

24. In the last 12 months, did your health plan give you any forms to fill out?

- ¹ Yes
² No → **If No, go to #26**

25. In the last 12 months, how often were the forms from your health plan easy to fill out?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

26. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

- 0 Worst health plan possible
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 Best health plan possible

About You

27. In general, how would you rate your overall health?

- ¹ Excellent
² Very good
³ Good
⁴ Fair
⁵ Poor

28. In general, how would you rate your overall **mental or emotional** health?

- ¹ Excellent
² Very good
³ Good
⁴ Fair
⁵ Poor

29. In the past 12 months, did you get health care 3 or more times for the same condition or problem?

- ¹ Yes
² No → **If No, go to #31**

30. Is this a condition or problem that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

- ¹ Yes
² No

31. Do you now need or take medicine prescribed by a doctor? Do **not** include birth control.

- ¹ Yes
² No → **If No, go to #33**

32. Is this medicine to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

- ¹ Yes
- ² No

33. What is your age?

- ¹ 18 to 24
- ² 25 to 34
- ³ 35 to 44
- ⁴ 45 to 54
- ⁵ 55 to 64
- ⁶ 65 to 74
- ⁷ 75 or older

34. Are you male or female?

- ¹ Male
- ² Female

35. What is the highest grade or level of school that you have completed?

- ¹ 8th grade or less
- ² Some high school, but did not graduate
- ³ High school graduate or GED
- ⁴ Some college or 2-year degree
- ⁵ 4-year college graduate
- ⁶ More than 4-year college degree

36. Are you of Hispanic or Latino origin or descent?

- ¹ Yes, Hispanic or Latino
- ² No, not Hispanic or Latino

37. What is your race? Mark one or more.

- ¹ White
- ² Black or African American
- ³ Asian
- ⁴ Native Hawaiian or Other Pacific Islander
- ⁵ American Indian or Alaska Native
- ⁶ Other

38. Did someone help you complete this survey?

- ¹ Yes
- ² No → **Thank you.**

Please return the completed survey in the postage-paid envelope.

39. How did that person help you? Mark one or more.

- ¹ Read the questions to me
- ² Wrote down the answers I gave
- ³ Answered the questions for me
- ⁴ Translated the questions into my language
- ⁵ Helped in some other way

Please print: _____

Thank you.

Please return the completed survey in the postage-paid envelope.

Appendix 2D

Consumer Assessment of Healthcare Providers and Systems Survey

Supplemental Items 4.0

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.



1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201
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Consumer Assessment of Healthcare Providers and Systems Survey

Selected measures from the CAHPS 4.0 Supplemental Items survey are being used according to the Agency for Healthcare Research and Quality’s protocol. The survey is attached.

CAHPS[®] Health Plan Survey 4.0

Supplemental Items for the Adult Questionnaires

Language: English



File name: 1157a_engadultsupp_40.doc
Last updated: September 28, 2009 .

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Important instructions

Placing Supplemental Items in the Core Questionnaires. After you copy one or more supplemental items into the core questionnaire:

- **Fix the formatting** of the items as needed to fit into the two-column format.
- **Renumber** the supplemental item and **ALL** subsequent items so that they are consecutive.
- **Revise ALL skip instructions** in the questionnaire to make sure they point the respondent to the correct item number.

Definition of Health Providers. If you choose to use one or more supplemental items that refer to other health providers, please insert this definition before the first of these items: “A health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, or anyone else you would see for health care.”

Behavioral Health

Insert MH1 – MH4 after core question 8. For Medicaid, reference period should be stated as “In the last 6 months.”

MH1. In general, how would you rate your overall **mental or emotional health**?

- ¹ Excellent
- ² Very good
- ³ Good
- ⁴ Fair
- ⁵ Poor

MH2. In the last 12 months, did you need any treatment or counseling for a personal or family problem?

- ¹ Yes
- ² No → **If No, go to core question 9**

MH3. In the last 12 months, how often was it easy to get the treatment or counseling you needed through your health plan?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

MH4. Using any number from 0 to 10, where 0 is the worst treatment or counseling possible and 10 is the best treatment or counseling possible, what number would you use to rate all your treatment or counseling in the last 12 months?

- 0 Worst treatment or counseling possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best treatment or counseling possible

Chronic Conditions

CC1 – CC23 – For Medicaid, reference period should be stated as “In the last 6 months,” except for CC21.

Insert CC1 – CC4 after core question 9.

CC1. Is this person a general doctor or a specialist doctor?

- ¹ General doctor (Family practice or internal medicine)
² Specialist doctor

CC2. How many months or years have you been going to your personal doctor?

- ¹ Less than 6 months
² At least 6 months but less than 1 year
³ At least 1 year but less than 2 years
⁴ At least 2 years but less than 5 years
⁵ 5 years or more

CC3. Do you have a physical or medical condition that seriously interferes with your ability to work, attend school, or manage your day-to-day activities?

- ¹ Yes
² No → **If No, go to core question 10**

CC4. Does your personal doctor understand how any health problems you have affect your day-to-day life?

- ¹ Yes
² No

Insert CC5 after core question 18.

CC5. In the last 12 months, how many times did you go to specialists for care for yourself?

- 1
 2
 3
 4
 5 to 9
 10 or more

Insert CC6 – CC8 after core question 14. Please refer to instructions at the front of this document about defining “health providers.”

CC6. We want to know how you, your doctors, and other health providers make decisions about your health care.

In the last 12 months, were any decisions made about your health care?

¹ Yes

² No → **If No, go to core question 15**

CC7. In the last 12 months, how often were you involved as much as you wanted in these decisions about your health care?

¹ Never

² Sometimes

³ Usually

⁴ Always

CC8. In the last 12 months, how often was it easy to get your doctors or other health providers to agree with you on the best way to manage your health conditions or problems?

¹ Never

² Sometimes

³ Usually

⁴ Always

Insert CC9 – CC14 after core question 8.

CC9. In the last 12 months, did you have a health problem for which you needed special medical equipment, such as a cane, a wheelchair, or oxygen equipment?

¹ Yes

² No → **If No, go to question CC11**

CC10. In the last 12 months, how often was it easy to get the medical equipment you needed through your health plan?

¹ Never

² Sometimes

³ Usually

⁴ Always

CC11. In the last 12 months, did you have any health problems that needed special **therapy**, such as physical, occupational, or speech therapy?

¹ Yes

² No → **If No, go to question CC13**

CC12. In the last 12 months, how often was it easy to get the special therapy you needed through your health plan?

¹ Never

² Sometimes

³ Usually

⁴ Always

CC13. Home health care or assistance means home nursing, help with bathing or dressing, and help with basic household tasks.

In the last 12 months, did you need someone to come into your home to give you home health care or assistance?

¹ Yes

² No → **If No, go to core question 9**

CC14. In the last 12 months, how often was it easy to get home health care or assistance through your health plan?

¹ Never

² Sometimes

³ Usually

⁴ Always

Measures of Health Status

Insert CC15 – CC17 after core question 28.

CC15. Because of any impairment or health problem, do you need the help of other persons with your personal care needs, such as eating, dressing, or getting around the house?

¹ Yes

² No

CC16. Because of any impairment or health problem, do you need help with your routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

¹ Yes

² No

CC17. Do you have a physical or medical condition that seriously interferes with your independence, participation in the community, or quality of life?

¹ Yes

² No

Insert CC18 – CC22 after core question 28.

CC18. In the last 12 months, have you been a patient in a hospital overnight or longer?

¹ Yes

² No

CC19. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

¹ Yes

² No → **If No, go to core question 29**

CC20. Is this condition a problem that has lasted for at least 3 months? Do **not** include pregnancy.

¹ Yes

² No

CC21. Do you now need to take medicine prescribed by a doctor? Do **not** include birth control.

¹ Yes

² No → **If No, go to core question 29**

CC22. Is this to treat a condition that has lasted for at least 3 months? Do **not** include pregnancy or menopause.

¹ Yes

² No

Claims Processing

Insert CP1 – CP3 before core question 20. For Medicaid, reference period should be stated as “In the last 6 months.” Please note that CP1 and CP2 repeat questions that appear in the HEDIS® set.

CP1. Claims are sent to a health plan for payment. You may send in the claims yourself, or doctors, hospitals, or others may do this for you. In the last 12 months, did you or anyone else send in any claims for your care to your health plan?

¹ Yes

² No → **If No, go to core question 20**

³ Don't know → **If Don't know, go to core question 20**

CP2. In the last 12 months, how often did your health plan handle your claims correctly?

¹ Never

² Sometimes

³ Usually

⁴ Always

⁵ Don't know

CP3. In the last 12 months, before you went for care, how often did your health plan make it clear how much you would have to pay?

¹ Never

² Sometimes

³ Usually

⁴ Always

Communication

Insert C1 after core question 12. For Medicaid, reference period should be stated as “In the last 6 months.”

C1. In the last 12 months, how often did you have a hard time speaking with or understanding your personal doctor because you spoke different languages?

¹ Never

² Sometimes

³ Usually

⁴ Always

Cost Sharing

Insert CSH1 after core question 27.

CSH1. People can pay for their health insurance directly or out of their pay check. Do you or your family pay any part of the cost of your health insurance?

¹ Yes

² No

Covered By Multiple Plans

Insert MP1 after core question 2. If HP1 is included, insert after HP1.

MP1. Not counting dental insurance, are you covered by any other health plan?

¹ Yes

² No

Dental Care*

Insert D1 – D3 after core question 8. For Medicaid, reference period should be stated as “In the last 6 months.”

D1. In the last 12 months, did you get care from a dentist’s office or dental clinic?

¹ Yes

² No → **If No, go to core question 9**

D2. In the last 12 months, how many times did you go to a dentist’s office or dental clinic for care for yourself?

None → **If None, go to core question 9**

1

2

3

4

5 to 9

10 or more

* The CAHPS family of products includes a CAHPS Dental Plan Survey. For more information, go to https://www.cahps.ahrq.gov/content/products/Dental/PROD_Dental_Intro.asp.

D3. Using any number from 0 to 10, where 0 is the worst dental care possible and 10 is the best dental care possible, what number would you use to rate all your dental care in the last 12 months?

- 0 Worst dental care possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best dental care possible

Health Plan

Insert HP1 after core question 2.

HP1. How many months or years **in a row** have you been in this health plan?

- ¹ Less than 1 year
- ² At least 1 year but less than 2 years
- ³ At least 2 years but less than 5 years
- ⁴ At least 5 years but less than 10 years
- ⁵ 10 years or more

Insert HP2 – HP7 after core question 21. For Medicaid, reference period should be stated as “In the last 6 months.” Please note that HP2 – HP7 repeat questions that appear in the HEDIS set.

HP2. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

- ¹ Yes
- ² No → **If No, go to core question 22**

HP3. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

HP4. Sometimes people need services or equipment beyond what is provided in a regular or routine office visit, such as care from a specialist, physical therapy, a hearing aid, or oxygen.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for a health care service or equipment?

- ¹ Yes
² No → **If No, go to core question 22**

HP5. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

HP6. In some health plans the amount you pay for a prescription medicine can be different for different medicines, or can be different for prescriptions filled by mail instead of at the pharmacy.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for specific prescription medicines?

- ¹ Yes
² No → **If No, go to core question 22**

HP7. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

HEDIS® Set

[Updated for HEDIS 2010]

The HEDIS Set is composed of items that the National Committee for Quality Assurance (NCQA) added to the core questionnaire to create their version of the CAHPS Health Plan Survey, known as CAHPS 4.0H. Survey sponsors can add these items to their questionnaire whether or not they are submitting results to NCQA. Please note that some of these items are repeated in other supplemental sets.

For Medicaid, reference period should be stated as “In the last 6 months.” Please refer to instructions at the front of this document about defining “health providers.”

Insert H1 – H4 after core question 7.

H1. In the last 12 months, how often did you and a doctor or other health provider talk about specific things you could do to prevent illness?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

H2. Choices for your treatment or health care can include choices about medicine, surgery, or other treatment. In the last 12 months, did a doctor or other health provider tell you there was more than one choice for your treatment or health care?

- ¹ Yes
² No → **If No, go to core question 8**

H3. In the last 12 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?

- ¹ Definitely yes
² Somewhat yes
³ Somewhat no
⁴ Definitely no

H4. In the last 12 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?

- ¹ Definitely yes
² Somewhat yes
³ Somewhat no
⁴ Definitely no

Insert H5 – H6 after core question 14.

H5. In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?

- ¹ Yes
² No → **If No, go to core question 15**

H6. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

Insert H7 – H12 after core question 21.

H7. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

- ¹ Yes
² No → **If No, go to question H9**

H8. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

(H9 is the same as HP4)

H9. Sometimes people need services or equipment beyond what is provided in a regular or routine office visit, such as care from a specialist, physical therapy, a hearing aid, or oxygen.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for a health care service or equipment?

¹ Yes

² No → **If No, go to question H11**

(H10 is the same as HP5)

H10. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for a health care service or equipment?

¹ Never

² Sometimes

³ Usually

⁴ Always

(H11 is the same as HP6)

H11. In some health plans, the amount you pay for a prescription medicine can be different for different medicines, or can be different for prescriptions filled by mail instead of at the pharmacy.

In the last 12 months, did you look for information from your health plan on how much you would have to pay for specific prescription medicines?

¹ Yes

² No → **If No, go to core question 22**

(H12 is the same as HP7)

H12. In the last 12 months, how often were you able to find out from your health plan how much you would have to pay for specific prescription medicines?

¹ Never

² Sometimes

³ Usually

⁴ Always

Insert H13 – H15 after core question 26.**(H13 is the same as CP1)**

H13. Claims are sent to a health plan for payment. You may send in the claims yourself, or doctors, hospitals, or others may do this for you. In the last 12 months, did you or anyone else send in any claims for your care to your health plan?

¹ Yes

² No → **If No, go to core question 27**

³ Don't know → **If Don't know, go to core question 27**

H14. In the last 12 months, how often did your health plan handle your claims quickly?

¹ Never

² Sometimes

³ Usually

⁴ Always

⁵ Don't know

(H15 is the same as CP2)

H15. In the last 12 months, how often did your health plan handle your claims correctly?

¹ Never

² Sometimes

³ Usually

⁴ Always

⁵ Don't know

Insert H16 to H25 after core question 28.

H16. Have you had a flu shot since September 1, 2010?

¹ Yes

² No

³ Don't know

- H17.** Do you now smoke cigarettes or use tobacco every day, some days, or not at all?
- ¹ Every day
² Some days
³ Not at all → **If Not at all, go to question H21**
⁴ Don't know → **If Don't know, go to question H21**
- H18.** In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
- ¹ Never
² Sometimes
³ Usually
⁴ Always
- H19.** In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.
- ¹ Never
² Sometimes
³ Usually
⁴ Always
- H20.** In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
- ¹ Never
² Sometimes
³ Usually
⁴ Always
- H21.** Do you take aspirin daily or every other day?
- ¹ Yes
² No
³ Don't know

H22. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

- ¹ Yes
² No
³ Don't know

H23. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

- ¹ Yes
² No

H24. Are you aware that you have any of the following conditions? Check all that apply.

- ¹ High cholesterol
² High blood pressure
³ Parent or sibling with heart attack before the age of 60

H25. Has a doctor ever told you that you have any of the following conditions? Check all that apply.

- ¹ A heart attack
² Angina or coronary heart disease
³ A stroke
⁴ Any kind of diabetes or high blood sugar

Interpreter

Insert I1 – I2 after core question 8. For Medicaid, reference period should be stated as “In the last 6 months.”

I1. An interpreter is someone who repeats or signs what one person says in a language used by another person.

In the last 12 months, did you need an interpreter to help you speak with doctors or other health providers?

- ¹ Yes
² No → **If No, go to core question 9**

I2. In the last 12 months, when you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

Insert I3 after core question 37.

I3. What language do you **mainly** speak at home?

- ¹ English
² [INSERT LANGUAGE 2]
³ [INSERT LANGUAGE 3]
⁴ [INSERT LANGUAGE 4]

Medicaid Enrollment

Insert ME1 to ME4 before core question 20. If you are including both ME1 and ME3 in your questionnaire, change the skip instruction for ME1 to “No → If No, go to question ME3.”

ME1. Some states pay health plans to care for people covered by {Medicaid/State name for Medicaid}. With these health plans, you may have to choose a doctor from the plan list or go to a clinic or health care center on the plan list.

Are you covered by a health plan like this?

- ¹ Yes
² No → **If No, go to core question 20**

ME2. Did you choose your health plan or were you told which plan you were in?

- ¹ You chose your plan
² You were told which plan you were in

ME3. You can get information about plan services in writing, by telephone, on the Internet, or in-person. Did you get any information about your health plan **before** you signed up for it?

- ¹ Yes
² No → **If No, go to core question 20**

ME4. How much of the information you were given before you signed up for the plan was correct?

- ¹ All of it
² Most of it
³ Some of it
⁴ None of it

People With Mobility Impairments

For Medicaid, reference period should be stated as “In the last 6 months.”

Your Personal Doctor

Insert IM1 – IM10 after core question 15.

IM1. In the last 12 months, did you visit your personal doctor for care?

- ¹ Yes
² No → **If No, go to core question 16**

IM2. When you visited your personal doctor’s office in the last 12 months, how often were you examined on the examination table?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

IM3. When you visited your personal doctor's office in the last 12 months, how often did someone weigh you?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

IM4. When you visited your personal doctor's office in the last 12 months, did you try to use the restroom?

- ¹ Yes
² No → **If No, go to question IM6**

IM5. In the last 12 months, how often was it easy to move around the restroom at your personal doctor's office?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

IM6. In the last 12 months, did you and your personal doctor talk about pain?

- ¹ Yes
² No

IM7. In the last 12 months, how often did pain limit your ability to do the things you needed to do?

- ¹ Never → **If Never, go to question IM9**
² Sometimes
³ Usually
⁴ Always

IM8. In the last 12 months, do you think that your personal doctor understood the impact that pain has on your life?

- ¹ Yes
² No

IM9. In the last 12 months, how often did fatigue limit your ability to do the things you needed to do?

- ¹ Never → **If Never, go to core question 16**
² Sometimes
³ Usually
⁴ Always

IM10. In the last 12 months, do you think that your personal doctor understood the impact that fatigue has on your life?

- ¹ Yes
² No

Your Health Plan**Insert IM11 – IM19 after core question 27.****IM11.** In the last 12 months, did you need physical or occupational therapy?

- ¹ Yes
² No → **If No, go to question IM13**

IM12. In the last 12 months, how often was it easy to get this kind of therapy through your health plan?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

IM13. In the last 12 months, did you need speech therapy?

- ¹ Yes
² No → **If No, go to question IM15**

IM14. In the last 12 months, how often was it easy to get speech therapy through your health plan?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

IM15. Mobility equipment includes things like a wheelchair, scooter, walker, or cane. In the last 12 months, have you used any mobility equipment to move around your home or community?

- ¹ Yes
² No → **If No, go to core question 28**

IM16. In the last 12 months, did you try to get your mobility equipment repaired through your health plan?

- ¹ Yes
² No → **If No, go to question IM18**

IM17. In the last 12 months, how often was it easy to get your mobility equipment repaired through your health plan?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

IM18. In the last 12 months, did you try to get or replace any mobility equipment through your health plan?

- ¹ Yes
² No → **If No, go to core question 28**

IM19. In the last 12 months, how often was it easy to get or replace the mobility equipment that you needed through your health plan?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

About You

Insert IM20 – IM21 after core question 32.

IM20. A quarter mile is about 5 city blocks or 0.4 kilometers. In the last 12 months, were you able to walk that far?

- ¹ Yes
² No → **If No, go to core question 33**

IM21. In the last 12 months, did you have difficulty or need assistance to walk that far?

- ¹ Yes
² No

Personal Doctor

Insert PD1 – PD2 after core question 15.

PD1. Did you have the same personal doctor **before** you joined this health plan?

¹ Yes → **If Yes, go to core question 16**

² No

PD2. Since you joined your health plan, how often was it easy to get a personal doctor you are happy with?

¹ Never

² Sometimes

³ Usually

⁴ Always

Pregnancy Care

Insert P1 – P3 after core question 14. Remove core question 34 from the Adult Questionnaire, as it is duplicated in P1.

P1. Are you male or female?

¹ Male → **If Male, go to core question 15**

² Female

P2. Are you pregnant now?

¹ Yes

² No → **If No, go to core question 15**

P3. A health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, a mid-wife, or anyone else you would see for health care when you are pregnant.

Have you been to a doctor or other health provider for a pregnancy care check-up for **this** pregnancy?

¹ Yes

² No

Prescription Medicine

Insert PM1 – PM3 after core question 27. For Medicaid, reference period should be stated as “In the last 6 months.”

PM1. In the last 12 months, did you get any new prescription medicines or refill a prescription?

¹ Yes

² No → **If No, go to core question 28**

PM2. In the last 12 months, how often was it easy to get your prescription medicine from your health plan?

¹ Never

² Sometimes

³ Usually

⁴ Always

PM3. In the last 12 months, how often did you get the prescription medicine you needed through your health plan?

¹ Never

² Sometimes

³ Usually

⁴ Always

Quality Improvement

For Medicaid, reference period should be stated as “In the last 6 months.”

Access to Routine Care

Insert AR1 – AR2 after core question 6. Please refer to instructions at the front of this document about defining “health providers.”

AR1. In the last 12 months, **not** counting the times you needed health care right away, how many days did you usually have to wait between making an appointment and actually seeing a health provider?

- ¹ Same day
- ² 1 day
- ³ 2 to 3 days
- ⁴ 4 to 7 days
- ⁵ 8 to 14 days
- ⁶ 15 to 30 days
- ⁷ 31 to 60 days
- ⁸ 61 to 90 days
- ⁹ 91 days or longer

AR2. In the last 12 months, how often did you have to wait for an appointment because the health provider you wanted to see worked limited hours or had few available appointments?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

Access to Specialist Care

Insert AS1 after core question 17, which should be modified to include the skip instructions presented below.

17. In the last 12 months, how often was it easy to get appointments with specialists?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always → **If Always, go to core question 18**

AS1 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

AS1. Were any of the following a reason it was not easy to get an appointment with a specialist?

- | | <u>Yes</u> | <u>No</u> |
|--|---------------------------------------|---------------------------------------|
| a) Your doctor did not think you needed to see a specialist | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| b) Your health plan approval or authorization was delayed | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| c) You weren't sure where to find a list of specialists in your health plan or network | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| d) The specialists you had to choose from were too far away | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| e) You did not have enough specialists to choose from | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| f) The specialist you wanted did not belong to your health plan or network | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| g) You could not get an appointment at a time that was convenient | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| h) Some other reason | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |

Please specify: _____

After Hours Care

Insert AH1 – AH3 after core question 8.

AH1. After hours care is health care when your usual doctor's office or clinic is closed. In the last 12 months, did you need to visit a doctor's office or clinic for after hours care?

- ¹ Yes
- ² No → **If No, go to core question 9**

AH2. In the last 12 months, how often was it easy to get the after hours care you thought you needed?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always → **If No, go to core question 9**

AH3 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

AH3. Were any of the following a reason it was not easy to get the after hours care you thought you needed?

- | | <u>Yes</u> | <u>No</u> |
|---|---------------------------------------|---------------------------------------|
| a) You did not know where to go for after hours care | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| b) You weren't sure where to find a list of doctor's offices or clinics in your health plan or network that are open for after hours care | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| c) The doctor's office or clinic that had after hours care was too far away | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| d) Office or clinic hours for after hours care did not meet your needs | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| e) Some other reason | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |

Please specify: _____

Calls to Personal Doctor's Office

Insert C1 – C5 after core question 14.

CO1. In the last 12 months, did you phone your personal doctor's office **during** regular office hours to get help or advice for yourself?

- ¹ Yes
- ² No → **If No, go to question CO3**

CO2. In the last 12 months, when you phoned during regular office hours, how often did you get the help or advice you needed?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

CO3. In the last 12 months, did you phone your personal doctor’s office **after** regular office hours to get help or advice for yourself?

- ¹ Yes
- ² No → **If No, go to core question 15**

CO4. In the last 12 months, when you phoned after regular office hours, how often did you get the help or advice you needed?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always → **If Always, go to core question 15**

CO5 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

CO5. Were any of the following a reason you did not get the help or advice you thought you needed when you phoned after regular office hours?

- | | <u>Yes</u> | <u>No</u> |
|---|---------------------------------------|---------------------------------------|
| a) You did not know what number to call | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| b) You left a message but no one returned your call | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| c) You could not leave a message at the number you phoned | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| d) Another doctor was covering for your personal doctor | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| e) Some other reason | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |

Please specify: _____

Coordination of Care from Other Health Providers

Insert OHP1 – OHP5 after core question 14. Please note that OHP1 – OHP2 repeat questions that appear in the HEDIS set. Please refer to instructions at the front of this document about defining “health providers.”

OHP1. In the last 12 months, did you get care from a doctor or other health provider besides your personal doctor?

- ¹ Yes
- ² No → **If No, go to core question 15**

OHP2. In the last 12 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always

OHP3. In the last 12 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?

- ¹ Yes
- ² No → **If No, go to core question 15**

OHP4. In the last 12 months, who helped to coordinate your care?

- ¹ Someone from your health plan
- ² Someone from your doctor's office or clinic
- ³ Someone from another organization
- ⁴ A friend or family member
- ⁵ You

OHP5. How satisfied are you with the help you received to coordinate your care in the last 12 months?

- ¹ Very dissatisfied
- ² Dissatisfied
- ³ Neither dissatisfied nor satisfied
- ⁴ Satisfied
- ⁵ Very satisfied

Customer Service

Insert CS1 – CS2 after core question 23, which should be modified to include the skip instructions presented below. Core question 24 also provides useful drill-down data on consumer encounters with customer service.

23. In the last 12 months, how often did your health plan’s customer service give you the information or help you needed?

- ¹ Never
- ² Sometimes
- ³ Usually
- ⁴ Always → **If Always, go to question CS2**

CS1 was designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

CS1. Were any of the following a reason you did not get the information or help you needed from your health plan’s customer service?

- | | <u>Yes</u> | <u>No</u> |
|--|---------------------------------------|---------------------------------------|
| a) You had to call several times before you could speak with someone | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| b) The information customer service gave you was not correct | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| c) Customer service did not have the information you needed | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| d) You waited too long for someone to call you back | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| e) No one called you back | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |
| f) Some other reason | ¹ <input type="checkbox"/> | ² <input type="checkbox"/> |

Please specify: _____

CS2. How many calls did it take for you to get the help or information you needed from your health plan’s customer service?

- ¹ 1 call
- ² 2
- ³ 3
- ⁴ 4
- ⁵ 5 or more calls
- ⁶ You are still waiting for help

Health Plan Information and Materials

Insert PW1 – PW8 after core question 21. Please note that PW1 – PW2 repeat questions that appear in the HEDIS set. If you use PW4 or PW8, please refer to instructions at the front of this document about defining “health providers.”

(PWI is the same as HP2)

PW1. In the last 12 months, did you look for any information in written materials or on the Internet about how your health plan works?

¹ Yes

² No → **If No, go to core question 22**

PW2. In the last 12 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

¹ Never

² Sometimes

³ Usually

⁴ Always

PW3. In the last 12 months, how often was it easy to use the information on how your health plan works?

¹ Never

² Sometimes

³ Usually

⁴ Always → **If Always, go to question PW6**

PW4 and PW5 were designed for and tested with a commercial population using primarily a self-administered format. Item wording and format may not be appropriate for other modes of administration or other populations (e.g., Medicaid, Medicare, low literacy).

PW4. What kind of information was **not** easy to use?

- | | <u>Yes</u> | <u>No</u> |
|--|----------------------------|----------------------------|
| a) Benefits and coverage for doctor or specialist visits | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b) Benefits and coverage for pharmacy | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c) Getting a referral to a specialist | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d) After hours or urgent care | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| e) Choosing a health provider | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| f) Getting care outside your network | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| g) Something else | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

Please specify: _____

PW5. Where did you get that information? Mark one or more.

- | | <u>Yes</u> | <u>No</u> |
|------------------------------|----------------------------|----------------------------|
| a) From your health plan | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| b) From your employer | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| c) From your doctor's office | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| d) From some other source | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| e) Not sure where you got it | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

PW6. When you looked for information in the last 12 months, did you go to your health plan's Internet site?

- 1 Yes
 2 No → **If No, go to core question 22**

PW7. How useful was the information you found on your health plan's Internet site?

- 1 Not at all useful
 2 A little useful
 3 Somewhat useful
 4 Very useful

PW8. In the last 12 months, did you use information on your health plan's Internet site to choose a doctor, specialist, or group of health providers?

- ¹ Yes
² No

Referrals

Insert R1 before core question 17. For Medicaid, reference period should be stated as "In the last 6 months."

R1. In the last 12 months, how often was it easy to get a referral to a specialist that you needed to see?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

Relation to Policyholder

Insert RP1 after core question 37.

RP1. Health insurance plans are usually in one person's name, the policyholder. Are you the policyholder?

- ¹ Yes
² No

Transportation

Insert T1 – T3 after core question 27. For Medicaid, reference period should be stated as "In the last 6 months."

T1. Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage.

In the last 12 months, did you phone your health plan to get help with transportation?

- ¹ Yes
² No → **If No, go to core question 28**

T2. In the last 12 months, when you phoned to get help with transportation from your health plan, how often did you get it?

- ¹ Never → **If Never, go to core question 28**
² Sometimes
³ Usually
⁴ Always

T3. In the last 12 months, how often did the help with transportation meet your needs?

- ¹ Never
² Sometimes
³ Usually
⁴ Always

Utilization

Insert UT1 after core question 6. For Medicaid, reference period should be stated as “In the last 6 months.”

UT1. In the last 12 months, how many times did you go to an emergency room to get care for yourself?

- None
 1
 2
 3
 4
 5 to 9
 10 or more

Insert UT2 after core question 19. For Medicaid, reference period should be stated as “In the last 6 months.”

UT2. In the last 12 months, was the specialist you saw most often the same doctor as your personal doctor?

- ¹ Yes
² No

Appendix 3

Metrics and Hypotheses

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HCIP Waiver Evaluation Planning: State's Medicaid Reporting Measures

Hypotheses

Metric Number	Indicator	Metric Name	Description	Data Source	Hypotheses			
					1. Access	2. Outcomes	3. Continuity	4. Cost
1	Medicaid Adult Core #1; CAHPS-H16; NCQA 0039	Flu Shots for Adults Ages 50 to 64	Rolling average represents the percentage of Medicaid enrollees ages 50 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 5.0H survey was completed	Survey	X	X		
2	Medicaid Adult Core #3; NQF 0031	Breast Cancer Screening	Percentage of women ages 42 to 69 that received a mammogram in the measurement year or the year prior to the measurement year	Medical claims	X	X		
3	Medicaid Adult Core #4; NQF 0032	Cervical Cancer Screening	Percentage of women ages 24 to 64 that received one or more PAP tests during the measurement year or the two years prior to the measurement year	Medical claims	X	X		
4	Medicaid Adult Core #7; NQF 1768	Plan All-Cause Readmission Rate	For enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission	Medical claims		X		
5	Medicaid Adult Core #9; PQI 01; NQF 0272	Diabetes Short-Term Complications Admission Rate	Number of discharges for diabetes short-term complications per 100,000 enrollees age 18 and older	Medical claims		X		
6	Medicaid Adult Core #10; PQI 05; NQF 0275	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Number of discharges for COPD per 100,000 enrollees age 18 and older	Medical claims		X		
7	Medicaid Adult Core #10; PQI 08; NQF 0277	Congestive Heart Failure (CHF) Admission Rate	Number of discharges for CHF per 100,000 enrollees age 18 and older	Medical claims		X		
8	Medicaid Adult Core #11; PQI 15; NQF 0283	Adult Asthma Admission Rate	Number of discharges for asthma per 100,000 enrollees age 18 and older	Medical claims		X		

Metric Number	Indicator	Metric Name	Description	Data Source				
					1. Access	2. Outcomes	3. Continuity	4. Cost
9	Medicaid Adult Core #13; NQF 0576	Follow-Up After Hospitalization for Mental Illness	Percentage of discharges for enrollees age 21 and older that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Medical claims		X		
10	Medicaid Adult Core #16; NQF 0403	Annual HIV/AIDS Medical Visit	Percentage of enrollees age 18 and older with a diagnosis of HIV/AIDS and with at least two medical visits during the measurement year, with a minimum of 90 and 180 days between each visit	Medical claims	X	X		
11	Medicaid Adult Core #18; NQF 0063	Comprehensive Diabetes Care: LDL-C Screening	Percentage of enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a LDL-C screening test	Medical claims		X		
12	Medicaid Adult Core #19; NQF 0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Percentage of enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a Hemoglobin A1C test	Medical claims		X		
13	Medicaid Adult Core #20; NQFA 0105	Antidepressant Medication Management	Percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression, that were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) and for at least 180 days (6 months)	Medical claims		X		
15	HEDIS NQF 1879	Adherence to Antipsychotics for Individuals with Schizophrenia	The percentage of members 18 or older during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Medical claims	X	X		
16	Medicaid Adult Core #26; NQF 1517	Postpartum Care Rate	Percentage of deliveries the year prior to the measurement year and that had a postpartum visit on or between 21 and 56 days after delivery.	Medical claims	X			

Metric Number	Indicator	Metric Name	Description	Data Source				
					1. Access	2. Outcomes	3. Continuity	4. Cost
17	HEDIS; NQF 0071	Persistence of Beta-Blocker Treatment After a Heart Attack	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.	Medical claims		X		
18	NQF 0543	Adherence to Statin Therapy for Individuals with Coronary Artery Disease	The percentage of individuals with Coronary Artery Disease (CAD) who are prescribed statin therapy that had a Proportion of Days Covered (PDC) for statin medications of at least 0.8 during the measurement period (12 consecutive months).	Medical and pharmacy claims		X		
19	HEDIS NQF 0021	Annual monitoring for patients on persistent medications	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the four rates separately and as a total rate. <ul style="list-style-type: none"> • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB). • Annual monitoring for members on digoxin. • Annual monitoring for members on diuretics. • Annual monitoring for members on anticonvulsants. • Total rate (the sum of the four numerators divided by the sum of the four denominators). 	Medical claims		X		
20	HEDIS	Adults' Access to Preventive/ Ambulatory Health Services	Utilization rates per 1000 enrollees	Medical claims	X			
21	HEDIS	Frequency of Selected Procedures	Utilization for selected procedures per 1000 enrollees	Medical claims	X			

Metric Number	Indicator	Metric Name	Description	Data Source				
					1. Access	2. Outcomes	3. Continuity	4. Cost
22	HEDIS	Ambulatory Care (Outpatient ER)	Utilization for selected procedures per 1000 enrollees	Medical claims	X			
23	HEDIS	Inpatient Utilization—General Hospital/ Acute Care	Inpatient service use by age	Medical claims	X			
24	CAHPS-4; NQF 0006	Got care for illness/injury as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
25	CAHPS-6; NQF 0006	Got non-urgent appointment as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
26	CAHPS-9; NQF 0006	How often it was easy to get necessary care, tests, or treatment	Survey based assessment of enrollee experiences	Survey	X			
27	CAHPS-10; NQF 0006	Have a personal doctor	Survey based assessment of enrollee experiences	Survey	X			
28	CAHPS-18; NQF 0006	Got appointment with specialists as soon as needed	Survey based assessment of enrollee experiences	Survey	X			
29	CAHPS-HP1; NQF 0007	Number of months or years in a row enrolled in health plan	Survey based assessment of enrollee experiences	Survey			X	
30	CAHPS-8; NQF 0007	Rating of all health care	Survey based assessment of enrollee experiences	Survey		X		
31	CAHPS-16; NQF 0007	Rating of personal doctor	Survey based assessment of enrollee experiences	Survey		X		
32	CAHPS-20; NQF 0007	Rating of specialist	Survey based assessment of enrollee experiences	Survey		X		
33	CAHPS-26; NQF 0007	Rating of health plan	Survey based assessment of enrollee experiences	Survey		X		
34	CAHPS-I1; NQF 0007	Needed interpreter to help speak with doctors or other health providers	Survey based assessment of enrollee experiences	Survey	X			
35	CAHPS-I2; NQF 0007	How often got an interpreter when needed one	Survey based assessment of enrollee experiences	Survey	X			
36	CAHPS-PD1; NQF 0007	Had same personal doctor before joining plan	Survey based assessment of enrollee experiences	Survey		X	X	

Metric Number	Indicator	Metric Name	Description	Data Source				
					1. Access	2. Outcomes	3. Continuity	4. Cost
37	CAHPS-PD2; NQF 0007	Easy to get personal doctor you were happy with	Survey based assessment of enrollee experiences	Survey		X		
38	CAHPS-AR1; NQF 0007	Days wait time between making appointment and seeing provider	Survey based assessment of enrollee experiences	Survey	X			
39	CAHPS-AR2; NQF 0007	How often had to wait for appointment because of provider's lack of hours/availability	Survey based assessment of enrollee experiences	Survey	X			
40	CAHPS-R1; NQF 0007	Easy to get a referral to a specialist	Survey based assessment of enrollee experiences	Survey	X	X		
41	CAHPS-UT1; NQF 0007	Times visited emergency room	Survey based assessment of enrollee experiences	Survey	X	X		
42	AR Medicaid Eval 02	Non-emergency transportation access	Use of non-emergency transportation services	Transportation data	X			
43	AR Medicaid Eval 03	Continuity of PCP care	Consistent use of the same primary care provider over time--proportion of primary care visits with same PCP	Medical claims	X		X	
44	AR Medicaid Eval 04	Continuity of Specialist care	Consistent use of the same specialist provider over time--proportion of type specific same specialist visits over time	Medical claims	X		X	
45	AR Medicaid Eval 05	PCP Network Adequacy	Adequacy of primary care provider network for enrolled populations--proportion of service area without primary care coverage within 30 miles	Carrier / Medicaid geomaps	X			
46	AR Medicaid Eval 06	PCP Network Accessibility	Accessibility of primary care provider network for enrolled populations--proportion of enrollees with primary care accessible within 30 miles	Carrier / Medicaid geomaps	X			
47	AR Medicaid Eval 07	Specialist network adequacy	Adequacy of specialist provider network for enrolled populations--proportion of service area without specialist coverage within 60 miles	Carrier / Medicaid geomaps	X			
48	AR Medicaid Eval 08	Specialist network accessibility	Accessibility of specialist network for enrolled populations--proportion of enrollees with specialist accessible within 60 miles	Carrier / Medicaid geomaps	X			
49	AR Medicaid Eval 09	Total and subgroup enrollment within carrier (e.g., market penetration)	Carrier, and carrier by market specific enrollment data	Enrollment			X	

Metric Number	Indicator	Metric Name	Description	Data Source				
					1. Access	2. Outcomes	3. Continuity	4. Cost
50	AR Medicaid Eval 10	Total and subgroup enrollment within each plan (e.g., plan differentiation)	Carrier, and carrier by market, and carrier by market by plan specific enrollment data	Enrollment			X	
51	AR Medicaid Eval 11	Total and subgroup enrollment within each method of entry (e.g., enrollment path)	Carrier specific enrollment path	Enrollment			X	
52	AR Medicaid Eval 12	Total and subgroup enrollment within each market (e.g., geographic uptake variation)	Carrier by market specific enrollment path	Enrollment			X	
53	AR Medicaid Eval 13	Total and Subgroup Medicaid Clinical costs	Direct payments by state Medicaid per enrollee	Cost				X
54	AR Medicaid Eval 14	Total and Subgroup Medicaid Administrative costs	Direct administrative costs attributed per enrollee	Cost				X
55	AR Medicaid Eval 15	Total and Subgroup Plan Admin Costs per Enrollee	Direct wrap costs attributed per enrollee	Cost				X
56	AR Medicaid Eval 16	Total startup programmatic costs (e.g., medical needs screener)	Total Program Start Costs	Cost				X
57	AR Medicaid Eval 17	Total startup programmatic costs (e.g., medical needs screener)	Direct Premium Assistance paid per enrollee	Cost				X
58	AR Medicaid Eval 18	Total and Subgroup Plan Admin Costs per Enrollee	Estimated plan administrative costs for premium assistance	Cost				X
59	AR Medicaid Eval 19	Arkansas Program Characteristics	Arkansas specific health insurance exchange program characteristics (e.g., number of plans per market area, actuary risk, average 2nd lowest premium cost)	Cost				X
60	AR Medicaid Eval 20	Contiguous State Program Characteristics	Contiguous state specific health insurance exchange program characteristics	Cost				X
61	AR Medicaid Eval 21	Regional average program characteristics	Regional average state specific health insurance exchange program characteristics	Cost				X

Appendix 4

Candidate Metrics by Approach

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Candidate Metrics by Approach

This table attributes the metrics that are referenced in Appendix 3 to the corresponding analytical design approach that will be used to address each of the evaluation hypotheses.

Hypotheses	Design Approach		
	Subgroup Comparison	Regression Discontinuity	Statewide Comparison
1—Access			
a. Premium Assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.		2, 3, 4, 10, 16, 20	1, 2, 3, 4, 10, 16, 20-22, 24-28, 43-48, 37-40, 45-48
b. Premium Assistance beneficiaries will have lower non-emergent use of emergency room services.	22, 41	22, 41	22, 41
c. Premium Assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.		4, 23	4-8, 23
d. Premium Assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.	18, 43-47		
e. Premium Assistance beneficiaries will have appropriate access to non-emergency transportation.	42	42	42
2—Care/Outcomes			
a. Premium Assistance beneficiaries will have equal or better access to preventive care services. (P – Primary Prevention; S – Secondary Prevention; T – Tertiary Prevention)		P: 2, 3 S: 9, 10 T: 11-13, 18-19	P: 1-3 S: 9-10 T: 11-13, 17-19
b. Premium Assistance beneficiaries will report equal or better experience in the care provided.			24-28, 30-35, 37-40

3—Continuity			
a. Premium Assistance beneficiaries will have fewer gaps in insurance coverage.		49-52	29, 49-52
b. Premium Assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.		49-52	29, 36(m), 43-44, 49-52
4—Cost Effectiveness			
a. Premium Assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.		2-4, 9-13, 16, 18-20, 22-23, 41-42, 54, 56-58	1-13, 16-28, 30-35, 37-52, 54, 56-58
b. Premium Assistance will reduce overall premium costs in the Exchange Marketplace and will increase quality of care.		2-4, 9-13, 16, 18-20, 22-23, 41-42, 59-61	1-13, 16-28, 30-35, 37-52, 59-61
c. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service in accordance with STC 68 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.		53-57	53-57

m = modification

Appendix 5

Arkansas Insurance Department Network Adequacy Guidelines and Targets

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Appendix 5

AID Network Adequacy Guidelines and Targets

45 CFR § 156.230 requires that Qualified Health Plans (QHPs) “...maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.” AID has developed the following network adequacy targets and data submission requirements to ensure adequacy of provider networks in QHPs offered in the Federally-Facilitated Marketplace (FFM, or “Marketplace”). Failure to meet these standards may not preclude participation in the FFM in the first year of evaluation, but may require additional justification. AID will evaluate whether or not the targets should be adopted as QHP standards in future years.

Medical issuers who apply for participation in the Marketplace may already be accredited and so may not need to submit additional network access information as part of the application process. Non-accredited issuers and dental issuers will be required to submit network information. Additional detail on submission requirements is outlined below. All issuers, both accredited and non-accredited, will be required to comply with the provider directory and ECP guidelines.

Note that QHP service areas in Arkansas may change and network adequacy requirements in this standard must apply to updated service areas.

Accreditation

Issuers are required to receive accreditation on network policies and procedures from a qualifying accreditation entity (NCQA or URAQ) prior to second year of Marketplace participation. Proof of accreditation must be submitted with the QHP application (SERFF binder).

Accreditation entities have indicated that they will consider state standards in evaluating network adequacy. AID will communicate the time and distance targets below to URAC and NCQA to be used in the accreditation process. If carriers currently assess networks with more stringent internal network requirements (i.e. PCP available within 15 minutes or 15 miles), then they should proceed with existing internal standards.

Accredited issuers should report time and distance GeoAccess Maps and metrics according to the standards below as part of QHP submission.

Time and Distance Targets

AID recommends that issuers and accreditation entities evaluate networks based on the following targets. If an issuer is not accredited, GeoAccess maps and other information demonstrating network access based on these targets must be submitted.

- PCP target: 1 provider within 30 miles or 30 minutes
- Specialty care target: 1 provider within 60 miles or 60 minutes
- Mental Health, Behavioral Health, or Substance Abuse (MH/BH/SA): 1 provider within 45 minutes or 45 miles

GeoAccess Map Guidelines

GeoAccess Maps and compliance percentages must be submitted for each of the categories below. Accredited carriers will be required to submit GeoAccess maps for reporting purposes. Map data is only required for service areas that are included in the QHP application. Requested maps can be submitted separately or combined and distinguished by color or other method. Please note exceptions for dental carriers.

- **Primary Care:** GeoAccess Maps must be submitted demonstrating a 30 mile or 30 minute coverage radius from each general / family practitioner or internal medicine provider, and each family practitioner/pediatrician. Maps should also show providers accepting new patients. Dental carriers are not required to submit separate categories, but should include only non-specialists in this requirement.
- **Specialty Care:** GeoAccess Maps must be submitted demonstrating a 60 mile or 60 minute coverage radius from each category of specialist (see list of categories below). Maps should also show providers accepting new patients. Specialists should be categorized according to the list below. (Dental carriers do not need to categorize specialists.)
 - Hospitals*
 - Home Health Agencies
 - Cardiologists
 - Oncologists
 - Obstetricians
 - Pulmonologists
 - Endocrinologists
 - Skilled Nursing Facilities
 - Rheumatologists
 - Ophthalmologists
 - Urologists
 - Psychiatric and State Licensed Clinical Psychologist

**Hospitals types should be categorized according to hospital licensure type in Arkansas.*
- **MH/BH/SA:** GeoAccess Maps must be submitted demonstrating a 45 mile or 45 minute coverage radius from MH/BH/SA providers for each of the categories below. Maps should also show providers accepting new patients.
 - Psychiatric and State Licensed Clinical Psychologist
 - Other (submit document outlining provider or facility types included)
- **Essential Community Providers:** GeoAccess Maps must be submitted demonstrating a 30 mile or 30 minute coverage radius from ECPs for each of the categories below. The provider types included in each of the categories align with federal guidelines for ECP providers, with the addition of school-based providers included in the “Other ECP” category
 - FQHC
 - Ryan White Provider
 - Family Planning Provider
 - Indian Provider
 - Hospital
 - Other ECP

Performance Metric Guidelines for Non-Accredited Carriers

Non-accredited issuers will be required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. Accredited issuers will be required to submit these metrics for reporting purposes. These include:

- The *number of members* and *percentage of total members* within access to a PCP within 30 minutes/miles, a specialist within 60 minutes/miles, or a MH/BH/SA provider within 45 minutes/miles.
- The average distance to first, second, and third closest provider for each provider type.

These figures should be provided overall (entire state) for each category as well as stratified by county for each category.

For example, the percent of enrolled members that are within 30 minutes or 30 miles of a general/family practitioner will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county.

Issuers who do not yet have enrollees in the State of Arkansas will be exempt from this requirement and must attest to not currently having enrollees in Arkansas.

Network Access Policies and Procedures for Non-Accredited Carriers

Non-accredited carriers should submit an access plan describing company policies and procedures for ensuring adequate and sufficient network access. The access plan should include narrative description that addresses each of the following:

- (1) The Qualified Health Plan Issuer’s network is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week;
- (2) The Qualified Health Plan Issuer’s procedures for making referrals within and outside its network and notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;
- (3) The Qualified Health Plan Issuer’s process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;
- (4) The Qualified Health Plan Issuer’s efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
- (5) The Qualified Health Plan Issuer’s methods for assessing the health care needs of covered persons;
- (6) The Qualified Health Plan Issuer’s method of informing covered persons of the plan’s services and features, including but not limited to, the plan’s grievance procedures, process for choosing and changing providers, and procedures for providing and approving emergency and specialty care;
- (7) The Qualified Health Plan Issuer’s method for assessing consumer satisfaction;

- (8) The Qualified Health Plan Issuer’s method for using assessments of enrollee complaints and satisfaction to improve carrier performance;
- (9) The Qualified Health Plan Issuer’s system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
- (10) The Qualified Health Plan Issuer’s process for enabling covered persons to change primary care professionals;
- (11) The Qualified Health Plan Issuer’s proposed plan for providing continuity of care in the event of contract termination of the Qualified Health Plan Issuer and any of its participating providers, or in the event of the Qualified Health Plan Issuer’s insolvency or other inability to continue operations. This plan shall explain how covered persons will be notified of the contract termination, or the Qualified Health Plan Issuer’s insolvency or other cessation of operations, and transferred to other providers in a timely manner;
- (12) The Qualified Health Plan Issuer shall provide access or coverage for health care providers as required by federal law;
- (13) The Qualified Health Plan Issuer’s procedures to ensure reasonable proximity of participating providers to the business or personal residence of covered persons;
- (14) The Qualified Health Plan Issuer’s plan that shows how it will continually monitor the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons;
- (15) The Qualified Health Plan Issuer’s procedures that ensure that if the Issuer has an insufficient number or type of participating providers to provide a covered benefit, the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers; and
- (16) Qualified Health Plan Issuer should file with the Commissioner sample contract forms proposed for use with its participating providers and intermediaries

In addition, the applicant should describe the process for ensuring that if there is insufficient number or type of participating providers for an enrollee to access covered benefits that there is at least one participating provider in the next closest city or mileage and drive time radius.

Standards for Essential Community Providers (ECPs)

Issuers (accredited and non-accredited) must complete and submit the Essential Community Providers template and must include in the template all qualifying ECPs in the network. Qualifying ECPs include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. AID will review plans according to the ECP standards in the April 5, 2013 Letter to Issuers unless CCHIO releases additional guidelines prior to the plan year 2015 certification period.

Each issuer will be required to meet conditions of the Private Option 1115 Waiver and offer at least one QHP that has at least one FQHC or RHC in each service area of the plan network.

ECPs in the provider network should be submitted in the FFM ECP template and the ECP Category below should be indicated (as in plan year 2014 QHP Certification).

**FFM Categorization of ECPs in ECP Data Submission Template
(with addition of school-based providers)**

ECP Categories	ECP Providers
FQHC	FQHC and FQHC look-alike clinica, Native Hawaiian Health Centers
Ryan White Provider	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X Look-Alike Family Planning Clinics
Indian Provider	Tribal and Urban Indian Organization Providers
Hospital	Disproportionate Share Hospitals (DSH), Children’s Hospitals, Rural Referral Centers, State Community Hospitals, Free-standing Cancer Centers, and Critical Access Hospitals
Other ECP Provider	Sexually Transmitted Disease (STD) Clinics, Tuberculosis (TB) Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and <i>School-Based Providers</i>

Inclusion of School-Based Providers

Providers who are school-based providers and meet credentialing and certification standards of issuers will be included in the ECP template submission, categorized as “Other”. Issuers should submit a separate list of school-based providers as part of the QHP application. At a minimum, providers should be identified by NPI, physician or clinic name, address, and provider type.

The 2013 Letter to Issuers also requires that issuers offer contracts prior to the coverage year to:

- *All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and*
- *At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.*

The AR Marketplace will additionally require that issuers offer a contract to at least one school-based provider in each county in the service area, where a school-based provider is identifiable and available and meets issuer certification and credentialing standards.

Provider Directories

45 CFR Section 156.230(b) states that “... a QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.”

AID has the following additional requirements in regard to provider directories:

- Online provider directories must be available in Spanish.
- The directory search must include the ability to filter by each category of ECP.
- The directory search must include an indication of part-time or full-time as well as after-hours availability as reported by providers.

Specialty Services

AID is in the process of developing a rule with guidelines for in-state coverage of specialty services (i.e. transplant, burn center), including services provided at Centers of Excellence. More details forthcoming.

Appendix 6

Arkansas Insurance Department Requirements for Qualified Health Plan Certification in the Arkansas Federally- Facilitated Partnership Exchange

June 25, 2013

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.



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Little Rock, Arkansas 72201
www.achi.net

Arkansas Insurance Department

Mike Beebe
Governor



Jay Bradford
Commissioner

BULLETIN NO. 3B-2013

TO: ALL LICENSED INSURERS, HEALTH MAINTENANCE ORGANIZATIONS (HMOs), FRATERNAL BENEFIT SOCIETIES, FARMERS' MUTUAL AID ASSOCIATIONS OR COMPANIES, HOSPITAL MEDICAL SERVICE CORPORATIONS, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, PRODUCER AND COMPANY TRADE ASSOCIATIONS, AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: REQUIREMENTS FOR QUALIFIED HEALTH PLAN CERTIFICATION IN THE ARKANSAS FEDERALLY-FACILITATED PARTNERSHIP EXCHANGE (MARKETPLACE)

DATE: June 25, 2013

Qualified Health Plans (QHP), which are non-grandfathered individual or small group plans certified and offered through an Individual or SHOP Marketplace for Arkansas consumers, will be offered through the federally facilitated Health Insurance Marketplace beginning on October 1, 2013, with an effective date of coverage of January 1, 2014. The Affordable Care Act (ACA) requires that all issuers and plans participating in the Federally-facilitated Marketplace Plan Management Partnership (Partnership) meet federal and state certification standards for QHPs. The Arkansas Insurance Department (AID) will require QHP Issuers to meet all state licensure requirements and regulations, as well as state specific plan and QHP requirements and regulations. QHP Issuers will also be responsible for all other State and Federal regulations already prescribed to insurance companies in today's market. The purpose of this Bulletin is to illustrate the new federal and state requirements to be a QHP in the Arkansas individual and SHOP Health Insurance Marketplace.

Beginning on March 5, 2013, and lasting through April 2013, NAIC provided training on the use of SERFF for application and plan submission to the Marketplace. Health Insurance Issuers responding to this guidance should submit their applications to become QHP Issuers together with included rate and form filings between March 28, 2013 and June 30, 2013. Stand Alone Dental (SAD) Issuers should submit their applications with their rate and form filings between May 20, 2013 and June 30, 2013. Toward a requirement that consumers in each of Arkansas's 75 counties have a choice among at least two health insurance issuers, each issuer is required to submit to AID their planned service areas for 2014 by June 3, 2013 to allow the Commissioner adequate time for review of proposed service areas. If changes in a proposed issuer's service area are required, the Commissioner will contact that issuer as soon as possible. Please send this submission to insurance.exchange@arkansas.gov.

The Commissioner will maintain flexibility to conduct ongoing negotiations to achieve a competitive Arkansas Marketplace. AID will review issuer applications through July 31, 2013 and will submit all approved and recommended applications to CMS for certification on July 31, 2013. All issuers waiting until the final deadline to submit their application to offer a QHP should be aware that AID will strive to review all filings and work with issuers to make QHP recommendations to CMS by July 31. Plans will be reviewed in the order received. Any plans not having undergone complete review gaining state approval for recommendation prior to July 31 will be ineligible for offering a QHP through the Marketplace during the 2013 Open Enrollment Period. Issuers will be given an opportunity to address any data errors during the plan review period in

late August. CMS will notify all issuers of the QHP Certification decision and complete the certification agreement in early September 2013. The Federal Government has stated that there will not be any federal appeals related to non-certification during the 2014 plan year due to the shortened first year.

Issuers notified the Marketplace of their intent to participate in the certification process by March 8, 2013 by sending an email to insurance.exchange@arkansas.gov. A secondary bulletin notifying issuers of the intent to participate by SAD Issuers was published on March 15, 2013.

On April 23, 2013, Arkansas enacted the Health Care Independence Act of 2013, establishing the Health Care Independence Program (hereinafter referred to as the “Private Option”). The intent of the Private Option is to create a fiscally sustainable, cost-effective, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options; promote accountability, personal responsibility and transparency; encourage and reward healthy outcomes and responsible choices; and promote efficiencies that will deliver value to Arkansans. The Act is expressly written to “improve access to quality health care...attract insurance carriers and enhance competition in the Arkansas Marketplace... [and] promote individually owned health insurance.” See Act 1498 of 2013, p.3. Through authority granted by the Health Care Independence Act and using the Medicaid premium assistance model, Arkansas Medicaid will purchase QHPs doing business in the Marketplace for certain Medicaid eligible beneficiaries. In 2014, Private Option eligible individuals will include childless adults between the ages of 19 and 65 with incomes below 138% of the federal poverty level (FPL) who are not enrolled in Medicare and parents between the ages of 19 and 65 with incomes between 17% of the FPL and 138 % FPL who are not enrolled in Medicare. Individuals who have been determined disabled or who have been determined to be more effectively covered under the standard Medicaid program (such as an individual who is medically frail or other individuals for whom coverage through the Health Insurance Marketplace is determined to be impractical, overly complex or would undermine continuity or effectiveness of care) will not be eligible for the Private Option.

Plan Year 2014 is considered a “transition to market” year and, as such, AID will allow flexibility with some certification standards in an effort to attract more issuers to the changing Arkansas Marketplace. Year one certification standards are outlined in the table below. In Plan Year 2015, AID expects to update these standards to include:

- Transition of current identified Medicaid populations off of Medicaid and on to the Private Option;
- Development of cost sharing parameters for 50-100% FPL; and
- Development of Health Savings Account and Medical Savings Account models for populations above 50% FPL.

In 2014, Private Option eligible individuals at or below 138% of FPL will be permitted to shop among and enroll in QHPs offered at the Silver metal level in the Marketplace, at the following actuarial value variations:

- **Eligible Individuals with Incomes from 0-100% of the Federal Poverty Level:** Zero Cost Sharing Silver Plan Variation (100% actuarial value) for year one. In year two, AID will implement cost sharing for this income group where actuarial value can be attained (e.g. 50-100% FPL).
- **Eligible Individuals with Incomes from 101-138% FPL:** High-Value Silver Plan Variation (94% +/- 1% actuarial value). To facilitate implementation of a consistent approach to cost sharing across all High-Value Silver Plan enrollees, AID will require that all QHP Issuers’ High-Value Silver Plan variations conform with prescribed cost sharing amounts as defined

by AID. (See Bulletin Section “*Plan Variations for Individuals Eligible for Cost Sharing: State Standards*”)

AID reserves the right to seek modified proposals and/or recommend non-certification of plans to the extent necessary to ensure cost effective pricing of QHPs across all seven rating areas. Because of significant reduction of uncompensated care for uninsured patients and related cost shifting, and increased competition in the marketplace, the State expects deflationary pressure on the cost of care which should reduce premium pricing.

Arkansas’s outreach and enrollment efforts will be substantial in order to reach and enroll as many individuals eligible for QHP coverage and the Private Option during the Open Enrollment period beginning on October 1, 2013 and ending on March 31, 2014.” These efforts will include targeted outreach to individuals enrolled in other low income programs such as SNAP, parents of AR Kids First enrollees, those receiving child care assistance, etc. AID will also establish a rolling Special Enrollment Period for individuals who are determined eligible or re-determined eligible for the Private Option. All Marketplace requirements with respect to Open Enrollment and Special Enrollment Periods will apply to all QHPs doing business on the Marketplace.

General Requirements	
<p>Federal Standard 45 CFR §§ 153.400, 153.410 45 CFR. § 153.610 45 CFR 155 and 156 45 CFR 156.20 42 USC §18021 42 USC §18022 42 USC §18031 CMS Guidance Rules ACA §1311 ACA §1002 ACA § 1341 ACA § 1343</p>	<p>A QHP Issuer must—</p> <ol style="list-style-type: none"> (1) Comply with all certification requirements on an ongoing basis; (2) Ensure that each QHP complies with benefit design standards; (3) Be licensed and in good standing to offer health insurance coverage in Arkansas; (4) Implement and report on a quality improvement strategy or strategies consistent with the standards described within the ACA, disclose and report information on health care quality and outcomes as will be later defined by the Centers for Medicaid and Medicare Services (CMS), and implement appropriate enrollee satisfaction surveys as required by the ACA; (5) Agree to charge the same premium rate for each QHP of the issuer without regard to whether the plan is offered through the Marketplace or whether the plan is offered directly from the issuer or through an agent; (6) Pay any applicable user fees assessed; (7) Comply with the standards related to the risk adjustment program administered by CMS; (8) Notify customers of the effective date of coverage; (9) Participate in initial and annual open enrollment periods, as well as special enrollment periods; (10) Collect enrollment information, transmit such to the Marketplace and reconcile enrollment files with the Marketplace enrollment files monthly; (11) Provide and maintain notice of termination of coverage. A standard policy must be established and include a grace period for certain enrollees that is applied uniformly. Notice of payment delinquency must be provided; (12) Segregate funds if abortion is offered as a benefit, other than in the case of an abortion provided under the Hyde Amendment exception; (13) Timely notify the Marketplace if it plans to not seek recertification, fulfill coverage obligations through the end of the plan/benefit year, fulfill data reporting obligations from the last

	<p>plan/benefit year, provide notice to enrollees, and terminate coverage for enrollees, providing written notice;</p> <p>(14) In the event that the QHP becomes decertified, terminate coverage after the notification to enrollees and after enrollees have had an opportunity to enroll in other coverage;</p> <p>(15) Meet all readability and accessibility standards;</p> <p>(16) Pay the same commission to producers and brokers for the sale of plans inside the SHOP as to similar plans sold in the outside market;</p> <p>(17) Provide a matching benefit plan and price off of the Marketplace if the plan offered within the Marketplace offers all ten Essential Health Benefits;</p> <p>(18) Participate in the reinsurance program, including making reinsurance contributions and receiving reinsurance payments; and</p> <p>(19) Participate in risk adjustment.</p>
<p>State Standard</p>	<p>AID will utilize a certification approach to reviewing, recommending, and submitting the rate, form and QHP Issuer application filings for compliance with federal and state rules and regulations. Certification will be good for a period of one (1) plan year. If an issuer wishes to continue offering a certain QHP following that plan year, the issuer must apply to have that QHP recertified. As part of the application, the QHP Issuer must fill out and submit the checklist that is attached in SERFF and is included for reference purposes only in this Bulletin as Appendix A.</p> <p>AID will review the pricing of QHPs, to ensure that all QHPs are adequately and appropriately priced for the Arkansas Marketplace.</p> <p>AID will work with CMS and the QHP Issuers to move enrollees to other available certified QHPs should a certified QHP in which a consumer is enrolled become decertified or allows its certification to expire. Additionally, AID will allow individuals to enroll in or change from one QHP to another as a result of an individual being determined eligible for or re-determined eligible for the Private Option.</p> <p>AID will also require all QHP Issuers offering a plan which has pediatric dental imbedded as part of its benefits to also offer an identical plan which does not include pediatric dental as part of its benefits. This requirement will be null and void and all QHP Issuers will be required to have an imbedded pediatric dental benefit should no SAD plans become certified on the Marketplace. Three (3) SAD Issuers notified AID of their intent to participate as published in AID Bulletin 8-2013. Another SAD Issuer has since given AID notice to participate. This requirement will not have any affect on the QHPs actuarial value (AV) results related to either the embedded or unembedded plan as the AV Calculator does not review pediatric dental as part of the standard population.</p> <p>Furthermore, in future years of the Marketplace, AID may limit the number of plans or benefit designs that may be offered by a carrier per "metal tier" level on the Marketplace.</p>

Licensure and Solvency	
Federal Requirements 45 CFR 156.200	A QHP Issuer must be licensed and in good standing with the State.
State Requirements	<p>A QHP Issuer must have unrestricted authority to write its authorized lines of business in Arkansas in order to be considered “in good standing” and to offer a QHP through the Marketplace. AID is the sole source of a determination of whether an issuer is in good standing.</p> <p>AID determinations of good standing will be based on authority found in Ark. Code Ann. § 23-63-202. Such authority may include restricting a QHP Issuer’s ability to issue new or renew existing coverage for an enrollee.</p> <p>An issuer will be allowed to apply for Arkansas licensure and QHP Issuer and plan certification simultaneously during the first QHP certification cycle; however, a QHP Issuer may not be certified for participation in the Marketplace until state licensure has been established.</p>
Network Adequacy	
Federal Standard 45 CFR 156.230 45 CFR 156.235 Public Health Services Act (PHS) §2702(c)	<p>A QHP Issuer must ensure that the provider network of each of its QHPs is available to all enrollees and:</p> <p>(1) (a) Includes essential community providers (ECP) in sufficient number and geographic distribution where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area.</p> <p>This must be done by demonstrating one of the following during the first year of the Marketplace:</p> <ul style="list-style-type: none"> • That the issuer achieved at least 20% ECP participation in network in the service area, agreed to offer contracts to at least 1 ECP of each type available by county; • That the issuer achieved at least 10% ECP participation in the network service area and submits a satisfactory narrative justification as part of its Issuer Application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its Issuer Application. <p style="text-align: center;"><u>OR</u></p> <p>(b) If an issuer provides a majority of covered services through employed physicians or a single contracted medical group complying with the alternate ECP standard identified within federal regulations, the issuer must verify one of the following:</p> <ul style="list-style-type: none"> • That the issuer has at least the same number of providers located in designated low income areas as the

	<p>equivalent of at least 20% of available ECPs in the service area;</p> <ul style="list-style-type: none"> • That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or • That the issuer failed to achieve either standard but submitted a satisfactory narrative justification as part of its Issuer Application. <p>(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder treatment services, to assure that all services will be accessible without unreasonable delay; and</p> <p>(3) Makes its provider directory for a QHP available to the Marketplace for publication online in accordance with guidance from the Marketplace and to potential enrollees in hard copy upon request noting which providers are not accepting new patients.</p>
State Standard	<p>AID will require an attestation from the QHP Issuer that states it is in compliance with all network adequacy requirements in addition to one of the following:</p> <ul style="list-style-type: none"> • The QHP Issuer provides evidence that it has accreditation from an HHS approved accrediting organization that reviews network adequacy as a part of accreditation; or • The QHP Issuer provides sufficient information through a PDF submission related to its policies and procedures to determine that the QHP Issuer's network meets the minimum federal requirements and complies with all requirements in AID Bulletin 11A-2013 <p>Any QHP Issuer that fails to achieve at least 10% ECP participation will undergo a stricter review of its Issuer Application. AID will not impose standards that exceed federal ACA standards in the first year. The percentage of ECPs in a network will be measured against the federal lists that can be found at https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu and https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq. To the extent that issuers subject to the alternate standard cannot meet the safe harbor or minimum expectation levels, factors and circumstances identified in the supplemental response along with an explanation of how the issuer will provide access to low-income and underserved populations will be taken into account. AID reserves the right to add additional state standards for future plan years of the Marketplace.</p>

Accreditation	
<p>Federal Standard 45 CFR 156.275 45 CFR 155.1045</p>	<ul style="list-style-type: none"> • QHP Issuers, excluding SAD Issuers, must maintain accreditation on the basis of local performance in the following categories by an accrediting entity recognized by HHS: Clinical quality measures, such as the HEDIS; Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS®)¹ survey; Consumer access; Utilization management; Quality assurance; Provider credentialing; Complaints and appeals; Network adequacy and access; and Patient information programs. • The Partnership will accept existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities. For the purposes of QHP Issuer certification in 2013, these are the National Committee for Quality Assurance (NCQA) and URAC. <ul style="list-style-type: none"> • To verify the accreditation information, QHP Issuers must upload their current and relevant accreditation certificates. • QHP Issuers must complete attestations about the accreditation data that will be displayed on the Marketplace website. • QHP Issuers will be required to authorize the release of their accreditation survey data and any official correspondence related to accreditation status to AID and the Partnership • QHP Issuers without existing commercial or Marketplace health plan accreditation from HHS-recognized accrediting entities must schedule an accreditation review during their first year of certification and receive accreditation on QHP Issuer policies and procedures prior to their second year of QHP Issuer certification. • Prior to the QHP Issuer's fourth year of QHP Issuer certification and in every subsequent year of certification, a QHP Issuer must be accredited in accordance with 45 CFR 156.275.
<p>State Standard</p>	<p>AID will follow the Federal requirements related to accreditation and will require the authorized release of all accreditation data. Additionally, AID will require an attestation by QHP Issuers not already accredited that those QHP Issuers will schedule, become accredited on policies and procedures in the plan types used, and provide proof of such accreditation on policies and procedures prior to submission of any application for recertification. The QHP Issuer must also indicate</p>

¹ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ) of HHS.

	that it will receive and provide proof of receipt of full Marketplace accreditation prior to its third recertification application.
Service Area	
Federal Standard 45 CFR 155.30 & 155.70	Service area for the Individual Marketplace is the geographic area in which an individual must reside. Service area may additionally be the geographic area where an individual is employed for the purposes of SHOP. A QHP Issuer must specify what service areas it will be utilizing. The service area must be established without regard to racial, ethnic, language or health status related factors or other factors that exclude specific high utilization, high cost or medically underserved populations.
State Standard	All QHP Issuers must file a statement of intent by June 3, 2013 indicating what service area(s) they intend to serve in 2014. Service areas will have the same geographic boundaries as rating areas as defined in Appendix C. The state will allow QHP Issuers to choose their service area(s) for year one with a goal of having at least three or more issuers per service area. The Commissioner reserves the right to require broader service areas as needed to achieve the state's coverage requirements of at least two issuers per service area. Any application not meeting this standard requires a justification as to why the QHP should be considered for certification and will be subject to stricter review.
Rating Area	
Federal Standard 45 CFR §156.255	As it applies to QHPs, the ACA defines a "Rating Area" as a geographic area established by a state that provides boundaries by which issuers can adjust premiums. The ACA requires that each state establish one (1) or more rating areas, but no more than nine (9) rating areas, within the State of Arkansas based upon its metropolitan areas for purposes of applying the requirement of this title.
State Standard	AID has approved a configuration of seven (7) rating areas to be utilized in Arkansas. These areas are specifically described in Appendix C.
Quality Improvement Standards	
Federal Standard 45 CFR 156.20 ACA §1311 ACA §2717	<p>A QHP Issuer must implement and report on a quality improvement strategy or strategies consistent with standards of the ACA to disclose and report information on healthcare quality and outcomes and implement appropriate enrollee satisfaction surveys which include but are not limited to the implementation of:</p> <ul style="list-style-type: none"> • A payment structure for health care providers that provides incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage; • Activities to prevent hospital readmissions through a

	<p>comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional;</p> <ul style="list-style-type: none"> • Activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; • Wellness and health promotion activities; and • Activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
<p>State Standard</p>	<p>AID will require all QHP Issuers to participate and report on the implementation of their quality improvement standards and results no less than quarterly. Any changes to the issuer's quality improvement initiatives must be reported to AID within thirty (30) days.</p> <p>Federal quality criterion is not established and therefore cannot be implemented until a future date. AID will notify issuers during the 2014 plan year as the measures are developed. Until the measures are adopted and implemented, AID intends to use Consumer Assessment of Healthcare Providers and Systems (CAHPS) data results from accredited commercial product lines when the data are available for the same QHP product types and adult/child populations.</p> <p><i>In order to advance quality and affordability, Arkansas will require participation in Arkansas's Payment Improvement Initiative no later than year two of the Marketplace. As part of the participation requirements for Plan Year 2015, Arkansas intends to transition participation in the Arkansas Payment Improvement Initiative by requiring, at a minimum, that QHP Issuers will assign a primary care clinician; provide support for patient-centered medical home; and provide access of clinical performance data for providers. Participation in the Arkansas Payment Improvement Initiative will also include a requirement to contribute claims and encounter data for the purposes of measuring cost, quality and access. Timing and processes related to these requirements are still under development and will be released in a future Bulletin.</i></p> <p>AID intends to establish during plan year 2014 a QHP submission process for 2014 claims and encounter data utilizing the X12 standards (www.X12.org) in eligibility files and medical claims, and the National Council for Prescription Drug Programs Standards in Pharmacy Claims Files. Submission will be implemented no sooner than three months from the end of the plan year (e.g., no sooner than April 2015) to support rate requests, assess network adequacy and support quality and payment improvement.</p>
<p>General Offering Requirements</p>	

<p>Federal Standard 45 CFR 155 and 156 45 USC §18022 45 C.F.R. § 156.130(a) 45 CFR §147.126 45 CFR §147.120 45 CFR §147.138 CMS Guidance Rules IRS Revenue Procedure 2013-25 Letter to Issuers</p>	<p>A QHP Issuer must offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level and a child-only plan at the same level of coverage as any QHP offered through either the individual Marketplace or SHOP to individuals who, as of the beginning of the plan year, have not attained the age of 21. This requirement may also be met by submitting an attestation that there is no substantive difference between having a child-only plan and issuing child only policies, and that the QHP Issuer will accept child only enrollees. QHP Issuers may also choose to offer a bronze or platinum metal level plan. All of the plans must meet the AV requirements as specified in 45 CFR 155 and will be verified by use of the AV Calculator. However, SAD plans may not use the AV Calculator and must demonstrate that the SAD plan offers the pediatric dental EHB at either a low level of coverage with an AV of 70% or a high level of coverage with an AV of 85%, and with a de minimis variation of +/-2%. This must be certified by an actuary accredited with the American Academy of Actuaries. Additionally, a catastrophic plan may be filed to be sold on the Marketplace in addition to the tiered metal levels. It should be noted that child-only policies are only available in the individual Marketplace.</p> <p>All offerings by a QHP Issuer, excluding stand alone dental issuers, on a single metal tier must show a meaningful difference between the plans and comply with standards in the best interest of the consumer. Moreover, the QHP, excluding pediatric dental, must provide coverage for dependents up to age 26 if the Plan offers dependent coverage. Pediatric dental and vision is required to cover dependents to age 19. The QHP must cover emergency services with no prior authorization, no limitation to participating or in-network providers. Emergency services must be covered at in-network cost-sharing level.</p> <p>Additionally, QHP Issuers will be required to meet all annual limitation and cost sharing requirements without affecting the AV of the plans within each of the tiers. The QHP Issuer must demonstrate in an Exhibit filed with the Plan that annual out of pocket cost sharing under the Plan does not exceed the limits established by federal and state laws and regulations. IRS published the high-deductible health plan limit for 2014 on May 6, 2013 stating that the annual limitation on cost sharing for embedded plans in the 2014 plan year will be \$6,350 for self-only coverage and \$12,700 for family coverage. For small group market plans, Issuers may establish separate out-of-pocket limits for medical and dental coverage as long as the total out-of-pocket limit does not exceed the total QHP limit for high deductible health plans. Moreover, the QHP must contain no lifetime limits on the dollar value of any EHB, including the specific benefits and services covered under the EHB-Benchmark Plan.</p> <p>For plans issued in the small group market, the deductible under the plan shall not exceed either:</p> <ul style="list-style-type: none"> • \$2,000 in the case of a plan covering a single individual; and • \$4,000 in the case of any other plan. <p>However, an issuer may propose a higher deductible in order to meet</p>
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	<p>the actuarial value of the plan that is proposed.</p> <p>SAD plans must demonstrate that they have a reasonable annual limitation on cost sharing. For 2014, “reasonable” means any annual limitation on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees. Catastrophic plans can be sold to individuals that have not attained the age of 30 before the beginning of the plan year; or an individual who has a certification in effect for any plan year exempt from the Shared Responsibility Payment by reason of lack of affordable coverage or hardship. If offered, Catastrophic Plans are offered only in the individual Marketplace and not in the SHOP. Additionally, child-only plans are not required to be offered at the catastrophic level of coverage.</p> <p>A QHP Issuer must comply with all federal and state laws related to rating rules, factors and tables used to determine rates. Such rates must be based upon the analysis of the plan rating assumptions and rate increase justifications in coordination with AID and timely submitted to the FFE-SHOP if appropriate. It should be noted that no additional age rating may be included in SAD plans for pediatric dental for purposes of completing the QHP application, but SAD Issuers may indicate whether the rate is estimated or guaranteed. If the rate is estimated, the SAD Issuer may later add more age rating factors.</p> <p>If a QHP Issuer would like to participate in the individual market, the QHP Issuer must also participate in the SHOP if the following requirements are met:</p> <ul style="list-style-type: none"> • The QHP Issuer offers products in the small group market and has at least a 20% market share in the small group market; or • The QHP Issuer is part of a holding company that also owns other issuers that participate in the small group market and that have at least a 20% market share of the small group market. <ul style="list-style-type: none"> • If the QHP Issuer under this example does not currently participate in the small group market, the affiliated QHP Issuer holding at least 20% of the small business market must participate in the SHOP. • If the QHP Issuer under this example does participate in the small group market, the QHP Issuer must participate in SHOP. <p>If a QHP Issuer offers a QHP in the SHOP, the QHP issuer will not be required to offer a QHP in the individual market.</p>
<p>State Standard</p>	<p>Specific state rate and form filing requirements may be found in Appendix A, attached.</p> <p>To the extent that Arkansas has benefits subject to “mandatory offering” statutes, these benefits, if not already imbedded into the QHP, must be offered by:</p> <ul style="list-style-type: none"> • Providing a link to a plan brochure that describes the

	<p>mandatory offering benefits and how to purchase; and</p> <ul style="list-style-type: none"> • Including an application and description of mandatory offering benefits in the mailing with the consumer's plan identification card. <p>Information regarding Arkansas mandatory offerings can be found at: http://www.insurance.arkansas.gov/LH/Mandates.html.</p>
Essential Health Benefit Standards	
<p>Federal Standards</p> <p>45 CFR 156.115 42 U.S.C. § 18022 45 CFR §147.130 45 CFR §148.170 45 CFR §155.170 45 CFR §156.110 45 CFR §156.125</p>	<p>The QHP Issuer must offer coverage that is substantially equal to the coverage offered by the state's base benchmark plan.</p> <p>A QHP Issuer is not required to offer abortion coverage within their benefit plans. The QHP Issuer will determine whether the benefits offered include abortion. If the QHP Issuer chooses to offer abortion benefits, public funds may not be used to pay for these services unless the services are covered as part of the Hyde Amendment exceptions. The QHP Issuer must provide notice through its summary of benefits if such benefit is being made available.</p> <p>The QHP must cover preventive services without cost sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF); certain immunizations, screenings provided for in HRSA guidelines for infants, children, adolescents, and women (including compliance with standards related to benefits for and current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention). Additionally, coverage for the medical treatment of mental illness and substance use disorder must be provided under the same terms and conditions as that coverage provided for other illnesses and diseases.</p> <p>Finally, any state mandates in effect as of December 2011 must apply as an EHB in the same way they apply in the current market. These benefits, as with all EHBs, must be offered without annual or lifetime dollar limitations.</p>
<p>State Standards</p>	<p>AID has adopted the Health Advantage Point of Service Plan as the Base Benchmark Plan to set the essential health benefits for Arkansas. AID substituted the mental health benefit with the Federal QualChoice Mental Health Benefit. AID also supplemented the Health Advantage Plan with the AR Kids B (CHIP) pediatric dental and vision plans. Finally, AID has adopted a definition of habilitative services, which may be found in Appendix B to this Bulletin.</p> <p>Additionally, Act 72 of 2013 was adopted which prohibits offering coverage of elective abortions as a part of EHBs on an Exchange established by Arkansas.</p> <p>AID will require an attestation from the QHP Issuer that states the issuer is in compliance with all EHB standards.</p>

Essential Health Benefit Formulary Review	
Federal Standards 45 CFR 156.120 45 CFR §156.295	<p>The QHP must cover at least the greater of one drug in every U.S. Pharmacopeial Convention (USP) category and class or the same number of drugs in each category and class as the base benchmark plan.</p> <p>Issuers must report data such as the following to U.S. DHHS on prescription drug distribution and costs (paid by Pharmacy Benefit Management (PBM) or issuer); percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies; percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type; aggregate amount and type of rebates, discounts or price concessions that the issuer or its contracted PBM negotiates that are attributable to patient utilization and passed through to the issuer; total number of prescriptions that were dispensed; aggregate amount of the difference between the amount the issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies.</p>
State Standards	<p>AID will require an attestation of compliance with EHB Formulary Standards.</p> <p>AID will require an attestation that the issuer: (1) provides response by telephone or other telecommunication device within 72 hours of a request for prior authorization, and (2) provides for the dispensing of at least a 72-hour supply of covered drugs in an emergency situation.</p>
Non-Discrimination Standards in Marketing and Benefit Design	
Federal Standard 45 CFR 156.125 45 CFR 156.200 45 CFR 156.225 45 CFR 155.1045 42 U.S.C. § 300gg-3 45 CFR §148.180	<p>(1) A QHP Issuer must:</p> <ul style="list-style-type: none"> • Be able to pass a review and an outlier analysis or other automated test to identify possible discriminatory benefits; and • Refrain from: <ul style="list-style-type: none"> ○ Adjusting premiums based on genetic information; ○ Discriminating with respect to its QHP on the basis of race, color, national origin, disability, expected length of life, present or predicted disability, degree of medical dependency, quality of life, sex, gender identity, sexual orientation or other health conditions; ○ Utilizing any preexisting condition exclusions; ○ Requesting/requiring genetic testing; or ○ Collecting genetic information from an individual prior to, or in connection with enrollment in a plan, or at any time for underwriting purposes.

	<p>(2) A QHP Issuer may not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.</p> <p>Outliers in benefit design with regards to QHP cost sharing as part of its QHP certification reviews to target QHPs for more in-depth reviews will be identified.</p>
State Standard	<p>QHP Issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers, including Ark. Code Ann. §23-66-201 et seq., Unfair Trade Practices Act and the requirements defined in Rules 11 and 19.</p> <p>QHP Issuers may inform consumers in QHP marketing materials that the QHP is certified by the Partnership as a QHP. The QHP Issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP.</p> <p>AID will require prior submission of QHP marketing material and an attestation that the QHP Issuer meets all Marketing Standards. Marketing materials must be submitted in PDF format. Any multi-media marketing materials should be provided through a link within a pdf document. AID reserves a right to request a timely upload of the multi-media files for review. If AID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, AID will enforce through use of state remedies up to and including the recommendation of the QHP for decertification.</p>
Actuarial Value Standards	
Federal Standards 45 CFR 156.135	<p>Plans being offered at the various metal tiers within the Marketplace must meet the specified levels of AV (or fall within the allowable variation):</p> <p>Bronze plan: 60% (58 to 62%) Silver plan: 70% (68 to 72%) Gold plan: 80% (78 to 82%) Platinum plan: 90% (88% to 92%)</p> <p>SAD plans must offer plans at either a 70% or 85% AV level.</p>
State Standards	AID will require an attestation of compliance with AV standards.
Quality Rating Standards	
Federal Standard 45 CFR §156.265 (b)(2) 45 CFR §156.265 (f); 45 CFR §156.400 (d) 45 CFR §156.285 (c) PHSA 2794	<p>HHS intends to propose a phased approach to new quality reporting and display requirements for all Marketplaces with reporting requirements related to all QHP Issuers expected to start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP Issuers in all Marketplaces. The results of such surveys and rating will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements.</p> <p>QHP Issuers must also provide plain language information/data on claims payment policies and practices, periodic financial disclosures,</p>

	data on enrollment and disenrollment, number of denied claims, rating practices, cost-sharing and payments for out-of-network coverage, and enrollee rights must be submitted to the Marketplace, HHS, and the Commissioner.
State Standard	The state will adopt the Quality Rating Standards as provided in federal guidance. Any AID requests for quality information must be made available upon request.
Rate Filing	
Federal Standard	<p>Premiums may be varied by the geographic rating area, but premium rates for the same plan must be the same inside and outside the Marketplace.</p> <ul style="list-style-type: none"> • Rating will be allowed on a per member basis. For SHOP plans, the geographic premium rating factor will be based on the geographic area of the employer. • ACA: premium rate may vary by individual/family, rating area, age (3:1), and tobacco use (1.5:1) <p>All rates filed for individual QHPs will be set for an entire benefit/plan year.</p> <p>For Marketplace plans with an embedded dental benefit, the dental issuer is not allowed to use different geographic area factors and/or network factors than the medical plan geographic and network factors. However, SAD Issuers will be able to make premium adjustments for their SAD plans that are considered excepted benefits upon consumer enrollment, but must indicate that rates are not guaranteed for QHPs offered on the Marketplace.</p> <p>Outlier identification on QHP rates will be conducted to identify rates that are relatively high or low compared to other QHP rates in the same rating area. Identification of a QHP rate as an outlier does not necessarily indicate inappropriate rate development. CMS will notify AID of the results of its outlier identification process. If AID confirms that the rate is justified, CMS expects to certify the QHP if the QHP meets all other standards.</p> <p>QHP Issuers, but not SAD Issuers, are required to submit the Unified Rate Review Template for rate increase.</p>
State Standard	<p>AID will continue to effectuate its rate review program and will review all rate filings and rate increases for prior approval. Rate filing information must be submitted to AID with any rate increase justification prior to the implementation of an increase. A QHP Issuer must prominently post the justification for <i>any</i> rate increase on its Web site.</p> <p>AID will limit the use of tobacco use as a rating factor to 1.2:1, applicable only to the individuals in the family that smoke. AID may later issue additional standards related to tobacco cessation.</p>

Plan Variations for Individuals Eligible for Cost Sharing	
Federal Standard 45 CFR §155.1030 45 CFR §156.420	<p>The QHP Issuer must offer three silver plan variations for each silver QHP, one zero cost sharing plan variation, and one limited cost sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing must be eliminated for the zero cost sharing plan variation. Cost sharing for certain services must be eliminated for the limited cost sharing plan variation. SAD plans are excluded from cost-sharing reduction (CSR) requirements. However, SAD plans must have a "reasonable" annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees.</p> <p>This will be completed via rate and benefit templates.</p>
State Standard	<p>AID will require an attestation of compliance with Plan Variation Standards.</p> <p>In support of the Private Option, AID will require that all QHP Issuers' High-Value Silver Plan variations (94% +/- 1% AV) conform to prescribed cost sharing amounts as defined by AID in Appendix D.</p>
Stand Alone Dental Plans	
Federal Standard 45 CFR 155 and 156 45 C.F.R. § 155.1065 PHS Act section 2791 45 C.F.R. § 146.145(c) 45 C.F.R. § 156.440(b)	<p>SAD Issuers and SAD plans must meet the same QHP certification standards as medical plans unless exceptions were noted in the above sections. Additionally, SAD plans are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. Moreover, SAD plans may impose up to a 24 month waiting period for orthodontia services.</p> <p>SAD plans intended to be utilized outside the Marketplace only for use to supplement medical plans such that the medical plans will comply with federal requirement of offering all 10 EHBs outside the Marketplace as required under the Public Health Services Act must follow the Marketplace certification filing process as described within this Bulletin.</p>
State Standard	<p>There are no additional state standards for SAD plans. SAD plans must comply with the AR EHB benchmark plan: AR Kids B (CHIP) pediatric dental.</p>


 JAY BRADFORD, COMMISSIONER
 ARKANSAS INSURANCE DEPARTMENT

June 25' 2013
 DATE

APPENDIX A

✓	Category	Statute Section
QHP Issuer Application Receipt		
<input type="checkbox"/>	Marketplace application data is complete	
<input type="checkbox"/>	Received Final QHP Issuer Application Submission Attestations, including: <ul style="list-style-type: none"> • Service Area Attestation • Rating Areas Attestation • Network Adequacy • Actuarial Value • Plan Variation Standards • Marketing Regulations and Transparency • Market Reform Rules • Licensure and solvency • Compliance with Essential Health Benefits • Accreditation • Child Only policy equivalence (if applicable) • AHIP EHB Formulary Compliance • AHIP Pharmacy Prior Authorization 	
Evaluation of QHP Issuer Application		
<i>Accreditation and Quality Standards</i>		45 CFR 156.275
<input type="checkbox"/>	Applicant has <i>Marketplace</i> accreditation through NCQA and/or URAC, or: Year 1- Applicant has applied for <i>Marketplace</i> accreditation through NCQA and/or URAC Year 2- Issuer procedures and policies are accredited	
<input type="checkbox"/>	Attestations and supporting documentation are accurate and complete or accreditation is verified in SERFF	
<input type="checkbox"/>	Issuer has authorized release of accreditation data	State Partnership Guidance 1/2013
<i>Complaint and Compliance</i>		
<input type="checkbox"/>	Requested complaint and compliance information (from consumer services division) received and reviewed	
<i>Cost-Sharing Reductions</i>		42 CFR 18022(c); 45 CFR 156.130(a); PPACA Section 1302(c) 45 CFR §155.1030 45 CFR §156.420
<input type="checkbox"/>	Three silver plan cost-sharing variations are submitted for each silver-level QHP.	PPACA 1402(a)-(c)
<input type="checkbox"/>	High-Value Silver Plan Variation (94% +/- 1% actuarial value) meets AHIP requirements.	
<input type="checkbox"/>	SAD plans must have a “reasonable” annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees.	

<input type="checkbox"/>	For each QHP at each level of coverage issuer must submit to the Exchange for certification the health plan and two variations of the health plan: <ul style="list-style-type: none"> No Cost Sharing Plan for individuals eligible for cost-sharing reductions under § 155.350(a) Limited Cost Sharing Plan for individuals eligible for cost-sharing reductions under § 155.350(b) 	PPACA 1402(d)
<input type="checkbox"/>	Cost-sharing incurred under plan do not exceed the dollar amount limits established by federal and state laws and regulations (\$6,350 for self-only coverage and \$12,700 for family coverage in plan year 2014).	
Benefit Design		45 CFR 156.225; 42 USC 18022
<input type="checkbox"/>	Actuarial Value <i>Issuer has separately offered at least one QHP at each of the following Actuarial Values:</i> <i>Gold: 80% (78 to 82%)</i> <i>Silver: 70% (68 to 72%)</i>	45 CFR 156.200
<input type="checkbox"/>	<i>Child-Only Plans are offered at each level of coverage (submitted as separate plans or confirmed by issuer attestation that there is no substantive difference between having a child-only plan and issuing child only policies, and that the QHP Issuer will accept child only enrollees. Catastrophic plans are excluded from this requirement.</i>	PPACA 1302(f)
<input type="checkbox"/>	Actuarial Memorandum and Certification Received	
<input type="checkbox"/>	<i>Verify that plan is substantially equal to benchmark plan</i>	
<input type="checkbox"/>	<i>If the issuer is substituting benefits, confirm that the issuer has demonstrated actuarial equivalence of substituted benefits</i>	45 CFR 156.115
<input type="checkbox"/>	<i>Compliance with premium rating factors including:</i> <i>Self-only or family enrollment,</i> <i>geographic rating areas (7 areas)</i> <i>Age (3:1 for adults)</i> <i>Tobacco use (1.2:1)</i>	PPACA 1201 SEC. 2701(a) PHSA 2701
<input type="checkbox"/>	<i>Justification information received for rate increase, if applicable</i>	
<input type="checkbox"/>	Confirm Benefit Substitution A/V	
<input type="checkbox"/>	Confirm Actuarial Metal Level Submitted <i>Bronze (60%)</i> <i>Silver (70%)</i> <i>Gold (80%)</i> <i>Platinum (90%)</i> <i>Catastrophic (<58%)</i> <i>(Allowable variance: +/- 2%)</i> <i>For Stand Alone Dental:</i> <i>Low (70%)</i> <i>High (85)</i> <i>(Allowable variance +/- 2%)</i>	
<input type="checkbox"/>	Meaningful Difference Compare all plans an issuer offers to identify multiple, identical plans that are offered in the same counties or have limited variation between deductible and out-of-pocket maximum.	
<input type="checkbox"/>	Inclusion of all 10 Essential Health Benefits that meet or exceed benchmark plan, including:	
<input type="checkbox"/>	Ambulatory patient services	

	<p><i>Primary care physician visits</i> <i>Specialist office visit</i> <i>Services and procedures provided in the Specialist office other than consultation and evaluation</i> <i>Outpatient Services</i> <i>Surgical Services - Outpatient</i> <i>Ambulatory Surgical Center Services</i> <i>Outpatient Diagnostics</i> <i>Advanced Diagnostic Imaging, subject to prior auth</i> <i>Outpatient Physical Therapy</i> <i>Outpatient Occupational Therapy</i> <i>Home Health</i> <i>Hospice Care for individuals with life expectancy of less than 6 months</i> <i>Qualified Assistant Surgeon Services</i></p>	
<input type="checkbox"/>	<p>Emergency services</p> <p><i>Emergency Care Services</i> <i>After-hours clinic or urgent care center</i> <i>Observation services</i> <i>Transfer to in-network hospital</i> <i>Ambulance Services</i></p>	
<input type="checkbox"/>	<p>Hospitalization</p> <p><i>Hospital Services</i> <i>Physician Hospital Visits</i> <i>Inpatient Services</i> <i>Hospital services in connection with Dental Treatment</i> <i>Surgical Services - Inpatient</i> <i>Inpatient Physical Therapy</i> <i>Inpatient Occupational Therapy</i> <i>Skilled Nursing Facility Services</i> <i>Organ Transplant Services</i></p>	
<input type="checkbox"/>	<p>Maternity and newborn care</p> <p><i>Certified nurse midwives</i> <i>Newborn care in the hospital</i> <i>In vitro fertilization for PPO plans</i> <i>Genetic testing to determine presence of existing anomaly or disease</i></p> <p><i>Prenatal and Newborn Testing</i> <i>Maternity and Obstetrics, including pre and post natal care</i></p>	§23-79-129 & Bulletin 1-84
<input type="checkbox"/>	<p>Mental health and substance use disorders, including behavioral health treatment</p> <p><i>Professional Services (by licensed practitioners acting within the scope of their license)</i> <i>Diagnostics</i> <i>Inpatient hospital or other covered facility</i> <i>Outpatient hospital or other covered facility</i></p>	
<input type="checkbox"/>	<p>Prescription drugs</p> <p><i>Prescription Drugs:</i> <i>Plan covers at least the greater of: (1) One drug in every category and class; or (2) the same number of drugs in each category and class as the EHB-benchmark plan</i></p> <p><i>Includes barbiturates, benzodiazepines, and agents used to promote smoking cessation,</i></p>	

	<i>including agents approved by the Food and Drug Administration as over-the-counter drugs for the purposes of promoting tobacco cessation.</i>	
<input type="checkbox"/>	Rehabilitative and habilitative services and devices <i>Physical, Occupational, and Speech Therapies</i> <i>Developmental services</i> <i>Durable Medical Equipment</i> <i>Prosthetic and Orthotic Devices</i> <i>Cochlear and other implantable devices for hearing, but not hearing aids</i> <i>Medical supplies</i>	
<input type="checkbox"/>	Laboratory services <i>Testing and Evaluation</i>	
<input type="checkbox"/>	Preventive and wellness services and chronic disease management <i>Case Management Communications made by PCP</i> <i>Preventive Health Services</i> <i>Routine immunizations</i> <i>US Preventive Services Task Force A or B rated benefits</i>	
<input type="checkbox"/>	Pediatric Dental (if applicable) <i>Consultations</i> <i>Radiographs</i> <i>Children's Preventive Services</i> <i>Space maintainers</i> <i>Restorations</i> <i>Crowns</i> <i>Endodontia</i> <i>Peridontal Procedures</i> <i>Removable prosthetic services</i> <i>Oral Surgery</i> <i>Professional visits</i> <i>Hospital Services</i> <i>Oral Surgery</i> <i>Childhood development testing</i> <i>Dental Anesthesia</i> <i>Medically-Necessary Orthodontia</i>	
<input type="checkbox"/>	Pediatric Vision <i>Eye Exam</i> <i>Surgical evaluation</i> <i>Eyeglasses – one pair per year</i> <i>Lenses</i> <i>Medically-Necessary Contact lenses</i> <i>Eye prosthesis</i>	

	Polishing services Vision Therapy Developmental Testing	
<input type="checkbox"/>	Miscellaneous Complications from Smallpox vaccine	
<input type="checkbox"/>	State Mandated Benefits Autism Spectrum Disorders Breast Reconstruction/Mastectomy Children's Preventive Health Care Colorectal Cancer Screening Dental Anesthesia Diabetic Supplies/Education Diabetes Management Services Equity in Prescription Insurance & Contraceptive Coverage Formula PKU/Medical Foods & Low Protein Modified Food Medical Foods and Low Protein Modified Foods Gastric Pacemakers In-Vitro Fertilization (insurance companies only) Loss or Impairment of Speech or Hearing Maternity & Newborn Coverage Mental Health parity Off-Label Drug Use Prostate Cancer Screening Orthotic & Prosthetic Devices or Services	23-99-418 23-99-405 23-79-141 et al. & Rule 45 23-79-1201 et al 23-86-121 23-79-601 et al & Rule 70 23-79-1101 et al 23-79-701 et al 23-99-419 23-85-137, 23- 86-118 & Rule 1 23-79-130 23-99-404; 23-79-129 23-99-501 et al 23-79-147 23-79-1301 23-99-417
<input type="checkbox"/>	Mandated Persons Covered, including:	
<input type="checkbox"/>	Adopted Children	
<input type="checkbox"/>	Handicapped Dependents	
<input type="checkbox"/>	Mandated Providers Ambulatory Surgery Center, Audiologists, Chiropractors, Dentists, Emergency Services, Nurse Anesthetists, Optometrists, Podiatrists, Psychologists, Physician Assistant	
<input type="checkbox"/>	Mandated Benefit Offerings Mandatory benefit offerings not in the benchmark plan (including hearing aids and TMJ) are included in the QHP, OR issuer demonstrates that they will be offered through URL to brochure that describes the mandatory offering benefits and how to purchase or mailed with an application and description of mandatory benefit offerings with the consumer's plan identification card.	
<input type="checkbox"/>	Elective Abortion Coverage of Elective Abortion is prohibited	Act 72 of 2013
	Discriminatory benefit design	PPACA §1311(c)(1)(A); PPACA §1302(b)(4)(B)
<input type="checkbox"/>	Plan does not employ benefit designs that have the effect of discouraging the enrollment of individuals with significant health care needs	PPACA §1311(c)(1)(A)

<input type="checkbox"/>	Benefits not designed in a way that discriminates against individuals because of age, disability, or expected length of life	PPACA §1302(b)(4)(B)
<input type="checkbox"/>	Completed form filings for certification that submission meets provisions of the Unfair Sex Discrimination rule in Sale of Insurance (New or revised filings must contain this certification)	AID Rule and Regulation 19, Ark Code Ann. 23-66-201
<i>Pre-existing conditions</i>		42 USC 300gg-3
<input type="checkbox"/>	Plan must contain no preexisting condition exclusions	
<i>State licensure, solvency, and good standing</i>		45 CFR 156.200(b)(4)
<input type="checkbox"/>	Issuer properly licensed	
<input type="checkbox"/>	Company financially solvent and in good standing	
<i>Marketing Standards</i>		45 CFR 156.220
<input type="checkbox"/>	Meets marketing standards as described in any applicable State Laws	45 CFR 156.225 Ark. Rule 19 and 11; Ark. Code Ann §23-66-201 et seq.
<input type="checkbox"/>	Meets requirement for transparency of coverage with attestation to include: Cost-sharing data is published on Internet Web Site Reporting requirements as listed in 45 CFR 156.22	45 CFR 156.220
<input type="checkbox"/>	Complies with Arkansas Discriminatory Benefit Design Regulations	Ark. Code Ann. § 23-66-201 et seq.;23-86- 314;23-98- 106;Ark. Rule 19; Ark. Rule 28; Ark. Rule 42; Attorney General Opinion 2004-274; Directive 2-2005
<input type="checkbox"/>	Received Attestation of compliance with marketing/discriminatory benefit design regulations	
<i>Market Reform Rules</i>		PHS 2701; PHS 2702; PHS 2703; PPACA 1302(e); PPACA 1312(c);PPACA 1402; 42 CFR 156; 42 CFR 147
<input type="checkbox"/>	QHP compliance with market reform rules in accordance with state and federal requirements	
<input type="checkbox"/>	Received QHP Market Reform Attestation of QHP compliance with market reform rules in accordance with state and federal requirements.	
<input type="checkbox"/>	Guaranteed Availability of Coverage	45 CFR § 147.104
<input type="checkbox"/>	Guaranteed Renewability of Coverage	45 CFR §

		147.106
<input type="checkbox"/>	Single Risk Pool	45 CFR § 156.80
<input type="checkbox"/>	Catastrophic Plan Requirements, including but not limited to: <ul style="list-style-type: none"> Provides coverage for at least three primary care visits per year before the deductible is met. No annual limits on the dollar value of EHBs; Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance; Plan is offered only in individual market, not in SHOP; Coverage for emergency services required; and Does not provide a bronze, silver, gold, or platinum level of coverage. 	45 CFR § 156.155
<i>Network Adequacy</i>		45 CFR 156.230; 45 CFR 156.235; PHS SEC.2702(c) ; PPACA 156.230
<input type="checkbox"/>	Submission of provider-enrollee ratios for each QHP network	45 CFR 156.230
<input type="checkbox"/>	Submission of time/distance measures for each QHP network	45 CFR 156.230
<input type="checkbox"/>	Essential community providers listed	45 CFR 156.235
<input type="checkbox"/>	Accredited policies and procedures that includes network adequacy	PHS SEC.2702(c)
<input type="checkbox"/>	Evaluation of issuer's network OR Attestation detailing issuer's ability to meet network adequacy standards including company policy for ensuring an adequate network	State Partnership Guidance 1/2013
<input type="checkbox"/>	Provider directory is available for online publication with indication of providers no longer accepting new patients	PPACA 156.230
<input type="checkbox"/>	Provider directory available to individuals in English and Spanish	PPACA 156.230
<i>Rating Areas and Actuarial Value</i>		
<input type="checkbox"/>	Rate-setting practices are consistent with the approved metrics	PHS SEC.2701(a)
<input type="checkbox"/>	Attestation of compliance with state rating areas (7 rating areas)	PHS SEC.2701(b)
<i>Service Areas</i>		
<input type="checkbox"/>	QHP service area covers at least one geographic rating area, OR issuer has submitted a hardship waiver that is approved by the Commissioner.	PPACA 155.1055(a)
<input type="checkbox"/>	Evaluate that QHP service area is established without regard to racial, ethnic, language, health status related factors, or other specified factors	PPACA 155.1055(b); PHS Act 2705
Receive Rate and Benefit Data and Information		
<input type="checkbox"/>	Plan data and supporting documentation complete	
<input type="checkbox"/>	Issuer submission of data completed before end of open enrollment period	
<input type="checkbox"/>	QHP rate and benefit data and information approved	
QHP Certification Agreement		
<input type="checkbox"/>	Issuer application and plan data approved	
<input type="checkbox"/>	Submit issuer and plan data to CMS	

<input type="checkbox"/>	CMS Certification Received	
Issuer or Plan Non Certification		
<input type="checkbox"/>	Notify issuer of non-certification of QHP(s) or Issuer	
<input type="checkbox"/>	Update QHP(s) and Issuer Account Information	

APPENDIX BDEFINITION OF HABILITATIVE SERVICES

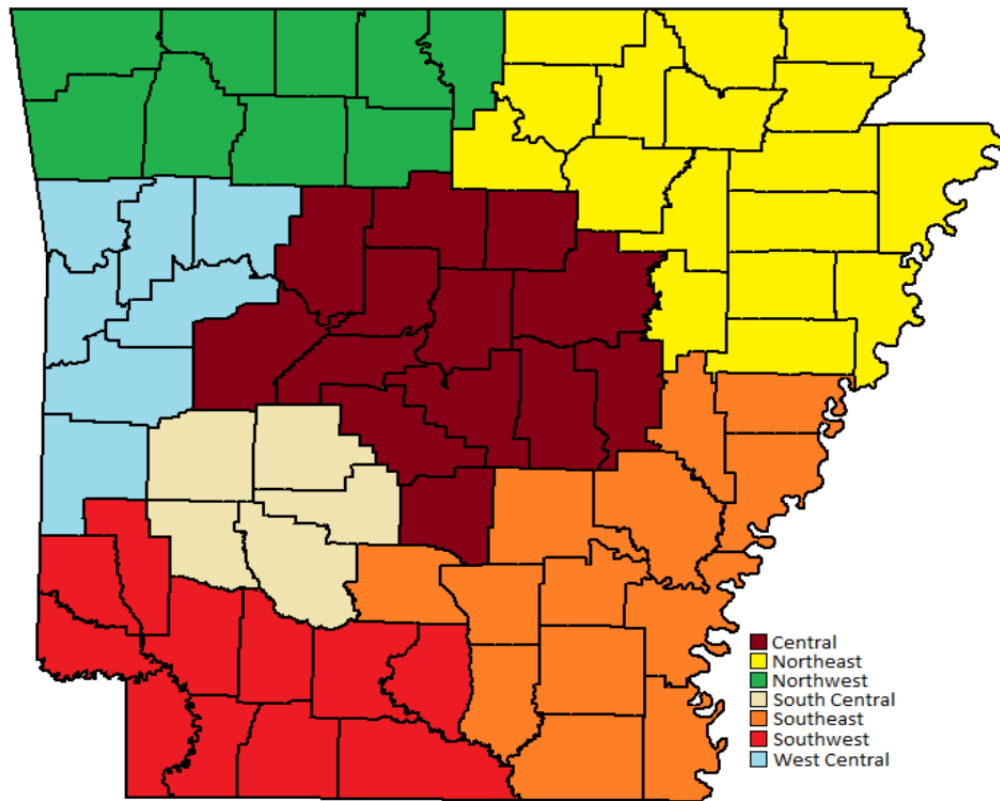
Habilitative Services are services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

COVERAGE OF HABILITATIVE SERVICES

Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder.

APPENDIX C

STATE RATING AND SERVICE AREAS



Arkansas Counties by Region

Region				
Central Rating Area 1	Cleburne Lonoke Pulaski Yell	Conway Perry Saline	Faulkner Pope Van Buren	Grant Prairie White
Northeast Rating Area 2	Clay Fulton Jackson Randolph Woodruff	Craighead Greene Lawrence Sharp	Crittenden Independence Mississippi St. Francis	Cross Izard Poinsett Stone
Northwest Rating Area 3	Baxter Madison Washington	Benton Marion	Boone Newton	Carroll Searcy
South Central Rating Area 4	Clark Pike	Garland	Hot Spring	Montgomery
Southeast Rating Area 5	Arkansas Cleveland Jefferson Phillips	Ashley Dallas Lee	Bradley Desha Lincoln	Chicot Drew Monroe
Southwest Rating Area 6	Calhoun Lafayette Ouachita	Columbia Little River Sevier	Hempstead Miller Union	Howard Nevada
West Central Rating Area 7	Crawford Scott Polk	Franklin Sebastian	Johnson	Logan

APPENDIX D**HIGH LEVEL SILVER PLAN COST SHARING VARIATION REQUIREMENT**

High-Value Silver Plan
100% FPL - 150% FPL

Overall Deductible:	\$150
Service Specific Deductibles:	
Medical	\$0
Brand Drugs	\$0
Dental	\$0
Member Out-of-Pocket Max (all services combined):	\$754

General Service Description	Subject to Deductible	Unit of Service	Copays	Coinsurance
Behavioral Health - IP	Yes	Day	\$ 140	100%
Behavioral Health - OP	No	Visit	\$ 4	100%
Behavioral Health - Professional	No	Visit	\$ 4	100%
Durable Medical Equipment	No	Service	\$ 4	100%
Emergency Room Services	No	Visit	\$ 20	100%
FQHC	No	Visit	\$ 8	100%
Inpatient	Yes	Day	\$ 140	100%
Lab and Radiology	No	Visit	\$ -	100%
Skilled Nursing Facility	Yes	Day	\$ 20	100%
Other	No	Visit	\$ 4	100%
Other Medical Professionals	No	Visit	\$ 4	100%
Outpatient Facility	Yes	Visit	\$ -	91%
Primary Care Physician	No	Visit	\$ 8	100%
Specialty Physician	No	Visit	\$ 10	100%
Pharmacy - Generics	No	Prescription	\$ 4	100%
Pharmacy - Preferred Brand Drugs	No	Prescription	\$ 4	100%
Pharmacy - Non-Preferred Brand Drugs	No	Prescription	\$ 8	100%
Pharmacy - Specialty Drugs (i.e. high-cost)	No	Prescription	\$ 8	100%

APPENDIX E**SUMMARY OF CHANGES FROM FEBRUARY 19, 2013 RELEASE**

- “Exchange” was changed to “Marketplace” throughout.
- Page 1, A Letter of Intent to cover specific service areas to the Commissioner must be submitted by June 1.
- Page 2-3, Information was added related to the Health Care Independence Program, including the requirement to submit a letter of intent to AID by June 1, 2013 describing the QHP Issuer’s intended service areas.
- Page 3-4, General Requirements: Lines numbered 16 and 17 were added to be in compliance with the recently released federal rule.
- Page 4, General Requirements/State Standards: Additional information related to the high value silver plan variations was added. Clarifications to requirements for SAD Issuers and Plans were included.
- Page 7, Network Adequacy/State Standards: A link to the ECP lists was included, as well as information clarifying how the standard would be measured.
- Page 7, Accreditation: Additional information was added related to SAD and clarifying what accreditation information must be submitted.
- Page 8, Service Area: Updated service area requirements.
- Page 8, Rating Areas: The federal definition of rating areas was updated to be in compliance with the recently released federal rule.
- Page 9, Quality Improvement Standards: Requirements to participate in the Arkansas Payment Improvement Initiative and reporting requirements were added.
- Page 10, General Offering Requirement: Information related to requirements for SHOP, child-only plans, mandatory benefit offerings, and high deductible health plan limits, SAD plan rating limitations were all added.
- Page 13, Essential Health Benefit Standards/State Standards: Notification of requirement to provide medically necessary orthodontia and prohibition to offer coverage of elective abortion as an EHB.
- Page 14, Essential Health Benefit Formulary Review: Requirement to provide at least a 72 hour supply of drugs in emergency situations, as well as the requirement to cover additional pharmaceuticals.
- Page 14-15, Nondiscrimination Standards in Marketing and Benefit Design: Marketing must be submitted to AID before it may be used. The original bulletin stated that all

marketing must be prior approved. CMS has since clarified its position that all marketing is not required to be prior approved, but that a state must at a minimum provide for spot checking marketing material. This new standard will allow for the state to be able to maintain compliance with that standard while giving more flexibility to the QHP issuers. Additionally, information related to outlier benefit review was included.

- Page 16, Rate Filing: Information added related to SAD Issuer/Plan rating requirements, outlier analysis Unified Rate Review Template and SHOP rating requirements.
- Page 17, Plan Variation for Individuals Eligible for Cost Sharing: Added information related to SAD Issuers/Plans and requirements for the high level silver plan variation.
- Page 18, Stand Alone Dental Plans: New section related to SAD Issuer/Plan requirements.
- Page 18, Appendix A: Checklist updated to match new information as included above.
- Page 37, Appendix C: Added rating area numbers to match federal templates and updated name to indicate that this is indicative of both rating and service areas.
- Page 38, Appendix D: Added High Level Silver Plan Cost Sharing Variation requirements.

SUMMARY OF CHANGES FROM JUNE 25, 2013 RELEASE

- The State Standard section under Quality Improvement standards was updated to show requirements related to the Arkansas Payment Improvement Initiative.
- Appendix D was updated with new information.