



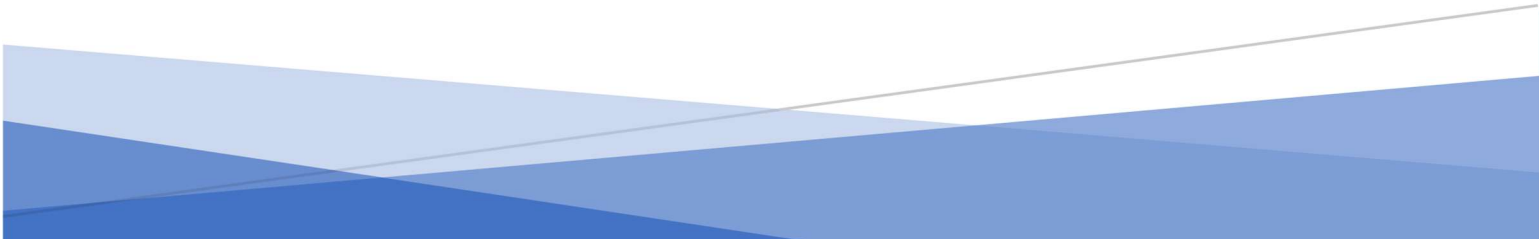
Stetson College of Law Special Needs Trust Conference

Medicaid Work Requirement – Is it Really “Community Engagement”,

What is It, and Will it Work?

Thomas Smith

Friday, October 24th, 2025



- I. Medicaid “Work Requirement” history from an Arkansas perspective.
 - a. The Patient Protection and Affordable Care Act (ACA) mandated states expand access to Medicaid to many adults with incomes up to 138% of the federal poverty level¹.
 - b. Later, the mandatory nature of Medicaid expansion was ruled unconstitutional².
 - c. However, over time 41 states and the District of Columbia have adopted some versions of Medicaid Expansion³.
 - i. Also see **Exhibit A**.
 - d. Arkansas adopted a unique form of expanded Medicaid expansion in late 2013⁴.
 - i. This form of Medicaid expansion uses Medicaid dollars to pay premiums to private insurers to provide coverage to the expanded group.
 - ii. This program is known as ARWorks or ARHome.
 - iii. So far this version of expanded Medicaid has survived myriads of legislative maneuvers.
 - e. Arkansas attempted its first “Work Requirement” in 2018⁵.

¹ H.R.3590 - 111th Congress (2009-2010): Patient Protection and Affordable Care Act, H.R.3590, 111th Cong. (2010), <https://www.congress.gov/bill/111th-congress/house-bill/3590>. ACA, Pub. L. No. 111-148, § 2001, 124 Stat. at 271.

² *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 588 (2012).

³ Kaiser Family Foundation, Status of State Medicaid Expansion Decisions, KFF (Sept. 12, 2025), <https://www.kff.org/medicaid/status-of-state-medicaid-expansion-decisions/>

⁴ Ark. Dep’t of Human Servs., *Arkansas Health Care Independence Program (“Private Option”) 1115 Waiver Application 1* (Aug. 2, 2013), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-submission-ltr-08022013.pdf>.

⁵ Kaiser Family Foundation, *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees*, KFF (Dec. 18, 2018), <https://www.kff.org/medicaid/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/>.

- i. The Work and Community Engagement (“WCE Requirement”) requirement applied primarily to ARWorks beneficiaries ages 19 – 49⁶.
 1. Copy of Waiver Request attached as **Exhibit B**.
 2. Arkansas Department of Human Services (“DHS”) estimated approximately 69,000 recipients would be impacted by the WCE Requirement⁷.
- ii. There were a number of exceptions to the WCE Requirement. To be exempt the beneficiary needed to⁸:
 1. Work at least 80 hours per month,
 2. Attend school full time,
 3. Receive SNAP benefits,
 4. Receive TEA Cash Assistance,
 5. Be medically frail or disabled,
 6. Incapacitated in the short term or otherwise unfit for unemployment,
 7. Caring for an incapacitated person,
 8. Live in a home with a dependent child age 17 or younger,
 9. Receive unemployment benefits,
 10. Participate in a substance abuse treatment program, or
 11. Be pregnant or entitled to postpartum care.

⁶ Ark. Dep’t of Human Servs., *Work & Community Engagement: Proposed Evaluation Design & Strategy* — *Arkansas Works Evaluation Design* (Aug. 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-cmmnty-engagement-draft-eval-dsgn-20180813.pdf>.

⁷ Ark. Dep’t of Human Servs., *Work & Community Engagement*, supra note 6, at 3.

⁸ Ark. Dep’t of Human Servs., *Work & Community Engagement*, supra note 6, at 4.

- iii. Within 9 months of implementation approximately 18,000 Medicaid recipients lost coverage⁹.
- iv. Many Arkansans were not sure if policy actually went into effect¹⁰.
- v. Large percentages of persons impacted experienced delayed care and delayed access to medications¹¹.
- vi. This first “work requirement” did not last long.
 - 1. The United States District Court for the District of Columbia held the Department of Human Service’s approval of the “work requirement” was arbitrary and capricious¹².
 - 2. The Court held that the department had failed to demonstrate how the waiver furthered Medicaid’s “core goal” of furnishing medical assistance to persons that struggle to afford it¹³.
 - 3. In support of it holding the Court relied heavily on previous case that dismissed Kentucky work requirement. *Stewart v. Azar*, 313 F. Supp. 3d 237 (2018)¹⁴.
 - 4. Of course, the important point to note is that the Court was interpreting a regulation as opposed to a statute.

vii. Pathway to Prosperity

⁹ Akeiisa Coleman and Sara Federman, “Work Requirements for Medicaid Enrollees” (explainer), Commonwealth Fund, Jan. 14, 2025. <https://doi.org/10.26099/r361-mv95>

¹⁰ *Id.*

¹¹ *Id.*

¹² *Grisham v. Azar* 363 F. Supp. 3d 165, 175 (2019).

¹³ *Id.*

¹⁴ *Id.*

1. Arkansas applied for an amended “work requirement” on January 28th, 2025 titled the “Pathway to Prosperity”¹⁵.
 - a. See **Exhibit C**.
2. As part of its waiver request the State of Arkansas noted that there are approximately 220,000 persons on it’s Medicaid expansion program¹⁶.
3. This Pathway to Prosperity is really just an amendment to the original “work requirement” waiver granted in 2018.
4. However, unlike the original waiver request, Pathway to Prosperity is designed to rely on personal interaction rather than technology to identify persons whom should receive “extra support to reach health and economic goals”¹⁷.
5. The amended waiver notes that many Medicaid recipients should have received exemptions from the original waiver¹⁸.
6. Pathways to Prosperity contemplates a program with no exemptions. Beneficiaries are either “on track” or “not on track” as defined by DHS¹⁹.

viii. Status of Arkansas’s Medicaid Work Requirement since passing of One Big Beautiful Bill Act (“OBBBA”).

II. Work Requirement or Community Engagement – What is it and whom is covered?

¹⁵ Ark. Dep’t of Human Servs., *Pathway to Prosperity 1115 Waiver Amendment 1* (Jan. 28, 2025), https://governor.arkansas.gov/wp-content/uploads/Pathway-to-Prosperity-1115-Waiver-Amendment_DHS-Final_1.28.2025.pdf.

¹⁶ Ark. Dep’t of Human Servs., *Pathway to Prosperity*, supra note 15, at 5.

¹⁷ Ark. Dep’t of Human Servs., *Pathway to Prosperity*, supra note 15, at 11.

¹⁸ *Id.*

¹⁹ Ark. Dep’t of Human Servs., *Pathway to Prosperity*, supra note 15, at 4.

- a. National Medicaid “Work Requirement” is found in the One Big Beautiful Bill Act (“OBBBA”).

- i. *One Big Beautiful Bill Act*, Pub. L. No. 119-21, 139 Stat. 72 (2025).

- 1. Title VII – Finance

- a. Subtitle B – Health

- i. Chapter 1 – Medicaid

- 1. Subchapter D – Increasing Personal Responsibility

- a. Section 71119 – Requirement for States to establish Medicaid community engagement requirements for certain individuals.

- ii. Now codified as 42 U.S.C. §1396a(xx) (2026).

- b. There is actually no “work requirement”. Rather the OBBBA refers to a “community engagement” requirement²⁰.

- c. Community Engagement only applies to “applicable individuals”²¹

- i. Applicable Individuals are persons enrolled in a Medicaid expansion program²².

²⁰ 42 U.S.C.S. §1396a(xx)(2) (2026).

²¹ *Id.*

²² 42 U.S.C.S. §1396a(xx)(9)A)(i)(I) (2026).

- ii. As a result Community Engagement is anticipated to apply to approximately 22.8 % of all Medicaid beneficiaries^{23, 24}.
 - iii. See **Exhibit D**.
- d. When does Community Engagement become effective?
 - i. No later than the first day of the first quarter that begins after December 31st, 2026. So, effectively sometime in early 2027²⁵.
- e. What is Community Engagement?
 - i. Community Engagement is tested on a month-to-month basis²⁶.
 - ii. An applicable individual meets Community Engagement requirements in any given month if he or she²⁷:
 1. Works not less than 80 hours,
 2. Completes not less than 80 hours of community service,
 3. Enrolled in an educational program at least half time,
 4. A combination of all the above,
 5. Has monthly income not less than federal minimum wage X 80 hours, or
 6. A seasonal worker as described in the statute²⁸.

²³ Kaiser Family Foundation, *Medicaid Expansion Enrollment*, State Health Facts, KFF, <https://www.kff.org/medicaid/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Sept. 22, 2025).

²⁴ Medicaid & CHIP, *Medicaid and CHIP Enrollment Data: Report Highlights*, Medicaid.gov, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights> (last visited Sept. 22, 2025).

²⁵ 42 U.S.C.S. § 1396a(xx)(1) (2026).

²⁶ 42 U.S.C.S. § 1396a(xx)(2) (2026).

²⁷ *Id.*

²⁸ 42 U.S.C.S. §1396a(xx)(2)(G) (2026).

- iii. Community Engagement includes a number of items other than “work” in the traditional sense.

f. Exemptions

- i. There are numerous exemptions from Community Engagement. Persons exempted include:

- ii. Specific Excluded Individuals²⁹

- 1. Certain Native Americans as defined by statute³⁰,
- 2. Parent, guardian, caretaker relative, or family caregiver of a dependent child 13 or under or a disabled person³¹,
- 3. A disabled veteran³²,
- 4. Is medically frail or has special medical needs including³³,
 - a. A person who is blind or disabled,
 - b. Has a substance abuse disorder,
 - c. Has a disabling mental disorder,
 - d. Has a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living,
 - e. Serious or complex medical issues,
- 5. Who is a recipient of Temporary Assistance for Needy Families³⁴,

²⁹ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii) (2026)

³⁰ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(II) (2026)

³¹ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(III) (2026)

³² 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(IV) (2026)

³³ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(V) (2026)

³⁴ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(VI) (2026)

6. Member of a household receiving supplemental nutrition assistance program benefits³⁵,
 7. Participating in a substance abuse rehabilitation program³⁶,
 8. An inmate in a public institution³⁷, or
 9. Who is pregnant or entitled to post-partum care³⁸.
- iii. Those persons under the age of 19³⁹.
 - iv. Those persons entitled to Medicare Parts A & B⁴⁰.
 - v. Among others⁴¹.
- g. Verification
- i. Community Engagement is, in theory, a program that an applicable individual qualifies for on a monthly basis⁴².
 - ii. However, states are only required to verify compliance during an applicable individual's regularly scheduled redetermination of eligibility⁴³.
 - iii. States are required to establish processes and use reliable information available to the State without requiring, where possible, the applicable individual to submit information. So called ex parte verifications⁴⁴.
1. Examples of such information include payroll data or payments.

³⁵ Id.

³⁶ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(VII) (2026)

³⁷ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(VIII) (2026)

³⁸ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(IX) (2026)

³⁹ 42 U.S.C.S. § 1396a(xx)(3)(A)(i)(II)(aa) (2026)

⁴⁰ 42 U.S.C.S. § 1396a(xx)(9)(A)(ii)(II)(bb) (2026)

⁴¹ 42 U.S.C.S. § 1396a(xx)(3)(A)(i)(II)(cc) (2026)

⁴² 42 U.S.C.S. § 1396a(xx)(2) (2026).

⁴³ 42 U.S.C.S. § 1396a(xx)(4) (2026).

⁴⁴ 42 U.S.C.S. § 1396a(xx)(5) (2026).

2. Standards for verification will be set by the Secretary of the Department of Health and Human Services⁴⁵.
- h. Procedures for Non-Compliance with Community Engagement Requirement.
 - i. If a State cannot verify compliance then the State shall provide a notice of noncompliance⁴⁶.
 1. The notice shall include information regarding
 - a. How an applicable individual may show actual compliance⁴⁷, or
 - b. Make a satisfactory showing that that the requirement does not apply to the individual⁴⁸, and
 - c. How such individual may reapply for medical assistance⁴⁹.
 - ii. States must give 30 calendar days from the date of the notice to:
 1. Make a satisfactory showing of compliance⁵⁰, or
 2. Make a satisfactory showing that the requirement does not apply⁵¹, and
 3. Continue to provide medical assistance during the 30-day notice period⁵².
 - iii. If no satisfactory showing is found then the State must
 1. Deny the application if applicable⁵³,

⁴⁵ Id.

⁴⁶ 42 U.S.C.S. § 1396a(xx)(6)(A)(i) (2026).

⁴⁷ 42 U.S.C.S. § 1396a(xx)(6)(B)(i) (2026).

⁴⁸ 42 U.S.C.S. § 1396a(xx)(6)(B)(ii) (2026).

⁴⁹ 42 U.S.C.S. § 1396a(xx)(6)(B)(iii) (2026).

⁵⁰ 42 U.S.C.S. § 1396a(xx)(6)(A)(ii)(I)(aa) (2026).

⁵¹ 42 U.S.C.S. § 1396a(xx)(6)(A)(ii)(I)(bb) (2026).

⁵² 42 U.S.C.S. § 1396a(xx)(6)(A)(ii)(II) (2026).

⁵³ 42 U.S.C.S. § 1396a(xx)(6)(A)(iii) (2026).

2. Disenroll the individual no later than the end of the month following the month in which the 30-day notice period ends; provided that
 - a. The State determines there is no other basis for eligibility⁵⁴,
and
 - b. The individual is provided written notice and granted an opportunity for a fair hearing⁵⁵.

i. Outreach

- i. States are required to periodically notify applicable individuals of the Community Engagement requirement⁵⁶.
- ii. The notice / outreach shall include:
 1. How to comply with the Community Engagement requirement as well as an explanation of exceptions⁵⁷,
 2. The consequences of noncompliance⁵⁸,
 3. How to report changes to an individual's status⁵⁹.
- iii. Outreach shall be delivered by mail and in one or more additional forms such as telephone, text, internet website, or other commonly available electronic means⁶⁰.

III. Policy Discussion / Debate.

- a. Why does this Community Engagement Requirement keep coming up?

⁵⁴ 42 U.S.C.S. § 1396a(xx)(6)(A)(iii)(I) (2026).

⁵⁵ 42 U.S.C.S. § 1396a(xx)(6)(A)(iii)(II) (2026).

⁵⁶ 42 U.S.C.S. § 1396a(xx)(8)(A) (2026).

⁵⁷ 42 U.S.C.S. § 1396a(xx)(8)(A)(i) (2026).

⁵⁸ 42 U.S.C.S. § 1396a(xx)(8)(A)(ii) (2026).

⁵⁹ 42 U.S.C.S. § 1396a(xx)(8)(A)(iii) (2026).

⁶⁰ 42 U.S.C.S. § 1396a(xx)(8)(B) (2026).

- i. A number of states have asked for a community engagement requirement at one time or another⁶¹.
 - ii. The first Trump Administration approved 13 work requirement waivers⁶².
 - iii. However, Arkansas was the only state that attempted to implement consequences such as loss of coverage⁶³.
 - iv. Even though Arkansas's first waiver was judicially dismissed, it has tried yet again with an amended waiver.
 - v. Preemption
 - 1. For the time being the OBBBA has mandated community engagement on a national level⁶⁴.
- b. Growth in Medicaid Spending.
 - i. Total Medicaid spending in 2002 was approximately \$257.6 billion⁶⁵.
 - ii. Total Medicaid spending in 2022 was approximately \$804 billion⁶⁶.
 - iii. More than 200% increase in 20 years.
 - iv. However, Medicaid spending has remained more or less consistent at 12.75% of the federal budget through this time period.
- c. Numbers and Percentages of Persons impacted by Community Engagement.

⁶¹ Elizabeth Hinton, Robin Rudowitz, *5 Key Facts About Medicaid Work Requirements*, KFF, Feb 18, 2025. <https://www.kff.org/medicaid/5-key-facts-about-medicaid-work-requirements/>

⁶² Id.

⁶³ Id.

⁶⁴ 42 U.S.C.S. §1396a(xx) (2026)

⁶⁵ Kaiser Family Foundation, *Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002*, KFF (Jan. 2013), <https://www.kff.org/wp-content/uploads/2013/01/medicaid-spending-what-factors-contributed-to-the-growth-between-2000-and-2002.pdf>

⁶⁶ Kaiser Family Foundation, *Medicaid Enrollment & Spending Growth: FY 2024 & 2025*, KFF (Oct. 23, 2024), <https://www.kff.org/medicaid/medicaid-enrollment-spending-growth-fy-2024-2025/>. (kff.org)

- i. Approximately 71 million people were enrolled in Medicaid in May 2025⁶⁷.
 - ii. Approximately 20 million are on a Medicaid expansion program⁶⁸.
- d. Estimates of savings as a result of Community Engagement.
 - i. Approximately 8% (1,600,000) of persons on Medicaid expansion are not working due to retirement, inability to find work, or other reasons⁶⁹.
 - ii. The CBO estimates that over ten years the community engagement requirement will result in 5.2 million fewer persons on Medicaid and result in savings of \$326 billion⁷⁰.
- e. Are you convinced?

⁶⁷ KFF, *Medicaid and CHIP Enrollment Data: Report Highlights*, supra note 24.

⁶⁸ KFF, *Medicaid Expansion Enrollment*, supra note 23.

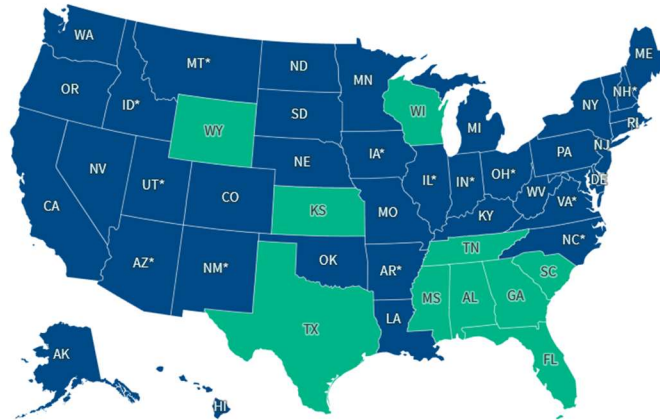
⁶⁹ Hinton, Elizabeth & Robin Rudowitz, *5 Key Facts About Medicaid Work Requirements*, KFF (Feb. 18, 2025), <https://www.kff.org/medicaid/5-key-facts-about-medicaid-work-requirements/>.

⁷⁰ Elizabeth Hinton, Amaya Diana & Robin Rudowitz, *A Closer Look at the Work Requirement Provisions in the 2025 Federal Budget Reconciliation Law*, KFF (July 30, 2025), <https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/>

EXHIBIT A

Status of State Action on the Medicaid Expansion Decision

■ Adopted and implemented (41 states including DC) ■ Not adopted (10 states)

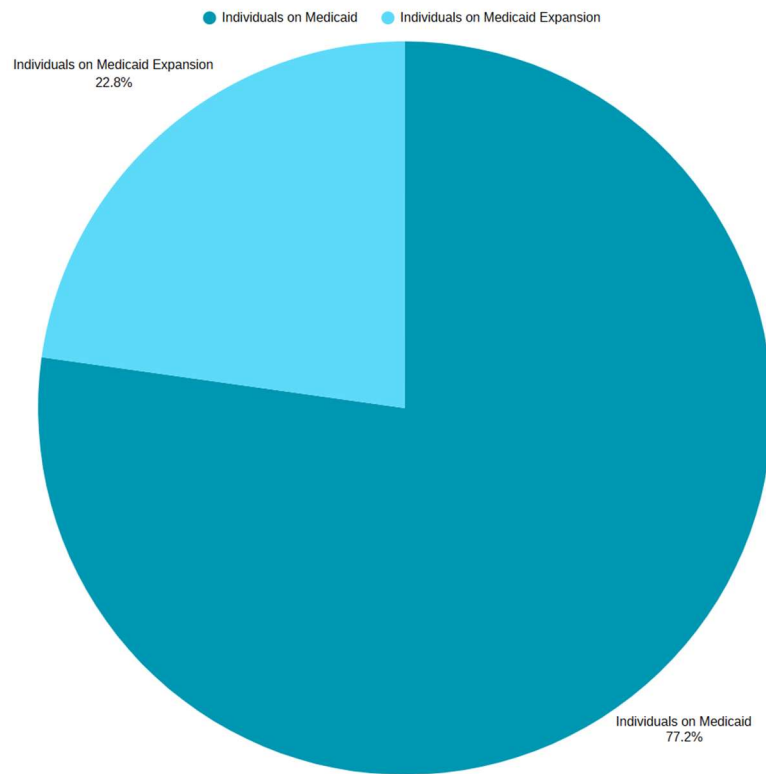


Note: * State has a trigger law that would end expansion coverage or require states to take steps to mitigate increases in state costs if federal funding for the expansion is reduced.

Source: KFF tracking and analysis of state actions related to adoption of the ACA Medicaid expansion and Searing, Adam. "Federal Funding Cuts to Medicaid May Trigger Automatic Loss of Health Coverage for Millions of Residents of Certain States." Say Ahhh! Georgetown Center for Children and Families, November 27, 2024 • [Get the data](#) • [Download PNG](#)

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Exhibit D^{71, 72}



⁷¹ KFF, *Medicaid and CHIP Enrollment Data: Report Highlights*, supra note 24.

⁷² KFF, *Medicaid Expansion Enrollment*, supra note 23.



ARKANSAS WORKS WORK AND COMMUNITY ENGAGEMENT REQUIREMENTS

**Medicaid Section 1115 Demonstration Project
Work Requirement Evaluation Design & Strategy**

Arkansas Department of Human Services

Original Submission: May 2018
Amended Submission: August 2018

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Proposed Evaluation Design & Strategy for Section 1115 Demonstration Waiver Work and Community Engagement Amendment

1. Overview

Arkansas Works, as amended, is a Demonstration Project of national significance. Medicaid is the largest single means-tested public assistance program administered by the states. Its role in providing access to medical services for people in poverty and near poverty is well established.

Section 1901 of Title XIX, under the Social Security Act, provides, “[f]or the purpose of enabling each State, as far as practicable under the conditions in such State to . . . help such families and individuals **attain or retain capability for independence**”¹ (Emphasis added.) The purpose of Medicaid, therefore, as defined by the statute, goes beyond paying for medical care.

Medicaid should not be a disincentive to work: work leads to independence and contributes to improved health, which are among the purposes of the Medicaid program. The rationale of the Work and Community Engagement (WCE) requirements are likewise intended to help individuals attain economic independence, lift themselves out of poverty and to improve their overall health. The overarching purpose of the work requirements (to help individuals attain economic independence) is in their interest, and therefore promotes the statutory objectives of the Medicaid program.

There is a long-documented correlation between employment and improved life circumstances.² For example, for individuals with substance abuse disorders, employment is generally viewed as an important component of recovery. Other correlative examples are set out in the graphic on page 3 of this document.

There is limited research, however, about the direct role of Medicaid in assisting people to increase work and wages sufficiently to rise out of poverty.

This proposed evaluation is meant to close the gap in available research regarding the correlation between Medicaid-required WCE, and the multiple positive effects on Medicaid beneficiaries.

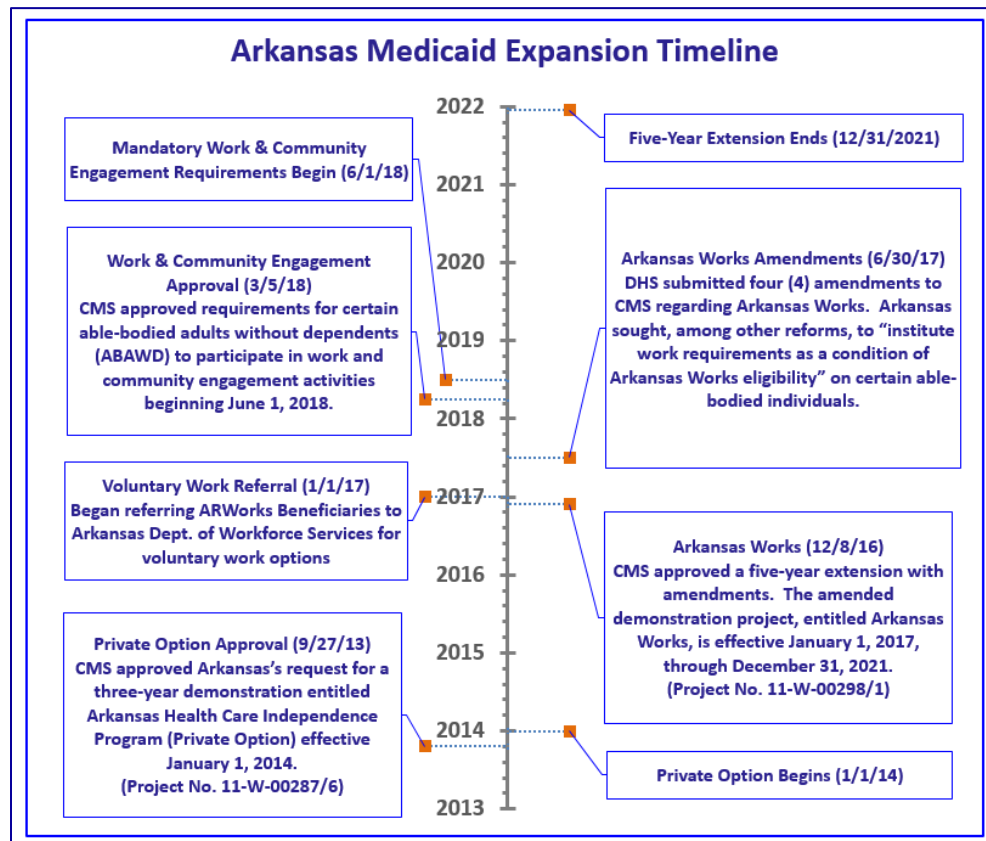
2. Arkansas Works Background and Timeline

As a largely-rural state with historically high unemployment, worse health and less education attained compared to other states, Arkansas presents a unique opportunity to turn around these statistics.

Beginning with the Arkansas Health Care Independence Program in 2014, Arkansas exercised its option to expand Medicaid coverage to 18- to 64-year olds with effective income of 138% of the federal poverty level (FPL) under the provisions of the Affordable Care Act (ACA). Also known as the Private Option, the expansion occurred through §1115 authority rather than through the

Medicaid state plan. This permitted the state, among other things, to provide coverage through insurance carriers rather than the Medicaid fee-for-service (FFS) delivery system. The insurance carriers that offer Qualified Health Plans (QHPs) for the Medicaid population also offer QHPs for individuals.

A consequence of this structure, the “Medicaid cliff,” i.e., the point at which a rise in income results in the loss of health insurance coverage, no longer exists in Arkansas. Low-income workers who increase their earnings will still receive coverage and subsidies, but through tax credit subsidies rather than Medicaid.



In 2016, Arkansas Works (“ARWorks”) amended the Private Option program. As part of the updated demonstration program, beginning in January 2017, the Arkansas Department of Human Services (DHS) referred all individuals enrolled in ARWorks to the Arkansas Department of Workforce Services (DWS). The referral allowed beneficiaries to voluntarily seek assistance with job training and job placement. However, from January to October 2017, only 4.7% of beneficiaries acted upon the referral and utilized the services provided by DWS. Of that number, 23% became employed through this process.

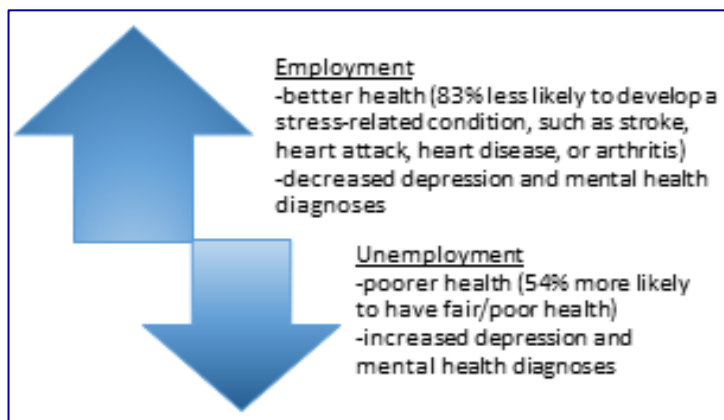
The June 2017 amendment requires certain able-bodied adults without dependents to participate in WCE requirements beginning June 1, 2018.³

In 2018, with the implementation of the ARWorks WCE requirements, Arkansas will be able to track mandatory referrals and test whether a “stronger incentive model is more effective in

encouraging participation.”⁴ The approved ARWorks amendment now requires approximately 69,000 abled-bodied individuals to engage in work activities, include education and training. Such requirements promote the objectives of Title XIX.

The benefits of the new requirements are multi-fold. First, individuals can continue to increase their earnings without losing the value of health insurance as there is no “Medicaid cliff” in Arkansas. In addition, finding employment has numerous tangible and intangible benefits:

- Improve the skill sets of individuals,
- Assist them to gain or increase employment, and
- Increase their earnings.



Each of these goals helps individuals to lift themselves out of poverty and to improve their overall health.

The purpose of this Evaluation Design is directed solely toward the amendment for implementation of the WCE requirement that will be in effect during the period June 1, 2018, through December 31, 2021. The evaluation will cover the implementation efforts, outcomes and effects (short-term and long-term, tangible and intangible), and sustainability of WCE requirements and activities as part of a lasting improvement to the social fabric and population health of all Arkansans.

3. Work and Community Engagement Overview

The ARWorks demonstration is targeted to individuals 19-49 years old. Based on data as of March 2, 2018, there were 171,449 ARWorks beneficiaries ages 19 – 49 (out of a total of 278,734). However, the majority of these individuals will meet at least of the exemption criteria. Approximately 69,000 have no initial exemption identified through system data.

Exemptions will be identified through a beneficiary’s initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including:

- Employment and self-employment of at least 80 hours a month,
- Medical frailty,
- Exemption from SNAP (Supplemental Nutrition Assistance Program) work requirement,
- Receipt of TEA (Transitional Employment Assistance) Cash Assistance, and
- Receipt of unemployment benefits.

Individuals will be required to participate in WCE requirements unless they meet the established criteria for exemption in the following table:

Exemption Criteria*	•Beneficiary's income is consistent with being employed or self-employed at least 80 hours per month •Beneficiary attends high school, an institution of higher education, vocational training, or job training on a full-time basis •Beneficiary is exempt from SNAP work requirements •Beneficiary is receiving TEA Cash Assistance •Medically frail / Disabled •Beneficiary is incapacitated in the short-term or is medically certified as physically or mentally unfit for unemployment •Beneficiary is caring for an incapacitated person •Beneficiary lives in a home with a dependent child age 17 or younger •Beneficiary is receiving unemployment benefits •Beneficiary is currently participating in a treatment program for alcoholism or drug addiction •Beneficiary is pregnant
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*Exemption duration is discussed in the chart below on page 19.

The exemptions may also provide a benefit. For example, many employers, including the State of Arkansas, require individuals who apply for employment to successfully pass a drug test prior to hiring. Treatment is a temporary means of demonstrating compliance with the WCE activities. Thus, successful treatment (the exemption) would therefore lead to employment (the ultimate goal).

Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval. Depending on the criteria, exemptions will be valid for the respective durations specified in the exemption chart. When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues.

The demonstration will be phased-in by two age groups. Based on data as of March 2, 2018, there were 171,449 ARWorks beneficiaries ages 19 – 49. Approximately 69,000 have no initial exemption identified through system data. Beginning June through September 2018, beneficiaries ages 30 – 49.

Based on the same data, there were 125,242 ARWorks beneficiaries ages 30 – 49. Of those, 38,321 have no exemption identified through system data. Arkansas has chosen to phase in this group over four (4) months based on when their cases are due for renewal. The chart below depicts the month the work requirement begins, the renewal months, and number of beneficiaries affected.

Month Work Requirement Begins	Renewal Months	Approximate #of Beneficiaries To report work activities
June 2018	Jan, Feb, Mar	9,152
July 2018	April, May, June	9,341
August 2018	July, August, September	8,682

September 2018	Oct, Nov, Dec	11,146
TOTAL		38,321

Data date: 3/2/2018

The 19- to 29-year-old age group will be phased in during 2019 between January and April.

Work and Community Engagement Requirements will be promulgated according to the State’s Administrative Procedures Act in Medicaid eligibility rules. The promulgated Medicaid eligibility manual can be accessed from the main public [DHS policy page](#).⁵

Arkansas has designed the WCE requirement for ARWorks to closely align with requirements in SNAP. [SNAP work requirements](#) can be found and reviewed online as part of the DHS/DCO policy manual.⁶

4. Evaluation Overview

This Evaluation Design is in addition to the previously approved Evaluation of ARWorks. It will be procured separately from the previously approved Evaluation due to the unique nature of WCE requirements. This feature makes the Demonstration resemble an income security program and will be evaluated accordingly.

The approved ARWorks amendment requires approximately 69,000 abled-bodied individuals to engage in work activities, which include education and training. This promotes the objectives of Title XIX as described in Section 1901: “[f]or the purpose of enabling each State, as far as practicable under the conditions in such State to . . . help such families and individuals **attain or retain capability for independence . . .**”⁷ (Emphasis added.) The purpose of Medicaid, therefore, as defined by the statute, goes beyond paying for medical care. The purpose of the WCE requirements is to improve the skill sets of individuals, assist them to gain or increase employment, increase their earnings, and thereby helping them lift themselves out of poverty and to improve their overall health. The purpose of the work requirements, to help individuals attain economic independence, is in their interest, and therefore promotes the statutory objectives of the Medicaid program.

It is widely recognized that employment improves an individual’s health:

- Work has a positive influence on an individual’s health and security;
- Returning to work has significant health benefits, especially mental health benefits;
- Work has a positive intergenerational influence;
- People who work live longer and healthier lives; and
- Work has non-financial rewards including socialization, stabilization, and support.

The Demonstration Evaluation will therefore answer three core questions surrounding enforceable WCE requirements in Medicaid:

1	Does WCE requirements promote personal responsibility and work?
2	Does WCE requirements encourage movement up the economic ladder?
3	Does WCE requirements facilitate transitions from ARWorks to employer-sponsored insurance and Marketplace coverage?

The purpose of work requirements is well summarized in a November 9, 2016, paper by the Congressional Research Service (CRS): “Four primary rationales for such policies have historically been put forth: offsetting work disincentives inherent in social assistance programs; promoting a culture of work rather than one of dependency; rationing scarce taxpayer dollars to the truly needy; and combating poverty.”⁸ The CRS authors observe, “[e]mpirical studies have generally confirmed that providing social assistance has a work disincentive, though the size of that disincentive has historically been in dispute.”⁹

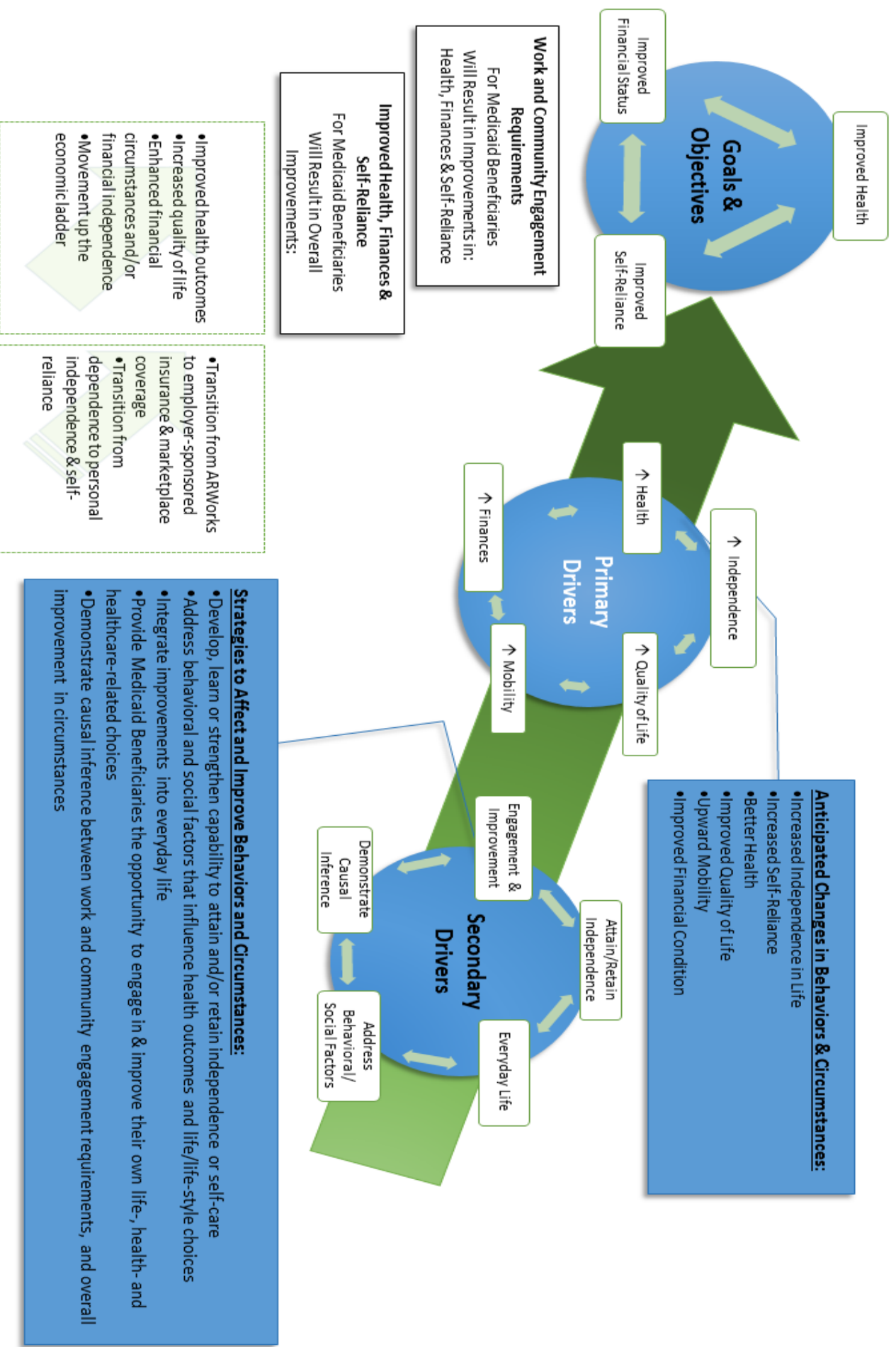
The relationship between not working and poverty is indisputable. According to CRS, the poverty rate for a family with a worker was 8.7% in 2015 compared to 90.8% for a family with no one who worked or had work-related benefits. The poverty rate for a family with a full-year, full-time worker was 4.2% in 2012 compared to 29.9% for a family with no full-year, full-time worker.¹⁰

Our hypothesis is that individuals enrolled in Arkansas Works sufficiently value health insurance coverage to comply with the work and community engagement activities which, over time, will lead to increased earnings and transition to other health insurance coverage.

Individuals will gain the understanding that increased earnings no longer results in the loss of access to necessary health care services. The continuation of coverage after a person earns more than the Medicaid income eligibility limits will demonstrate that Medicaid, with work requirements, is not a disincentive to work. DHS will be able to measure and report on participation but has not set targets given the unique nature of this Demonstration.

The purpose of the Demonstration is to increase earnings of individuals enrolled in ARWorks in order for them to rise above the poverty level. This pathway begins with notifying nonexempt individuals that they are subject to WCE requirements and ends when their earnings exceed the program parameters. The Evaluation will address the hypotheses about whether Medicaid WCE requirements result in sufficiently increasing income to rise above the poverty level.

The Driver Diagram on the next page sets out graphically the goals, as well as the primary and secondary drivers related to the enumerated goals.



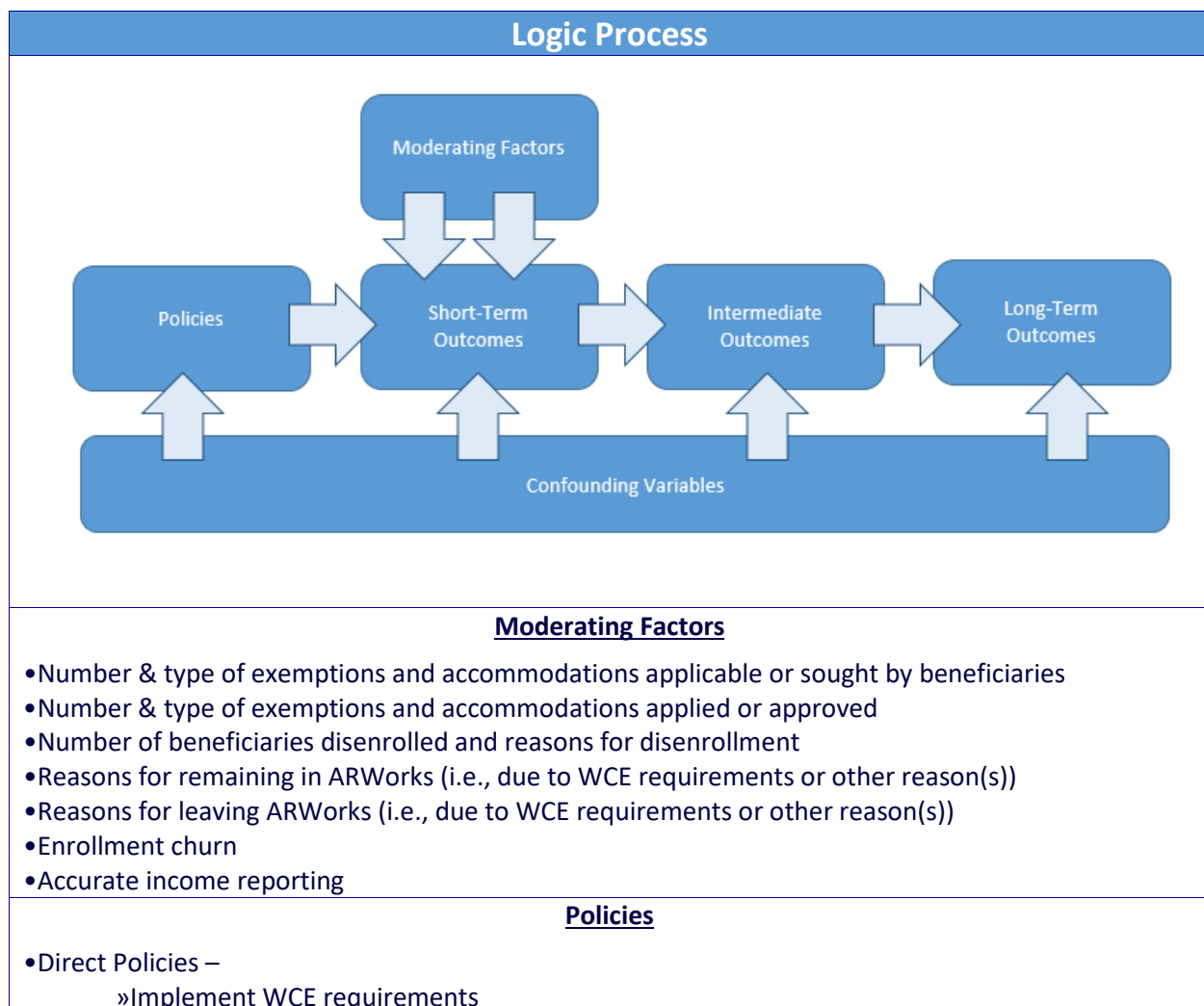
DHS will use a public Request for Proposal (RFP) process to procure the capabilities necessary for evaluation of the Demonstration. The Evaluation will use a combination of data sources including monthly data on enrollment and participation on all individuals who are not exempt. These data sets will be augmented by interviews with a statistically valid sample of individuals who remain on the program and those who leave the program. The successful bidder must have demonstrated experience in evaluating the impact of work requirements on participation in income security programs.

Evaluation questions will be developed in the RFP process and specific interview questions of participants will be developed by the successful bidder.

The following graphic sets forth the ultimate goals of the WCE requirements, as well as the primary and secondary drivers of the evaluation hypothesis:

5. Evaluation Design

The overall evaluation design will follow the process below, taking into consideration all factors that would influence Medicaid beneficiaries' choices, decisions, actions and outcomes:



»Tie requirements to continued enrollment in ARWorks »Applies to and dovetails with other income security programs (e.g., TEA, SNAP) •Work Strategies – Provide work and career training, which promotes the opportunity to: »Learn a trade »Take current training and skills to a higher level »Receive placement services »Decrease perception of reliance and increase independence •Health and Healthcare Strategies – Advantages of improved health: »Encourages taking control over health and health-related activities »Promotes personal self-reliance »Supports return-to-work strategies •Identify and track work-related metrics and outcomes •Provide the bridge to obtaining employer-sponsored or marketplace insurance		
<u>Short-Term Outcomes</u> •Culture of Work (i.e., promote a culture of work over dependency) •Increased: »Work history and experience assists with future employment opportunities »Skills translates to promotions, job stability, marketable and transferable skills »Computer literacy/internet/email experience by required use of the ARWorks Portal •Positive impact on: »Socialization opportunities »Personal and life stability »Support structure		
<u>Intermediate Outcomes</u> •Enhanced financial circumstances, and improved financial stability •Improved health and personal security •Decreased perception of challenges in life and for employment, promotion, etc.		<u>Long-Term Outcomes</u> •Significant health and mental health benefits •Upward mobility •Financial independence •Positive inter-generational influence •Longer, healthier lives
<u>Intermediate & Long-Term Outcomes</u> •Prioritization of governmental resources •Increased sustainability of the Arkansas Medicaid program with the goal of being able to provide medical assistance to those needing such programs		
<u>Confounding Variables</u>		
•<u>Current work status</u> »Already working – -Full time -Part time »Not working due to – -School attendance -Care-giving -Illness or disability -Another reason	•<u>Social Determinants of Health</u> »Current health status and medical issues »History of job instability or unemployment »Education level »Multi-generational poverty »Support system (Lack of one) »Housing & Food insecurity	•<u>Life Disruptions (Major/Minor)</u> »Divorce »Becoming a caretaker for family member »Death of spouse/family member »Unintended pregnancy »Becoming homeless »Natural disaster/catastrophe
•<u>Personal Characteristics</u> »Learned behaviors		•<u>Economic environment:</u> »Overall economy

- | | |
|-----------------------------|--|
| »Personal goals and desires | »Location-specific economic factors
(e.g., local, regional, rural, urban, etc.)
»Strong/Weak job market (↑ or ↓ success) |
|-----------------------------|--|

The Evaluation population will consist of those individuals who are enrolled in ARWorks and were not initially exempt from the WCE requirements. The Evaluation population will include current and newly-enrolled beneficiaries. Their participation in ARWorks will be tracked over time. A subset of this group will be interviewed over time in order to understand the individual's reason(s) a person chose to participate or not.

There are 69,000 individuals that DHS estimates will not be initially exempt from the WCE requirements. This is a sufficiently large group to support a statistically reliable sample size. The Evaluation will use a variety of data sources including monthly enrollment data and the data under the Outcome Monitoring Plan ("Monitoring Plan") which will contain the following statistics:

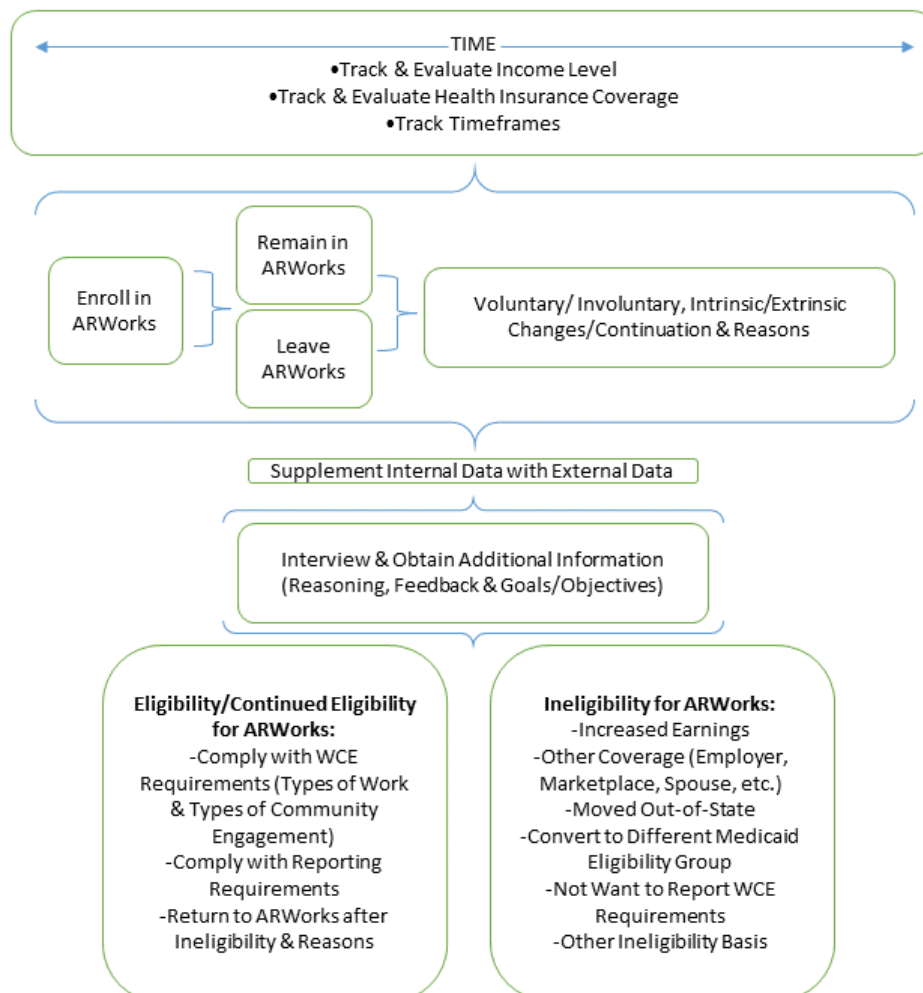
•Number and percentage of:	-individuals required to report each month -beneficiaries who are: »exempt from the community engagement requirement. »requesting good-cause exemptions from reporting requirements »granted good-cause exemption from reporting requirements »requesting reasonable accommodations -beneficiaries disenrolled for: »failing to comply with community engagement requirements »failing to report »failing to meet community engagement and reporting requirements -community engagement appeal requests from beneficiaries -applications made in-person, via phone, via mail and electronically
•Number, percentage and type of:	-reasonable accommodations provided to beneficiaries -community engagement good-cause exemptions: »requested »granted -reporting good-cause exemptions: »requested »granted

In addition, the Evaluation will include personal interviews with individuals to understand their reasons for their choices. Through their choices, individuals will create subgroups that will describe their experiences to remain or leave the program over time.

Remain – Those who remain on the program (or return to it) may do so for a variety of reasons that are important to understand: •Comply with WCE requirements in order	A sample of those who remain will be interviewed to obtain their views on the importance of insurance coverage and on their access to health care. DHS anticipates that
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to maintain coverage •Convert to a different Medicaid eligibility group (pregnancy, disability) •Return to ARWorks, even after a loss of coverage for a new coverage year	appropriate questions from the National Health Interview Survey for adults will be used for this purpose.¹¹
Leave – It is also critical to understand why individuals leave ARWorks, which may be categorized as voluntary/involuntary, intrinsic/extrinsic, or in multiple categories, from the beneficiary’s and DHS’s standpoint: •Earnings increased •Alternate coverage source (e.g., spouse) •Did not want to report •Moved out-of-state •Requested or Required closure •Noncompliance/Sanctioned (case closed)	A sample of those who leave will be interviewed to obtain their views on the importance of insurance coverage and on their access to health care. DHS anticipates that appropriate questions from the National Health Interview Survey for adults will be used for this purpose.

DHS anticipates that the WCE requirement cycle – and subsequent evaluation – will broadly follow this evolution of adherence or non-adherence:



By definition, everyone in the Evaluation group has low wages at the point-in-time in which they reported income at or below 138% FPL (\$16,753 annually; \$1,396 monthly for a single individual) and were enrolled in ARWorks. The Evaluation will examine how individuals who leave because of increased wages:

- Learned new skills
- Completed education
- Increased from part-time to full-time work

The Evaluation Period will use data from January 2018 through December 2021. Although the WCE activities do not begin until June 1, 2018, data prior to the implementation is necessary to set the baseline for comparison.

The principal measures are income levels and health insurance coverage. Overall, the experience of individuals will be analyzed over time, comparing their income and health insurance coverage at the end of the Demonstration on December 31, 2021, to their income and health insurance coverage on January 1, 2018. Additionally, a sample of participants will be interviewed to obtain their views on the importance of insurance coverage and on their access to health care. DHS anticipates that appropriate questions from the National Health Interview Survey (NHIS) for adults will be used for this purpose.

Data sources will include enrollment sets from DHS and from the Monitoring Plan. In addition, a statistically-valid sample population will be interviewed by a contractor selected through a RFP process.

There are two major challenges to be faced in the Evaluation:

1	Enrollment churn: Individuals moving on and off the program for reasons unrelated to work requirements.
2	Income is likely under-reported. Currently: »80.5% of able-bodied adults without dependents age 19 to 29 and »88% of able-bodied adults without dependents age 30 to 49 report income of 0 to 25% of the FPL.

CONTINUED ACCESS TO HEALTH CARE

Should individuals choose not to participate in the Medicaid work requirements and involuntarily leave their coverage, they will still have access to health care. Although it is one of the poorest states in the nation, Arkansas is fortunate to have more than 100 Community Health Center (CHC) service locations across the state. In addition, there are 13 Community Mental Health Centers (CMHC) that are responsible for providing services to uninsured individuals with mental health needs in regions that cover the entire state. These clinics are geographically dispersed throughout the state and cover counties with the highest poverty levels within the state.

The CHCs and CMHCs served many low-income Arkansans prior to adoption of the Adult Expansion Group regardless of their insurance status. They provide a “patient-centered model of healthcare delivery, offering comprehensive services to patients at each clinic.” (See End Note 12.) Services include:

- Family medicine
- Internal medicine
- Pediatrics
- Obstetrics and gynecology
- Oral health
- Diagnostic and basic radiology services
- Mental health and behavioral healthcare
- Healthcare accessibility services like transportation and translation/interpretation

However, DHS anticipates that the successful RFP contractor will have the skills to mitigate these challenges.

The Monitoring Plan, described herein, provides additional information on the implementation of the Demonstration. The analytic methods will be described in detail through the RFP process and the successful contractor.

DHS fully expects this to be a rigorous Evaluation with sufficient data and protocols to strongly support this Demonstration Project of national significance. Additional information about the independent evaluator, the evaluation budget and supplementary timeline points and major milestones will be added at a future date because of the RFP process which generally is a six- to nine-month procurement process.

As the RFP is developed, and feedback is received from potential vendors, the Design Table for the Demonstration Evaluation, below, will continue to mature:

Research Question	Outcome Measures Used to Address the Research Question	Sample or Population subgroups to be compared	Data Sources	Analytic Method
Hypothesis 1: Work and Community Engagement requirements promote personal responsibility and work				
•Changes in work status before, during and after WCE requirements period over time •Changes in level of job placement and job security over time •Changes in level of independence over time •Changes in intrinsic perception of personal responsibility and ability for self-care over time	•Work situation, including FT, PT, seasonal, etc., including any changes •Utilization rate of services offered by Arkansas DWS •Determine measurement (how beneficiary measures the benchmark), baseline and subsequent changes in: »Job security »Independence »Personal Responsibility »Ability for self-care	•Medicaid beneficiaries without ARWorks exemptions/accommodation •Medicaid beneficiaries with ARWorks exemptions/accommodation •Medicaid beneficiaries not subject to ARWorks requirements	•Claims data •Self-reported information from Medicaid beneficiaries through the ARWorks portal •Interviews •Surveys •Information from other programs and partners, including community engagement resources	•Will be fully developed and refined in RFP process

Hypothesis 2: Work and Community Engagement requirements encourage movement up the economic ladder				
•Changes in level of income and benefits provided through work or other sources over time •Changes in level of housing and food security over time •Changes in intrinsic perception of: »Financial Success »Challenges faced to obtain an improved life •Changes in intrinsic perception of self-reliance over time	•Determine measurement (how Medicaid beneficiary subject to ARWorks requirements measures the benchmark), baseline and subsequent changes in: »Financial Success »Housing Situation »Food situation »Life challenges »Self-Reliance	•Medicaid beneficiaries without ARWorks exemptions/accommodation •Medicaid beneficiaries with ARWorks exemptions/accommodation •Medicaid beneficiaries not subject to ARWorks requirements	•Tax returns •Self-reported information from Medicaid beneficiaries through the ARWorks portal •Interviews •Surveys •Information from other programs and partners, including community engagement resources	•Will be fully developed and refined in RFP process
Hypothesis 3: Work and Community Engagement requirements facilitate transition from ARWorks to employer-sponsored insurance or marketplace coverage				
•Changes in health insurance coverage before and during WCE requirements period •Changes in health before and during WCE requirements period	•Track type, source and benefit level of health insurance •Determine measurement (how Medicaid beneficiary subject to ARWorks requirements measures the benchmark), baseline and subsequent changes in health situation	•Medicaid beneficiaries without ARWorks exemptions/accommodation •Medicaid beneficiaries with ARWorks exemptions/accommodation •Medicaid beneficiaries not subject to ARWorks requirements	•Claims data •Tax returns •Self-reported information from Medicaid beneficiaries through the ARWorks portal •Interviews •Surveys •Information from other programs and partners, including community engagement resources	•Will be fully developed and refined in RFP process

6. Outcome Monitoring Plan and Timeline

Planning, policy and system development, partner and stakeholder engagement, and resource availability assessment began in January 2017 and have been ongoing.

Upon approval of the work and community engagement amendment, Arkansas began finalizing plans and testing of the process to implement the requirement on June 1, 2018.

The planning, testing, implementation, and monitoring timeline is provided below:

•3/15/18	»Mass notice was issued to all ARWorks beneficiaries informing them of the change in the program and upcoming implementation of WCE requirements. »The notice instructed them that no additional action is required at that time and will encourage them to provide an email address to Arkansas DHS if they have not already.
•3/30/18	»Successful “go live” for the ARWorks online portal. »Beneficiaries are able to begin linking their secure online accounts and reporting exemptions.
•4/1/18	»New ARWorks beneficiaries ages 30 – 49 approved beginning April 1, 2018, or later will become subject to the WCE. »These beneficiaries will have their begin dates for completing and reporting work activities set to begin the second month after approval.
•4/1/18 – 4/8/18	»Work requirement begin months will be set for beneficiaries 30 – 49 years of age. »Notices will be mailed to each individual with specific details about the WCE requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
•4/13/18	»The first data file of ARWorks beneficiaries containing specific information regarding WCE details were provided to Arkansas DWS, the Medicaid Beneficiary Relations vendor, and QHP carriers. »Outreach and education will begin. »Updated files will be provided weekly thereafter.
•5/8/18	»ARWorks beneficiaries ages 30 – 49 who are scheduled to begin the WCE requirement in June 2018 were mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. »Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. »Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of June 2018. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
•6/1/18	»Implementation of mandatory work requirements begins for individuals ages

	30 - 49.
•6/8/18	»ARWorks beneficiaries ages 30 – 49 who are scheduled to begin the WCE requirement in July 2018 will be mailed individually tailored notices.
•7/8/18	»ARWorks beneficiaries ages 30 – 49 who are scheduled to begin the WCE requirement in August will be mailed individually tailored notices.
•7/30/18	»Monitoring phase begins. »First quarterly report will be submitted to CMS (Center for Medicare and Medicaid Services).
•8/8/18	»ARWorks beneficiaries ages 30 - 49 who are scheduled to begin the WCE requirement in September 2018 will be mailed individually tailored notices.
•10/30/18	»Second quarterly monitoring report will be submitted to CMS.
•11/1/18	»New ARWorks beneficiaries ages 19 - 29 approved beginning November 1, 2018, or later will become subject to the WCE. »Their beginning dates for completing and reporting work activities set to begin the second month after approval.
•11/1/18 – 11/8/8	»Work requirement phase in will be set based on renewal months for beneficiaries 19 - 29 years of age. »Notices will be mailed to each individual with specific details about the WCE requirement, services available through Arkansas DWS, and instructions on how to access and log in to the online portal.
•12/8/18	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in January 2019 will be mailed individually tailored notices. The notice will contain information regarding any exemption and the type of exemption that has been identified through data in systems. »Those who are exempt will be instructed that no additional action is necessary unless their circumstances change and that they will be notified when they are expected to take further action. »Those without an identified exemption will receive a notice that instructs them that they will be required to begin completing and reporting work activities during the month of January 2019. The notice will contain full details about the work requirement, how and where to report a previously unidentified exemption and / or completion of work activities. The notice will inform them of the consequence of non-compliance.
•1/1/19	»Implementation of mandatory work requirements begins for individuals ages 19 - 29.
•1/8/19	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in February 2019 will be mailed individually tailored notices.
•1/30/19	»Third quarterly monitoring report will be submitted to CMS.
•2/8/19	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in March 2019 will be mailed individually tailored notices.
•3/8/19	»ARWorks beneficiaries ages 19 - 29 who are scheduled to begin the WCE requirement in April 2019 will be mailed individually tailored notices.
•4/30/19	»Fourth quarterly monitoring report will be submitted to CMS.

All of the data required to produce these Outcome Monitoring reports is owned by Arkansas DHS. With the exception of the good-cause exemption reports and the WCE appeal requests,

these reports will be system-generated from the eligibility system data warehouse. Requirements, design, and delivery of these reports are covered by the Arkansas DHS contractual agreement with the eligibility system developer.

A database outside of the eligibility system is being developed by DHS to track and report all good-cause exemption metrics. Appeal metrics will be tracked and provided by the DHS Office of Chief Counsel Appeals and Hearings section. These reports will be compiled monthly and will be reported to CMS quarterly. Documentation on design requirements for each report will be available at a later date when report development is complete.

7. Arkansas Works Application and Renewal Overview

Applications for healthcare coverage are accepted through multi-channels including online, by phone, in person, and by mail. Application assistance is provided by Arkansas DHS staff both in person and by phone.

No changes are needed to the current process for applications related to the addition of the WCE requirement. Assistance is provided in local offices to those who need assistance completing applications. Arkansas DHS also maintains a contract with a vendor who provides interpretation and translation services. This service is accessible statewide and each DCO county office (DHS Division of County Operations) can access the vendor as needed to assist individuals.

Arkansas DHS also accepts applications from incarcerated individuals up to forty-five (45) days prior to release. The Arkansas Department of Corrections has contracted with a vendor to assist exiting inmates with the application process for Medicaid prior to release.

Applications received from beneficiaries who lost eligibility due to non-compliance with WCE requirements will be denied if received prior to the yearly open enrollment period. Applications received during open enrollment will be processed with coverage beginning on January 1 of the following year for beneficiaries that are otherwise eligible. The State's reasonable accommodation process is available in a procedural desk guide.

Renewals are conducted monthly through an *ex-parte* process. Beneficiaries whose renewals cannot be completed *ex-parte* are sent specific notices to provide information that is needed to complete the renewal. Beneficiaries are not required to complete forms that require information that has been previously provided or is available to DHS.

ARWorks beneficiaries who are subject to WCE requirements will have their renewals completed by the same method as beneficiaries who are not subject to WCE activities. Work activity reporting continues through the online portal with no interruption or change to the reporting process during renewal. Being non-compliant in the month a beneficiary's case is due for renewal does not prevent the *ex-parte* renewal process from occurring.

Arkansas monitors Medicaid timeliness with data, and conducts a weekly Medicaid Eligibility Operations meeting to review progress and develop strategies to address any issues that arise. Weekly management reports are reviewed by the team during each meeting. Timeliness reports

can be provided along with other quarterly reports. Additional information is also reported to CMS monthly through Performance Indicators.

Arkansas DHS completes daily electronic account transfers to the federally-facilitated marketplace for individuals determined to be ineligible for Medicaid.

No changes to this process are necessitated by the addition of the WCE process.

8. Work and Community Engagement Overview and Operational Approach

Population Subject to Work Requirements

Once work requirements are implemented in June of 2018, ARWorks beneficiaries ages 19 to 49 who do not meet established exemption criteria will be required to meet work requirements as a condition of continued ARWorks eligibility. Work requirements will not apply to ARWorks beneficiaries ages 50 and older.

Allowed Work Activities and Work Activity Hour Calculations

ARWorks beneficiaries ages 19–49 who are not exempt must engage in 80 hours of monthly WCE activities. ARWorks beneficiaries can meet the work requirements by either meeting SNAP work requirements or by completing at least 80 hours per month of some combination of the following activities as deemed appropriate by the state. ARWorks beneficiaries must demonstrate electronically on a monthly basis that they are meeting the work requirement.

Work Activity	Work Activity Hours
Employment or Self-Employment	•Reported income divided by Arkansas minimum wage = work activity hours
Going to school, job training, vocational, or other educational program	•English As a Second Language (ESL): 1 hour of instruction = 2.5 work activity hours •GED (General Equivalency Diploma)/Basic Skills/Literacy: 1 reported hour = 2 work activity hours •College/University: 1 credit hour = 2.5 work activity hours •High School: 1 hour of instruction = 2.5 work activity hours •Occupational Training: 1 hour of instruction = 2 work activity hours •Unpaid Job Training: 1 reported hour = 1 work activity hour •Vocational Training: 1 credit hour = 2.5 work activity hours
Volunteering	•1 reported hour = 1 work activity hour

Job Search or Job Search Training up to 39 total hours each month	•Job Search: 1 reported job contact = 3 work activity hours •Job Search Training: 1 reported hour = 1 work activity hour
Health Education Class up to 20 hours each year	•1 reported hour = 1 work activity hour
Any activity that satisfies the SNAP Work Requirement	•Determined by the SNAP program

Exemption from Work Requirements

ARWorks beneficiaries meeting one of the criteria below will be exempt from work requirements. Exemptions will be identified through a beneficiary's initial application for coverage, an electronic submission demonstrating the exemption, or a change in circumstances submission. Depending on the criteria, exemptions will be valid for the respective durations specified below.

When a beneficiary's exemption expires, he or she will be required to demonstrate that the exemption is still valid and continues. Information provided during the application process and data obtained systematically will be used to identify several types of exemptions including employment and self-employment of at least 80 hours a month, medical frailty, exemption from the SNAP work requirement, receipt of TEA Cash Assistance, and receipt of unemployment benefits. Beneficiaries for whom an exemption is not established during the application process will have an opportunity to attest to an exemption upon approval.

Exemption Criteria	Duration of Exemption
Beneficiary's income is consistent with being employed or self-employed at least 80 hours per month	Exemption valid until a change in circumstances or renewal
Beneficiary attends high school, an institution of higher education, vocational training, or job training on a full-time basis	Exemption valid for six months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is exempt from SNAP work requirements	Exemption valid for duration of SNAP exemption
Beneficiary is receiving TEA Cash Assistance	Exemption valid for duration that individual is receiving TEA Cash Assistance
Medically frail / Disabled	Exemption valid until a change in circumstance

Beneficiary is incapacitated in the short-term or is medically certified as physically or mentally unfit for unemployment	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is caring for an incapacitated person	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary lives in a home with a dependent child age 17 or younger	Exemption valid until a change in circumstances
Beneficiary is receiving unemployment benefits	Exemption valid for six months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is currently participating in a treatment program for alcoholism or drug addiction	Exemption valid for two months before beneficiary is required to demonstrate that he or she is still exempt; beneficiary must demonstrate meeting the exemption again at renewal
Beneficiary is pregnant	Exemption valid until end of post-partum care

Disenrollment for Failure to Meet Work Requirement

Beneficiaries who are subject to work requirements will lose eligibility for ARWorks if they fail to meet work requirements for any three (3) consecutive or non-consecutive months during the coverage year. Effective as of the end of the third month of noncompliance, such beneficiaries who fail to meet the work requirements will be terminated from coverage, following proper notice and due process, and subject to a lockout of coverage until the beginning of the next coverage year, at which point they will be permitted to reenroll in ARWorks.

ARWorks beneficiaries whose coverage has been terminated due to non-compliance may apply for and receive coverage in other Medicaid categories if eligible during the lockout period. Notices of denial and closure due to non-compliance with WCE requirements will contain information about how to access primary and preventive care services at low or no cost at free health clinics and community health centers.¹² Closure of the ARWorks case will be transmitted to the InterChange Medicaid Management Information System (MMIS). Termination of the QHP premium payment is automated in the InterChange system.

Online Reporting

Arkansas has enhanced the innovation and administrative efficiency of the WCE requirement by planning and designing an online portal for beneficiaries to report their work activities, exemptions, and other household changes. This portal is actually an enhancement of the Cúram eligibility system that has already passed CMS readiness review standards. DHS required

through contract with Cúram developers that the portal is mobile-device friendly and ADA-compliant (Americans with Disabilities Act).

Beneficiaries will use an email address and password to access the online portal. Rather than providing verification of exempt or compliant status with paper documentation, beneficiaries will enter and attest to the information submitted through the online portal. These attestations will be evaluated through a robust quality assurance process. Use of the portal promotes WCE goals by reinforcing basic computer literacy/skills, internet navigation, and communication via email – all of which provide the beneficiaries additional transferrable work-related skills.

This approach is administratively efficient to implement. The eligibility system processes information submitted via the online portal automatically without worker intervention. This allows Arkansas to implement the WCE requirement without additional resources. Individuals, who are disabled, including mental and physical disability, will be exempt from WCE requirements and will not be at risk for losing coverage. Arkansas DHS will provide reasonable accommodations to assist individuals with the online reporting requirement. Beneficiaries may receive in-person assistance through the local DHS/DCO county offices. All notices provide instructions to contact the Access Arkansas Call Center or a DHS/DCO county office for help regarding WCE requirements.

Arkansas DHS has also developed a “Registered Reporter” process to assist individuals with their online reporting requirements. Individuals may become a registered reporter by reviewing specified online training material, signing a Registered Reporter Acknowledgement Form and emailing that form to Arkansas DHS. The beneficiary must also authorize the reporter to serve in that role. To promote this as an additional reporting support for ARWorks beneficiaries, Arkansas DHS will announce this process through a press release and schedule meetings and webinars with stakeholder agencies. Information on the process and training is available on the [ARWorks public SharePoint site](#):

Beneficiary Work and Community Engagement Online Reporting Requirements

Beneficiaries must use the online portal to report exemptions and submit completion of WCE activities. The WCE portal is part of the existing eligibility system. Information entered into the portal is seamlessly processed by the eligibility system with no additional beneficiary or DHS staff requirement to re-key or transfer the information into the system.

Exemptions must only be re-attested to by the beneficiary at the required intervals specified above. Completion of work activities must be entered and attested to monthly. Individuals will have until the 5th day of the following month to attest for the previous month.

The online portal is secure, mobile-device friendly, and compliant with the ADA. The portal requires an email address and password to access. To assist beneficiaries to prepare for this requirement, Arkansas DHS and the vendor-provided call center have conducted a campaign over the last several months where DHS encouraged beneficiaries to provide an email address. DHS also offered information about how to obtain free email addresses and assistance with setting up email addresses. DHS has been able to collect several thousand email addresses during this effort.

DHS has taken great care to make the reporting process as user-friendly as possible, and beneficiaries are provided a number of services related to the portal that will assist with this requirement:

- Password Reset: The portal allows beneficiaries to reset passwords through self-service.
- Customer Support:
 - »Technical assistance will also be available through the Access Arkansas call center for website and password issues.
 - »Beneficiaries who require assistance using the portal can receive assistance from several sources, including Arkansas DHS staff, call center agents, Arkansas DWS staff, or the beneficiary's QHP carrier.
 - »Each notice and flier regarding WCE direct beneficiaries who need help to contact the DHS via the toll-free call center or local DHS/DCO county office.
- Literacy Levels:
 - »Arkansas DHS worked with the University of Arkansas for Medical Sciences (UAMS) Center for Health Literacy team to help develop language for WCE notices and fliers.
 - »Similar verbiage was used on the portal for consistency and understanding at lower literacy levels.
- Interpretation/Translation: Arkansas DHS maintains a contract for language interpretation and translation. Beneficiaries who need assistance with languages other than English will be assisted in the local DHS/DCO county offices.
- Hours of Operation:
 - »The portal will be available daily between 7 AM and 9 PM except for times when it is necessary to take the portal offline for system upgrades.
 - »The website displays a notice each time it is offline for maintenance.
 - »Those outages when necessary are scheduled over weekends for minimal disruption.

»The State will make every effort not to schedule maintenance during the first through the fifth of each month for beneficiaries who need to report the previous month's activities before the reporting deadline.

Upon logging into the portal, beneficiaries will be able to see their WCE status for the current reporting month as well as history for the year-to-date. They will be able to update and confirm their contact information and household composition. Beneficiaries will know immediately upon submission if they have entered enough information to be considered compliant or exempt for the reporting month. If they have not yet completed 80 hours, the portal will display the number of hours needed to become compliant. Each portal screen includes information about the method for calculating completed hours for that activity.

Good-Cause Exemptions / Catastrophic Events

Beneficiaries who have experienced a catastrophic event during a month they were required to complete work activities will be exempt from work requirements or reporting by requesting and being granted a good-cause exemption. Circumstances that may lead to an approved good-cause exemption include, but are not limited to:

- Natural disaster,
- Hospitalization or serious illness,
- Birth or death of a family member living in the home, or
- Domestic violence.

Beneficiaries who have lost coverage due to non-compliance with the WCE requirement will have their cases reinstated without a new application if they are granted a good-cause exemption and are otherwise eligible.

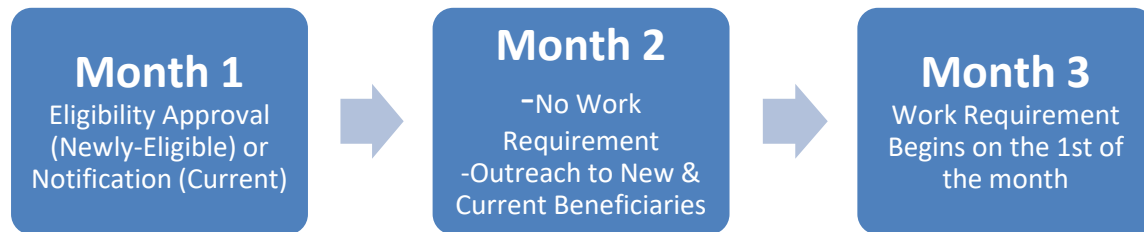
Information about good cause exemptions and how to request these is provided in all WCE notices. Verification of the catastrophic event which caused the beneficiary not to complete and/or report required activities will be required as part of the good-cause approval process. DHS staff may use discretion to waive the verification in cases such as natural disaster when the event is known to the general public.

Interim Period Prior to Work and Community Engagement Requirement – Outreach and Education

Newly-approved ARWorks beneficiaries who are subject to the WCE requirement will have an interim period of up to 59 days prior to beginning work activities. The work requirement will begin on the first of the second month after the month of approval. For example, a non-exempt beneficiary approved in the ARWorks program on any day during the month of April will be required to begin completing work activities on June 1st.

Through the implementation plan, existing beneficiaries will also have an interim period after notification before they are required to begin completing and reporting work activities. The interim period after notification will be used to conduct outreach to beneficiaries to educate them on all aspects of the work requirement including using the online portal, connecting with the Arkansas Department of Workforce Services and other resources to assist them with compliance

with work activities. The outreach will be done through a multi-media and multi-partner approach that includes Arkansas DHS, Arkansas DWS, the Medicaid Beneficiary Relations vendor, and QHP carriers.



Over the last several months, Arkansas DHS has developed several educational tools regarding WCE requirements that are intended to assist beneficiaries and partners alike. These tools include a computer-based training on the ARWorks program and the WCE requirement. Tutorials on linking their secure account on the portal, entering work activity and exemption information on the portal have also been developed. This ARWorks toolkit is available online to the public so that partners and beneficiaries can access the information as needed. The ARWorks toolkit, with links to education and outreach information, can be found on the [ARWorks public SharePoint site](#) shown above.

Work and Community Engagement Notices

In addition to traditional postal mail, Arkansas DHS will communicate with ARWorks beneficiaries who have provided email addresses through an electronic message to a secure inbox. The content of the notices will meet all requirements in the standards, terms, and conditions reflected in the approved §1115 waiver amendment. With the exception of good-cause exemption denials, all notices related to the WCE requirement are automated and system-generated in real time. This automation ensures that timely and adequate notice requirements are met. Specific notices related to WCE requirements have been developed and contain detailed information for beneficiaries.

Notices of either approval or denial of a good cause exemption will be manually generated and uploaded to the electronic case record. Additionally, a good-cause exemption functionality is on the roadmap to be developed in within the DHS eligibility system.

A separate tracking website will be developed and maintained for Arkansas DHS staff to use to track good cause exemption requests for noncompliance with work activities or reporting requirements until this capability is achieved in the eligibility system to meet CMS monitoring and reporting requirements included in the approved waiver amendment.

Community Resource Availability and Mapping

Arkansas DHS has been working with a team of partners and stakeholders for several months to identify community engagement resources throughout the state. This team includes Arkansas DHS, Arkansas DWS, Arkansas Center for Health Improvement, representatives from each ARWorks qualified health plan carrier, the Arkansas Hospital Association, UAMS, and the Arkansas Department of Career Education. Input and participation is open to interested

stakeholder organizations. DHS is also actively engaging other state agencies and non-profit agencies to assess their willingness and capacity to provide support to ARWorks beneficiaries in this and other ways. Arkansas DHS has lead on this project.

As a result of this effort, an ARWorks Resource Dashboard and Interactive Resource Map has been developed for users to click county by county for specific information on local resource availability. The [Resource Dashboard](#) allows beneficiaries to located valuable and needed information for effectively complying with all WCE requirements.

The [County-Specific Resources](#) resource map contains information on work and employment services, education and training opportunities, and volunteerism opportunities. The resource map also contains information on locations with public access to computers and free Wi-Fi and other supportive resources such as public transportation, substance abuse treatment, housing, and more. Public access to computers is being provided by Arkansas DHS, Arkansas DWS, Arkansas libraries and other community organizations.

Locations where beneficiaries and former beneficiaries can access free and reduced-cost health care have also been collected and made available in this map. DHS will include information in

notices for individuals who lose coverage due to non-compliance in addition to sharing this information through social media. This resource map will be available to the public online in the ARWorks information SharePoint site and will be updated quarterly and as new information becomes available.

An example of the ARWorks Resource Guide for Pulaski County, Arkansas, where Little Rock is located, is attached hereto as Attachment 1. The guides are down-loadable and have hyperlinks throughout for each easy access to additional resources.

Quality Assurance and Fraud Process

Arkansas DHS will conduct a monthly quality assurance process to validate exemptions and work activities that have been attested to by beneficiaries as a special effort in addition to normal PERM (Payment Error Rate Measurement) and MEQC (Medicaid Eligibility Quality Control) requirements. The quality assurance process will include reviewing a statistically valid random sample to achieve a 95% (+ / - 3% variance) level of confidence.

In addition to these quality assurance reviews, Arkansas DHS will review data on attestations monthly and quarterly from the universe of ARWorks beneficiaries who are subject to WCE requirements to identify trends and potential anomalies that should also be reviewed for

accuracy. Based on the outcomes of these reviews, the quality assurance process will be enhanced with additional reviews in error-prone areas.

The quality assurance component will be promulgated in Medicaid eligibility rules. Specific quality assurance processes will be outlined in a procedural desk guide for DHS staff. If inaccuracies are discovered during the quality assurance process, appropriate action will be taken to remove months of exemption or compliance. If this results in three months of non-compliance for the calendar year, the ARWorks case will be closed and referred for investigation as potential fraud and overpayment.

Appeal Process

Beneficiaries will be provided full appeal rights with regard to WCE requirements just as they have for other Medicaid eligibility determinations. The process will be the same regardless for the reason for appeal. Each notice contains information about beneficiaries' rights to appeal and how to request an appeal. Requests for appeal that are received in DHS/DCO county offices are forwarded to the DHS Office of Chief Counsel Appeals and Hearings Unit who schedule and conduct appeal hearings and render decisions.

Data Exchange between Programs and Partners

To ensure that dual ARWorks and SNAP beneficiaries have no additional compliance or reporting requirements, Arkansas DHS will use data exchanges between systems to record compliance and exemption information. This data exchange is currently in the final stages of testing.

SNAP and ARWorks beneficiaries may choose to comply through either program.

To ensure a robust outreach and education process, a weekly data file will be shared with Arkansas DWS, the DHS Medicaid Beneficiary Relations vendor, and each QHP carrier. Information provided to carriers will be limited to ARWorks beneficiaries that are members of their individual plans. The file will contain information on each beneficiary that includes:

- Contact information,
- Work and community engagement exemption and compliance information,
- Type of exemption,
- Number of months of cumulative non-compliance,
- Compliance status for the current month, and
- Renewal month.

This level of detail will allow DHS's partners to conduct specific outreach and education encouraging beneficiaries to participate and complete work activities.

Arkansas DHS has also leveraged its current contract for Medicaid beneficiary relations with the Arkansas Foundation for Medical Care (AFMC) to provide outreach and education about the WCE requirement. AFMC will do active outreach to educate ARWorks beneficiaries who need to complete WCE activities to make sure they understand the requirements. AFMC will also provide education and assistance to beneficiaries on how to properly and timely report their

activities and to direct them to the Arkansas Department of Workforce Services, SNAP Employment and Training (SNAP E&T) vendors, or other resources as appropriate to help them comply with work requirements. Contractual requirements for WCE include an outreach period 30 days prior to the beginning of WCE requirements for existing ARWorks beneficiaries.

Outreach and education methods will include outbound phone contact as well as an inbound integrated voice response system where beneficiaries can receive education about WCE requirements. All scripts and materials used by AFMC will be approved by DHS. AFMC will also spend the first 12 days conducting outreach and education after an ARWorks beneficiary is approved with WCE requirements. AFMC must successfully contact and educate 30% of existing ARWorks beneficiaries and 40% of newly-approved ARWorks beneficiaries. To facilitate the successful outreach and education, AFMC staff has received training and access to the DHS Cúram eligibility system. AFMC will also be receiving a daily and monthly file containing ARWorks beneficiaries with WCE requirements and their current status related to these activities. AFMC is required to make a minimum of two (2) attempts by a live agent to contact beneficiaries by phone when a phone number is available. Additional attempts and methods used by AFMC to reach their contractual obligations are not specified. AFMC will be required to provide DHS with results of outreach efforts through various reports.

Arkansas implemented the requirement to work in SNAP statewide in January 2016. Participation in SNAP E&T is one option available to SNAP recipients as a means to comply with SNAP work requirements. SNAP recipients may also comply on their own through work, education, training, or community service and volunteerism activities.

Since inception of the SNAP work requirement, Arkansas DHS partnered with the United States Department of Agriculture (USDA) Food and Nutrition Services (FNS) to expand the SNAP program in Arkansas. Initially, SNAP E&T was available in thirteen (13) counties across Arkansas. As of July 2018, Arkansas now has increased the number of counties with a SNAP E&T program to sixty-six (66) out of seventy-five (75) counties – and the number of included counties continues to increase.

In each county where it is available, DHS has either a contract or sub-grant agreement in place with at least one SNAP E&T vendor. Each SNAP E&T vendor must have a physical location to provide employment and training services.

USDA/FNS has also approved Arkansas to pilot virtual SNAP E&T case management. This will also participants in rural counties to meet with their E&T case manager virtually by using a laptop available for this purpose in the DHS/DCO county office.

Point-in-time data comparison in March 2018 between the SNAP program and ARWorks has shown that approximately twenty-two to twenty-five percent (22-25%) of ARWorks beneficiaries also receive SNAP. DHS plans to leverage the expanded SNAP E&T program to assist individuals who are dually-eligible for SNAP and ARWorks: ARWorks beneficiaries can be referred to SNAP E&T vendors for appropriate for assistance with job search and training in order to meet WCE requirements.

SNAP E&T vendors already conduct outreach to engage SNAP recipients. SNAP recipients who are also enrolled in ARWorks may satisfy WCE requirements in both programs by participating in a SNAP E&T program. A list of these SNAP E&T vendors and locations are included in the ARWorks county-specific resource guide, and as Attachment 2 hereto.

Dual SNAP and ARWorks beneficiaries will be allowed to satisfy the WCE requirement for both programs by participating in and reporting in either SNAP or the ARWorks program. They will not be required to comply with or report separately to both programs to maintain continued eligibility.

The ARWorks, SNAP and TEA programs reside in separate eligibility systems operated by Arkansas DHS. Working with contracted developers for both systems, Arkansas DHS developed a process whereby data files will be exchanged between these systems daily to update exemption and compliance information in both programs without manual intervention by the beneficiaries or DHS staff.

END NOTES

¹ Section 1901 of the Social Security Act, under Title XIX – Grants to State for Medical Assistance Programs (www.ssa.gov/OP_Home/ssact/title19/1901.htm).

² See, e.g., *How Does Employment – or Unemployment – Affect Health?*, Robert Wood Johnson Foundation Health Policy Snapshot, March 2013 Issue Brief (www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360), and *The Impacts of Unemployment on Mental and Physical Health, Access to Health Care and Health Risk Behaviors*, Pharr, Jennifer R., et al., (www.hindawi.com/journals/isrn/2012/483432/). Disadvantages developed by unemployed workers, as well as advantages inured to employed adults, include, but are not limited to:

- “Laid-off workers are 54 percent more likely than those continuously employed to have fair or poor health, and 83 percent more likely to develop a stress-related condition, such as stroke, heart attack, heart disease, or arthritis.”
- “With respect to mental health, a 2010 Gallup Poll found that unemployed Americans were far more likely than employed Americans to be diagnosed with depression ...”.
- “The relationship between unemployment and poor health has been well documented.”
- “Unemployed participants had significantly worse perceived mental health profiles ...”.
- “Studies have also demonstrated a positive correlation between employment and better health, improved self-confidence, self-esteem, and happiness.”

Fortunately, a strong economy provides opportunities for lower-skilled workers. This includes younger workers, “mother headings families, and other groups not favored in the labor market.” *An Overview of Economic, Social and Demographic Trends Affecting the US Labor Market*, Lerman, Robert I. and Stefanie R. Schmidt, The Urban Institute, Final Report, August 1999, at page 1 (www.dol.gov/oasam/programs/history/herman/reports/futurework/conference/trends/trends.pdf).

³ See Arkansas’s Amended Waiver Request (www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-works-pa2.pdf). The purpose of the amendments is to “test innovative approaches to promoting personal responsibility and work, encouraging movement up the economic ladder, and facilitating transitions from Arkansas Works to employer-sponsored insurance and Marketplace coverage.” *Ibid*.

⁴ See Letter dated March 5, 2018, from Ms. Seema Verma, CMS Administrator, to Ms. Cindy Gillespie, Director, Arkansas DHS, regarding approval of Arkansas’s proposed amendment to the Arkansas Works program. On pages 3-4, Ms. Verma noted that:

Arkansas’ approach [to the WCE requirements] is informed by the state’s experience with the voluntary work-referral program in its current demonstration, which the state has not found to be an effective incentive. Since January 2017, certain individuals enrolled in Arkansas Medicaid have been referred to the Arkansas Department of Workforce Services (DWS), which provides a variety of services to assist individuals in gaining employment. Through October 2017, only 4.7 percent of beneficiaries followed through with the referral and accessed DWS services. Of those who accessed DWS services, 23 percent have become employed. This result suggests that referrals alone, without any further incentive, may not be sufficient to encourage the Arkansas Works population to participate in community engagement activities. CMS will therefore allow

Arkansas to test whether the stronger incentive model is more effective in encouraging participation.

⁵ On the Arkansas DHS public SharePoint site for DHS Policies and Publications (ardhs.sharepointsite.net/DHSPolicy/default.aspx), select “Division of County Operations Policies”.

⁶ Arkansas DHS/DCO Supplemental Nutrition Assistance Program (SNAP) Policy Table of Contents (ardhs.sharepointsite.net/DHSPolicy/DCOPublishedPolicy/Forms/SNAP.aspx).

⁷ See End Note No. 1, *supra*.

⁸ *Work Requirements, Time Limits, and Work Incentives in TANF, SNAP, and Housing Assistance*, Falk, Gene, Maggie McCarty and Randy Alison Aussenburg, Congressional Research Service, November 9, 2016, at page 2 ([greenbook-waysandmeans.house.gov/sites/greenbook-waysandmeans.house.gov/files/R43400%20-%20Work%20Requirements,%20Time%20Limits,%20and%20Work%20Incentives%20in%20TANF,%20SNAP,%20and%20Housing%20Assistance 0.pdf](https://greenbook-waysandmeans.house.gov/sites/greenbook-waysandmeans.house.gov/files/R43400%20-%20Work%20Requirements,%20Time%20Limits,%20and%20Work%20Incentives%20in%20TANF,%20SNAP,%20and%20Housing%20Assistance%200.pdf)).

⁹ *Ibid*.

¹⁰ *Ibid.*, Table 5, at page 27.

¹¹ See *Detailed outline of core topics in the Redesigned National Health Interview Survey (NHIS) Sample Adult Questionnaire, Version: October 2017*, United States Center for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) (www.cdc.gov/nchs/data/nhis/AdultNHISRedesignTopics20171027.pdf).

¹² Community Health Centers of Arkansas (chc-ar.org/) maintains a list and map of all CHC locations across Arkansas at chc-ar.org/find-a-clinic/ and chc-ar.org/health-centers-map/. See also “About Us” (chc-ar.org/about-us/) and “What Are CHCs?” (chc-ar.org/what-are-chcs/).

ABBREVIATIONS AND ACRONYMS

ACA	Affordable Care Act
ADA	Americans with Disabilities Act
AFMC	Arkansas Foundation for Medical Care
ARWorks	Arkansas Works
CHC	Community Health Center
CMHC	Community Mental Health Centers
CMS	Center for Medicare and Medicaid Services
CRS	Congressional Research Service
DCO	Division of County Operations
DHS	Department of Human Services
DWS	Arkansas Department of Workforce Services
E&T	Employment and Training
ESL	English As a Second Language
FFS	fee-for-service
FNS	Food and Nutrition Services
FPL	federal poverty level
GED	General Equivalency Diploma
MEQC	Medicaid Eligibility Quality Control
MMIS	InterChange Medicaid Management Information System
NHIS	National Health Interview Survey
PERM	Payment Error Rate Measurement
QHP	Qualified Health Plan
RFP	Request for Proposal
SNAP	Supplemental Nutrition Assistance Program
TEA	Transitional Employment Assistance
UAMS	University of Arkansas for Medical Sciences
USDA	United States Department of Agriculture
WCE	Work and Community Engagement

ATTACHMENTS

- | | |
|--------------|---|
| Attachment 1 | Arkansas Works – Pulaski County Resource Guide (22 pages/pdf) |
| Attachment 2 | SNAP E&T Coordinator List (8 pages/Word) |

Request to Amend the
ARHOME Section 1115 Demonstration Project
Project No. 11-W-00365/4

State of Arkansas
Department of Human Services



January 28, 2025

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Section I: Executive Summary

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS), respectfully requests approval of this amendment, “Pathway to Prosperity,” to the current Arkansas Health and Opportunity for ME (ARHOME) Section 1115 Demonstration Project (waiver). The ARHOME program is Arkansas’ Medicaid expansion that provides health care coverage to more than 220,000 able-bodied adults ages 19-64 with income at or below 138% of the Federal Poverty Level (FPL). Pathway to Prosperity establishes work and community engagement requirements for the Medicaid expansion population that will drive improved health and economic independence outcomes for working age nondisabled adults and their families.

This amendment reflects lessons learned from the state’s efforts in 2018-2019 to institute work requirements as a condition of maintaining eligibility for Medicaid under the expansion program, then known as “Arkansas Works.” Assessments of Arkansas Works showed that many people did not know whether they were subject to participation requirements and, if they were, what they needed to do monthly to demonstrate compliance.

Lessons learned include the importance of providing clear communications through multiple means, simplicity in design, and the need for personal interaction rather than over-reliance on technology. Pathway to Prosperity will use data-matching to identify individuals who could benefit from extra support to reach health and economic goals.

For nearly 50 years Medicaid covered only the elderly, people with long-term physical or intellectual disabilities, low-income children, and the parents/caretakers of dependent children whose household income was near or below the federal poverty level. The Affordable Care Act (ACA) changed that. A new eligibility group was created to allow states to make able-bodied working age adults eligible for Medicaid. These individuals are reasonably expected to be substantially engaged in the workforce. Indeed, many of these individuals are employed, though most are not working full-time, year-round.

Pathway to Prosperity will help provide a bridge over the “benefits cliff” that keeps people from moving into economic stability and off of public assistance. Title XI, which gives authority to the Secretary of the U.S. Department of Health and Human Services to approve demonstration programs and pilots under Section 1115, allows the Secretary to “waive” federal laws and regulations for the purpose of encouraging state and local governments to improve the effectiveness of certain public assistance programs.

Moreover, in the design of Pathway to Prosperity, DHS is cognizant of the situations and circumstances of the plaintiffs from the previous legal case brought against Medicaid work requirements, *Gresham v Azar*.¹ Pathway to Prosperity will address the courts’ analysis that “... the Secretary’s failure to consider *the effects of the project on coverage* alone renders his decision arbitrary and capricious; it does not matter that HHS deemed the project to advance other objectives of the act (emphasis added).”² The Amendment makes significant policy and procedural changes from the previous version to respond to the question of coverage.

¹ https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58

² *Ibid.* p. 23

The design of Pathway to Prosperity also reflects the recent U.S. Supreme Court decision in *Loper Bright Enterprises v Raimondo*³ in how the courts are to evaluate administrative actions. While Title XI of the Social Security Act (the Act) provides the Secretary of the Department of Health and Human Services with broad authority for determining the purposes of Title XIX of the Act, the lower courts in *Gresham v Azar* provide an important framework for evaluating how the Secretary must fulfill his responsibilities. Specifically, the courts applied their own interpretation as to whether the Secretary sufficiently assessed the impact of work requirements and community engagement on the core purpose of Medicaid to provide coverage.

To whom does Pathway to Prosperity Apply?

- Pathway to Prosperity applies to all individuals ages 19-64 who are eligible through the new adult expansion group, who have income ranging from 0% FPL to 138% FPL, and who are covered by a QHP.
- There are no exemptions to participation; individuals will be assessed by DHS as “on track” or “not on track” through data matching.
- Those who are identified as not on track will be provided the opportunity to receive focused care coordination services to support health and economic self-sufficiency.

Focused Care Coordination and Personal Development Plan

DHS will utilize data matching to identify individuals who appear to be not on track towards meeting their personal health and economic goals. If DHS confirms that an individual is not on track, it will coordinate with the QHPs to provide focused care coordination services to eligible individuals. These services include the establishment and monitoring of a Personal Development Plan (PDP).

Employment is vital to a person’s long-term health as poverty is directly linked to poor health outcomes. A person who is unemployed will benefit from the support of focused care coordination to connect the individual with needed resources such as career training and transportation. In addition, individuals who are on a path to self-sufficiency may not be aware of the resources and opportunities available to them across Arkansas.

If a person is not employed, he or she must be engaged in qualifying advancement, learning, or service activities to be considered “on track.” Advancement can come from a variety of activities including training, workforce development, apprenticeships and internships. Learning includes formal education, vocational education, and activities that enhance a person’s skills such as through mentoring programs or life skills development. Service in one’s community may be demonstrated in a variety of ways, including caring for a dependent child, an elderly parent, or a person with a disability.

Coverage Value & Consequences

Active participation in health and workforce development will become part of the expectation of receiving health care through a QHP. In January 2025, DHS will pay the QHPs an average monthly premium of \$577.62, advanced cost sharing reduction payments of \$202.17 per month and “wrap around” payments of \$4.53. Together, these represent an average annual value of \$9,411.72 per enrolled member. Coverage provided by Arkansas Medicaid pays not only for

³ https://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf

medical treatment at the time of illness or accident, but for preventative services as well that can provide high value to individuals.

Despite these opportunities, some individuals will choose not to participate in any of these investments in their health. Individuals who refuse to cooperate with DHS and decline to use services and incentives covered by QHPs will have their ARHOME coverage suspended. Benefits can be restored if the individual chooses to get “on track” with their PDP.

Suspension from ARHOME Coverage

Individuals who decline to participate in Pathway to Prosperity workforce development will have their ARHOME coverage - QHP benefits - suspended through the end of the calendar year. They will not be disenrolled from the Medicaid program. To become “active” again and have full benefits restored, they need only notify DHS of their intention to cooperate with personal development plan requirements. As Pathway to Prosperity does not make compliance a condition of eligibility, individuals will not be required to complete a new Medicaid application unless they have passed the date for their annual redetermination of eligibility.

During the suspension period, DHS will not make monthly premium payments nor Advanced Cost Sharing Reduction (ACSR) payments to the QHP.

Normal appeal rights will be available to an individual who is suspended.

Section II: Background & Historical Narrative

Since 2014, Arkansas has provided health care coverage to the Medicaid new adult group made eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. The Arkansas Department of Human Services (DHS) uses Medicaid funds to purchase coverage from Qualified Health Plans (QHPs), which are private health insurance plans licensed by the Arkansas Insurance Department (AID).

Arkansas currently provides health care coverage to more than 220,000 beneficiaries in this eligibility group. They are adults between the ages of 19 and 64 who are not enrolled in Medicare and who are either:

- (1) childless adults with household income at or below 138% of the federal poverty level (FPL),
or;
- (2) parents with dependent children whose income is between 14% and 138% FPL.

Of the more than 220,000 adults in Medicaid expansion, approximately 188,000 individuals currently receive their benefits primarily through Qualified Health Plans (QHPs) through the authorities granted in the Arkansas Health and Opportunity for ME (ARHOME) waiver. The remainder of the new adult group receive their benefits in the Medicaid Fee-For-Service (FFS) delivery system. Most of these FFS individuals were recently determined eligible for Medicaid and are waiting to be enrolled in a QHP (the interim group). About 13,000 other individuals are “medically frail” and will remain in the FFS model of care because it provides additional services, such as personal care, that the QHPs do not. A small number of individuals may be enrolled into the Provider-led Arkansas Shared Savings Entity (PASSE) program due to the presence of a serious mental illness and confirmation of a need for Home and Community Based Services (HCBS) through an Independent Assessment (IA).

The current version of the ARHOME waiver was approved by the Centers for Medicare & Medicaid Services (CMS) to be effective January 1, 2022, through December 31, 2026. ARHOME is designed to improve the quality of services provided by the QHPs and the health of beneficiaries assigned to them. An amendment to ARHOME was approved in November 2022 to provide intensive care coordination services for certain targeted populations through Life360 HOMEs.⁴ In 2024, the first Life360 Homes, serving pregnant women diagnosed as high risk went live.

The fundamental goal of this new Pathway to Prosperity amendment is to support Governor Sarah Huckabee Sanders' vision to assist low-income Arkansans enrolled in ARHOME with moving from government dependence to economic independence and ultimately to obtain health insurance coverage through employment or the individual insurance marketplace as do most Americans.

The Centers for Medicare & Medicaid Services (CMS) estimates that in 2025, 92.3% the U.S. population will have health care coverage. In the unique American system of health insurance, coverage in 2025 will be provided through the following sources⁵:

- Employer Sponsored Insurance: 177.8 million enrollees (52.6%)
- Medicaid: 79.4 million enrollees (23.5%)
- Medicare: 68.0 million enrollees (20.1%)
- Direct purchase (individual insurance market, subsidized and unsubsidized): 38.3 million enrollees (11.3%)
- Children's Health Insurance Program (CHIP): 7.8 million enrollees (2.3%)
- Uninsured: 26.1 million individuals (7.7%)

According to the U.S. Census Bureau, insurance coverage varies by age and poverty level. "Adults ages 19-64 generally have lower coverage rates than those under age 19 and adults age 65 and older. That's because their coverage is directly tied to employment. They do not qualify for programs intended for children and only qualify for public programs under specific medical or income-level circumstances."⁶

Another Census study shows that "[a]dults age 65 and older are the least likely to be uninsured since they have near universal Medicare coverage. As a result, the uninsured rate for adults age 65 and older remained below 3.0% for all states in 2013, 2019, and 2023."⁷

⁴ <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-ca-11012022.pdf>

⁵ [https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected Table 17](https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected%20Table%2017). Percentages are calculated by total population as individuals may have more than one source of coverage.

⁶ <https://www.census.gov/library/stories/2024/09/health-insurance-coverage.html#:~:text=Health%20Insurance%20Coverage%20by%20Age%20and%20Income%2Dto%2DPoverty%20Ratio&text=In%20each%20year%2C%20over%20three,10.3%25%20between%202020%20and%202023>.

⁷ <https://www.census.gov/library/stories/2024/09/acs-health-insurance.html>

The distribution among sources of coverage is somewhat different in Arkansas than the nation as a whole. Individuals are less likely to have employer coverage and are more likely to have Medicare or Medicaid coverage or to be uninsured in Arkansas.⁸

A Closer Look at the Uninsured

Reducing risk is the very core of insurance, that is, to protect against a future and unforeseeable financial loss by sharing the cost of insurance coverage with others. Health insurance both protects against financial loss and increases access to medical services. Coverage also varies by individuals' perceptions of affordability. According to a study by the National Center for Health Statistics, "[a]mong uninsured adults aged 18-64, the most common reason for being uninsured, affecting 7 in 10 (73.7%), was because they perceived that coverage was not affordable."⁹

The Congressional Budget Office (CBO) estimated that in 2019, nearly 30 million people were uninsured. However, 67% of the total number of people without health insurance were eligible to purchase coverage using a subsidy.

Coverage changes over time. In a study conducted for the National Center for Health Statistics (NCHS), 31.6% of the adults ages 18-64 who were uninsured in 2016 were uninsured for less than 12 months and 68.4% were "chronically uninsured." However, 55.8% of the 18-64-year-old adults who were chronically uninsured reported that their health was "excellent or very good" while only 11% of the chronically uninsured reported that their health was "fair or poor."

There are also differences in coverage based on gender and age. Males are more likely to be chronically uninsured (59.7% of total) than females. The oldest age group (45-64) were the most likely to be chronically uninsured (32% of total). Two-thirds of the chronically uninsured are employed, which suggests that coverage also varies by individuals' perceptions of "affordability." Moreover, only 10% are unemployed while 22.4% are not in the workforce.¹⁰

Together, the two studies are part of a larger body of research that shows there are several variables resulting in an individual becoming uninsured even though the person is eligible for subsidies for coverage, including Medicaid and CHIP which provide coverage at little or no cost.

Poverty is Linked to Poor Health and Premature Death

The population served under ARHOME live in households with income near or below the federal poverty level. It is well-documented that poverty is closely connected to poor health outcomes and even premature death. One study found that "experiencing poverty or near poverty (living at incomes below 200 percent of the federal poverty level) imposed the greatest burden and lowered quality-adjusted life expectancy more than any other risk factor ...".¹¹

Poverty is a "root cause" of poor health. DHS administers other human services programs in addition to the Medicaid program and provides links to workforce development programs that

⁸ <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁹ <https://www.cdc.gov/nchs/data/databriefs/db382-H.pdf>

¹⁰ https://www.cdc.gov/nchs/data/nhis/earlyrelease/erchronicunins_1016_f.pdf

¹¹ <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf> p. 8.

can help reduce the risks associated with poverty. Addressing poverty serves the purpose of the Medicaid program.

Medicaid is an Anti-poverty Program but Presents a “Benefit Cliff”

Title XI, which gives authority to the Secretary of the U.S. Department of Health and Human Services (HHS) to approve demonstration programs and pilots under Section 1115, was added in 1962 with the purpose of encouraging states and local governments to redesign certain public assistance programs to improve the effectiveness of such programs. By allowing the Secretary to “waive” federal laws and regulations under Section 1115 authority, Congress and President John F. Kennedy offered states an opportunity to achieve better results for people in poverty. A Section 1115 waiver is a multi-year agreement (usually five years) negotiated between the Secretary of HHS and the Governor of a state. In exchange for federal funds, the state agrees to administer the new program in a manner that is budget neutral to the federal government and to evaluate whether the new program achieves its intended goals.

Medicaid was created in 1965 as a component of the “War on Poverty.” However, it is widely recognized that the flaw in the design of many public assistance programs, including Medicaid, is as beneficiaries increase their household income, benefits are reduced. This is known as the “benefit cliff.”

Individuals and their families face this cliff when the reduction in benefits is greater than the net financial gain. The existence of the benefit cliff is recognized by policy experts at all points along the political spectrum. For example, the National Conference of State Legislatures (NCLS) reported in “Introduction to Benefit Cliffs and Public Assistance Programs” “Benefits cliffs (the cliff effect) refer to the sudden and often unexpected decrease in public benefits that can occur with a small increase in earnings.”¹² “While minimum wages differ state to state, the risk of falling off a ‘benefits cliff’ is particularly likely for people making between \$13 and \$17 per hour. The economic consequences of benefits cliffs impact both families and employers: businesses are unable to meet their workforce needs because workers have a disincentive to increase hours or advance in a job, and families experience economic instability and limited economic mobility.”¹³ Many individuals reduce their risk by foregoing additional income, which typically impacts the number of hours worked over a year’s time.

Moreover, employer-sponsored health insurance coverage typically includes a deductible and other cost-sharing obligations that must be paid by the employee. Individual health care marketplace plans also include out-of-pocket payments, even if the premium is 100% subsidized by the federal government. In contrast, premiums are prohibited for Medicaid coverage and cost-sharing is nominal.

For nearly 50 years Medicaid covered only the elderly, people with long-term physical or intellectual disabilities, low-income children, and the parents/caretakers of dependent children with household incomes near or below the federal poverty level. Individuals in these eligibility groups were generally limited from substantial engagement in the workforce and unable to quickly increase household income to earn their way out of poverty, or it was very unlikely that their disability would be cured, thus removing them from the Medicaid rolls.

¹² <https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs>

¹³ Ibid.

The “benefit cliff” was reduced for children with the creation of the state Children’s Health Insurance Program in the Balanced Budget Act (BBA) of 1997. States were allowed the option to extend coverage to children in families with higher income levels. In accepting federal funding, states also had greater flexibility in administering the program. CHIP helps to “smooth” out the cliff for families by phasing out the amount of subsidies (replaced by a family’s cost-sharing responsibilities) as income increases.

The “benefit cliff” for adults was potentially reduced by the Affordable Care Act (ACA). In contrast to the original Medicaid coverage groups, many of these individuals **are** reasonably expected to be substantially engaged in the workforce. Nationally, it is estimated that 42 percent of Medicaid beneficiaries aged 19-64 are employed. However, most are not working full-time, full-year jobs. Approximately 23 percent of this age group are not working due to a disability and another 35 percent are parents with dependent children.¹⁴

Full-time employment is the solution to poverty. The U.S. Census Bureau estimates that 20 million people, 10% of the total population of individuals age 18 to 64, were living in poverty in 2023. Only 1.8% of full-time workers were living in poverty, compared to 11.7% who worked part-time and 29.7% who did not work.¹⁵

The 2024 federal poverty level (FPL) for a single person was \$15,060.¹⁶ The minimum wage in Arkansas is now \$11 per hour. A single person working full-time, year around (2080 hours) would earn \$22,880, or 152% of FPL, exceeding the upper threshold for ARHOME eligibility (138% FPL). A person in this situation could be covered by employer sponsored insurance or qualify for subsidies to directly purchase coverage through the Marketplace.

Here is where the ACA diverged from the CHIP model. Rather than providing subsidies for individuals with income above the poverty level - as high as 400% FPL in CHIP - through the administrative structure of a state, the ACA provides its subsidies to people above the poverty level through the income tax system. Thus, individuals moving out of Medicaid are able to receive a subsidy to purchase individual coverage through the Marketplace if coverage is not available through an employer. Under the current structure in Arkansas, a person would be able to choose continued coverage in the same QHP with the same provider network.

In the unique American system of health insurance, the federal government subsidizes coverage across various sources including through subsidies for employer-sponsored health insurance without regard to income level through the tax code. According to a September 2023 report by the Congressional Budget Office (CBO), the federal government will provide subsidies totaling \$25 trillion over the next ten years across Medicare (\$11.7 trillion), Medicaid and CHIP (\$6.3 trillion), employment-based coverage (\$5.3 trillion), ACA marketplace plans (\$1.1 trillion) and other federal sources (\$0.6 trillion).¹⁷

As Chief Justice Roberts wrote in the Supreme Court decision, *NFIB v Sebelius*, which upheld the constitutionality of the ACA, “It [Medicaid] is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal

¹⁴ <https://aspe.hhs.gov/sites/default/files/documents/779b6ef3fbb6b644cdf859e4cb0cedc6/medicaid-esi-unwinding.pdf>

¹⁵ <https://www2.census.gov/library/publications/2024/demo/p60-283.pdf> Table A-1 p.20

¹⁶ <https://www.govinfo.gov/content/pkg/FR-2024-01-17/pdf/2024-00796.pdf>

¹⁷ <https://www.cbo.gov/system/files/2023-09/59273-health-coverage.pdf>

coverage. Indeed, the manner in which the [Medicaid] expansion is structured indicates that while Congress may have styled the expansion a mere alternation of existing Medicaid, it recognized it was enlisting the States in a new health care program.”¹⁸ Thus, Medicaid is a part of, rather than separate from, the rest of the health care coverage system.

The purpose of this waiver is to provide a bridge over the “benefits cliff” that discourages people from moving into the working class. Pathway to Prosperity will increase individuals’ understanding of the value of health insurance and show individuals how to maintain health care coverage as they prepare to move out of poverty and support them on their pathway to independence.

It is significant that coverage for able-bodied working aged adults was added under the authority of the Social Security Act. The Act represents one of the most important social compacts among the American people, between workers and beneficiaries. The collective interdependence of Social Security is built on the foundation of individual workers. Without enough productive, healthy workers, Social Security will collapse. An individual’s future benefits as a retiree are based on his/her own work history.

Public Health Emergency Unwind Reduced Medicaid Enrollment as was Expected

Some empirical evidence exists for what happens to health coverage for adults moving out of Medicaid into other coverage, but research is limited. Pathway to Prosperity will thus make a significant contribution to this body of knowledge. In estimating the potential impact of the Pathway to Prosperity amendment on coverage, DHS reviewed available research on changes in coverage among previously enrolled individuals whose coverage was terminated due to the end of the Public Health Emergency (PHE). For example, in August 2022, the HHS Assistant Secretary for Planning and Evaluation (ASPE) released an Issue Brief that found “[a]lmost one-third (2.7 million) of those predicted to lose eligibility are expected to qualify for Marketplace premium tax credits.”¹⁹ In April 2023, ASPE released an Issue Brief that found “[a]pproximately 2 million (15 percent) working Medicaid enrollees aged 19-64 also report having employer sponsored insurance ...”.²⁰ Thus, HHS itself expected individuals who lost Medicaid eligibility would move into other coverage.

The PHE unwind in Arkansas, saw enrollment in the new adult group with QHP coverage reach 307,819 individuals in September 2022. Two years later with the return to the normal eligibility redetermination process there are now nearly 190,000 covered through QHPs.

Lessons Learned

Arkansas and Kentucky were the first states to receive approval for implementing Medicaid work and community engagement requirements for their adult expansion populations. Both states were ultimately sued by plaintiffs who alleged they experienced harm from the requirements. This Pathway to Prosperity amendment reflects lessons learned from Arkansas’s efforts in 2018-2019 to require working-age, nondisabled adults to participate in workforce activities as a condition of maintaining eligibility for Medicaid under the expansion program, then known as

¹⁸ <https://supreme.justia.com/cases/federal/us/567/519/> p.54

¹⁹ <https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf>

²⁰ <https://aspe.hhs.gov/sites/default/files/documents/779b6ef3fbb6b644cdf859e4cb0cedc6/mcaid-esi-unwinding.pdf>

“Arkansas Works.” Assessments of Arkansas Works showed that many people did not know whether they were subject to participation requirements and, if they were, what they needed to do monthly to demonstrate compliance.

Other lessons learned include the importance of providing clear communications through multiple means, simplicity in design, and the need for personal interaction rather than over-reliance on technology. Pathway to Prosperity will use data-matching to identify individuals who could benefit from extra support to reach health and economic goals. However, one of the lessons learned in Arkansas Works is the limitation of data matching. Researchers at the Urban Institute found that “[d]espite DHS’s efforts to identify exempt beneficiaries, advocates and various stakeholders were concerned that many enrollees were ‘falling through the cracks.’ They were particularly concerned about beneficiaries with medical conditions that prevented them from working. Two providers we spoke with told us they had patients with disabilities who should have received exemptions but had not.”²¹ Thus, DHS will not rely solely on data matching to assess individuals’ needs for support.

In developing the Pathway to Prosperity framework, DHS also considered the lessons learned from the unwinding of the COVID PHE, which included further enhancements to the Arkansas Medicaid Enterprise System.

Some of these lessons are to:

- Apply new program requirements to the entire population in a more streamlined way. The previous work requirement was to be implemented in phases by age group over a two-year period and exempted certain populations, which resulted in confusion and uncertainty.
- Increase personal contact. The DHS and DHS-sponsored communications and interventions were too far removed to be utilized effectively.
- Simplify how engagement is demonstrated by discontinuing the previous monthly reporting requirement and using data matching and/or regular audits of activity/income in lieu of manual reporting by the beneficiary.

Data Matching, Success Coaching, and Personal Development Plan

DHS will identify individuals who may be most at risk for poor health outcomes due to long-term dependency. DHS will utilize data matching to identify ARHOME beneficiaries who appear to be not on track towards meeting their personal health and economic goals. Factors for identifying this group may include an individual’s income level, employment history, educational status, whether a dependent child is in the household,²² length of enrollment in ARHOME, and other criteria.

If data matching indicates that an individual is not on track, DHS will identify a Success Coaching resource to contact the individual to determine whether the individual could benefit from additional supports. Success Coaching is intensive care coordination engaging individuals to improve their health, employment, advancement, learning, and community engagement.

²¹ <https://www.urban.org/research/publication/lessons-launching-medicaid-work-requirements-arkansas> p.20.

²² Current data matching shows that 58,241 ARHOME enrollees or 30.5% have a dependent child in the household

As the role of Success Coaching involves multiple functions, DHS is currently assessing public and private sector options for acquiring talent to fulfill these functions. DHS intends to leverage resources available through QHPs, state agencies such as Arkansas Workforce Centers and Arkansas Career and Technical Education, as well as local community partners.

By engaging the individual in Success Coaching, it may become clear that the individual is on track and does not need further assistance. The individual's information will be updated in the ARHOME case management system and in the Medicaid Enterprise System. If engagement with Success Coaching determines that the individual would benefit from additional support, the eligible individual will receive focused care coordination services, including the development and monitoring of a Personal Development Plan (PDP). An individual's PDP may include goals that address:

- Being healthy: being healthy is much broader than receiving a medical service; it includes the individual's physical, mental, and social well-being;
- Employed: employment is vital to a person's long-term health as poverty is directly linked to poor health outcomes;
- Advancing: advancement comes from a variety of activities including career training and workforce development;
- Learning: includes formal education, vocation education, and enhancing skills; and
- Serving: includes a variety of ways of supporting others in one's community and in one's own home.

Success Coaching will be delivered by entities that have experience working with individuals who face the challenges of poverty and will include training to provide focused care coordination services. Among other things, they will be thoroughly knowledgeable about resources available in the beneficiary's local community. They will develop the PDP with the individual which will include screening for Health-Related Social Needs (HRSN) and detailed actions for addressing those needs. Success Coaching training will include assisting individuals in understanding the long-term implications of employment including future Social Security benefits for dependents and retirees as well as maintaining health care coverage.²³

Focused care coordination provided through Success Coaching will be an extra service not generally available to the Medicaid population. In addition, the QHPs are required by DHS to offer incentives to participate in health improvement and economic independence activities. These extra advantages to being enrolled in a QHP are not available to those covered through FFS delivery system.

Consequence

Despite these opportunities, DHS anticipates that some individuals will choose not to participate in any of these investments in their health and economic stability. Individuals who refuse to cooperate with DHS and decline to use services and incentives covered by QHPs will have their ARHOME coverage suspended. ARHOME benefits can be restored if the individual subsequently chooses to engage in Success Coaching to get "on track" with their PDP.

Coverage

²³ See <https://www.urban.org/research/publication/balancing-edge-cliff>

In the design of the Pathway to Prosperity amendment, DHS is cognizant of the situations and circumstances of the plaintiffs involved in the work requirements litigation *Gresham v Azar*. Pathway to Prosperity will address the courts' analysis that "... the Secretary's failure to consider *the effects of the project on coverage* alone renders his decision arbitrary and capricious; it does not matter that HHS deemed the project to advance other objectives of the act (emphasis added).²⁴ The Amendment makes significant policy and procedural changes from the previous version to respond to the question of coverage.

The design of Pathway to Prosperity also reflects the recent U.S. Supreme Court decision in *Loper Bright Enterprises v Raimondo*²⁵ in how the courts are to evaluate administrative actions. While Title XI of the Social Security Act (the Act) provides the Secretary of the Department of Health and Human Services with broad authority for determining the purposes of Title XIX of the Act, the lower courts in *Gresham v Azar* provide an important framework for evaluating how the Secretary fulfilled his responsibilities.²⁶

For low-income, working age, able-bodied adults, Medicaid should be just a stop along an individual's pathway to a healthy life, and not the destination. With approval of the Pathway to Prosperity amendment, DHS will assist individuals achieve their own health goals including physical health, mental health, and social supports provided by QHPs, employers, workforce development, and faith and community partners. With such assistance, more Arkansans will find a pathway to achieve economic independence and self-sufficiency for themselves and their families. The amendment is designed to assist many more Arkansans to move from Medicaid into private insurance coverage.

2.1 Summary of Current ARHOME Section 1115 Demonstration

The current ARHOME waiver, approved for the period running January 1, 2022, through December 31, 2026, continues the preexisting structure in which Arkansas Medicaid purchases coverage from QHPs for the majority of program enrollees. Current benefit packages for QHPs and FFS also remained the same in the ARHOME renewal waiver.

Arkansas Medicaid currently provides coverage to more than 220,000 individuals in the new adult group. Approximately 188,000 of these individuals receive coverage through QHPs. Under the approved Demonstration, DHS makes monthly capitated payments to the QHPs to cover the cost of premiums. It also makes advanced cost sharing reduction (ACSR) payments to the QHPs to reimburse providers the cost of deductibles and copayments. The difference between the ACSR payments and actual cost sharing payments from the QHPs to providers is reconciled annually. The estimated total cost of the ARHOME program in calendar year 2024 was approximately \$2.2 billion.

Another way to measure the value of the state's contribution to coverage is the Actuarial Value (AV) of these payments to QHPs. The QHPs also sell individual health insurance products available through the Federally Facilitated Marketplace (FFM). Health plans offered in the individual and small group markets, both inside and outside of the Exchanges must provide a

²⁴ Ibid. p. 23

²⁵ https://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf

²⁶ <https://clearinghouse.net/doc/101905/>

minimum AV for purposes of determining levels of coverage to a standard population. Under federal law, a Bronze Plan must have an AV of 60 percent which means the plan will cover 60% of expected total costs for health services for those enrolled in the QHP. The AV is 70% for a Silver Plan; 80% for a Gold Plan; and 90% for a Platinum Plan.

Arkansas Medicaid purchases coverage that is equivalent to the cost of the second-lowest Silver Plan available in the state's FFM. As the state is prohibited from charging premiums and cost-sharing is limited to 5% of a household's income, the AV from the perspective of a Medicaid enrollee exceeds 94%. For those with income at or below 20% FPL (46% of ARHOME enrollees) who have no obligation for copayments, the AV is 100%.

When an individual's household income increases to above 138% FPL, the individual can remain in the same plan with the same Essential Health Benefits (EHB) and network of providers. This seamless transition is unique to Arkansas because of the 2014 waiver and provides a way for individuals to avoid the benefits cliff Medicaid enrollees typically face when their incomes increase. Although Medicaid would no longer pay premiums on behalf of an individual who is no longer eligible due to a higher income level, the majority likely would qualify for federal tax subsidies to cover all or some of their health care costs.

Everyone who is determined eligible for Arkansas Medicaid under the new adult group begins coverage in the Medicaid FFS delivery system. Approximately 24,000 beneficiaries per month are temporarily in FFS awaiting enrollment into a QHP. Beneficiaries may choose a QHP at time of enrollment. However, if a beneficiary does not pick a plan within 42 days of enrollment, DHS auto-assigns the beneficiary to a QHP.

The benefits for the new adult group, both in QHPs and FFS, meet the requirements of the Essential Health Benefit (EHB) package. QHPs form their own provider networks throughout the state and FFS does as well. DHS data analysis shows that the Medicaid FFS provider network (including primary care physicians and specialists) is similar to the number of providers in the networks offered by the QHPs. However, some providers may limit the number of Medicaid enrollees they serve due to lower Medicaid reimbursement rates. The QHPs pay providers at commercial rates.

Beyond benefits and provider networks, enrollment in a QHP provides certain advantages to beneficiaries compared to FFS. These include:

- A seamless transition to private insurance available in the Marketplace. This promotes continuity of care.
- Incentives (rewards) for their beneficiaries to participate in health improvement and economic independence initiatives. The QHPs are required by DHS purchasing guidelines and the annual Memorandum of Understanding (MOU) to offer incentives directly to the member or a provider along with EHB.
- Enhanced performance/outcomes requirements. The QHPs are required to meet performance measures in 23 reporting categories from the Medicaid Adult Core Set measures and 3 birth outcome reporting categories.

2.2 Overview of Program Goals

The current Demonstration's goals include, but are not limited to:

- Providing continuity of coverage for individuals;

- Improving access to providers;
- Improving continuity of care across the continuum of coverage;
- Furthering quality improvement and delivery system reform initiatives that are successful across population groups;
- Improving health outcomes for Arkansans, especially in maternal and infant health, rural health, behavioral health, and those with chronic diseases;
- Providing supports to assist beneficiaries, especially young adults in target populations, to move out of poverty; and
- Slowing the rate of growth in federal and state spending on the program so the demonstration will be financially sustainable.

In 2014, the uninsured rate for 19–to-64-year-olds in Arkansas was 17.7%. By 2023, the uninsured rate for this age group had declined to 12.5%.²⁷ However, despite the gains in health insurance coverage, Arkansas continues to struggle to improve its rankings among states for measuring health outcomes and for reducing poverty. For many Arkansans, health coverage alone has not been sufficient to improve their health and economic conditions.

Alleviating the effects of poverty upon beneficiaries, and the public as a whole, is a very important objective of the Medicaid program. In fact, the very first section of the Medicaid Act demonstrates the Congressional intent for appropriating federal funds to the program each fiscal year. The funds are to furnish: “1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, and 2) rehabilitation and other services to **help such families and individuals attain or retain capability for independence or self care.**”²⁸

This squares with one of the specified goals of the current waiver, which is “[p]roviding supports to assist beneficiaries, especially young adults in target populations to move out of poverty ...”.²⁹ Medicaid has been described as an anti-poverty program from its very origins. CMS and the U.S. Department of Health and Human Services (HHS) recognize the correlation between poverty, poor health, and shortened life expectancy. The *Healthy People 2020* report called poverty “an important public health issue” and stated, “researchers agree that there is a clear and established relationship between poverty and socioeconomic status, and health outcomes—including increased risk for disease and premature death.”³⁰ The updated *Healthy People 2030* continues to recognize economic stability as a key social determinant of health, and the federal initiative includes several objectives aimed at reducing the proportion of people living in poverty and increasing employment in working-age people.³¹

The amendment aligns fully with the health objectives of ARHOME, as data show that poverty is closely connected to poor health outcomes and even premature death. According to the American Academy of Family Physicians paper, “Poverty and Health – The Family Medicine Perspective,” “[p]overty affects beneficiaries insidiously in other ways that we are just beginning

²⁷ <https://www.commonwealthfund.org/datacenter/uninsured-adults>

²⁸ 42 U.S.C.A. §1396-1 (emphasis supplied).

²⁹ Approved ARHOME Section 1115 Demonstration, p.8.

³⁰ National Center for Health Statistics. Healthy People 2020 Final Review. 2021. DOI: <https://dx.doi.org/10.15620/cdc:111173>

³¹ Office of Disease Prevention and Health Promotion, <https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability>

to understand. Mental illness, chronic health conditions, and substance use disorders are all more prevalent in populations with low income.”³²

The negative impact of long-term poverty does not just affect adults, but carries forward throughout the lifetimes of their children as well. According to a paper by the Urban Institute, “[b]eyond issues of economic inequality that arise when millions of children live in poor and persistently poor families, poor children can perpetuate the cycle as they become adults. Prior research shows that children who are born poor and are persistently poor are significantly more likely to be poor as adults, drop out of high school, have teen premarital births, and have patchy employment records than those not poor at birth ...”³³ According to a study, “Early Childhood Development and Social Determinants,” [t]he earliest years of a person’s existence is thought to be the most crucial for his or her development. What happens to a child in the early years is crucial to the child’s life course and developmental trajectory.”³⁴

Movement from one source of coverage to another is a routine feature of the American health insurance system. For example, the headline of a Georgetown University paper in February 2024 was “Marketplace Enrollment Surges Among Those Losing Medicaid Coverage During Unwinding.”³⁵ On December 20, 2024, the headline from CMS was “HealthCare.gov Breaks New Record with 16.6 Million Consumers Signing Up for Coverage—The Highest Ever for January 1 Coverage.”³⁶

The relationship between income and health is well-established. Adults experiencing poverty may struggle to access adequate food, housing, or childcare, and subsequently experience elevated stress and associated health risks.³⁷ For example, adults living in poverty are at a higher risk of adverse health effects from obesity, smoking, and substance use. Additionally, older adults with lower incomes experience higher rates of disability and mortality.³⁸ Individuals with lower income are also less likely than individuals with higher income to access preventive healthcare, decreasing the likelihood that a health issue can be identified and addressed before it worsens.³⁹

By contrast, raising one’s income is associated not only with improved health, but greater quality of life. People with higher incomes report lower prevalence of disease, live longer, and report fewer feelings of worthlessness, hopelessness, and sadness.⁴⁰ Because of the close connection between poverty and poor health, policies that drive economic advancement can be associated directly to improved health outcomes. Research has found that earnings and asset development programs that increase the economic self-sufficiency of low-income families can offer promise for improving health.⁴¹ Therefore, economic policies that create jobs and teach marketable skills not only foster economic success, but also lead to better health outcomes due to the strong

³²<https://www.aafp.org/about/policies/all/poverty-health.html> p.3

³³<https://www.urban.org/sites/default/files/publication/32756/412659-Child-Poverty-and-Its-Lasting-Consequence.PDF> p. 9

³⁴<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9596089/pdf/cureus-0014-00000029500.pdf>

³⁵<https://ccf.georgetown.edu/2024/02/07/marketplace-enrollment-surges-among-those-losing-medicaid-coverage-during-unwinding/>

³⁶<https://www.cms.gov/about-cms/contact/newsroom>

³⁷<https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks>

³⁸<https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty>

³⁹<https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks>

⁴⁰<https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf>

⁴¹ *Id.*

connection between health and income.⁴² Healthcare, or receiving services related to health conditions, whether that be preventive care or an emergency interdiction for an acute condition, is not an end in itself. The American Medical Association Code of Medical Ethics defines basic healthcare as a “fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives.”⁴³

This Pathway to Prosperity amendment will be part of beneficiaries’ pathways as they seek to advance their careers and improve their lives, their families, and their communities. Some adults on Medicaid will create their own opportunities and find their own pathway to full employment and independence without assistance from government. Others are on track towards engagement but short of attaining economic independence. These beneficiaries may not be aware of the opportunities available to them and will benefit from stronger connections and more formal coaching. With that goal in mind, this amendment seeks to engage beneficiaries in their current circumstances and empower them to engage in accessing the opportunities that exist within each community.

Section III: Proposed Amendment

3.1 Requested Program Enhancements

The amendment will create new paths and opportunities for beneficiaries to improve their overall health and financial well-being. These tenets align directly with the objectives of the Medicaid program in several key aspects. First, the principal objective of the Medicaid program is to provide health care coverage. The Pathway to Prosperity amendment intends to increase the use of vital medical and social services. The Pathway to Prosperity amendment adds a new service, focused care coordination, which will lead to accessing resources an individual needs to address his/her HRSNs. As such, the amendment aligns with other very important objectives of the Medicaid program, as detailed in the Social Security Act, which include supporting beneficiaries as they attain or retain capacity for independence.⁴⁴

The amendment recognizes there are significant differences in the characteristics of ARHOME enrollees. DHS can stratify the population by demographics including age, income level, family size and rural/urban communities. It should be expected that many participants will be enrolled temporarily. However, this will vary by age and income level. For example, the expected turnover rate for a 64-year-old is 100% as the individual will age out of Medicaid and move onto the Medicare program.

Data for assessing how long people are enrolled in ARHOME is skewed by the continuity of coverage provision that was in effect during the PHE and may not be reliable. DHS will

⁴² *Id.* (See also, Healthy People 2030, Employment Literature Summary available at <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment#cit34>; Robert Wood Johnson Foundation, How Does Employment, or Unemployment, Affect Health? available at <https://www.rwjf.org/en/insights/our-research/2012/12/how-does-employment--or-unemployment--affect-health-.html>; Social Determinants of Health: Employment at <https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Social-Determinants-of-Health-Employment>.)

⁴³ AMA Code of Medical Ethics, Opinion 11.1.1 *Defining Basic Health Care*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/defining-basic-health-care>

⁴⁴ 42 U.S.C.A. §1396-1

recalculate the rate of beneficiaries who remains on Medicaid for each age group and income group annually.

DHS will use a combination of data to identify individuals most at risk for poor health outcomes due to long-term poverty. Such data includes, but is not limited to:

- Newly eligible: enrolled for 0-6 months
- Employment match:
 - Unemployed: household income at or below 20% of FPL
 - Under-employed: household income 21-80% FPL enrolled for 24+ months which may indicate at risk for long-term poverty
 - Employed: household income 81%-138% FPL enrolled for 36+ months which may indicate at risk for long-term poverty
- Medical claims match: Individuals who have been enrolled in a QHP for 6 months+ but have no medical claims and have not participated in any incentive offered by the QHP.

Role of Success Coaching

DHS will assign Success Coaching for individuals who are identified as most at risk of long-term poverty. As an individual engages in Success Coaching, additional information may show that the person is “on track” and has no need for the additional focused care coordination services.

If DHS confirms that an individual is not on track, Coaching will provide focused care coordination services to the eligible individual including the establishment and monitoring of a Personal Development Plan (PDP).

Being healthy is much broader than just receiving medical services, although determining whether an individual is accessing services is an important consideration. An individual's goals to become or remain healthy may include engaging in a wide range of activities including quitting smoking, increasing physical activity, and improving nutrition. Success Coaching might connect the individual to a variety of community resources. For example, more communities are adopting “food as medicine” strategies which might be part of an individual's PDP.

Employment is vital to a person's long-term health as poverty is directly linked to poor health outcomes. A person who is unemployed will benefit from the support of Success Coaching that can connect the individual with needed resources such as transportation.

Advancement comes from a variety of activities including training, workforce development, apprenticeships, and internships.

Learning includes formal education, vocational education, and a variety of activities that enhance a person's skills such as through a mentoring program.

Serving may be demonstrated in a variety of ways. For some, service in one's own home to care for a child, an elderly parent, or a person with a disability may be the person's highest priority at a given point in time.

Success Coaching will be delivered by entities experienced in working with individuals who face the challenges of poverty. Among other things, they will be thoroughly knowledgeable about resources available in the person's local community.

The complete focused care coordination planning process will include the following activities, at a minimum:

1. Reporting in a DHS-approved case management system;

2. Identifying any HRSN and assisting the individual access community services to address HRSN;
3. Development of an individualized PDP that facilitates access to opportunities for employment, education, and training, including technical skill development, resume writing, interview coaching and other job readiness preparations;
 - a. the PDP should identify goals and measure progress over 3-, 6-, 9-, and 12-month periods
4. Tracking and documenting monthly progress which will eliminate the reporting requirement on the individual that was widely criticized in the Arkansas Works demonstration; and
5. Monitoring and follow-up activities, including verification of engagement and a final determination of progress toward the goals and steps laid out in their PDP.

Success Coaching will include responsibility for communicating with beneficiaries at least once a month, either in person or through virtual means (phone, text, Zoom, etc.). Within 30 days of contacting a beneficiary, Success Coaching must include development of the PDP based on the beneficiary's specific needs and personal goals. The PDP should outline a feasible pathway for meeting the individual's goals for independence, including maintaining health care coverage.

Beneficiaries will not be required to work a minimum number of hours per month, nor will they be required to report any activities to DHS outside of their required contacts with their Success Coaching entity. DHS will ensure language translation services are available for all beneficiaries, as needed.

Success Coaching entities will also have access to recent advancements in the state's technology infrastructure:

- SHARE: state health care information exchange
- Arkansas Data Hub
- LAUNCH: an online service for job seekers⁴⁵
- CiviForm: a one-stop online form that shares individual information across state agency and job-seeker platforms

Early Movers

With the additional support of Success Coaching, DHS expects that some QHP enrollees will increase their income sufficiently to move above the Medicaid eligibility threshold. These individuals are "early movers," that is, they will move into other coverage sooner than expected compared to baseline data. DHS will survey these individuals annually to track their economic progress and health care coverage.

Suspension from ARHOME Coverage

If through Success Coaching it is determined that an individual is not on track and fails to cooperate, the Success Coaching entity may make a recommendation to suspend ARHOME coverage. The recommendation will be reviewed by a three-person DHS panel. If the

⁴⁵ <https://jobseeker.launch.arkansas.gov/>

suspension is approved, the individual will receive a written notice of the action with a right to appeal.

Individuals who decline to cooperate with Success Coaching will have their ARHOME coverage – QHP benefits - suspended through the end of the calendar year. They will not be disenrolled from the Medicaid program. To become “on track” and have QHP benefits restored, they will notify their Success Coaching entity of their intention to cooperate with their PDP. As Pathway to Prosperity does not make compliance a condition of eligibility, individuals will not be required to complete a new Medicaid application unless they have passed their date for their annual redetermination of eligibility.

During the suspension period, DHS will not make monthly premium payments nor Advanced Cost Sharing Reduction (ACSR) payments to the QHP.

Implementation

The Pathway to Prosperity amendment has an anticipated start date of January 1, 2026.

3.2 Impact of Proposed Amendments

3.2.1 Impact to Eligibility

Arkansas is not proposing any changes to Medicaid eligibility through this Section 1115 Demonstration Amendment request. The Pathway to Prosperity amendment will potentially impact all beneficiaries through communications on health and economic opportunities, providing focused care coordination services to those eligible for a personal development plan, and expanding the number of beneficiaries who are likely to receive HRSN through local community resources. However, these changes have no impact to individual underlying Medicaid eligibility.

3.2.2 Impact to Delivery System

In general, the state is requesting to continue the current adult eligibility group, with the same benefit packages and models of care that are currently utilized: QHPs, FFS, and PASSE.

Pathway to Prosperity will help identify the model of care most appropriate for an individual. For example, approximately 13,000 “medically frail” individuals in the new adult group remain in FFS where they are eligible to receive additional services not offered by the QHPs, such as personal care. An individual with a serious mental illness may be best served in the Provider-led Arkansas Shared Services Entity (PASSE) program. Pathway to Prosperity will continue to identify pregnant women with high-risk pregnancies who could benefit from the state’s Maternal Life 360 ARHOME program. In that program, these women will receive home visiting services and intensive care coordination, including assistance in enrolling in the Women, Infants, and Children (WIC) program and for childcare subsidies.

Important information about income, family size, and disability is collected at the time an individual applies for coverage. Data matching may yield additional information about the individual that points to follow-up actions that are in the best interests of the individual. During the data matching and assignment of Success Coaching process, some beneficiaries may be found to benefit from enrollment in the PASSE program or moved to another Medicaid eligibility group due to a disability and into the FFS model of care.

3.2.3 Impact to Covered Benefits/Cost Sharing

The QHPs provide an Essential Health Benefit (EHB) Plan that meets the requirements of coverage available through the federal individual insurance Marketplace. A major benefit of QHP coverage is continuity of coverage. The QHPs provide health insurance coverage through the individual insurance Marketplace. Thus, an individual enrolled in a QHP whose income increases above Medicaid eligibility will be able to stay in the same plan with the same benefits and providers. This continuity of coverage (and with continuity of substantial federal subsidies) may help avoid disruption in medical treatment over time. In addition, the QHPs are required to offer incentives to their members that are not available to the general Medicaid population.

After Success Coaching has been assigned to an unemployed individual, he/she will have three months to demonstrate he/she is “on track.” The potential outcomes for individuals are:

1. “On track” and QHP benefits continue;
2. QHP benefits are suspended for failure to complete a Personal Development Plan (PDP) or cooperate with their PDP;
3. QHP benefits are restored after the individual contacts DHS with agreement to cooperate with their PDP;
4. Moves to Other Medicaid model of care (FFS for medically frail or to the PASSE program for individuals with serious mental illness);
5. Moves to Other Medicaid eligibility group (due to a disability);
6. Moves to Other Coverage (no longer eligible for Medicaid due to increase in income or to Medicare);
7. Moves to Other Coverage or uninsured if Medicaid eligibility is not met at 12-month redetermination or;
8. Moves back to QHP if is redetermined to be eligible and chooses a QHP at open enrollment

A suspension of QHP benefits will be considered to be an “adverse action” and the individual will be provided a notice with instructions for filing an appeal. The Amendment does not make any changes to cost sharing.

Section IV: Requested Waivers and Expenditure Authority

The Demonstration will continue to operate all existing waivers and expenditure authorities pursuant to the Special Terms and Conditions (STCs) issued on December 21, 2021, and as amended on November 1, 2022.

In addition, DHS requests all necessary additional waiver and expenditure authority to implement the Amendment request, including at minimum, the following:

Amount, Duration, and Scope of Services and Comparability	Section 1902(a)(10)(B) and 1902(a)(17)
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To the extent necessary to enable DHS to offer focused care coordination services to the populations as described in this Amendment, which may vary and not otherwise be available to all beneficiaries in the same eligibility group.

To the extent necessary to enable DHS to suspend QHP benefits for beneficiaries who are not engaging in their QHP health plan.

Statewideness**Section 1902(a)(1)**

To the extent necessary to enable DHS to provide focused care coordination services on a less than statewide basis.

Freedom of Choice**Section 1902(a)(23)(A)**

To the extent necessary to enable DHS to limit beneficiaries' freedom of choice with respect to focused care coordination services.

To the extent necessary to enable Arkansas to limit the freedom of choice of providers for focused care coordination services to staff employed by the Arkansas Department of Human Services or other entities, including state agencies and private sector partner(s), under contract for such services.

Expenditures for Communications, Training, and Enhanced Case Management System

Expenditure authority is requested to support an automated call system, train entities to deliver Success Coaching, and procure a case management system necessary to support the development and tracking of Personal Development Plans.

Section V: Evaluation and Program Oversight**5.1 Evaluation and Demonstration Hypothesis**

The primary intervention in Pathway to Prosperity is the focused care coordination services provided through Success Coaching. This intervention will be evaluated in the following areas:

1. Increase income/hours worked per week/month/year
2. Use of Health Care Coverage – increase appropriate utilization of services
3. Increase access to coverage through private insurance or maintain Medicaid coverage in most appropriate model of care
4. Address HRSN

Goal 1: Increase Income

With the guidance and counseling of Success Coaching, DHS anticipates that enrollees at every income level (unemployed, underemployed, and employed) will experience an increase in earnings over time.

Goal 2: Use of Health Care Coverage

Experience shows that coverage alone is not sufficient to improve health outcomes. Research demonstrates that the total cost of health care can be reduced by accessing services in the community rather than in emergency departments and by avoiding preventable hospitalizations. Under ARHOME, QHPs are required to offer incentives to improve the appropriate use of preventive and primary care services. However, there is a low take-up rate of these opportunities.

With the guidance and counseling of Success Coaching, DHS anticipates that a greater percentage of enrollees will access preventive and primary care services.

Goal 3: Increase Access to Private Insurance Coverage or Maintain Coverage in Most Appropriate Medicaid Model of Care

With the guidance and counseling of Success Coaching, DHS anticipates that many enrollees at every income level (unemployed, underemployed, and employed) will experience an increase in household income and cross the “benefit cliff” into private insurance coverage. Others will maintain coverage in the most appropriate Medicaid model of care.

Engagement with Success Coaching may result in eight potential outcomes related to coverage:

1. “On track” and QHP benefits continue;
2. QHP benefits are suspended for failure to complete a Personal Development Plan (PDP) or cooperate with their PDP;
3. QHP benefits are restored after the individual contacts DHS with agreement to cooperate and get “On track” with PDP;
4. Moves to Other Medicaid model of care (FFS for medically frail or the PASSE program for individuals with serious mental illness);
5. Moves to Other Medicaid eligibility group (due to a disability);
6. Moves to Other Coverage (no longer eligible for Medicaid due to increase in income or to Medicare); or
7. Moves to Other Coverage or uninsured if Medicaid eligibility is not met at 12-month redetermination.
8. Moves back to QHP if is redetermined to be eligible and chooses a QHP at open enrollment.

DHS will calculate an “Expected Move Rate” for each of these outcomes. As the PHE skewed the outcomes in prior years, DHS will start with data collected in 2024 and 2025. The Evaluation will compare the “Expected Move Rate” to “Actual Move Rate.”

Goal 4: Address HRSN

With the guidance and counseling of Success Coaching, DHS anticipates that a greater percentage of enrollees will access community supports and services to address their HRSN. Data suggests that the greatest need for services are for nutritional assistance, transportation, and housing. As a rural state, transportation is especially important for maintaining employment.

The state views the following goals, hypotheses, and measures included in the existing ARHOME evaluation plan as relevant to the addition of focused care coordination from Success Coaching via this Amendment:

Goals and Hypotheses Table 1

Goal #	Goal Description	#	Hypothesis Description	Measure #	Measure	Comparisons
1	Increasing household income	A	Beneficiaries engaged with Success Coaching will experience an increase in household income	1.A	Change in earnings reported for those who are unemployed (<21% FPL)	Expected Move Rate Beneficiaries not engaged with Success Coaching

		B	Beneficiaries engaged with Success Coaching will experience an increase in household income	1.B	Change in earnings reported for those who are underemployed (<81% FPL) and enrolled for at least 24 months	Expected Move Rate Beneficiaries not engaged with Success Coaching
		C	Beneficiaries engaged with their Success Coaching will experience an increase in household income	1.C	Change in earnings reported for those who are above 80% FPL and enrolled for at least 36 months	Expected Move Rate Beneficiaries not engaged with Success Coaching
2	Improving utilization of services and appropriateness of care	A	Beneficiaries engaged with their Success Coaching will have greater use of preventive and other primary care services	2.A.1	Medicaid Adult Core Set Measures	Beneficiaries not engaged with Success Coaching
		B	Beneficiaries engaged with Success Coaching will have lower non-emergent use of emergency department services	2.B.1	Non-Emergent Emergency Department (ED) Visits	Beneficiaries not engaged with Success Coaching
				2.B.2	Emergent ED Visits	Beneficiaries not engaged with Success Coaching
		C	Beneficiaries engaged with Success Coaching will have lower use of potentially preventable emergency department services and lower incidence of preventable hospital	2.C.1	Preventable ED Visits	Beneficiaries not engaged with Success Coaching
				2.C.2	All-Cause Readmissions	Beneficiaries not engaged with Success Coaching
				2.C.3	Follow-Up After Emergency Department Visit for People with Multiple	Beneficiaries not engaged with Success Coaching

			admissions and readmissions		High-Risk Chronic Conditions	
3	Increase access to private coverage in crossing the benefit cliff	A	Beneficiaries engaged with Success Coaching will have an increased rate of private coverage	3.A	Comparisons of expected move rate to actual move rate	Beneficiaries not engaged with Success Coaching
	Maintain coverage in most appropriate model of care	B	Beneficiaries engaged with Success Coaching will maintain their coverage in the most appropriate Medicaid model of care	3.B	Comparisons of changes in model of care to historical changes	Beneficiaries not engaged with Success Coaching
4	Reducing health-related social needs (HRSN) through intervention	A	Beneficiaries engaged with Success Coaching will have fewer health-related social needs and improved HRSN compared to similar beneficiaries who are not engaged with Success Coaching	4.A.1	HRSN Population Comparisons	Beneficiaries not engaged with Success Coaching
		B	Beneficiaries engaged with Success Coaching will receive an appropriate intervention if they screen positive for a HRSN	4.B.1	HRSN Screening/Intervention	Beneficiaries not engaged with Success Coaching

5.2 Oversight, Monitoring, and Reporting

DHS will abide by all existing Demonstration reporting and quality and evaluation plan requirements, including the requirements outlined in the approved Monitoring Protocol. DHS will continue to monitor and track QHP performance and adherence to program expectations. Ongoing oversight of Life360 HOMEs will also remain a priority of the state as it tracks selected quality of care and health outcomes metrics for this key initiative. Finally, the state will incorporate tracking, monitoring, and reporting requirements as necessary for focused care coordination provided through Success Coaching. Quality of care and participant outcomes data will be collected and analyzed.

Section VI: Budget Neutrality Impact

The costs of the Pathway to Prosperity amendment to the ARHOME Section 1115 Demonstration Project (Project No. 11-W-00365/4) is primarily due to the addition of focused care coordination services that will be provided to certain individuals who meet the state's criteria for selection. There are limited additional costs associated with training for Success Coaching and enhancing the current infrastructure to upgrade the DHS case management system, including monthly update reports to track progress of individuals in the targeted groups, and screen and refer individuals for Health-Related Social Needs (HRSN). Total costs are estimated to be \$42.8 million over the five-year period. The cost of services and infrastructure will be counted in the proposed Budget Neutrality limits and are expressed in Table 2 below:

Table 2		
Capped Hypothetical Budget Neutrality Limits <i>(shown in millions)</i>		
	Services	Infrastructure
Demonstration Year (DY)	Proposed Limit	Proposed Limit
DY01	\$6.6	\$4.1
DY02	\$6.9	\$0.6
DY03	\$7.2	\$0.6
DY04	\$7.6	\$0.6
DY05	\$8.0	\$0.6

Savings will be generated by suspending ARHOME benefits for a relatively small number of individuals for a temporary period of time. During the suspension period, DHS will not make monthly premium payments nor Advanced Cost Sharing Reduction (ACSR) payments to the QHPs nor for “wrap around services.”

Savings will also be generated by individuals who move off Medicaid sooner than expected due to changes in household income.

In January 2025, DHS is projected to pay the QHPs an average monthly premium of \$577.62, advanced cost sharing reduction payments of \$202.17 per month and “wrap around” payments of \$4.53 for a total PMPM of \$784.31. Coverage provided by Arkansas Medicaid pays not only for medical treatment at the time of illness or accident, but for preventative services as well that provide high value to individuals.

Assumptions

The Pathway to Prosperity amendment represents a new approach to engaging beneficiaries. As such, there is limited empirical data for analysis. It is sufficiently different from the 2018-2019 work requirement period which suggests that data from that time is not applicable. Thus, DHS has based the impact of the amendment on reasonable assumptions to reflect a mid-point in a range of participation. Actual results over a five-year period will likely vary.

DHS assumes 50% of individuals assigned to Success Coaching will cooperate with DHS and be “on track” with no change in their QHP benefits; 25% of individuals will be “early movers” due to change in household income and move to other coverage; and 25% will fail to cooperate and will have their ARHOME coverage - QHP benefits - suspended. However, DHS assumes 50% of those who were suspended will inform DHS of their willingness to cooperate and thereby return to coverage.

Savings accrued due to early mover or suspension status is estimated to be an average of three months.

Estimated Savings Under Current Assumptions Table 3

	DY1	DY2	DY3	DY4	DY5	Total
Data Matching to Screen at Risk/Assign Success Coaching	18,450	23,575	25,625	30,750	32,800	
On Track	9,225	11,788	12,813	15,375	16,400	
25% Early Movers	4,613	5,894	6,406	7,688	8,200	
25% Failure to Cooperate: Suspended	4,613	5,894	6,406	7,688	8,200	
Saved Member Months (3X)	27,675	35,363	38,438	46,125	49,200	
Savings	\$21,705,779	\$28,567,215	\$31,982,863	\$39,630,818	\$43,431,192	\$165,217,870

The effective date of the amendment is expected to be January 1, 2026, which is Demonstration Year 5 of the current waiver. As waivers are typically approved for a period of five years, Table 3 presents a five-year budget impact which is estimated to be a total savings of \$165.2 million and net savings of \$122.8 million.

For a full development of these values please see the actuarial statement at [*Attachment 1*](#).

Section VII: Public Notice & Comment Process

7.1 Overview of Compliance with Public Notice Process

In accordance with 42 CFR §431.408, DHS provided the public the opportunity to review and provide input on the Amendment through a formal thirty-day public notice and comment process which ran from **date to be provided**, through **date to be provided**. During this time, the state will hold two dedicated public hearings.

Public Notice

The state verifies that the abbreviated public notice of the Amendment application was published on **date to be provided** to the Arkansas Democrat-Gazette, the newspaper with widest circulation in each city with a population of 100,000 or more in accordance with 42 CFR §431.408(a)(2)(ii). In addition, DHS used its standard electronic mailing list of interested parties, comprised of more than 150 individuals and organizations, to notify the public of the Amendment, the public hearings, and the opportunity to comment on the waiver Amendment draft. While there are no federally recognized tribes in the state of Arkansas, DHS proactively reached out to tribal representatives in neighboring Oklahoma to ensure all interested parties were included in the electronic mailing list and able to participate in the public comment period.

A copy of the formal public notice shall be attached as Attachment 2 and a copy of the abbreviated public notice document shall be attached as Attachment 3. Both documents, along with a copy of the complete Amendment draft, will also be made available for viewing in hard copy format as well as on the state's website: <https://humanservices.arkansas.gov/rules/arhome/>.

Public Hearings

DHS will hold two public hearings during the notice and comment period in geographically diverse areas of the state. The hearings were attended by interested persons both in person and via the Zoom platform.

The state confirms that the two public hearings will be held on the following dates and physical locations, in addition to being available for statewide virtual participation, as scheduled and as publicized in the formal notice:

Public Hearing #1	Public Hearing #2
Date, time, and place to be provided	Date, time, and place to be provided

7.2 Summary of Public Comments & State Responses

To be added after the public comment period.

Section IX: State Contact

Name and Title: Janet Mann, Deputy Secretary of Programs and State Medicaid Director,
Arkansas Department of Human Services

Telephone Number: (501) 682-1001

Attachment 1: Budget Neutrality

Attachment 2: Public Notice

Attachment 3: Abbreviated Public Notice