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 3
Section II: Background & Historical Narrative 5
2.1 Summary of Current ARHOME Section 1115 Demonstration 13
2.2 Overview of Program Goals 14
Section III: Proposed Amendment 17
3.1 Requested Program Enhancements 17
3.2 Impact of Proposed Amendments 20
3.2.1 Impact to Eligibility 20
3.2.2 Impact to Delivery System 20
3.2.3 Impact to Covered Benefits/Cost Sharing 21
Section IV: Requested Waivers and Expenditure Authority 21
Section V: Evaluation and Program Oversight 22
5.1 Evaluation and Demonstration Hypothesis 22
5.2 Oversight, Monitoring, and Reporting 26
Section VI: Budget Neutrality Impact 26
Section VII: Public Notice & Comment Process 28
7.1 Overview of Compliance with Public Notice Process 28
7.2 Summary of Public Comments & State Responses 28
Section IX: State Contact 28
Attachment 1: Budget Neutrality 30
Attachment 2: Public Notice 31
Attachment 3: Abbreviated Public Notice 32

Section I: Executive Summary

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

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

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

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

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

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

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[1] https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58
[2] Ibid. p. 23

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

To whom does Pathway to Prosperity Apply?

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

Focused Care Coordination and Personal Development Plan

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

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

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

Coverage Value & Consequences

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

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

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

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

Suspension from ARHOME Coverage

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

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

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

Section II: Background & Historical Narrative

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

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

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

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

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

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

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

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

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

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

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

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

A Closer Look at the Uninsured

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

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

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

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

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

Poverty is Linked to Poor Health and Premature Death

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

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

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

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

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

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

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

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

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

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

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

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

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

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[12] https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs
[13] Ibid.

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

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

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

The 2024 federal poverty level (FPL) for a single person was $15,060.[16] The minimum wage in Arkansas is now $11 per hour. A single person working full-time, year around (2080 hours) would earn $22,880, or 152% of FPL, exceeding the upper threshold for ARHOME eligibility (138% FPL). A person in this situation could be covered by employer sponsored insurance or qualify for subsidies to directly purchase coverage through the Marketplace.

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

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

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

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[14] https://aspe.hhs.gov/sites/default/files/documents/779b6ef3fbb6b644cdf859e4cb0cedc6/medicaid-esi-unwinding.pdf
[15]https://www2.census.gov/library/publications/2024/demo/p60-283.pdf Table A-1 p.20
[16] https://www.govinfo.gov/content/pkg/FR-2024-01-17/pdf/2024-00796.pdf
[17] https://www.cbo.gov/system/files/2023-09/59273-health-coverage.pdf

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

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

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

Public Health Emergency Unwind Reduced Medicaid Enrollment as was Expected

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

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

Lessons Learned

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

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[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

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

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

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

Some of these lessons are to:

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

Data Matching, Success Coaching, and Personal Development Plan

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

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

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

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

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

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

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

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

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

Consequence

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

Coverage

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

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

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

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

2.1 Summary of Current ARHOME Section 1115 Demonstration

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

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

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

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

[26] https://clearinghouse.net/doc/101905/

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

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

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

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

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

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

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

2.2 Overview of Program Goals

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

- Providing continuity of coverage for individuals;

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

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

Alleviating the effects of poverty upon beneficiaries, and the public as a whole, is a very important objective of the Medicaid program. In fact, the very first section of the Medicaid Act demonstrates the Congressional intent for appropriating federal funds to the program each fiscal year. The funds are to furnish: "1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals whose income and resources are insufficient to meet the costs of necessary medical services, and 2) rehabilitation and other services to **help such families and individuals attain or retain capability for independence or self care."[28]** This squares with one of the specified goals of the current waiver, which is "[p]roviding supports to assist beneficiaries, especially young adults in target populations to move out of poverty …".[29] Medicaid has been described as an anti-poverty program from its very origins. CMS and the U.S. Department of Health and Human Services (HHS) recognize the correlation between poverty, poor health, and shortened life expectancy. The *Healthy People 2020* report called poverty "an important public health issue" and stated, "researchers agree that there is a clear and established relationship between poverty and socioeconomic status, and health outcomes—including increased risk for disease and premature death."[30] The updated *Healthy People 2030* continues to recognize economic stability as a key social determinant of health, and the federal initiative includes several objectives aimed at reducing the proportion of people living in poverty and increasing employment in working-age people.[31]

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

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[27] https://www.commonwealthfund.org/datacenter/uninsured-adults
[28] 42 U.S.C.A. §1396-1 (emphasis supplied).
[29] Approved ARHOME Section 1115 Demonstration, p.8.
[30] National Center for Health Statistics. Healthy People 2020 Final Review. 2021. DOI: https://dx.doi.org/10.15620/cdc:111173
[31] Office of Disease Prevention and Health Promotion, https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability

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

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

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

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

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

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[32] https://www.aafp.org/about/policies/all/poverty-health.html p.3
[33] https://www.urban.org/sites/default/files/publication/32756/412659-Child-Poverty-and-Its-Lasting-Consequence.PDF p. 9
[34] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9596089/pdf/cureus-0014-00000029500.pdf
[35] https://ccf.georgetown.edu/2024/02/07/marketplace-enrollment-surges-among-those-losing-medicaid-coverage-during-unwinding/
[36] https://www.cms.gov/about-cms/contact/newsroom
[37] https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks
[38] https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty
[39] https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks
[40] https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf
[41] *Id*.

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

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

Section III: Proposed Amendment

3.1 Requested Program Enhancements

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

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

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

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

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

[44] 42 U.S.C.A. §1396-1

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

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

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

Role of Success Coaching

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- SHARE: state health care information exchange
- Arkansas Data Hub
- LAUNCH: an online service for job 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 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

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

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

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

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

Implementation

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

3.2 Impact of Proposed Amendments

3.2.1 Impact to Eligibility

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

3.2.2 Impact to Delivery System

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

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

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

3.2.3 Impact to Covered Benefits/Cost Sharing

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

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

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

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

Section IV: Requested Waivers and Expenditure Authority

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

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

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B) and 1902(a)(17)**

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 Health Care Coverage – increase appropriate utilization of services
3. Increase access to coverage through private insurance or maintain Medicaid coverage in most appropriate model of care
4. Address HRSN

Goal 1: Increase Income

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

Goal 2: Use of Health Care Coverage

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

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

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

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

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

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

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

Goal 4: Address HRSN

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

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

Goals and Hypotheses Table 1

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

		B	Beneficiaries engaged with Success Coaching will experience an increase in household income	1.B	Change in earnings reported for those who are underemployed (<81% FPL) and enrolled for at least 24 months	Expected Move Rate Beneficiaries not engaged with Success Coaching
		C	Beneficiaries engaged with their Success Coaching will experience an increase in household income	1.C	Change in earnings reported for those who are above 80% FPL and enrolled for at least 36 months	Expected Move Rate Beneficiaries not engaged with Success Coaching
2	Improving utilization of services and 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	2.C.1	Preventable ED Visits	Beneficiaries not engaged with Success Coaching
				2.C.2	All-Cause Readmissions	Beneficiaries not engaged with Success Coaching
				2.C.3	Follow-Up After Emergency Department Visit for People with Multiple	Beneficiaries not engaged with Success Coaching

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

5.2 Oversight, Monitoring, and Reporting

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

Section VI: Budget Neutrality Impact

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

Table 2

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

Demonstration Year (DY)	**Services** Proposed Limit	**Infrastructure** Proposed Limit
DY01	$6.6	$4.1
DY02	$6.9	$0.6
DY03	$7.2	$0.6
DY04	$7.6	$0.6
DY05	$8.0	$0.6

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

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

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

Assumptions

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

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

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

Estimated Savings Under Current Assumptions Table 3

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

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

For a full development of these values please see the actuarial statement at *Attachment 1*.

Section VII: Public Notice & Comment Process

7.1 Overview of Compliance with Public Notice Process

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

Public Notice

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

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

Public Hearings

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

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

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

7.2 Summary of Public Comments & State Responses

To be added after the public comment period.

Section IX: State Contact

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

Telephone Number: (501) 682-1001

Attachment 1: Budget Neutrality

Attachment 2: Public Notice

Attachment 3: Abbreviated Public Notice