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 DY1Q4 report*
Reporting period	10/01/22-12/31/22
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 client 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. The program currently covers about 347,000 people with 302,500 enrolled in a QHP.

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 clients above 20% of the federal poverty level.

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

There were no unexpected changes affecting the ARHOME program in Q4 2022.

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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		This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
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: 1.2.1.a Beneficiaries exempt from premiums or account payments	X		
1.2.1.b Beneficiaries subject to premiums or account payments but exempt from compliance actions	NA		
1.2.1.c Process for claiming financial hardship	NA		
1.2.1.d Process for determining premium or account contribution amounts beneficiaries will pay	X		
1.2.1.e Process for determining that beneficiaries have reached the aggregate spending cap specified in the STCs			To determine the total cost sharing clients were subject to, the state combined the total monthly ARHOME premium clients were charged, any TEFRA premiums the client's household were charged, and any copay charged to the client as recorded in QHP claims data. This total was compared with 5% of the beneficiary's household income.
1.2.1.f Other policy changes	X		No policy changes for Q4 2022. The state stopped allowing premiums for clients in Q1 2023.

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		ARHOME does not use beneficiary health accounts. ARHOME clients who were subject to a premium in 2022 paid their QHP. Client who failed to pay their premium to the QHP were not subject to disenrollment
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		The state stopped allowing premiums for clients in Q1 2023.

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 is not charging beneficiary premiums beginning 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.	X		The state is not charging beneficiary premiums beginning 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 is not charging beneficiary premiums beginning Q1 2023.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
PR.Mod_5. Operationalize strategies for noncompliance			
PR.Mod_5.1 Metric trends			
5.1.1 Discuss any data trends related to the number of beneficiaries who have experienced the below. Describe and explain changes (+ or -) greater than two percent. 5.1.1.i New disenrollments	NA		
5.1.1.ii New suspensions	NA		
5.1.2 Discuss any data trends related to beneficiaries in grace periods, non-eligibility periods, and/or other statuses. Describe and explain changes (+ or -) greater than two percent.	NA		
5.1.3 Discuss any data trends related to the number of beneficiaries who had collectible debt. Describe and explain changes (+ or -) greater than two percent.	NA		
PR.Mod_5.2 Implementation update			
5.2.1 Compared to the demonstration design details outlined in the implementation plan, describe any changes or expected changes to: 5.2.1.a Implementation of compliance actions	X		No policy changes for Q4 2022. The state stopped allowing premiums for clients in Q1 2023.
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: 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:	X		No changes for Q4 2022. The state stopped allowing premiums for clients in Q1 2023.
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		

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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.			In mid-December 2022, the state sent notices to all ARHOME beneficiaries above 100% FPL and enrolled in a QHP to let them know they would no longer be responsible for paying a beneficiary premium. Notices for new enrollees were also amended to remove refences to a client premium. The new notices were coordinated with the ARHOME QHPs and the ARHOME call center contractor to ensure QHP and call center staff were prepared to answer questions about the change. The information was also posted on the DHS website and distributed to Medicaid providers.
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		The notices describing the client cost sharing are provided in English, Spanish, and Marshallese, depending on the beneficiary's documented language preference. The notices also provide instructions for obtaining the notice in another language or in another format.

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			To provide data for PR_3, the state requested from the QHPs data on client premiums paid by month. The state does not track client premium payments beyond the purpose of these metrics as the beneficiary premium payment is considered an obligation to the QHP not to the state.
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.			In 2022, the state paid the QHPs one premium rate for clients who were not subject to a premium and that same rate, less $13/month for clients who were subject to a client premium. Beginning in 2023, the premiums the state pays to the QHPs do not have that $13 deduction for any clients.

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.			This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.

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.			This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
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		This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.

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

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
AD.Mod_1 Metrics and operations for any demonstrations with eligibility and coverage policies (Any demonstration topics are applicable for reporting on the state's broader section 1115 demonstration. In support of CMS's efforts to simplify data collection and support analysis across states, report for all beneficiaries in the demonstration, not only those subject to eligibility and coverage policies.)			
AD.Mod_1.1 Metric trends			
1.1.1 Discuss any data trends related to overall enrollment in the demonstration. Describe and explain changes (+ or -) greater than two percent.	X	*AD_1; AD_4; AD_7-AD_10; AD_12-AD_17; AD_19-AD_21; AD_24-AD_32*	This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
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.	X	*AD_7-10*	This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
1.1.3 Discuss any data trends related to enrollment duration at time of disenrollment. Describe and explain changes (+ or -) greater than two percent.	X	*AD_12*	This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
1.1.4 Discuss any data trends related to renewals. Describe and explain changes (+ or -) greater than two percent.	X	*AD_17; AD_19-AD_21*	This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
1.1.5 Discuss any data trends related to cost sharing limits. Describe and explain changes (+ or -) greater than two percent.	X	*AD_23*	This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
1.1.6 Discuss any data trends related to appeals and grievances. Describe and explain changes (+ or -) greater than two percent.	X	*AD_24-AD_28*	This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.

Prompt		State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
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*	This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.
1.1.8	Discuss any data trends related to quality of care and health outcomes. Describe and explain changes (+ or -) greater than two percent.	NA		
1.1.9	Discuss any data trends related to administrative costs. Describe and explain changes (+ or -) greater than two percent.	NA		
AD.Mod_1.2. Implementation update				
1.2.1	Highlight significant demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, compliance with requirements, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.			In Q4 2022, the state set health performance targets for the QHPs to meet in 2023. During Q4 2022, the state prepared for 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.	X		This is the first quarter of data the state has provided, so there are no quarter-to-quarter changes to report.

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 $653.91 for the quarter, the state is currently under the budget neutrality limit of $717.25. This does not include the final annual cost settlement reconciliation the state has with the carriers to adjust for actual cost share reduction payments.
1.2	**Implementation update**		
1.2.1	Describe any anticipated program changes that may impact financial/budget neutrality.		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.		The state is currently working on the evaluation design for the Life360 HOME program that is due to CMS by 4/28/23.
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.		The state is currently working on the evaluation design for the Life360 HOME program that is due to CMS by 4/28/23 and is on track for submission by the due date
2.1.3 List anticipated evaluation-related deliverables related to this demonstration and their due dates.		Life360 HOME Evaluation Design is due 4/28/23 Draft ARHOME Interim Evaluation is due 12/31/25 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.	X	The state is drafting 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	During Q4 2022, CMS approved an amendment to the ARHOME STCs that allows the state to implement the Life360 HOME program. The program will provide intensive care coordination services to ARHOME beneficiaries who are at risk of long-term poverty. The program is developing necessary program operational structures, has received legislative approval for program rules, and has received and approved four letters of intent from hospitals that want to become Life360 HOME providers.

*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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