Request to Amend the
ARHOME Section 1115 Demonstration Project

Project No. 11-W-00365/4

State of Arkansas

Department of Human Services

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Contents

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's 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 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 court's 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.

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

[1] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58
[2] Ibid. p. 23
[3] http://www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf

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 Qualified Health Plan (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 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 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.

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 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 to move from government dependence to economic independence and ultimately to obtain health insurance coverage through employment or the individual insurance marketplace as do most Americans.

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

CMS estimates that in 2025, 92.3% of 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 sources[5]:

- 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 nonsubsidized): 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]

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 (NCHS), "[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 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 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

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[5] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected, Table 17. 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] www.census.gov/library/stories/2024/09/acs-health-insurance.html

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

[9] www.cdc.gov/nchs/data/databriefs/db382-H.pdf

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 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 reported in “Introduction to Benefit Cliffs and Public Assistance Programs” “[b]enefits 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

[10] 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.
[12] www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs

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 healthcare 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.

The benefit cliff was reduced for children with the creation of the state Children's Health Insurance Program in the Balanced Budget Act 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% of Medicaid beneficiaries aged 19–64 are employed. However, most are not working full-time, full-year jobs. Approximately 23% of this age group are not working due to a disability and another 35% 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 ages 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 2025 FPL for a single person is $15,650[16]. The minimum wage in Arkansas is now $11 per hour. A single person working full time, year around (2,080 hours) would earn $22,880, or 146% 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

[13] Ibid.
[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.federalregister.gov/documents/2025/01/17/2025-01377/annual-update-of-the-hhs-poverty-guidelines

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, 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 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 healthcare 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 or 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.

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[17] www.cbo.gov/system/files/2023-09/59273-health-coverage.pdf

[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/medicaid-esi-unwinding.pdf

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 "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 communication 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

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

[22] Current data matching shows 58,241 ARHOME enrollees (30.5%) have a dependent child in the household

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. 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 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 healthcare 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 the Fee-for-Service (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.

[23] See www.urban.org/research/publication/balancing-edge-cliff

Coverage

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 court's 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 help 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 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

[24] Ibid. p. 23
[25] www.supremecourt.gov/opinions/23pdf/22-451_7m58.pdf
[26] https://clearinghouse.net/doc/101905/

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 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 FFM. 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 aligns 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 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

[27] 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
[32] https://www.aafp.org/about/policies/all/poverty-health.html p.3

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 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

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[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] Ibid.
[42] Ibid. (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.)

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 the 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 healthcare 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 or her Health-Related Social Needs (HRSN). 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 Public Health Emergency and may not be reliable. DHS will 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

[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

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, Success 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 healthcare 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 seekers[45]
- 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 Qualified Health Plan (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 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 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

[45] https://jobseeker.launch.arkansas.gov/

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, Fee-for-Service (FFS), and Provider-led Arkansas Shared Services Entity (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 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)**

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 — **Section1902(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 healthcare 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 Health-Related Social Needs (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 Healthcare 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);
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.

DHS will calculate an Expected Move Rate for each of these outcomes. As the Public Health Emergency 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.

Under 42 CFR § 431.412, a demonstration application must include "the research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative design is feasible, the identification of appropriate evaluation indicators." Accordingly, the state plans to use available data sources to support the evaluation activities. The state will utilize qualitative and quantitative research analysis methods, as appropriate, including without limitation descriptive methods, trend analysis, and comparison groups quasi-experimental research designs to conduct robust evaluation of the demonstration. Once the demonstration is approved, DHS will work with CMS to finalize an evaluation design that will guide evaluation activities.

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 appropriate-ness 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 admissions and readmissions	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 High-Risk Chronic Conditions	Beneficiaries not engaged with Success Coaching
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.	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.	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 a five-year period. The costs of services and infrastructure are expressed in Table 2 below:

Table 2

Capped Hypothetical Budget Neutrality Limits *(shown in millions)*

	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 Qualified Health Plans (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 Per Member Per Month 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

As waivers are typically approved for a period of five years, Table 3 presents a five-year budget impact that is estimated to be a total savings of $165.2 million and net savings of $122.8 million.

However, the effective date of the amendment is expected to be January 1, 2026, which is Demonstration Year 5 of the current waiver. The current ARHOME waive expires December 31, 2026. Thus, the amendment does not seek to change the current budget neutrality limit for the last year of the current waiver. Please see the attached actuarial statement.

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 with the opportunity to review and provide input on the amendment through a formal thirty-day public notice and comment process that ran from February 2, 2025, through March 3, 2025. During this time, the state held four dedicated public hearings.

Public Notice

The state verifies that the abbreviated public notice of the amendment application was published on February 3, 2025, in 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. 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.

On February 14, 2025, DHS provided notice of a third public hearing scheduled for February 19, 2025. On February 26, 2025, DHS provided notice of a fourth public hearing scheduled for March 3, 2025, at Fort Smith, Arkansas. Copies of the formal public notices are attached. All documents, along with a copy of the complete amendment draft, have been 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 held two in-person public hearings during the notice and comment period in geographically diverse areas of the state (Little Rock, Arkansas, and Fort Smith, Arkansas). The hearings were attended by interested persons both in person and via the Zoom platform. DHS also held two virtual public hearings.

The state confirms that the hearings were 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 notices:

Public Hearing #1 General Public Forum (online only)	Public Hearing #2 ARHOME Advisory Panel (in person and online)
February 12, 2025, at 10:30 a.m. CST Via Zoom	February 14, 2025, at 10:00 CST at the Arkansas Department of Human Services (DHS) Donaghey Plaza South Bldg. 700 Main St. Little Rock, Arkansas 72203 and Via Zoom

Public Hearing #3 General Public Forum (online only)	Public Hearing #4 General Public Forum (in person and online)
February 19, 2025, at 10:00 a.m. CST Via Zoom	March 3, 2025, at 11:00 a.m. Fort Smith Clinic Boardroom 2901 South 74th St., Fort Smith, Arkansas 72903 and Via Zoom

7.2 Summary of Public Comments & State Responses

In total, DHS received 56 timely written comments from the public and other interested parties during the public comment period. Of the 21 commenters who expressed opposition to the amendment, nine (9) are from medical organizations that submitted similar letters, three (3) are from public policy groups, and nine (9) are from individuals.

DHS received 31 comments that expressed support for work requirements, although some expressed opposition or concern about the amendment in its current form. One (1) of the commenters is a public policy organization. One (1) of the commenters is a transportation broker.

Four (4) individuals and organizations provided nonresponsive comments expressing neither support nor opposition.

DHS also received five (5) oral comments during the four hearings. Of these, four (4) were presented by representatives of public advocacy organizations. All five commenters expressed opposition to the amendment. The comments and questions reflected similar comments and questions expressed in the written comments.

This section consolidates and summarizes the comments to specific provisions in the Pathway to Prosperity amendment. DHS identified each unique item of feedback contained within an individual commenter's formal submission and thoughtfully analyzed and carefully considered each comment.

Ultimately, while the state is not proposing any policy changes to the amendment based on public comment, DHS has strengthened Section V: Evaluation and Program Oversight by incorporating additional language regarding data collection and research analysis methods. DHS also recognizes that it is standard practice in the negotiations of a Section 1115 Demonstration Project to include additional operational details through the Special Terms and Conditions (STCs) developed in partnership with CMS.

Medical Organizations Express Opposition

DHS received letters of opposition from nine (9) medical organizations based on four concerns: (1) barriers to coverage, including administrative errors and arbitrary time limits; (2) challenges of implementation; (3) more specifications needed; and (4) conflict with the goals of Medicaid.

DHS Response

The Pathway to Prosperity amendment incorporates several safeguards to ensure individuals with heart disease, cancer, cystic fibrosis, epilepsy, multiple sclerosis, HIV, and other chronic diseases and health conditions will continue to receive healthcare coverage through their QHP. Data matching with QHPs will confirm that individuals are "on track" by accessing medical services to treat their disease(s)/conditions. In these cases, there is no need for success coaching. DHS has made three major enhancements to mitigate any risk that an individual might lose coverage erroneously. First, DHS acknowledges there are limitations to data matching. Accordingly, if there are gaps in data matching and success coaching is activated, personal communication between the Medicaid enrollee and the coaching resource can fill in any missing information. The individual will be offered success coaching for three months, which is sufficient time to gather needed information from the individual and the QHP regarding medical conditions. Second, prior to any change in coverage, the individual's information will be reviewed by a three-person panel to eliminate the potential for administrative error. Finally, suspension rather than disenrollment will allow an individual to have coverage restored significantly more quickly. These three enhancements provide enhanced protections to ensure each individual's information and any action taken by DHS is correct.

The amendment does not impose a time limit on Medicaid coverage, as was alleged. The amendment includes a provision that potentially indicates the use of success coaching for individuals who have been enrolled in QHPs as adults for 24 months or 36 months or more. As long-term poverty is linked to poor health and even premature death, it is important to engage these individuals quickly to help them obtain skills and experience needed to bridge the benefit gap.

With respect to the comments regarding the challenges of implementation, and in light of the 2018–2019 experience, DHS has taken a fresh approach to engaging the new adult group. One of the medical organizations recommended that DHS apply automatic exemptions based on certain medical conditions. Among the criticisms was that implementation was too complex with

rigid rules that created uncertainty among enrollees. Part of that uncertainty may have caused by use of terms such as “exempt” and “compliance.” In some cases, individuals may have made such determinations for themselves without the benefit of direct communication with DHS regarding their status. Moreover, the monthly self-reporting feature was criticized as “burdensome.” The Prosperity amendment will significantly simplify implementation for enrollees, addressing many of the primary concerns.

Commenters also based their opposition to the amendment on the lack of key details regarding suspension, qualifications and services of success coaching, and criteria and consistent standards for the personal development plan.

These are areas that are typically addressed through implementation and monitoring plans according to the Special Terms and Conditions negotiated with CMS and any state manuals that may be necessary to meet the objectives of the amendment. A demonstration project application requests authority to “waive” current law and regulations. The details of how such authority is implemented are developed over time after approval.

Commenters expressed their view that the amendment is not in line with the goals of the Medicaid program. DHS respectfully disagrees. As the application describes in detail, the purpose of Medicaid is to assist individuals and families achieve independence. Poverty is the greatest predictor of poor health over a person’s lifetime. It would be incompatible with the mission of Medicaid as an anti-poverty program to merely accept the status quo. Moreover, federal law created the Medicaid “benefit cliff,” which inhibits nonelderly, nondisabled people in poverty from increasing their income. The use of Section 1115 authority is the best tool available to Arkansas to help people bridge that cliff, reach independence, and improve their health.

Historically, Medicaid covered only individuals who were not expected to be engaged in the workforce—the elderly, people with disabilities, children, and their parents/caretaker relatives. As Chief Justice Roberts noted in his opinion in *NFIB v Sebelius*, the creation of the new adult group represented a clear departure from the past. The purpose, goal, and mission of Medicaid has inherently been updated to include all of the people it now serves.

Public Policy Advocacy Organizations Express Opposition

DHS received three (3) letters from public policy advocacy organizations in opposition to the amendment. Two of the organizations are based in Arkansas, and one is a national organization. Collectively, they oppose the amendment for the following reasons: 1) over 18,000 individuals lost coverage during the 2018–2019 implementation of work requirements; 2) it does not meet Medicaid’s objectives; 3) it will fail to improve employment; 4) it is expensive to implement; 5) it will drive economic instability for families; 6) work requirements put hospitals and the healthcare system at risk; 7) factors that may identify individuals as “not on track” are undefined, arbitrary, vague, and subjective; 8) data matching and untested automated systems raise concerns; 9) success coaching may introduce bias and therefore requires clarity in requirements for tracking and monitoring of the Personal Development Plan; and 10) suspension of coverage is not meaningfully different from termination and is therefore a new eligibility requirement.

<u>DHS Response #1</u>

As previously described in the application, there are major differences between the 2018–2019 experience with Arkansas Works and the Pathway amendment, which makes comparisons null. The enhancements in the amendment mitigate the risks of administrative errors. Even absent work and community engagement requirements, there is significant routine disenrollment in the Medicaid population, especially the modified adjusted gross income (MAGI) adult population. In

an October 2021 Issue Brief, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that of the 26.1 million nondisabled, nonelderly adults "ever enrolled" in 2018, 7.2 million (28%) were disenrolled in 2018. However, 2.3 million (9%) re-enrolled within 12 months.[46]

When individuals leave Medicaid coverage and return within 12 months, researchers refer to this as "churn." There are various reasons for "churn" to occur, including fluctuations in household income, household size, and lack of understanding of program rules to verify eligibility. After the Arkansas Works work requirement ended, Arkansas lacked the authority to formally evaluate the prior period against historical data and post-disenrollment data. Data pulled in 2020 shows that more than 6,000 individuals who had been disenrolled during the work requirement period had returned to Arkansas Medicaid in 2019 after the work requirement had been ended.

The assertion that everyone who leaves Medicaid will lack health care coverage is erroneous. National data from the "unwinding" of the COVID-19 Public Health Emergency (PHE) provides evidence that the majority of individuals transitioned from Medicaid coverage to private coverage. On January 8, 2025, the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS), released an Issue Brief, "Healthcare Insurance Coverage, Affordability of Coverage, and Access to Care, 2021-2024," which specifically examined enrollment in Medicaid, CHIP, and Marketplace coverage prior to the PHE, during the PHE, and after the PHE. ASPE reported that in February 2020, (pre-Medicaid continuous enrollment) there were 71.4 million people enrolled in Medicaid/CHIP and 10.5 million enrolled in a Marketplace plan. In March 2023 (pre-Medicaid unwinding) there were 94.3 million people enrolled in Medicaid and 15.4 million in a Marketplace plan. In September/December 2024 (post-Medicaid unwinding), Medicaid/CHIP had declined by 14.9 million people, but Marketplace enrollment increased by 8.9 million. Millions of others obtained other coverage, such as employer-sponsored health insurance or Medicare. ASPE concluded that, "[d]espite the decline in Medicaid/CHIP coverage, overall coverage remained steady as enrollment in Marketplace and employer-based insurance increased."[47] Contrary to concerns that the Medicaid PHE unwind would result in significant increases in people without coverage, the national uninsured rate in the second quarter of 2024 was 7.6%, the lowest on record.[48]

Arkansas state leadership has made it clear that the goals of the amendment are to increase household income *and* maintain health insurance coverage through the private sector. Adults ages 19–64 experience the highest rate of being uninsured in the U.S. categorized by age groups. The rigorous evaluation required for Section 1115 waivers will be of national importance by showing what happens to the 19–64 population after they leave Medicaid coverage.

DHS Response #2

DHS respectfully disagrees with the narrow view that the amendment does not promote the objectives of the Medicaid program. Section 1901 of the Social Security Act states that, "[f]or the *purpose of enabling each State, as far as practicable under the conditions in such State*, 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 families and individuals attain or retain capability for independence* …" (emphasis added). Section 1115 of the Social Security Act states that "[i]n the case of any experimental, pilot, or demonstration project which, *in the*

[46] https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf Table 1
[47] https://aspe.hhs.gov/sites/default/files/documents/9a943f1b8f8d3872fc3d82b02d0df466/coverage-access-2021-2024.pdf p.8
[48] Ibid. Figure 1 p.3

judgment of the Secretary, is likely to assist in promoting the objectives of … title XIX …--the Secretary may waive compliance with any of the requirements … to the extent and for the period he finds necessary to enable such State or States to carry out such project …" (emphasis added).

When the Affordable Care Act (ACA) was enacted, Congress did not add the new adult group to the Appropriations purpose language. But it would be an absurdity to argue that the 200,000 Arkansans enrolled in the ARHOME Demonstration are excluded from the purpose of Medicaid as described in the Appropriations section. It would be incongruent to say that services to help families and individuals attain or retain capability for independence applies only to some Medicaid enrollees but not others. If, in the judgment of the Secretary, promoting independence is an objective of title XIX for some, it must mean it is an objective for all.

DHS Response #3

Commenters rely on the 2018–2019 experience to assert that "work reporting requirements fail to improve employment." The Pathway to Prosperity amendment is such a significantly different approach that the comparison is flawed. It takes an individualized approach rather than a timekeeping, one-size-fits-all approach. The stated goal is to increase household income across the different federal poverty level (FPL) bands (<21% FPL; <81% FPL; >81% FPL).

DHS agrees that many ARHOME enrollees are employed, but the data based on FPL bands demonstrates that the majority of enrollees are unemployed or underemployed. The 2025 FPL for a single person is $15,650 annually. The Medicaid threshold is 138% of (FPL, or $21,597 annually. The minimum wage in Arkansas is $11 per hour. A single person who makes minimum wage and works full-time year-around (2,080 hours) would earn $22,880 annually, which equals 146% FPL, which exceeds the Medicaid threshold of 138% FPL. If employer-sponsored insurance is not available, the person would be eligible for generous federal tax subsidies to purchase individual coverage through the Marketplace. A person who works 38 hours per week (1,976 hours annually) at minimum wage would earn $21,736 annually, still too high for Medicaid. However, a person who works 37 hours per week (1,920 hours) would earn $21,164 annually, which equals 135% FPL and would be Medicaid eligible. Thus, the difference between being Medicaid eligible or not for many Arkansans may be just one hour of work per week. Commenters provide no evidence that this is not achievable for most working age Arkansans on the ARHOME program. These examples do illustrate the risk associated with the Medicaid "benefit cliff" in which small changes can have a dramatic effect.

Because ARHOME uses Medicaid funds to purchase coverage through QHPs, an individual can transition from Medicaid to private coverage with the same plan and same provider network, maintaining continuity of coverage. Part of the role of success coaching is to help individuals cross the Medicaid "benefit cliff" and achieve personal and family sustainability.

DHS Response #4

Commenters object to the cost of implementing the amendment and advocate for using the funding to increase the use of other public subsidies such as SNAP benefits.

DHS views these costs as justifiable investments in assisting individuals achieve personal and family sustainability and in enabling them to make greater contributions to their families, communities, and the state. Participation helps complete the social contract between Arkansans. It is an investment in the future as well. It has been estimated that childhood poverty costs more than $1 trillion annually. While public assistance benefits help alleviate the detrimental effects of poverty in the short-term, the research on the long-term effects of poverty is vast. Healthy People

2030 summarizes the lasting impacts of living in poverty:

> Childhood poverty is associated with developmental delays, toxic stress, chronic illness, and nutritional defects. Individuals who experience childhood poverty are more likely to experience poverty into adulthood, which contributes to generational cycles of poverty. In addition to lasting effects of childhood poverty, adults living in poverty are at a higher risk of adverse health effects from obesity, smoking, substance abuse, and chronic stress. Finally, older adults with lower incomes experience higher rates of disability and mortality.[49]

DHS Response #5

Commenters state that work reporting requirements drive economic instability.

Respectfully, DHS asserts that economic instability describes the status quo. Enrolling in the Medicaid program itself reflects economic instability. As the application describes, some will find their own pathway out of poverty without any need for additional support from DHS. However, for those who cannot, the Pathway amendment offers individuals opportunities to chart a new course. An individual's Personal Development Plan may include goals that address being healthy, gaining employment, advancing, learning, and serving. The Medicaid "benefit cliff" was created through the program's original design 60 years ago as an "all or nothing" proposition that presents significant risk to people in poverty. The amendment is intended to construct a bridge over that cliff. An individual must still choose to cross it.

DHS Response #6

Commenters state that work reporting requirements put hospitals and the health care system at risk by increasing uncompensated care for hospitals.

The projected savings due to the number of individuals who will leave Medicaid are significantly less than the impact of the PHE unwind. Moreover, the experience of the PHE unwind demonstrates that the majority of individuals who leave will obtain private sector coverage that will pay for needed medical care.

DHS Response #7

Commenters state that the factors that may identify individuals as "not on track" are undefined, arbitrary, vague, and subjective.

DHS agrees that these are important considerations. However, such details are generally not specified in a waiver application nor even the Special Terms and Conditions (STCs) that will be negotiated with CMS. The waiver simply provides authority. Further details will be provided through a variety of forms, including the implementation plan and potentially state program manuals.

DHS Response #8

Commenters raised concerns regarding data matching and untested automated systems.

DHS agrees that the future design, development, and implementation of IT systems are vital to

[49] https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty

success. These will be addressed in the future implementation phase. The amendment presents an opportunity for statewide connections between Health-Related Social Needs resource platforms and case management systems that currently are not interoperable.

DHS Response #9

Commenters raised concerns about Success Coaching and Personal Development Plans.

DHS agrees that the recruitment and training of individuals who will deliver the focused care coordination services, including interactions with those individuals identified as potentially benefiting from such services, are critical to success. DHS intends to leverage existing state resources already engaged in education and training, workforce support, and care coordiantion. Again, these are details that typically are not included in a waiver application nor STCs. They will be developed in future actions.

DHS Response #10

Commenters state that suspension of coverage is not meaningfully different from termination and that suspended beneficiaries would not have Medicaid coverage.

DHS respectfully disagrees that suspension is not different from termination. Suspension can be lifted and coverage restored within a few days, while termination means an individual is disenrolled from the program. In that situation, the individual would be required to restart the entire process of eligibility determination, which can take up to 45 days. Therefore, suspension is not a new eligibility requirement. To equate suspension with termination and the concomitant application process is inaccurate.

It is important to reiterate that an individual will have multiple opportunities over not less than three months to participate in their own health and economic self-interest. DHS appreciates the viewpoint that there should be no consequence for choosing to not participate but respectfully disagrees.

Individuals Express Opposition

DHS received six (6) comments from the general public in opposition to the amendment. Collectively, they oppose the amendment as too high a risk that people will fall through the cracks and that their healthcare coverage should not be tied to employment. People need assistance and compassion, not “more obstacles put in their path forward.” One commenter submitted several questions about the amendment regarding the organizational structure and operational activities.

DHS Response

DHS appreciates that each commenter took the time and effort to communicate their views on this important issue of public policy. However, DHS also recognizes the risks of long-term poverty on the health and lives of individuals. The risk of the status quo is well-known. The benefits of changing the status quo are why federal law allows the Secretary of HHS to design and administer demonstration projects of national significance.

With respect to the operational and organizational questions raised, these are details that typically are not included in a waiver application nor STCs. They will be developed in future actions.

Public Policy Advocacy Organization Expresses Support for Work Requirements but States that the Waiver Amendment is "Insufficient"

DHS received comments from one public policy advocacy organization that expressed support for a work requirement for able-bodied adults but outlined seven reasons as to why the amendment is "insufficient": (1) misrepresents the success of Arkansas's previous work requirement "leading to massive taxpayer savings, increases in work participation, and significant reductions in government dependency"; (2) does not contain a real work requirement; (3) contains virtually no sanctions associated with noncompliance; (4) does not achieve meaningful cost savings; (5) lacks other essential cost containment reforms, such as time limits, an enrollment cap, or an enrollment freeze; (6) relies on a vulnerable legal framework; and (7) requires the continued use of Arkansas's failed 'private option' approach to "Obamacare Medicaid expansion.

DHS Response #1"

The commenter acknowledged that DHS made significant outreach efforts in 2018 to communicate with enrollees: more than 230,000 phone calls, 311,000 emails, and more than half a million letters.

However, the organization stated in its own report: "Post-work requirements, there were 137,927 Arkansas Works case closures. Only 18,164 were due to non-compliance with the requirements—just 13 percent. More than 119,000 cases were closed due to increased income, ineligibility and various other reasons unrelated to noncompliance with the work requirement." [50]

DHS Response #2

The commenter states that "Arkansas should follow the widely accepted standard that requires individuals participate in 80 hours per month (20 hours per week) of work, training, or volunteering in order to receive taxpayer-funded Medicaid benefits."

The economic independence focus of the Pathway amendment is to assist individuals increase their earnings sufficiently to move out of poverty and into personal and family sustainability. Even working 20 hours a week is only about half of the hours of work necessary to earn sufficient income to rise above the 138% poverty threshold for Medicaid eligibility. Training and volunteering certainly have short-term benefits in developing technical and social skills necessary to be successful in the workplace. DHS takes a long-range view, which is reflected within the amendment. The longer a person remains in poverty, the greater the risk of poor health outcomes. Accordingly, Success Coaching may be appropriate for individuals who participate in volunteerism on a regular basis but have remained in Medicaid for 24 months or more. Individuals may be more likely to respond positively to a Personal Development Plan (PDP) that they establish for themselves under the guidance of a success coaching resource rather than a standardized approach that simply counts hours.

One of the lessons learned in the 2018–2019 experience was the complexity of measuring compliance in the multiple situations in which there is no database to record activities. The mixing and mingling of volunteering, caregiving, and job searching can satisfy the number of hours needed to demonstrate compliance, but it was unclear whether such activities would lead somewhere or simply allow someone to remain in the same place. DHS was largely dependent on self-attestation by enrollees.

[50] Ibid. p.8

Compared to the previous experience, the Pathway amendment strengthens accountability at the state level. The PDP, with the benefit of focused care coordination and support of success coaching, will be far more meaningful at the individual level than the previous version. Further, the ability for the LAUNCH platform to help with tracking activity is also under consideration. LAUNCH is Arkansas' skills-based platform that allows users to explore career paths based on their in-demand skills and connects them with training to boost their qualifications.

DHS Response #3

The commenter states that the amendment contains virtually no sanctions for noncompliance. Under the proposal, DHS will temporarily pause medical assistance for the month that the beneficiary fails to comply with the work requirement. DHS believes this is a sanction.

DHS Response #4

The commenter claimed that "… based on disenrollments that have occurred in states with other work requirements, a real work requirement with real sanctions could be expected to generate a staggering $1.44 billion in total annual savings and $144 million in state annual savings …".

Arkansas was the only state to implement work requirements that resulted in disenrollments, so there is no data upon which to base such an estimate. Second, the organization's own work contains a chart that shows the total Arkansas Medicaid expansion spending as $2.04 billion. The notion that the state can save $1.44 billion out of a total cost of $2.04 billion is not credible.

DHS Response #5

The commenter makes recommendations to include an enrollment cap or freeze, a lifetime limit for enrollees, and a rollback of retroactive eligibility. These are beyond the scope of a work requirement.

DHS Response #6

This comment that the amendment relies on a vulnerable legal framework and that the state should adopt Georgia's waiver is not aligned with DHS' legal analysis. DHS respectfully disagrees.

DHS Response #7

The commenter recommends the premium assistance model that DHS has used successfully since 2014 be abandoned. If the state modifies its Medicaid expansion framework, DHS will adjust its work requirement policy accordingly.

DHS Response #8

It will generate an estimated net savings of $122.8 million over five years.

A Transportation Broker Expresses Support

DHS received comments from one (1) transportation broker that expressed support for the continuation of the non-emergency medical transportation benefit.

DHS Response

Transportation is widely recognized as one of the top services needed to help people access medical services. As a rural state in particular, DHS recognizes the necessity of the benefit.

Individuals Express Support

DHS received 31 comments from the general public that expressed support for a work requirement. One commenter captured the essence of the amendment thus: “[w]ork builds character, character builds responsibility which helps the person physically, mentally, and financially.” Several commenters emphasized that there should be a “real” work requirement with “real effort” and “real teeth” and should result in “real savings.”

DHS Response

Overall, the comments reflect that Arkansans are not indifferent to their neighbors in poverty. They support the Medicaid program, at an annual cost of approximately $9.3 billion, and dozens of other federal and state programs providing nutritional assistance, housing assistance, workforce development, and training.

The social contract that binds citizens and communities together is one of reciprocal expectations. DHS emphasizes again that the benefit cliff was designed by government. It is proper that government, therefore, on behalf of all citizens, construct a right and just solution. The Pathway to Prosperity amendment strikes that balance.

Section VIII: State Contact

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