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 DY2Q3 report*
Reporting period	*07/01/23-09/30/23*
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 most significant change occurring during Q3 2023 was continuing beneficiary disenrollment due to the end of the Public Health Emergency on 3/31/23. The program's enrollment decreased about 17.5% during the quarter.

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Premiums and account payments (PR)			
PR.Mod_1. Eligibility and payment amounts			
PR.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to beneficiaries subject to premiums or account payments. Describe and explain changes (+ or -) greater than two percent.	X		
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.	NA		
2.2.2 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to how beneficiary health accounts work, including state contributions, use of account funds to pay for services, and rules for account rollovers and balances.	NA		

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

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

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

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

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

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

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

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
Retroactive eligibility waiver (RW)			
RW.Mod_1. Retroactive eligibility waiver and demonstration requirements			
RW.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to beneficiaries subject to retroactive eligibility waivers. Describe and explain changes (+ or -) greater than two percent.	NA		RW_2 increased during the quarter due to beneficiaries being disenrolled after the public health emergency ended and then reenrolling once they realized they had been disenrolled.
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			

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 program's enrollment (AD_1) decreased about 17.5% during the quarter due to continuing disenrollments due to the end of the Public Health Emergency on 3/31/23. The number of people in a QHP increased in August, while the number of people awaiting enrollment in a QHP decreased. This was due to the end of the suspension of auto-assignments. Beginning September 1, 2022, DHS opted to suspend enrollee auto-assignment into QHPs to help with budgetary constraints. After nine months of suspended auto-enrollment, QHP enrollments dropped below the specified threshold, and auto-assignment resumed. About 25,000 beneficiaries who had been awaiting QHP enrollment were assigned to a QHP, with an enrollment start date of August 1, 2023. We believe AD_4 increased significantly in August due to beneficiaries, who were disenrolled in the first months of the PHE unwind, realizing they were disenrolled and reapplying for coverage. Many of those reenrolled may have had 90 day gap in coverage, making it appear, for the purposes of this metric, that they were new enrollees. The closure metrics (AD_7-AD_10 continued to decrease due to the disenrollments related to the PHE unwind.

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*	Closures other than at renewal (AD_7-AD_10) continued to be higher than in 2022 due to the end of the Public Health Emergency, but did not follow a predictable pattern, due to the unprecedented nature of the PHE.
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*	Closures other than at renewal continued to be higher than in 2022 due to the end of the Public Health Emergency, affecting the duration of enrollment metrics (AD_12-AD_14). But the increase did not follow a predictable pattern, due to the unprecedented nature of the PHE.
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*	Beneficiaries with a renewal due (AD_15-AD_21) continued at higher than normal levels in July due to the end of the Public Health Emergency and the redetermination process that reset renewal due dates to the months following the 3/31/23 PHE end date. Renewals decreased in August, with a resumption to more normal levels.

	Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1.1.5	Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.		*AD_23*	In reporting AD_23, we discovered data issues resulting in some people appearing to have paid cost sharing that exceeded the 5% household 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 continued decreasing during Q3 due to several steps the state has taken to address these issues. Eligibility caseworkers have received additional training to ensure the household income used to determine FPL is the same household income entered and later used to determine cost sharing limits. Additionally, DHS has worked with ARHOME QHPs to identify and avoid charging excessive copays (for example, reporting back to them beneficiaries who 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*	*AD_24 increased during Q3 due to the end of the public health emergency, which caused an increase in adverse redeterminations and therefore appeals of those decisions.*
1.1.7	Discuss any data trends related to access to care. Describe and explain changes (+ or -) greater than two percent.	X	*AD_29-AD_32*	
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.			*The Public Health Emergency ended 3/31/23, causing an increase in disenrollments from the ARHOME program. The program lost 17.5% of its enrollment over the course of Q3 2023.*

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 $747.46 for the first three quarters of the demonstration year, 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.		*Work on the ARHOME evaluation continued. DHS met all evaluation timelines and expects no barriers in meeting future timelines.*
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.		*Work on the ARHOME evaluation continued. DHS met all evaluation timelines and expects no barriers in meeting future timelines.*
2.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates.		Draft Life360 HOME Interim Evaluation is due 12/31/25 Draft ARHOME Interim Evaluation is due 12/31/25 Draft Life360 HOME Summative Evaluation is due 6/30/29 Draft ARHOME 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 submitted 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	*X*	

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:

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

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