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

Medicaid Section 1115 Eligibility and Coverage Demonstrations Monitoring Report Template

Note: PRA Disclosure Statement to be added here

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

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

Overall section 1115 demonstration	
State	Arkansas
Demonstration name	*Arkansas Health and Opportunity for Me (ARHOME)*
Approval period for section 1115 demonstration	*01/01/22-12/31/26*
Demonstration year and quarter	*EandC DY2Q1 report*
Reporting period	*01/01/23-03/31/23*
Premiums or account payments	
Premiums or account payments start date	01/01/22
Implementation date, if different from premiums or account payments start date	NA
Retroactive eligibility waiver	
Retroactive eligibility waiver start date	*01/01/22*
Implementation date, if different from retroactive eligibility waiver start date	*07/01/22*

Notes:

1. **Eligibility and coverage demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective* date listed in the state's STCs at time of eligibility and coverage demonstration approval. For example, if the state's STCs at the time of eligibility and coverage demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its eligibility and coverage demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example,

CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

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

2. Executive summary

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

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

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

As part of the demonstration, Arkansas requested and received permission to shorten the allowable retroactive eligibility period from 90 days to 30. The demonstration also included beneficiary premiums of $13 per month and copays of $4/$8, up to a maximum of $60 per quarter for individuals above 100% of the federal poverty level.

The state implemented other program provisions aimed at improving beneficiaries' health outcomes. In 2022, QHPs were required to provide at least one health improvement incentive to encourage the use of preventive care and one health improvement incentive for each of the following populations:

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

QHPs were also required to offer one economic independence incentive to encourage advances in beneficiaries' economic status or employment prospects.

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

CMS approved an amendment to the ARHOME demonstration on November 21, 2022, to allow the state to implement the Life360 HOME program. This component of the ARHOME program seeks to provide supplemental care coordination services to address health-related social needs for individuals at high risk of long-term poverty. The amendment also allowed the state to implement copays of $4.70/$9.40 for most beneficiaries above 20% of the federal poverty level.

Quarterly copay limits were set to six different levels depending on the beneficiary's federal poverty level.

The ARHOME program had three significant changes affecting the program in Q1 2023:

- The end of the beneficiary premiums,
- The implementation of the change in the copay structure described above and
- The end of the public health emergency and the disenrollment of ineligible beneficiaries, beginning in March 2023

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

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_1.2 Implementation update			
1.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state defines:	X		
1.2.1.a Beneficiaries exempt from premiums or account payments			
1.2.1.b Beneficiaries subject to premiums or account payments but exempt from compliance actions	X		
1.2.1.c Process for claiming financial hardship	X		
1.2.1.d Process for determining premium or account contribution amounts beneficiaries will pay	X		
1.2.1.e Process for determining that beneficiaries have reached the aggregate spending cap specified in the STCs			To determine the total cost sharing to which beneficiaries were subject, the state combined any copay charged to beneficiaries or beneficiaries in their household as recorded in QHP and MMIS claims data and any TEFRA premiums beneficiaries or beneficiaries in their household were charged during the quarter. This total was compared with 5% of the beneficiary's household income for the quarter.
1.2.1.f Other policy changes	X		

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_3. Invoicing and payments			
PR.Mod_3.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_3.2 Implementation update			
3.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to invoicing and payment processes (including invoicing, beneficiary payments, grace periods, and deadlines for reporting a change in circumstance that would affect premium liability, and compliance actions).			The state stopped allowing premiums for beneficiaries in Q1 2023.
3.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to procedures for beneficiaries to pay premiums or account payments, or for third parties to pay premiums or account payments on behalf of beneficiaries.			The state stopped allowing premiums for beneficiaries in Q1 2023.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_4. Reduction to premiums for non-income related reasons			
PR.Mod_4.1 Metric trends -- ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_4.2 Implementation update			
4.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to incentives or rewards related to premium or account payments (if applicable).			The state stopped allowing premiums for beneficiaries in Q1 2023.

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

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

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

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_7. Develop and modify systems			
PR.Mod_7.1 Metric trends – ***No metric trend analysis is required for this reporting topic.***			
PR.Mod_7.2 Implementation update			
7.2.1 Describe whether the state has developed or enhanced its systems capabilities as described in the implementation plan for: 7.2.1.a Accepting premiums or account payments	X		
7.2.1.b Tracking premiums or account payments	X		
7.2.1.c Establishing beneficiary accounts (if applicable)	X		
7.2.1.d Operationalizing compliance actions (if applicable)	X		
7.2.2 Describe any additional systems modifications that the state is planning to implement.			In 2022, the state paid the QHPs one premium rate for beneficiaries who were not subject to a premium and that same rate, less $13/month for beneficiaries who were subject to a beneficiary premium. Beginning in 2023, the premiums the state pays to the QHPs do not have that $13 deduction for any beneficiaries.

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Retroactive eligibility waiver (RW)			
RW.Mod_1. Retroactive eligibility waiver and demonstration requirements			
RW.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to beneficiaries subject to retroactive eligibility waivers. Describe and explain changes (+ or -) greater than two percent.			The state had an increase in February in the number of applicants with unpaid medical bills (RW_1), but the numbers remain small (less than 15) and therefore difficult to identify a trend. RW_2 increased beginning in Q1 as the public health emergency end required the disenrollment of beneficiaries who did not complete their application paperwork beginning in March. Once some beneficiaries realized they had been disenrolled, they completed their paperwork and were reenrolled with a gap in coverage.
RW.Mod_1.2 Implementation update			
1.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how the state will determine whether beneficiaries are exempt from the retroactive eligibility waiver.	X		
1.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any modifications or expected modifications to Medicaid applications to reflect the retroactive eligibility waiver.	X		
1.2.3 Report any modifications to the appeals processes for beneficiaries subject to retroactive eligibility waivers.	X		

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

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

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_1 Metrics and operations for any demonstrations with eligibility and coverage policies (Any demonstration topics are applicable for reporting on the state's broader section 1115 demonstration. In support of CMS's efforts to simplify data collection and support analysis across states, report for <u>all beneficiaries in the demonstration</u>, not only those subject to eligibility and coverage policies.)			
AD.Mod_1.1 Metric trends			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.1 Discuss any data trends related to overall enrollment in the demonstration. Describe and explain changes (+ or -) greater than two percent.		*AD_1; AD_4; AD_7-AD_10; AD_12-AD_17; AD_19-AD_21; AD_24-AD_32*	*The state changed its criteria for calculating AD_4 for Q1 2023. In the previous quarter, AD_4 counted new enrollment for new enrollees without prior Medicaid segments in the three months prior to the quarter. The new calculation provides new enrollees each month of the quarter without prior Medicaid segments in the three months prior to the enrollment month. The state can submit revised Q4 2022 data at CMS request.* With the new criteria, new enrollment increased to higher than normal levels in November, December, and January. This may be the result of a typical increase in individuals applying for services, such as SNAP and TEA, during those months. Because our eligibility system is integrated across Medicaid and these programs, increases in applications in SNAP and TEA could also result in higher new enrollment for ARHOME. Also, some individuals have decreased income during the winter months, leading to increases in Medicaid applications. The decline in new enrollment in February may be the result of a return to normal levels after the winter increases.

	Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.2	Discuss any data trends related to mid-year loss of demonstration eligibility. At a minimum, changes (+ or -) greater than two percent should be described.		*AD_7-10*	*In its Q4 2022 monitoring report, the state used the closure reason code caseworkers assigned to closures to categorize closures in AD_7-AD_ and closures associated with renewals AD_15-AD_21. However, we discovered that closures with the reason code indicating the client was eligible in another Medicaid program did not align with actual transfer to another Medicaid program. The state is now relying on evidence of an actual transfer for AD_10 and AD_17, increasing the numbers for those metrics and decreasing them for the other closure metrics.* *AD_7-AD_14 (mid-year closures) increased in March during the quarter due to the end of the public health emergency. Disenrollments began 3/31/23.*
1.1.3	Discuss any data trends related to enrollment duration at time of disenrollment. Describe and explain changes (+ or -) greater than two percent.		*AD_12*	*AD_12-AD_14 (mid-year closures) increased in March during the quarter due to the end of the public health emergency. Disenrollments began 3/31/23.*
1.1.4	Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.		*AD_17; AD_19-AD_21*	*In its Q4 2022 monitoring report, the state used the closure reason code caseworkers assigned to closures to categorize closures associated with renewals AD_16-AD_21. However, we discovered that closures with the reason code indicating the client was transferred to another Medicaid program did not align with actual transfer to another Medicaid program. The state is now relying on evidence of an actual transfer for AD_17, increasing the numbers for those metrics and decreasing them for the other closure metrics.*

1.1.5	Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.		*AD_23*	The state changed its premium and copay structure in Q1 2023. In 2022, The demonstration included beneficiary premiums of $13 per month and copays of $4/$8, up to a maximum of $60 per quarter for individuals above 100% of the federal poverty level enrolled in a QHP. Beginning Q1 2023, the state stopped requiring beneficiaries to pay premiums, increased the number of people subject to copays and increased the copays beneficiaries are charged. CMS approved an amendment to the ARHOME demonstration on November 21, 2022, allowing the state to implement copays of $4.70/$9.40 for most beneficiaries above 20% of the federal poverty level. In reporting AD_23, we had data issues resulting in some people appearing to have paid cost sharing that exceeded the 5% limit. We believe these results stem from retroactive changes affecting beneficiaries' FPL after a copay has been charged, misalignment of the household income used to determine FPL for eligibility and household income used to determine copays, and QHPs unintentionally overcharging client copays. AD_23 decreased during Q1 due to several steps the state has taken to address these issues. When premiums were eliminated, the premium cost stopped being a factor in retroactive eligibility changes (i.e., someone who is charged a premium and then reports a retroactive loss of income for months when they have already been charged a premium.) Eligibility caseworkers have received additional training to ensure the household income used to determine FPL is the same household income entered and later used to determine cost sharing limits. Additionally, DHS has worked with ARHOME QHPs to identify and avoid charging excessive copays (for example, reporting back to them the beneficiaries who

	Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
				were charged more than the highest quarterly limit and requiring beneficiary repayment).
1.1.6	Discuss any data trends related to appeals and grievances. Describe and explain changes (+ or -) greater than two percent.		*AD_24-AD_28*	*We believe AD_24 increased during Q1 due to increased awareness of the end of the public health emergency, which caused an increase in adverse redeterminations and therefore appeals of those decisions.* *One ARHOME QHP identified its increase in appeals due to denial of benefits (AD_25) to an increase in appeals involving claims that denied for prior approval related reasons in Q1 of 2023 (i.e., home health/spine injection/DME/inpatient claim denials). It is thought this was a result of the fact that these PA requirements had been on pause due to COVID and then reinstated on 7/31/2022. Providers appealed denials related to these re-instated PA requirements during the first quarter and this resulted in an increase above the normal/expected volume.*
1.1.7	Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.		*AD_29-AD_32*	*AD_30 (PCP active participation) saw a 4% increase between Q3 2022 and Q4 2022 (the quarter reported in this Q1 2023 report). The increase may be due to increased efforts by the ARHOME QHPs to encourage their members to complete a wellness visit before the year's end.*
1.1.8	Discuss any data trends related to quality of care and health outcomes. Describe and explain changes (+ or -) greater than two percent.	NA		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.9 Discuss any data trends related to administrative costs. Describe and explain changes (+ or -) greater than two percent.	NA		
AD.Mod_1.2. Implementation update			
1.2.1 Highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, compliance with requirements, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.			During Q1 2023, the state implemented changes to the state's cost sharing structure, effective January 1, 2023. The state eliminated the $13 per month premium (previously charged to beneficiaries above 100% FPL). The program increased the service-specific copays to $4.70/$9.40, depending on the service and began charging copays to non-exempt individuals between 20% and 100% FPL. Previously, copays were charged only to beneficiaries above 100% FPL. Additionally quarterly copay limits were changed from $60 per quarter, to a quarterly limit based on the beneficiary's FPL. The new limits range from $27 per quarter to $163 per quarter.

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

5. Narrative information on other reporting topics

	Prompt	State has no update to report (place an X)	State response
1.	**Budget neutrality**		
1.1	**Current status and analysis**		
1.1.1	Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the eligibility and coverage policy component is part of a comprehensive demonstration, the state should provide an analysis of the eligibility and coverage policy related budget neutrality and an analysis of budget neutrality as a whole.		With a PMPM cost of $730.71 for the quarter, the state is currently under the budget neutrality limit of $758.85. This does not include the final annual cost settlement reconciliation the state has with the carriers to adjust for actual cost share reduction payments.
1.2	**Implementation update**		
1.2.1	Describe any anticipated program changes that may impact financial/budget neutrality.		With the implementation of the Life360 HOME component of the ARHOME waiver, the state anticipates new expenditures in the coming quarters. Because these expenditures are reported separately from ARHOME's PMPM budget neutrality, the state expects no impact from the Life360 HOME program to its PMPM cost.

Prompt	State has no update to report (place an X)	State response
2. Eligibility and coverage demonstration evaluation update		
2.1 Narrative information		
2.1.1 Provide updates on eligibility and coverage policy evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per 42 Code of Federal Regulations (CFR) § 431.428a(10) for annual [monitoring] reports. See Monitoring Report Instructions for more details.		*DHS submitted its revised evaluation design on February 7, 2023, incorporating feedback from CMS.*
2.1.2 Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.		*DHS submitted its revised evaluation design on February 7, 2023, incorporating feedback from CMS. DHS is meeting established timelines.*
2.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates.		Draft ARHOME Interim Evaluation is due 12/31/25 Draft Life360 HOME Interim Evaluation is due 12/31/25 Draft ARHOME Summative Evaluation is due 6/30/29 Draft Life360 HOME Summative Evaluation is due 6/30/29

Prompt	State has no update to report (place an X)	State response
3. Other eligibility and coverage demonstration reporting		
3.1 General reporting requirements		
3.1.1 Describe whether the state foresees the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.		The state has drafted an amendment request to implement an Opportunities for Success Initiative to incentivize and connect ARHOME beneficiaries to work, education, volunteering activities and resources to address health-related social needs. If granted, this amendment would require changes to the ARHOME STCs.
3.1.2 Compared to the details outlined in the STCs and the monitoring protocol, describe whether the state has formally requested any changes or whether the state expects to formally request any changes to: 3.1.2.a The schedule for completing and submitting monitoring reports		The STCs call for the state to submit a monitoring protocol for the Life360 HOME program 150 days after the November 1, 2022, approval of the amended STCs. CMS has indicated it will not expect the state to submit the revised monitoring protocol until CMS has provided the monitoring metrics it expects the state to report.
3.1.2.b The content or completeness of submitted monitoring reports and or future monitoring reports	X	
3.1.3 Describe whether the state has identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.		The STCs call for the state to submit a monitoring protocol for the Life360 HOME program 150 days after the November 1, 2022, approval of the amended STCs. CMS has indicated it will not expect the state to submit the revised monitoring protocol until CMS has provided the monitoring metrics it expects the state to report.
3.1.4 Provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, per 42 CFR 431.428(a)5		

Prompt	State has no update to report (place an X)	State response
3.2 Post-award public forum		
3.2.1 If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held indicating any resulting action items or issues. A summary of the post-award public forum should be included here for the period during which the forum was held and in the annual monitoring report.	*X*	

	Prompt	State has no update to report (place an X)	State response
4.	**Notable state achievements and/or innovations**		
4.1	**Narrative information**		
4.1.1	Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies (1) pursuant to the eligibility and coverage policy hypotheses (or if broader demonstration, then eligibility and coverage policy related) or (2) that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms (e.g., number of impacted beneficiaries).	*X*	

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

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

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

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until

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

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