicit information that addresses research hypotheses regarding the financial burden of the program and access to medical equipment and medical therapies. On an annual basis, the TEFRA Beneficiary Satisfaction Survey (TEFRA survey) has been conducted by the Arkansas Division of Medical Services (DMS) in collaboration with the Arkansas Foundation for Medical Care (AFMC), a National Committee for Quality Assurance (NCQA) Certified Healthcare Effectiveness Data and Information Set (HEDIS®) survey vendor. All beneficiaries in the TEFRA-like demonstration will be included in the analyses. The TEFRA survey will follow a traditional NCQA sampling strategy—1,650 beneficiaries will be randomly selected from the Medicaid Management Information System (MMIS). To be eligible for the study, beneficiaries must be enrolled in the program for at least six months, with no more than one 30-day gap in enrollment.

TEFRA Disenrollee Beneficiary Survey

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

Medicaid ARKids A and ARKids B Beneficiary Surveys

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

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

The beneficiary satisfaction survey for the ARKids First B is a CAHPS-like survey and is currently conducted on an annual basis. The survey was adopted using HEDIS/CAHPS® guidelines and protocol, from the CAHPS 5.0H survey to assess beneficiaries' experiences with their health plans.

The ARKids First B beneficiary survey has included five composite measures, six rating questions and two summary rates. Survey vendor used a systematic sampling method as provided by NCQA's protocol for administering HEDIS/CAHPS surveys. Similar to ARKids First A, the criteria at 30 days was used because the enrollment data are reported monthly. The sampling frame consisted of all ARKids First B PCCM enrollees ages 17 and younger as of the end of the reported calendar year. The beneficiaries' six-month continuous enrollment began six months prior to the reported calendar year. Beneficiaries selected for other surveys within the last 12 months were excluded from the population this year, and only one beneficiary per household was selected.

Medicaid Survey Comparison

A comparison group for selected metric on the survey-based questions (i.e. timely and appropriate preventive care) will use a variety of state driven beneficiary satisfaction surveys. As an example, selected composite (i.e. *Getting care quickly* and *How well doctors communicate*) and individual scores (i.e. *Rating of health care*) from TEFRA beneficiary survey results if applicable will be compared to ARKids First A and First B beneficiary survey results. Also, TEFRA disenrollee beneficiary survey results, if available, will be compared to TEFRA beneficiary survey results in the domain of *Special equipment and supplies*. When possible, evaluation survey results will incorporate national survey results provided by National CAHPS Benchmarking Database (NCBD) for comparison purposes (see **Appendix C**, under "National Benchmark" row for applicable metrics). The NCBD is a national repository funded by Agency for Healthcare Research and Quality (AHRQ) containing data from the CAHPS health plan survey to provide comparative data on health plans.

Analytic Methods

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

The two main analytic methods used to determine whether the beneficiaries in the TEFRA-like population are doing as well or better than non-TEFRA-like Medicaid beneficiaries in the traditional Medicaid program with the selected primary diagnosis conditions on the various metrics in the evaluation are cross-sectional analysis, such as the t-test and longitudinal data analysis, such as linear mixed models. The t-test will be used for TEFRA-like vs. non-TEFRA-like single group methods of assessment as well as for cross-sectional comparisons of two groups at one point in time. A chi-squared test will be used to compare the proportion of respondents' experience on selected questions from TEFRA Beneficiary Satisfaction Survey compared to similar questions from Medicaid ARKids A and ARKids B Beneficiary Surveys. The longitudinal nature of the data will be exploited to establish trends in outcomes for the TEFRA-like population trend.

Evaluation Outcomes and Metrics

Appendix C exhibits the evaluation design outcome and metric description names along with numerator and denominator descriptions. If applicable for benchmarking, analysis will use data from publicly available national surveys. Outcomes such as quality of care, access to health care, health outcomes, and beneficiary experience will be examined. In learning from previous evaluation design results and experience of state specific data, Arkansas has value-added components to its current evaluation design. For example, Arkansas included specific TEFRA-like DMS homegrown metrics for evaluation design approach (see **Appendix C** Metric 2.2a as an example). TEFRA-like population homegrown metrics were developed with oversight from Arkansas' Medical Director and driven from exploratory analysis of CY2016 findings. Also, Arkansas will use national selected evaluation design metrics as provided in CMS' Core Set of Health Care Quality Measures for Children in Medicaid and CHIP[4] and Pharmacy Quality Alliance (PQA-like)[5] sources.

IV. Special Methodological Considerations

The demonstration evaluation from the perspective of beneficiaries provides an opportunity to understand the impact of services that improve or maintain a child's health, or prevent a child's health from getting worse. Two methodological considerations that have impacted our choice of evaluation approaches include: 1) the long standing nature of the TEFRA-like program with a lack of baseline data, and 2) the difficulty of identifying a comparison group for the specificities of the target population. Since the program was launched many years ago, a true baseline in which a similar group can be compared year over year is difficult to establish. Additionally, since the program has a

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

very specific population of TEFRA-like beneficiaries, the complexity of determining a true comparison population is challenging. The target population consists of a small sample size of less than 6,000 beneficiaries. As such, the comparative methods are descriptive and will include survey comparisons of TEFRA beneficiary survey results to ARKids First A and First B beneficiary survey results. If feasible, evaluation survey results will incorporate national survey results provided by the National CAHPS Benchmarking Database (NCBD) for comparison purposes.

Methodological Limitations

The evaluation design has limitations on the lack of a truly comparative TEFRA-like population for selected metrics. TEFRA-like enrollees may not have prior Medicaid coverage, thus there are limitations around baseline values for the evaluation design metrics. The design will treat Year 1 of the current demonstration period of performance, 2018, as a baseline from which to measure changes over the course of the demonstration, and will analyze survey scores on patient's health care plan experience in the six months before enrolling in TEFRA (pre-TEFRA) compared to post enrollment in the TEFRA health plan (post-TEFRA). The evaluation will also conduct an in-state analysis comparing TEFRA-like population to a group with similar primary diagnosis conditions as a "comparison population". Another drawback related to surveys is getting scores on an annual basis for comparison from the ARKids First A beneficiary survey. A comparison will be evaluated every two years due to the survey being conducted every two years to address this challenge.

Attachments

Appendix A. Driver Diagram

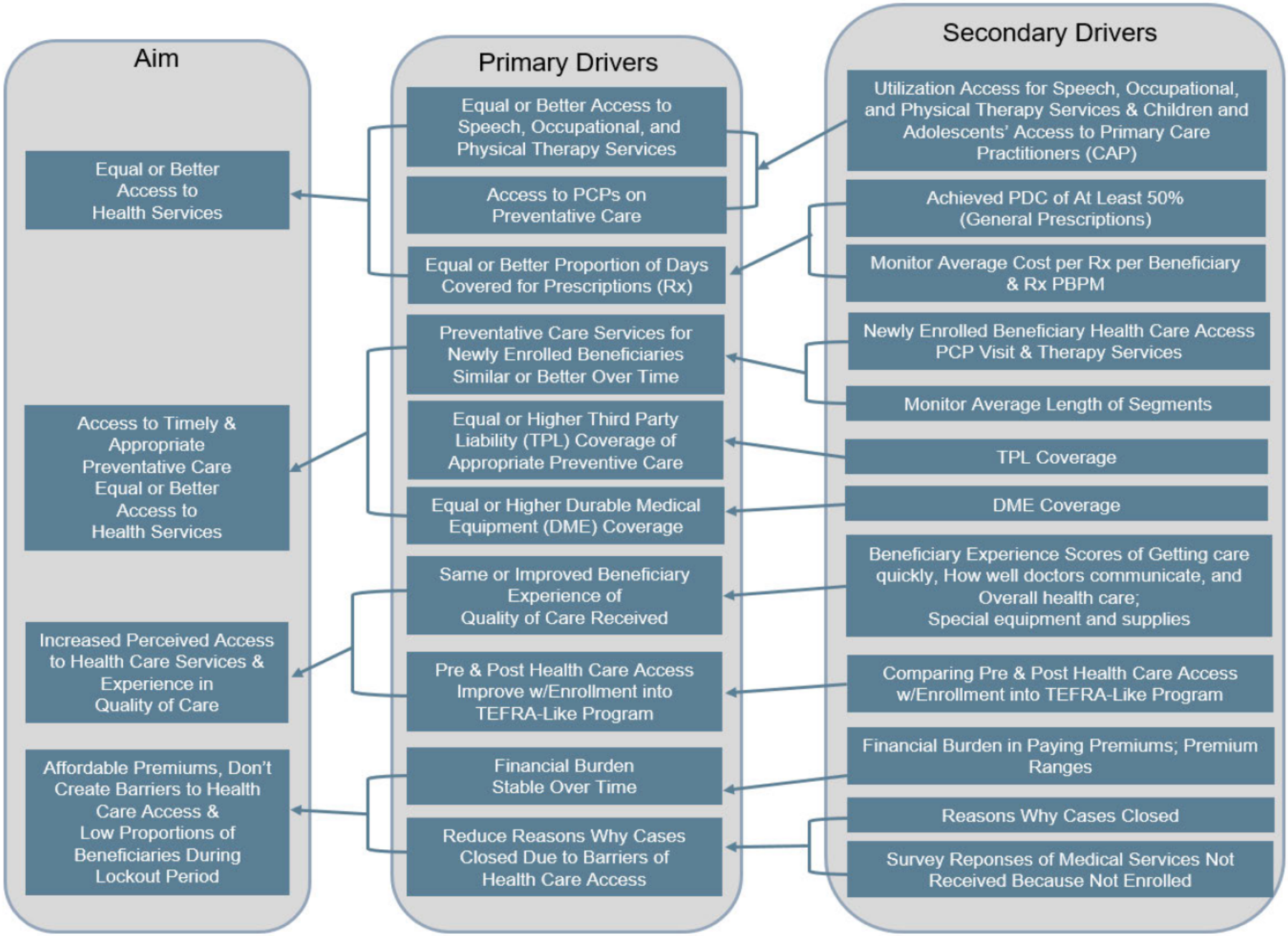
Appendix B. Four Goals with Evaluation Hypotheses and Drivers

Appendix C. Research Questions, Evaluation Design Outcome and Metrics, Comparison Populations, Data Sources, and Analytic Methods Summary Table

Appendix D. Independent Evaluator

Appendix E. Evaluation Budget

Appendix A. Driver Diagram



Appendix B. Four Goals with Evaluation Hypotheses and Drivers

#	Goal	Hypotheses	Drivers
1	Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population	Hypothesis 1.1: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better access to health services compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Hypothesis 1.2: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).	Utilizing claims-based & beneficiary's experience of therapy services. Examining PCP visits, Rx proportion of days covered, Rx costs and usage of seizure medications.
2	Ensuring demonstration enrollees have access to timely and appropriate preventive care	Hypothesis 2.1: Preventive care services for newly enrolled beneficiaries of the Arkansas TEFRA-like demonstration are similar or better over time. Hypothesis 2.2: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of third-party liability (TPL) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Hypothesis 2.3: The beneficiaries of the Arkansas TEFRA-like demonstration have equal or higher rates of durable medical equipment (DME) coverage of appropriate preventive care compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like).	Examining TEFRA-like coverage. Reviewing PCP visits and therapy services access on newly enrolled TEFRA-like beneficiaries. Utilizing beneficiary's experience of access to health care. Investigating TPL and DME coverage.
3	Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received	Hypothesis 3.1: Patient experience for the quality of care and access to health care services received by the beneficiaries in the Arkansas TEFRA-like demonstration has remained the same or improved over time. Hypothesis 3.2: Patient's experience with access to health care services improve with enrollment into TEFRA-like program.	Utilizing beneficiary's experience of doctor communication and overall health care. Impacts on health care access pre and post.
4	Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low	Hypothesis 4.1: Premium barriers for TEFRA-like beneficiaries will remain stable over time. Hypothesis 4.2: Reduce the number of reasons why Arkansas TEFRA-like beneficiaries' cases were closed due to program barriers of health care access.	Examining percent of TEFRA-like lockouts and financial burden. Utilizing disenrollees experience of therapy services. Investing reasons why cases were closed.

Appendix C. Research Questions, Evaluation Design Outcome and Metrics, Comparison Populations, Data Sources, and Analytic Methods Summary Table

The nine research hypotheses are grouped according to the four demonstration goals as described in **Appendix B**. The descriptions presented below under each hypotheses specify outcomes and metrics, comparison methods, data sources for the research questions to assess the evaluation design.

For *Goal 1: Ensuring that demonstration enrollees have equal or better access to health services compared to the Medicaid fee-for-service population*, Metrics 1.1a – 1.1c and 1.2a – 1.2d will be used.

Hypothesis 1.1 will compare the access to therapy health care services for beneficiaries in the TEFRA- like demonstration to the beneficiaries in the Medicaid non-TEFRA-like population based on similar beneficiary characteristics. In order to evaluate access to health services across all age groups, comparisons will be made using a HEDIS metric, Children and Adolescents' Access to Primary Care Practitioners (CAP). This metric measures the percentage of beneficiaries who had a visit with a PCP during the measurement year. In exploratory research, results were calculated and reviewed over several national metrics under the Child Core Set and HEDIS metrics such as Well-Child Visits in the First 15-Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, Annual Dental Visit (ADV), and Medication Management for People with Asthma (MMA) but small denominator sizes were not always valid under the TEFRA-like population for comparison to Medicaid non-TEFRA-like population. Contractor will examine access to health services by analyzing survey questions from the TEFRA beneficiary satisfaction survey "In the last 6 months, how much of a problem, if any, was it to get the therapy services your child needed through TEFRA?" Results will be broken down by a) speech, b) occupational, and c) physical therapy services and also a composite score as needed. For comparison between the TEFRA-like and non-TEFRA-like populations, the percentage of beneficiaries who are utilizing each or combination of therapy services will be analyzed using administrative claims during similar performance periods. Hypothesis 1.2 will assess if the Arkansas TEFRA-like demonstration have equal or better proportion of days covered for prescriptions compared to the Medicaid fee-for-service population (Medicaid Non-TEFRA-like). Specifically for Pharmacy Quality Alliance (PQA-like) and home-grown metric of proportion of days covered (PDC) on general prescriptions, the percentage of TEFRA beneficiaries with at least two prescriptions and who achieved a PDC of at least 50% was developed. Seizure medications were analyzed during initial research on the study group. Results showed almost 10% of TEFRA-like beneficiaries had at least two seizure medications filled during CY2016. In addition, the state will analyze the average cost per prescription (Rx) per beneficiary and prescriptions (Rx) per beneficiary per month (PBPM) for the

TEFRA-like population. Hypothesis 1.1 and 1.2 will use a t-test or other applicable bivariate testing to evaluate statistically significant differences between the TEFRA-like demonstration population and the Medicaid non-TEFRA- like population. The analysis will be tested using a significance level of $p < 0.05$.

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

Metric 1.1a	Claims-based therapy services
Description:	The percentage of beneficiaries < 19 years of age who are utilizing therapy services during the measurement period (By a) speech, b) occupational, and c) physical therapy services)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Numerator is number of beneficiaries < 19 years of age that were continuously enrolled utilizing therapy services during the measurement period (By a) speech, b) occupational, and c) physical therapy services). Therapy Service: Identify beneficiaries who received at least one therapy visit from value set codes as defined below for Occupational Therapy Value Set, Occupational/Physical Therapy Value Set, Physical Therapy Value Set, Speech Therapy Value Set, and Therapy Assistant Modifiers Value Set during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.1a & 1.1b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State."
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.1b	Survey-based therapy services (i.e. special therapies)
Description:	Scores of the TEFRA beneficiary satisfaction survey questions of "In the last 6 months, how much of a problem, if any, was it to get the therapy services your child needed through TEFRA?" (By a) speech, b) occupational, and c) physical therapy services) (Domain: *Special therapies*)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator is number of respondents who answered "Not a problem," in the last 6 months to get therapy your child needed through TEFRA. (By a) speech, b) occupational, and c) physical therapy services). "In the last 6 months, how much of a problem, if any, was it to get the speech therapy your child needed through TEFRA?", "In the last 6 months, how much of a problem, if any, was it to get the occupational therapy your child needed through TEFRA?" and "In the last 6 months, how much of a problem, if any, was it to get the physical therapy your child needed through TEFRA?". (Domain: *Special therapies*).
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	1.1b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Therapy claims-based service rates compare to TEFRA satisfaction survey scores of getting speech, occupational, and physical therapies, where applicable. Trend over time of TEFRA satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 1.1c	Children and Adolescents' Access to Primary Care Practitioners (CAP)
Description:	The percentage of beneficiaries 12 months–18 years of age who had a visit with a PCP. Report four age stratifications. • Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–18 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries for a) 12 months – 6 years of age that were continuously enrolled during the measurement period and b) 7 – 18 years of age that were continuously enrolled during the measurement period and year prior to the measurement period. Numerator(s): For 12–24 months, 25 months–6 years: One or more visits with a PCP (Ambulatory Visits

	Value Set) during the measurement period. For 7–11 years, 12–18 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period or the year prior to the measurement period. Count all beneficiaries who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits. In addition, similar check was applied as used for Core Set CAP metric implementation of header billing provider type in ('01' '02' '03' '04' '05' '24' '29' '49' '58' '62' '69' '81'). Numerator is the number of beneficiaries a) 12 months – 6 years of age who had one or more visits with a PCP during the measurement period and b) 7 – 18 years of age who had one or more visits with a PCP during the measurement period or the year prior to the measurement period.
Continuous Enrollment:	For 12–24 months, 25 months–6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For 7–11 years, 12–18 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.1c
Metric Steward:	NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test
National Benchmark:	CMS Core Set Mean Rate Across Reported States by CMS[6]; NCQA's State of Health Report Card (Medicaid HMO)[7]

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

Metric 1.2a	Proportion of days covered (PDC) threshold of 50%
Description:	The percentage of beneficiaries < 19 years of age who met the proportion of days covered (PDC) threshold of 50% during the measurement period (General Prescriptions)

[6] CMS annually releases information on state progress in reporting the Child Core Set measures and assesses state-specific performance for measures that are reported by at least 25 states and which met internal standards of data quality. https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

[7] NCQA's State of Health Care Quality Report. NCQA produces every year to focus on major quality issues the U.S. faces and to support the spread of evidence-based care. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/.

Technical Specifications:	Denominator: The eligible population. Denominator is number of beneficiaries < 19 years of age who were dispensed at least two prescriptions on two unique dates of service during the measurement period. Numerator(s): Numerator is number of beneficiaries who met the 50% PDC threshold (from Index Prescription Start Date (IPSD) to the end of the measurement period) during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2a & 1.2b
Sub-group:	By parts of the state with low and high access. By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State".
Metric Steward:	PQA-Like/DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.2b	**Average cost per prescription (Rx) per beneficiary**
Description:	The average cost per prescription (Rx) per beneficiary for < 19 years of age that were continuously enrolled during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the total number of prescriptions dispensed for beneficiaries < 19 years of age that were continuously enrolled during the measurement period. If multiple prescriptions are dispensed on the same day, calculate number of unique ICNs. Numerator(s): Calculate the total cost of prescriptions dispensed during the measurement period. Sum across claims on header paid amount for total cost of prescriptions. Numerator is the total prescription costs during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2c
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By gender: Female, Male, and Unknown. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as "Out-of-State". Identify the top five prescriptions based upon average cost per prescription (Rx) per beneficiary (or number of beneficiaries). To review the top five prescriptions based upon number of beneficiaries who qualified for

	the denominator.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.2c	**Prescriptions (Rx) per beneficiary per month (PBPM)**
Description:	The prescriptions (Rx) per beneficiary per month (PBPM) for < 19 years of age during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiary months. Beneficiary months are a beneficiary's contribution to the total 12-month enrollment. Beneficiary months are calculated by summing the total number of months each beneficiary is enrolled in the program during the measurement period. Numerator(s): Calculate the total number of prescriptions dispensed during the measurement period. Numerator is the number of general prescriptions filled for beneficiaries during the measurement period. If multiple prescriptions are dispensed on the same day, calculate number of unique ICNs.
Beneficiary Months:	Verify Medicaid enrollment on the last day of each month during the measurement period. Count the month if the beneficiary is enrolled and < 19 years of age.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2d
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 1.2d	**Anti-Seizure**
Description:	The percentage of beneficiaries < 19 years of age taking at least two seizure medications during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period.

	Numerator(s): Numerator is the number of beneficiaries who have at least two seizure prescriptions during the measurement period. Anti-seizure medications may be dispensed on the same day. 1. At least two medications from Anticonvulsants Medications Value Set (i.e. H4A or H4B). 2. Or one medication from Anticonvulsants Medications Value Set (i.e. H4A or H4B) and at least one medication from Benzodiazepines Medications Value Set (i.e.H8R).
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	1.2e
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

For *Goal 2: Ensuring demonstration enrollees have access to timely and appropriate preventive care*, Metrics 2.1a – 2.1c, 2.2a – 2.2b, and 2.3a will be used.

Hypothesis 2.1 will identify the newly enrolled TEFRA-like beneficiaries and determine the rate of beneficiaries receiving first health care visit to PCP within 60 days of enrollment. Similar analysis on newly enrolled TEFRA-like beneficiaries will calculate the rate of beneficiaries receiving first health care visit to speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period. Exploratory analysis for CY2016 showed that TEFRA-like beneficiaries are enrolled for the vast part of the year (i.e. average length of over 11 months out of a calendar year). Under this hypothesis a trend will evaluate of this a continued pattern or fluctuates year by year.

Under hypothesis 2.2, the percentage of TEFRA-like beneficiaries who have third-party liability (TPL) coverage will be calculated to compare if rates are equal to or higher than the Medicaid Non-TEFRA-like group. The state will determine which geographic regions have low percentages and high percentages of TPL coverage for both target and comparison populations. Lastly, the contractor will investigate if there is a difference between rates of beneficiaries who had at least one Medicaid claim paid by TPL coverage and who had a visit with a PCP during measurement period.

Similar to 2.2, hypothesis 2.3 will study TEFRA-like beneficiaries who have durable medical equipment (DME) services. TEFRA-like beneficiary's primary care physician involvement is important in determining if DME services are medically necessary and prescribed on a

regular basis. Another indication to analyze DME services was found in exploratory analysis of TEFRA-like beneficiaries primary diagnosis groupings. Based on exploratory analysis during CY2016 of selected primary diagnosis group for medical conditions, *Other Congenital Anomalies* was affecting slightly over 14% for the TEFRA-like population. Hypothesis 2.2 - 2.3 will use a t-test or other applicable bivariate testing to evaluate statistically significant differences between the TEFRA-like demonstration population and the Medicaid non-TEFRA- like population. The analysis will be tested using a significance level of $p < 0.05$.

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

Metric 2.1a	First health care visit to PCP w/in 60 days
Description:	The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit to PCP within 60 days of enrollment during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of newly enrolled TEFRA-like beneficiaries < 19 years of having an enrollment start date of at least 60 days before the end of the measurement period. Numerator(s): Numerator is the number of newly enrolled TEFRA-like beneficiaries for which the TEFRA-like beneficiary received first health care visit to PCP within 60 days of enrollment during the measurement period.
Newly Enrolled:	Identify newly enrolled TEFRA-like beneficiaries where an enrollment start date is at least 60 days before the end of the measurement period
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1a
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown; CAP Portion: NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Trend over time of TEFRA-like coverage
Comparison Method(s):	Longitudinal data analysis

Metric 2.1b	First health care visit for therapy services w/in 60 days
Description:	The percentage of newly enrolled TEFRA-like beneficiaries < 19 years of age for which the TEFRA-like beneficiary received first health care visit for speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of newly enrolled TEFRA-like beneficiaries < 19 years of having an enrollment start date of at least 60 days before the end of the measurement period. Numerator(s): Numerator is the number of newly enrolled TEFRA-like beneficiaries for which the TEFRA-like beneficiary received first health care visit to speech, occupational, or physical therapy services within 60 days of enrollment during the measurement period. Therapy Service: Identify beneficiaries who received at least one therapy visit from value set codes as defined below for Occupational Therapy Value Set, Occupational/Physical Therapy Value Set, Physical Therapy Value Set, Speech Therapy Value Set, and Therapy Assistant Modifiers Value Set during the measurement period.
Newly Enrolled:	Identify newly enrolled TEFRA-like beneficiaries where an enrollment start date is at least 60 days before the end of the measurement period
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as “Out-of-State”.
Metric Steward:	DMS Homegrown; CAP Portion: NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 2.1c	Average length of TEFRA-like segments
Description:	The average length (in months) of TEFRA-like segments for beneficiaries <19 years of age during the measurement period.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of TEFRA-like beneficiaries < 19 years of age enrolled during the measurement period.

	Numerator(s): Calculate the total number of days each TEFRA-like beneficiary is enrolled during the measurement period. Sum across all TEFRA-like beneficiaries for overall total number of days. Numerator is the total number of days across all enrolled TEFRA-like beneficiaries during the measurement period. Average Length in Months: Calculate the average length in months as ((total number of days each TEFRA-like beneficiary is enrolled during the measurement period divided by number of TEFRA-like beneficiaries < 19 years of age enrolled during the measurement period) then divided by 30 calendar days. Outcome is total number of months each TEFRA-like beneficiary is enrolled during the measurement period.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.1c
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total.
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Trend over time of TEFRA-like coverage
Comparison Method(s):	Longitudinal data analysis

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

Metric 2.2a	Third Party Liability (TPL) coverage
Description:	The percentage of beneficiaries <19 years of age who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) that were continuously enrolled during the measurement period. TPL coverage represents where a beneficiary had a TPL claim within the measurement period.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Count all beneficiaries where private insurance amount (header) is > $0 or had a crossover claim (Medicare coverage) during the measurement period. Numerator is the number of beneficiaries who had at least one TPL claim during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.2a & 2.2c
Sub-group:	By region: Central, Northeast, Northwest, Southeast, and Southwest. Beneficiaries not associated with above regions will be denoted as “Out-of-State”.
Metric Steward:	DMS Homegrown

Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

Metric 2.2b	**Third Party Liability (TPL) coverage & CAP**
Description:	The percentage of beneficiaries 12 months–18 years of age who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP. Report four age stratifications. • Children 12–24 months and 25 months–6 years who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP during the measurement year. • Children 7–11 years and adolescents 12–18 years who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) and who had a visit with a PCP during the measurement year or the year prior to the measurement year.
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries who had at least one Medicaid claim paid by Third Party Liability (TPL) coverage (non-Medicaid) for a) 12 months – 6 years of age that were continuously enrolled during the measurement period and b) 7 – 18 years of age that were continuously enrolled during the measurement period and year prior to the measurement period. Numerator(s): For 12–24 months, 25 months–6 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period. For 7–11 years, 12–18 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement period or the year prior to the measurement period. Count all beneficiaries who had an ambulatory or preventive care visit to any PCP. Exclude specialist visits. In addition, similar check was applied as used for Core Set CAP metric implementation of header billing provider type in ('01' '02' '03' '04' '05' '24' '29' '49' '58' '62' '69' '81'). Numerator is the number of beneficiaries who had a visit with a PCP a) 12 months – 6 years of age who had one or more visits with a PCP during the measurement period and b) 7 – 18 years of age who had one or more visits with a PCP during the measurement period or the year prior to the measurement period.
Continuous Enrollment:	For 12–24 months, 25 months–6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For 7–11 years, 12–18 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment.
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.2b
Metric Steward:	DMS Homegrown; NCQA/Core Set of Health Care Quality Measures for Children in Medicaid and CHIP
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)

Comparison Method(s):	Two-group t-test

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

Metric 2.3a	Durable Medically Equipment (DME) coverage
Description:	The percentage of beneficiaries <19 years of age who had at least one DME coverage claim that were continuously enrolled during the measurement period
Technical Specifications:	Denominator: The eligible population. Denominator is the number of beneficiaries < 19 years of age that were continuously enrolled during the measurement period. Numerator(s): Numerator is the number of beneficiaries who had at least one DME coverage claim during the measurement period.
Continuous Enrollment:	No more than one gap in enrollment of up to 45 days during each period of continuous enrollment
Exclusion Criteria:	Beneficiaries in hospice are excluded from the eligible population
Research Question(s):	2.3a & 2.3b
Sub-group:	By age group: 0-4 years, 5-8 years, 9-12 years, 13-18 years, and Total. Identify top primary dx conditions and conditions types on number of claims and beneficiaries <19 years of age who have DME coverage for beneficiaries who qualified for the numerator during the measurement period. To review the top 10 primary diagnosis conditions and condition types (i.e. groupings) by number of claims for beneficiaries who qualified for the numerator. In addition, to review number of beneficiaries for each top 10 primary diagnosis condition. Number of claims and beneficiaries for the top 10 primary diagnosis conditions (based on the total number of distinct claims from the beneficiaries who have DME coverage).
Metric Steward:	DMS Homegrown
Data Source(s):	MMIS eligibility and beneficiary demographic files linked to claims-based data files
Measurement Period:	2018 – 2019 (January 1, 2018 – December 31, 2019) for interim evaluation report; 2018 – 2022 (January 1, 2018 – December 31, 2022) for summative evaluation report
Comparison Group:	Medicaid Non-TEFRA-like beneficiary comparison group (Ages <19 and selected primary dx conditions)
Comparison Method(s):	Two-group t-test

For *Goal 3: Ensuring enrollment in the demonstration increases beneficiaries' perceived access to health care services and experience in the quality of care received*, Metrics 3.1a – 3.1c and 3.2a – 3.2c will be used.

TEFRA Beneficiary Satisfaction Survey questions related to access to health care services and quality of care received will be organized into three domains and records beneficiary's experience for each domain. A composite score will be used from each of the three domains.

A composite score domain combines the responses of two or more questions, except for "Overall health care" domain, to obtain a single score. The composite domains represent the percentage of beneficiaries who responded favorably. For example, questions scaled as "Never," "Sometimes," "Usually" and "Always," a favorable response represents the proportion of beneficiaries who selected "Usually" or "Always."

- ***Domain 1 - Getting care quickly:***
  - *Obtaining care right away for an illness/injury/condition*
  - *Obtaining care when wanted, but not needed right away*
- ***Domain 2 - How well doctors communicate:***
  - *Doctors explaining things in an understandable way to your child*
  - *Doctors listening carefully to you*
  - *Doctors showing respect for what you had to say*
  - *Doctors spending enough time with the child*
- ***Domain 3 - Overall health care:***
  - *Rating of health care*

Sequential trend analyses will be used to assess whether beneficiary experience has improved over time or remained the same. The scores, if available, will be compared to both ARKids First A and First B beneficiary survey data. TEFRA Beneficiary Satisfaction Survey asked patients to compare certain aspects of the health care plan their child had in the six months before enrolling in TEFRA (pre-TEFRA) with post enrollment in the TEFRA health plan (post-TEFRA). The three survey questions will be evaluated to determine the impact of patient experience on access to health care services after receipt of enrollment into TEFRA-like program (i.e. questions of "How much of a problem, if any, was it for your child to see a personal doctor or nurse?", "How much of a problem, if any, was it to get your child's prescription medication?", and "How much of a problem, if any, was it for your child to get urgent care?"). A chi-square goodness of fit test will be used to test whether the observed proportions for a categorical variable differ from assumed proportions. The analysis will be tested using a significance level of $p < 0.05$.

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

Metric 3.1a	Survey-based getting care quickly
Description:	The percentage of survey responses marked "Usually" or "Always" (i.e. favorably) for domain of Getting care quickly (i.e. receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed). (Domain: *Getting care quickly*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 2) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed (for each survey question). Questions on Obtaining care right away for an illness/injury/condition ("In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?") and Obtaining care when wanted, but not needed right away ("In the last 6 months, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as your child needed?") (Domain: *Getting care quickly*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1a
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report)
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey. Questions on Obtaining care right away for an illness/injury/condition ("In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?") and Obtaining care when wanted, when not needed right away ("In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?").

	Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Metric 3.1b	**Survey-based how well doctors communicate**
Description:	The percentage of survey responses marked "Usually" or "Always" (i.e. favorably) for domain of How well doctors communicate (i.e. Doctors explaining things in an understandable way, Doctors listening carefully to you, Doctors showing respect for what you had to say, AND Doctors spending enough time with you. (Domain: *How well doctors communicate*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 4) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" on Doctors explaining things in an understandable way to your child AND Doctors listening carefully to you AND Doctors showing respect for what you had to say AND Doctors spending enough time with your child (for each survey question). Questions on Doctors explaining things in an understandable way to your child ("In the last 6 months, how often did doctors or other health providers explain things in a way your child could understand?"), Doctors listening carefully to you ("In the last 6 months, how often did your child's doctors or other health providers listen carefully to you?"), and Doctors showing respect for what you had to say ("In the last 6 months, how often did your child's health care professional show respect for what you had to say?"), and Doctors spending enough time with your child ("In the last 6 months, how often did doctors or other health providers spend enough time with your child?"). (Domain: *How well doctors communicate*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report)
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey.

	Questions on Doctors listening carefully to you ("In the last 6 months, how often did your child's personal doctor listen carefully to you?"), Doctors showing respect for what you had to say ("In the last 6 months, how often did your child's personal doctor show respect for what you had to say?"), Doctors explaining things in an understandable way to your child ("In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?"), and Doctors spending enough time with your child ("In the last 6 months, how often did your child's personal doctor spend enough time with your child?"). Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Metric 3.1c	**Survey-based overall health care**
Description:	The percentage of survey responses marked ratings of 8, 9, or 10 (i.e. favorably) for Overall health care. (Domain: *Overall health care*).
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of 8, 9 or 10. Question on rating of health care, ("We want to know your rating of all your child's health care in the last 6 months from all doctors and other health providers. How would you rate all your child's health care?"). (Domain: *Overall health care*).
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.1c
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	TEFRA Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey: 2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report); Child (ARKids First A) Beneficiary Satisfaction Survey: 2017 & 2019 (interim evaluation report); 2017, 2019, & 2021 (summative evaluation report);
Comparison Group:	Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey. Question on rating of health care, where numerator represents responses of 8, 9 or 10, ("Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number

	would you use to rate all your child's health care in the last 6 months?"). Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

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

Metric 3.2a	Survey-based of Pre-TEFRA vs. Post-TEFRA: Personal doctor or nurse
Description:	The percentage of survey responses marked "Big or small problem" on "How much of a problem, if any, was it for your child to see a personal doctor or nurse?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on "How much of a problem, if any, was it for your child to see a personal doctor or nurse?".
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2a
Sub-group:	Pre-TEFRA vs. Post-TEFRA
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 3.2b	Survey-based of Pre-TEFRA vs. Post-TEFRA: Prescription
Description:	The percentage of survey responses marked "Big or small problem" on "How much of a problem, if any, was it to get your child's prescription medication?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question.

	Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on “How much of a problem, if any, was it to get your child’s prescription medication?”.
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 3.2c	**Survey-based of Pre-TEFRA vs. Post-TEFRA: Urgent care**
Description:	The percentage of survey responses marked "Big or small problem" on “How much of a problem, if any, was it for your child to get urgent care?”.
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "Big or small problem". Question on “How much of a problem, if any, was it for your child to get urgent care?”.
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	3.2c
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

For *Goal 4: Ensuring premium contributions are affordable, do not create a barrier to health care access, and that the proportion of beneficiaries who experience a lockout period for nonpayment of premiums is relatively low*, Metrics 4.1a – 4.1b and 4.2a – 4.2d will be used.

Families of children determined eligible for the TEFRA-like program whose annual income after allowable deduction exceeds 150 percent of the federal poverty level are required to pay a monthly premium to participate in the program. Monthly premiums are based on a family's household size, the number of people living in the household, and the annual income as reported to the Internal Revenue Service. Families can deduct $600 for each dependent child living in the home, along with excess medical and dental expenses as shown on Schedule A of the parents' federal tax returns[8]. The beneficiary's experience on TEFRA-like premiums in view of financial burdensome will be evaluated to determine affordability of premiums. Along with testing the stability if the caretaker's experience on TEFRA-like premiums are a financial burden, the premium range (i.e. $20–$41 vs. $208–$250) can provide information on how much these ranges differ. The contractor will review the top five reasons why TEFRA-like beneficiary cases were closed. This will aid in understanding reasons why disenrollment and if child is receiving health care during a closed case. The state will also investigate barriers of therapy services during the patient's lockout period. The three survey questions related to getting special therapies for a) speech, b) occupational, and c) physical therapy will be utilized between TEFRA Disenrollee Beneficiary Survey data and TEFRA Beneficiary Survey data, where applicable for measurement periods. Lastly, the state will compare the common medical services a patient could not get will not enrolled in TEFRA-like program (i.e. regular physician visits, visits to a specialist, emergency room visits, dental visits, prescription medicine, special therapy, and medical equipment) and determine if any overlap exists with the top common diagnosis conditions for the TEFRA-like beneficiaries.

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

Metric 4.1a	Survey-based premium barriers
Description:	The percentage of survey responses marked "A big financial burden" on "In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?".
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question. Numerator(s): Numerator is number of survey responses of "A big financial burden". Question on "In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?".
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one

[8] https://humanservices.arkansas.gov/about-dhs/dms/tefra/cost.

	gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	4.1a
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 4.1b	**Survey-based premium ranges for premium barriers**
Description:	A cross-table of the survey responses marked "A big financial burden" on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” by the premium ranges survey responses marked on “A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?”
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question of "A big financial burden" on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” Numerator(s): Numerator is the number of survey responses for each premium range. Questions on “In the last 6 months, how much of a financial burden, if any, was it to pay the TEFRA program premiums?” and “A premium is the amount of money you must pay monthly to receive services covered under the TEFRA program. What is your monthly TEFRA premium?”
Sampling Frame:	NCQA guidelines require each beneficiary to be enrolled for a minimum of six months with no more than one gap in enrollment of up to 45 days prior to participating in the survey. Although NCQA defines the allowable gap as 45 days, Arkansas Foundation for Medical Care (AFMC) sets this criterion at 30 days because the enrollment data is reported monthly. Beneficiaries selected for other surveys within the last 12 months were excluded from the population, and only one beneficiary per household was selected.
Research Question(s):	4.1b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report); 2018 – 2022 (summative evaluation report)
Comparison Group:	Trend over time of TEFRA satisfaction survey scores
Comparison Method(s):	Two-group t-test; Chi-squared test

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

Metric 4.2a	Survey-based reasons why cases closed
Description:	Identify the top five reasons why TEFRA-like beneficiary cases were closed from beneficiary satisfaction survey.
Technical Specifications:	Question on "What was the reason that your child's TEFRA case was closed? (Check all that apply)?".
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2a
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Satisfaction Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	Trend over time of top five reasons why TEFRA-like beneficiary cases were closed

Metric 4.2b	Survey-based getting care quickly for disenrollees
Description:	The percentage of survey (Disenrollee) responses marked "Usually" or "Always" (i.e. favorably) for domain of Getting care quickly (i.e. receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed). (Domain: *Getting care quickly*)
Technical Specifications:	Denominator: Eligible population. Denominator is the number of survey questions (n = 2) used for composite score. Number of respondents who answered the survey question (for each survey question). Numerator(s): Numerator is combination of scores (percentage). Number of respondents who answered "Usually" or "Always" receiving care right away for an illness, injury, or condition AND able to get an appointment at a doctor's office or clinic as soon as needed (for each survey question). Questions on Obtaining care right away for an illness/injury/condition ("During the period your child's TEFRA was closed, when your child needed care right away, how often did your child get care as soon as he or she needed?"). and Obtaining care when wanted, but not needed right away ("During the time your child's TEFRA case was closed, not counting the times your child needed care right away, how often did you get an appointment for health care at a doctor's office or clinic as soon as soon as your child needed?"). (Domain: *Getting care quickly*)
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified.

	This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2b
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	TEFRA Beneficiary Survey, Child (ARKids First A) Beneficiary Satisfaction Survey and Child (ARKids First B) Beneficiary Satisfaction Survey, where applicable. Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test
National Benchmark:	National CAHPS Benchmarking Database (NCBD)

Metric 4.2c	**Survey-based therapy services (i.e. special therapies) for disenrollees**
Description:	Percentage of survey responses marked “Not a problem” by a) speech, b) occupational, and c) physical therapy services
Technical Specifications:	Denominator: Eligible population. Denominator is the number of respondents who answered the survey question (for each survey question). If reviewing composite score, denominator is the number of survey questions (n = 3). Numerator(s): Number of respondents who answered "Not a problem", to get therapy your child needed. (By a) speech, b) occupational, and c) physical therapy services) (for each survey question). Combined scores (percentage) of not a problem of Getting Special therapies for a) speech, b) occupational, and c) physical therapy services divided by number of survey questions (n = 3). Questions on not a problem of Getting speech therapy (“During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the speech therapy your child needed?”), Not a problem of Getting occupational therapy (“During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the occupational therapy your child needed?”), and Not a problem of Getting physical therapy (“During the time your child's TEFRA case was closed, how much of a problem, if any, was it to get the physical therapy your child needed?”).
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year’s premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.

Research Question(s):	4.2c
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	TEFRA Beneficiary Survey, where applicable. Trend over time of satisfaction survey scores.
Comparison Method(s):	Two-group t-test; Chi-squared test

Metric 4.2d	**Survey-based medical services not received for disenrollees**
Description:	Responses to survey question: What types of medical services could you not get for your child because your child was not enrolled in the TEFRA program?
Technical Specifications:	List the top medical services of beneficiaries not enrolled in TEFRA-like program. Question on "What types of medical services could you not get for your child because your child was not enrolled in the TEFRA program? (Check all that apply)?".
Sampling Frame:	Beneficiaries who had a break of at least one month in previous year's premium payments were identified. This included all TEFRA-like beneficiaries with premium payment amounts ranging from $0 to $458. TEFRA beneficiaries who showed premium payments for all 12 months in previous year were excluded from the population. The sample was de-duplicated by household. Where more than one beneficiary was found in a household, the youngest beneficiary was utilized for survey purposes.
Research Question(s):	4.2d
Metric Steward:	NCQA/DMS/Arkansas Foundation for Medical Care (AFMC)
Data Source(s):	CAHPS or CAHPS-like questions modeled after CAHPS 5.0H Medicaid Child survey; TEFRA Disenrollee Beneficiary Survey
Measurement Period:	2018 – 2019 (interim evaluation report) or as results are reported; 2018 – 2022 (summative evaluation report) or as results are reported.
Comparison Group:	Trend over time of top medical services of beneficiaries not enrolled in TEFRA-like program. Review the types of medical services related to the top common diagnosis conditions/codes for TEFRA-like beneficiaries.

Appendix D. Independent Evaluator

Based on State protocols, DMS did follow established policies and procedures to acquire an independent entity or entities to conduct the TEFRA-like demonstration evaluation. The State did either undertake a competitive procurement for the evaluator or did contract with entities that had an existing contractual relationship with the State. An assessment of potential contractors' experience, knowledge of State programs and populations, and resource requirements was determined during selection of the final candidate, including steps to identify and/or mitigate any conflicts of interest.

The contractor evaluator hired to conduct the analysis and write the valuation report is ensured to have no actual or potential conflicts of interests. The state hires a contractor independent from DHS and Arkansas Medicaid. The evaluation design includes a "No Conflict of Interest" signed confirmation statement from the independent evaluator. The federal approval of the TEFRA-like demonstration is prepared upon compliance with a set of Special Terms and Conditions. Specific to the program evaluation, the Special Terms and Conditions outline four goals that the State must investigate. DMS and the evaluator develop multiple hypotheses and research questions around these terms and conditions. The evaluation design includes a discussion of the goals, objectives, hypotheses, and research questions, including those that focus specifically on target and comparison populations, and more generally on beneficiaries and beneficiary's experience of services. The evaluator will continue to maintain separation throughout the demonstration evaluation to avoid potential conflicts of interest.

Appendix E. Evaluation Budget

An estimated total cost for the development and production of the TEFRA-like evaluation design and the resulting TEFRA-like evaluation reports are included in **Table 3.** This includes a breakdown of the estimated cost for staff and administration work, an approximation of cost and overall price to complete the five-year TEFRA-like evaluation. Cost includes data cleaning, analyses and the actual production of the evaluation design and evaluation report deliverables.

Table 3. Total TEFRA-Like Analysis Estimated Costs for Five Year Evaluation

Staff/ Work performed	Costs
Evaluation design/protocol	$9,977.73
Data preparation/cleaning	$21,635.37
Data analysis	$74,686.68
Report production	$12,046.21
Project Planning/Management	$5,647.29
Administration	$58,732.92
Estimated total cost	**$182,726.19**