ARKANSAS DEPARTMENT OF HUMAN SERVICES

DHS Deputy Secretary Janet Mann
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July 8, 2025

Ms. Caprice Knapp
Interim Deputy Administrator and
Director, Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

Dear Ms. Knapp:

The Arkansas Department of Human Services (DHS) has carefully reviewed all of the comments submitted during the April 10-May 9, 2025 federal comment period on the Pathway to Prosperity amendment to the ARHOME Section 1115 Demonstration Project. Many of the comments reflect a misunderstanding of the amendment as well as the history and purpose of Section 1115 Demonstration Projects.

DHS requests that you consider our responses as part of the decision-making process and that the attached responses and citations to supporting research be considered part of the formal administrative record. Many thanks for your consideration. If you have any questions, please do not hesitate to contact me at (501) 682-1001.

Sincerely,

[redacted]

Janet Mann
Deputy Secretary
Programs/State Medicaid Director

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Public Comments on Pathway to Prosperity Amendment and Arkansas Department of Human Services Responses

Summary

On April 10, 2025, the Centers for Medicare & Medicaid Services (CMS) determined that the application for the "Pathway to Prosperity" amendment to the Arkansas Health and Opportunity For ME (ARHOME) Section 1115 Demonstration Project was complete. The amendment application was posted on the CMS website for the federal public comment period through May 9, 2025.

More than 50 comments were received, the majority of which were in opposition to work requirements and the amendment. A significant number of comments were duplicative. The Arkansas Department of Human Services (DHS) has consolidated similar comments and offers responses for the Secretary's review and consideration.

Overview

Opponents of the Pathway amendment portray it as a mere re-run of the previous Arkansas Works design and implementation. However, the differences are significant in the following areas:

1. Length of sanction
2. Restoration of coverage
3. Focused care coordination services
4. Connect individuals with local resources to address Health-Related Social Needs (HRSN)
5. Personal Development Plan (PDP) instead of rigid standardization
6. PDP based on beneficiary's own goals, including being healthy
7. PDP measures progress instead of fixed hours
8. Application is targeted based on months of data matching and confirmation
9. Eliminates confusion as to whom it will be applied
10. Beneficiary can satisfy reporting with a telephone call, eliminating the problems of lack of internet access and lack of familiarity with technology
11. Additional layers of review prevent potential errors including review by a three-person DHS panel before suspension occurs

12. Human interaction instead of sole reliance on technology

These differences will be discussed further in the comment/response sections.

Even though commenters oppose the idea that there is a consequence to a person's decline to multiple offers of opportunities, there were numerous positive remarks about focused care coordination and addressing individuals' HRSN. These comments are evidence that the Pathway amendment is significantly different from the previous design.

For example, commenters cited a study published in the September 2020 edition of *Health Affairs*, "Medicaid Work Requirements in Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability of Care," which provides evidence that DHS has addressed several of the concerns expressed by people who had been disenrolled. The article points to misinformation and confusion as major barriers to implementing work requirements.[1] The survey asked respondents about their "preferred method of reporting work and qualifying activities." Only 11.3 percent preferred using a computer and internet website which was the principle means of communication in the 2018-2019 work requirement.

According to the survey, 60% preferred using a smartphone for internet access or the telephone which will be emphasized in the Pathway model. The Pathway amendment is designed to mitigate these communications barriers, especially through personal contact with individuals.

The survey also asked a sample of residents who were not meeting the work requirement or an exemption. Of these (n=106), "… 28.1 percent reported that they would like to start working if a job were available. When these respondents were asked about whether various state services would help them find a job, 80.6 percent specified job training or more education, and 72.2 percent specified transportation to and from work …".[2] These responses validate Arkansas's fresh approach to link individuals to the supports they want and need.

It is also important at the outset to address three recurring and frequent statements from various commenters: "loss of coverage," "disability," and the lack of details about how success coaching Personal Development Plans (PDP) will be implemented.

First, while "loss of coverage" refers only to the loss of Medicaid coverage, it must not be taken to mean "uninsured." Opponents are generally careful not to confuse the difference. Even as they cite the 18,0000 individuals who were disenrolled during the 2018-2019 implementation, they present no other data as to how many of these individuals remained uninsured over time. Indeed, more than 6,000 individuals returned to Arkansas Medicaid within 12 months.

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[1] Medicaid Work Requirements In Arkansas: Two-Year Impacts On Coverage, Employment, And Affordability Of Care | Health Affairs

[2] Ibid. p.1527, 1528

The authors of the Health Affairs article concede, "[i]mportantly, we could not determine which coverage losses and affordability changes were due directly to the work requirement policy …".[3] But what happened to the other two-thirds of those who were disenrolled? Commenters present no data about this larger group. They did not demonstrate a spike in uncompensated care which would have occurred if thousands of people sought medical care without a source of coverage. Researchers simply stopped looking.

National data published by the Biden Administration regarding the Medicaid "unwind" from the Public Health Emergency (PHE) is useful and instructive in understanding what happened to those who left Medicaid and did not return. In February 2020, prior to the continuous enrollment condition, there were 71.4 million individuals enrolled in Medicaid or the state Children's Health Insurance Program (CHIP) and 10.5 million enrolled in Marketplace coverage. In March 2023, Medicaid/CHIP enrollment had increased to 94.3 million and Marketplace enrollment had increased to 15.4 million people. In the September/December 2024 post-unwinding period, Medicaid/CHIP enrollment had declined to 79.4 million while Marketplace coverage increased to 23.5 million. While 14.9 million people left Medicaid/CHIP, the percentage of uninsured Americans **declined** to 7.6%, the lowest level since 2015 when the uninsured rate was 9.1%.[4] The only plausible explanation is that the people who left Medicaid/CHIP found other coverage, including through Marketplace plans.

Indeed, opponents cited a Kaiser Family Foundation (KFF) national survey study that showed 23% of people who lost Medicaid during the unwind remained uninsured, which *means more than 75% were insured* in the same time period.

Commenters also offered a study published in JAMA's Health Forum, "Coverage and Access Changes During Medicaid Unwinding" which consisted of telephone surveys of Medicaid recipients in Arkansas, Kentucky, Louisiana, and Texas.[5] The survey consisted only of adults ages 19 to 64 years old reporting 2022 incomes at or less than 138% of the federal poverty level (FPL). The survey found that just 12.5% of adults left the Medicaid program. Of those who left, 48% were uninsured and 52% moved into new sources of coverage.

The JAMA study had nothing to do with studying the effects of work requirements. The primary message of the study was that people who move from one type of health insurance coverage to another often face a gap in coverage and that "state and federal policymakers should pursue policies to mitigate adverse outcomes associated with coverage disruptions during and after

[3] Ibid. p 1525

[4] coverage-access-2021-2024.pdf

[5] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2820644

Medicaid unwinding." With the Pathway amendment, Arkansas is doing just that. The Pathways Waiver amendment assumes 50% of the people will be "early movers," who will leave Medicaid because their income will quickly exceed 138% FPL.

Second, there are numerous references to "people with disabilities." DHS recognizes there are multiple definitions of disability. The American with Disabilities Act (ADA), for example, is significantly broader than those used by the Social Security Administration in determining eligibility for Disability Insurance or the Supplemental Security Income (SSI) program.

DHS administers a number of programs and waivers that are specifically directed to serve people with disabilities including the Provider-led Arkansas Shared Savings Entity (PASSE) program that targets adults with Serious Mental Illness (SMI). The amendment application describes eight potential outcomes of the Pathways program, including moving to other models of coverage such as the PASSE program.

The Pathway amendment includes "the use of healthcare coverage" as a specific goal. "Being healthy" is a specific goal of Pathway and is to be included in an individual's PDP. Individuals with cancer, HIV, End Stage Renal Disease (ESRD), and other diseases identified by commenters will be identified by the data matching process with the Qualified Health Plan (QHP). Receiving treatment for such diseases demonstrates that an individual is "on track."

Finally, a common theme from opponents is the lack of specifications regarding data matching, success coaching, the PDP, and qualifications of those individual providing the focused care coordination service. Opponents do not agree whether the cost of implementation is too much or too little.

A Section 1115 Demonstration Project typically does not dive deeply into such details. The application and Special Terms and Conditions (STCs) are focused on giving the state waiver and expenditure authority. After approval, CMS and the state agree on an implementation plan. Approval may mean, for example, that a state may need to make modifications to its IT systems. A state may embark on some preliminary planning but would not likely actually start making system changes until federal approval is secured. A state may need to promulgate state rules to support implementation. Thus, while such details have not been finalized at this stage, they will subsequently become public.

Background

The Secretary of the U.S. Department of Health and Human Services (HHS) has the authority to approve a demonstration "…which, in the judgment of the Secretary, is likely to assist in

promoting the objectives of title … xix …".[6] As part of the approval process, the Secretary must (1) determine whether the amendment is likely to assist in promoting the objectives of Medicaid, (2) engage in reasoned decision-making, (3) examine all relevant factors and record evidence, and (4) adequately analyze the consequences of his actions. The DHS responses concentrate on these four areas.

It is useful to begin the analysis of public comments with an historical understanding of why Section 1115 authority even exists—simply put, because poverty programs designed by the federal government were not achieving their intended purpose: that is, to help poor people transition out of poverty. In his February 1, 1962 "Special Message to Congress on Public Welfare Programs," President John F. Kennedy observed:

> Our basic public welfare programs were enacted more then (sic) a quarter of century ago. Their contribution to our national strength and well-being in the intervening years has been remarkable. *But the times, the conditions, the problems have changed—and the nature and objectives of our public assistance and child welfare programs must be changed, also, if they are to meet our current needs* (emphasis added).
>
> Moreover, even the nature and causes of poverty have changed. At the time *the Social Security Act established o*ur *present basic framework for public aid*, the major cause of poverty was unemployment and economic depression. Today, in a year of relative prosperity and high employment, we are more concerned about the poverty that persists in abundance (emphasis added).
>
> We must find ways of returning far more of our dependent people to independence. We must find ways of returning them to a participating and productive role in the community.

President Kennedy continued:

> The reasons are more social than economic, more often subtle than simple.
>
> Public welfare, in short, must be more than a salvage operation, picking up debris from the wreckage of human lives. Its emphasis must be directed increasingly toward *prevention and rehabilitation*—on reducing not only the long-range cost in budgetary terms but the long-range cost in human terms as well (emphasis added). Poverty weakens individuals and nations. Sounder public welfare policies will benefit the nation, its economy, its morale, and, most importantly, its people.
>
> No study of the public welfare program can fail to note the difficulty of the problems faced or the need to be imaginative in dealing with them. Accordingly, I recommend that

[6] Social Security Act §1115

amendments be made to encourage experimental, pilot, or demonstration projects that would promote the objectives of the assistance titles and help make our welfare programs more flexible and adaptable to local needs.

The goals of our public welfare programs must be positive and constructive—*to create economic and social opportunities for the less fortunate—to help them find productive, happy and independent lives* (emphasis added).

Communities which have—for whatever motives—attempted to save money through ruthless and arbitrary cutbacks in their welfare rolls have found their efforts to little avail. The root problems remained.

But communities which have tried the rehabilitative road—the road I have recommended today—have demonstrated what can be done with creative, thoughtfully conceived, and properly managed programs of prevention and social rehabilitation. In those communities, families have been restored to self-reliance, and relief rolls have been reduced.

To strengthen our human resources—to demonstrate the compassion of free men—and in the light of our own constructive self-interest—we must bring our welfare programs up to date. I urge that the Congress do so without delay.[7]

Congress responded affirmatively to the President and amended Title XI of the Social Security Act to give the Secretary the authority to approve experimental, pilot, or demonstration projects under Section 1115. Three years later, the Medicare (Title XVIII) and Medicaid (Title XIX) programs were added to the Social Security Act.

Based on President Kennedy's outline and vision, the **objectives of assistance** are properly to be viewed collectively as well as individually. The "basic framework for public aid" includes all of the 21 titles of the Social Security Act and **the search for the objectives of assistance** cannot be confined to a single objective of a single title of the Act.

Section 1115 Demonstration Projects have a history of their own. By 1992, the percentage of children in poverty reached 22.3 percent and the working age adults was up to 11.9 percent and states were demanding relief from the rise in welfare caseloads. On February 2, 1993, just a few weeks after taking the oath of office, President Bill Clinton, former governor of Arkansas, shared his views on the use of Section 1115 waivers to address the root problem of poverty in remarks to the National Governors' Association:

[7] Social Security History

> Fourth, we need to encourage experimentation in the States. I will say again what you know so well: There are many promising initiatives right now at the State and local level, and we will work with you to encourage that kind of experimentation. I do not want the Federal Government, in pushing welfare reforms on these general principles, to rob you of the ability to do more, to do different things.
>
> I know I was perplexed during the recent campaign when I tried to make a statement that some people in the press said reflected waffling, and it seemed to me to express the real genius of the federal system. I said that if I were President I would approve waivers of experiments that I did not necessarily agree with.
>
> So I encourage all of us to work together to try things that are different. And the only thing I want to ask you in return is, let us measure these experiments and let us measure them honestly, so that if they work, we can make them the rule, we can all adopt things that work. And if they don't, we can stop and try something else. That's the only thing I ask of you.[8]

Three years later, based in part on the knowledge gained by welfare reform waivers, President Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

The Times, the Conditions, the Problems Have Changed but Poverty Rates Have Not

In 1966, the poverty rate for children was 17.6 percent and 10.5 percent for adults ages 18-64. By 1970, 15.1 percent of children and 9.0 percent of adults ages 18-64 lived below poverty. According to the most recent Census data available for 2023, there are now 11 million children (15.3 percent) and 20 million adults ages 18-64 (10.0 percent) who live below the federal poverty level.[9] There seems to be little progress in nearly 55 years in reducing the poverty rates for low-income working aged Americans and their children and future children. It has been estimated that the cost of childhood poverty exceeds $1 trillion annually.[10] Such sobering statistics would seem to indicate it is time to challenge the entrenched conformity to the status quo.

The federal government and states are facing enormous budgetary pressures. As Medicaid is one of the largest components of every state budget, lawmakers' and taxpayers' expectations for efficiency, effectiveness, and improved outcomes are higher than ever.

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[8] Remarks to the National Governors' Association Conference | The American Presidency Project

[9] Poverty in the United States: 2023 U.S. Census Bureau September 2024. Table A-3.

[10] America Looks at Poverty All Wrong | TIME

There is a flaw in the design in a number of public assistance programs, including Medicaid, known as the "benefits cliff" in which the loss of public assistance benefits is greater than gains in income, at least in the short-term. People at all income levels make reasoned economic decisions that they perceive are in their own best self-interest. For many low-income individuals, the existence of the benefit cliff contributes to their decision to forego additional earnings.
The dilemma faced by low-income Americans is described in a January 2020 Federal Reserve Bank of Atlanta research report, "Benefits Cliffs and the Financial Incentives for Career Advancement: A Case Study of a Health Care Career Pathway":

> Some low-income workers, particularly those with children, face a disincentive to pursue a higher paying job through so-called benefits cliffs, which arise when earnings gains are offset by the loss of means-tested public financial supports, such as childcare subsidies. These benefits cliffs can be so severe that low-income workers may be temporarily better off financially by not advancing to take a higher paying job.[11]

Other publications that discuss the effects of the benefits cliff include:

- National Council of State Legislatures (NCSL): "Addressing Benefits Cliffs"[12]
- Congressional Budget Office (CBO): "Effective Marginal Tax Rates for Low-and Moderate -Income Workers in 2016"[13]

Thus, the existence of the benefit cliff is not in question. The question is whether Medicaid has a role in actively *assisting* low-income Arkansans to cross the bridge over the benefit gap.
Earnings, of course, are tied to the level of wages employers are willing to pay. After Arkansas adopted the new adult group, the people of Arkansas also raised the state minimum wage over a period of time to its current level of $11 per hour compared to the federal minimum wage of $7.25.
The hourly wage is part of the earnings equation, the other part is the number of hours worked. Full-time, full-year employment is 2080 hours. While commenters cite research that shows the new adult group is working, most are working only part-time. According to the U.S. Census Bureau, while only 1.8 percent of full-time workers and 11.7 percent of part-time workers are below the poverty level using the Official Poverty Measure and 4.1 percent of full-time workers

11 Benefits Cliffs and the Financial Incentives for Career Advancement: A Case Study of a Health Care Career Pathway
12 Addressing Benefits Cliffs
13 Effective Marginal Tax Rates for Low- and Moderate-Income Workers

are below the poverty level, 14.7 percent of part-time workers are below the poverty level using the Supplemental Poverty Measure.[14]

Medicaid was originally created for children, their parent/caretaker relatives, people with disabilities, and the elderly. The individuals covered in each of these groups shared common situations and conditions, most particularly that they are not expected to be engaged in the workforce.

In contrast, the new adult group created by the Affordable Care Act (ACA) is in significantly diverse situations. The group (ages 19-65) spans 46 years, the youngest age cohort having little in common with the oldest age cohort, most especially, in their work histories and health status. There are wide variations in life experiences among the 14 million U.S. adults made eligible through the ACA including due (to name a few) to:

- Educational levels
- Employment history
- Incarceration and challenges for returning to their communities, most especially in "systemic health system biases against justice-involved individuals, and a variety of pressing health-related social needs, including obtaining housing, accessing food, securing employment, and reestablishing interpersonal relationships."[15]
- Incidence of Substance Use Disorders
- Health-related Social Needs

The original Medicaid program was created for populations *outside* the rest of the health insurance system. Indeed, Medicaid was not considered insurance at all but rather medical assistance. But Chief Justice Roberts found that Congress broke with the past and that Medicaid had a new purpose in the *NFIB v Sebelius* decision:

> The Medicaid expansion, however, accomplishes a shift in kind, not merely degree. The original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children.
>
> Previous amendments to Medicaid eligibility merely altered and expanded the boundaries of these categories. Under the Affordable Care Act, Medicaid is transformed into a program to meet the health care needs of the entire nonelderly population with

[14] Census Bureau, Poverty in the United States: 2023 p.5 Figure 2 and p. 7 Figure 4.

[15] Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group p. 5.

income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.[16]

This movement from Medicaid into other health insurance coverage is a key element of the Pathway amendment.

Organization of Comments and Responses

The Comments and DHS Responses are organized by the following categories of commenters:

- Public policy/advocacy organization
- Health/medical organization/provider
- Legal advocacy organization
- General public

DHS has consolidated similar comments to avoid duplication. For brevity, DHS generally does not respond to comments from organizations that were submitted during the state public comment period. For these organizations, DHS refers CMS and interested parties back to the Pathway amendment application to avoid duplication. DHS responses are focused on facts to ensure the record is accurate and complete.

Public Policy/Advocacy Organizations:

- American Public Health Association (APHA) with 65 cosigners
- Arkansas Advocates for Children and Families (state public comments)
- Arkansas Community Organizations (state public comments)
- Center on Budget and Policy Priorities and Georgetown University Center for Children and Families
- Center for the Study of Social Policy
- Families USA
- Opportunity Arkansas (state public comments)
- Urban Institute

Health/Medicaid Organizations/Providers:

- American Cancer Society Cancer Action Network
- American College of Obstetricians and Gynecologists (ACOG)
- Association for Clinical Oncology

16 NATIONAL FEDERATION OF INDEPENDENT BUSINESS v. SEBELIUS, 567 U.S. 519 (2012)| Supreme Court | US Law | LII / Legal Information Institute

- Caring Across Generations
- DaVita
- Leukemia & Lymphoma Society
- Modivcare (state public comments)
- National Alliance on Mental Illness (NAMI)
- National Comprehensive Cancer Network
- National Council of Urban Indian Health
- Partnership to Protect Coverage (31 organizations; state public comment)
- Planned Parenthood Federation of America
- Power to Decide
- ViiV Healthcare (state public comment)

Legal advocacy organizations:

- Bazelon Center for Mental Health Law
- Justice in Aging
- Legal Action Center
- Legal Aid of Arkansas (state public comment)
- National Health Law Program (NHeLP)
- National Women's Law Center

Eight (8) Public Policy/Advocacy Organizations

One of the commenters presents itself as "the only organization that combines a 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health." It is significant that none of the commenters, including this one, disputed in any way DHS's assertion that decades of research demonstrates that poverty has a negative impact on health status, including premature death. Nor do they dispute the reality of the Medicaid "benefit cliff."

Comment

"While Arkansas claims that its new proposal differs from its previous work requirement, the proposal contains the same fundamental flaws, including data matching that risks eligible people losing coverage, required monthly contacts between enrollees and 'Success Coaching entities,' and inadequate protections for people with disabilities."

DHS Response

There are clear differences between the previous work and community engagement requirement and the Pathway Amendment. In its comments, APHA draws extensively on the work of Harvard economist Ben Sommers. However, Professor Sommers recently was quoted to say that Pathway is significantly different from the previous work requirement: "This is fundamentally different than what I think a lot of the rhetoric around work requirements is typically talking about," said Harvard's Sommers. "Rather than, 'do these things or else we take your coverage,' this is, 'do these things, and if not, we're going to work with you to try to improve things for you.'"[17]

Arkansas Advocates also states, "[T]his proposal differs from Arkansas's 2017 work requirements waiver proposal in implementation …". And, "[w]e recognize and appreciate that Pathway to Prosperity will not rely solely on data matching to assess individuals' needs for supports."

Comment

"Despite Arkansas's assertion that its proposal differs from its previous work requirement, Arkansas projects that 25 percent of enrollees subject to its proposal will lose Medicaid coverage."

DHS Response

DHS projects an average monthly caseload of 205,000 individuals and that the initial round of data matching will confirm that half are "on track" and there is nothing more to be done. Further data matching, including with the QHPs will confirm that all but 18,450 individuals are "on track." Of these individuals, DHS expects that contact with these individuals will confirm that half of these will be "on track" leaving 9,225 who will reach the stage of success coaching and the development of a PDP. That is only 4.5 percent of the original caseload who will even need a PDP.

Moreover, there are significant differences from the original requirement in the following areas:

1. Length of sanction
2. Restoration of coverage
3. Focused care coordination services
4. Connect individuals with local resources to address Health-Related Social Needs (HRSN)
5. Personal Development Plan (PDP) instead of rigid standardization
6. PDP based on beneficiary's own goals to achieve, including being healthy

[17] Medicaid Work Requirements Are Back. What You Need To Know - Tradeoffs

7. PDP measures progress instead of fixed hours
8. Application is targeted based on months of data matching and confirmation
9. Eliminates confusion as to whom it will be applied
10. Beneficiary can satisfy reporting with a telephone call, eliminating the problems of lack of internet access and lack of familiarity with technology
11. Additional layers of review to prevent potential errors including review by a three-person DHS panel
12. Human interaction instead of sole reliance on technology

Half of the projected savings are attributed to "early movers," people who successfully increase their income to rise above 138% of FPL. As described in the waiver application, there are eight potential outcomes a person may experience. The potential outcomes are:

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

DHS projects that only 4,613 individuals (2.3% of total enrollment) will have coverage suspended for an average of three (3) months. By comparison, more than 18,000 individuals were disenrolled in the 2018-2019 version.

Comment

"We are also concerned that Success Coaches would be poorly trained and use subjective criteria to determine engagement which could unfairly disadvantage enrollees that have less in common with the Coach." Finally, we are concerned that the state's proposal does not

include—or signal any intent to develop—the necessary investments in training and supporting Success Coaches."

DHS Response

Among other things, the Pathway amendment adds a new, vital service of focused care coordination to be provided by success coaching resources. DHS reiterates here that success coaching intends to leverage existing resources, i.e., individuals who already are engaged in providing workforce support services in various state and community partner settings.

DHS appreciates the commenter's concern and is very much aware that those providing success coaching must have adequate training and support. Additionally, DHS is very much aware of the need for listening to individuals who are receiving public assistance. For example, a September 2021 article released by the Assistant Secretary for Planning and Evaluation (ASPE), "Complex Rules and Barriers to Self-Sufficiency in Safety Net Programs: Perspectives of Working Parents," found:

> The low-income parents we spoke with expressed a strong desire to be independent of the federal benefit programs they used while at the same time they saw real value in them, particularly to help their children. Their experiences with program policies and administration were, by and large, difficult. While they described the benefits as generally helpful, they felt interactions with the system were often frustrating or even demeaning. Many participants saw the system as disjointed, challenging to access, and indifferent to their families' stability and advancement.[18]
>
> Several parents said they felt the system existed to keep people poor rather than to give them the employment assistance and education they needed to become truly financially secure.[19]

While various commenters have expressed concerns about the caliber of success coaching, there is no evidence to suggest it will not be done well especially in comparison to current practices.

Comments

"The state indicates that 'there are no exemptions to participation' from the proposed work requirement. This means that the policy would apply to someone who is pregnant and is enrolled in the expansion group."

"Work requirements inherently create broad harms to people with disabilities and the state would not be able to avoid improper terminations for this population."

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[18] mtr-qualitative-brief-2022.pdf

[19] Ibid.

DHS Response

The statement “there are no exemptions to participation” is accurate because DHS has taken an entirely different approach to engaging individuals. DHS no longer uses terms such as “exemptions” and “noncompliance” as they do not fully reflect that individuals make progress and learn at their own pace that reflect the realities in their lives. For example, a person who recently lost his/her apartment places finding a stable housing situation as the priority over other challenges they may be facing.

The number one priority for a woman who is pregnant and a person with a disability is to be healthy as described in the Pathway amendment. Actively participating in one’s own medical treatment or working a PDP with a goal of finding stable housing demonstrates the person is “on track.”

Comment

“The current proposal bears a strong resemblance to Georgia’ Pathways to Coverage program which was implemented in mid-2023.”

DHS Response

The Georgia version is used to screen individuals **prior to becoming enrolled** in Medicaid. The Arkansas version is designed to engage 205,000 people **already on Medicaid**. Georgia has none of the features of success coaching, PDPs, etc.

Comment

Medicaid is an economic lifeline for hospitals in rural and medically underserved areas which rely on Medicaid-funded services to keep their doors open. Given rural communities’ reliance on Medicaid for reimbursement, eligibility restrictions like work requirements are functional cuts to Medicaid itself.” Thousands of disenrolled Medicaid patients will then no longer be able to afford the same level of care, leading to loss of income for local health care providers, and from there, a loss of local providers, health service reductions, and closures for essential rural health centers.”

DHS Response

The commenter offers no evidence from the 2018-2019 experience or the Medicaid “unwinding” from the PHE to support its claims. There have been no hospital closures, no spikes in use of emergency rooms, nor any increases in uncompensated care in Arkansas linked to the previous work requirement or the PHE unwind.

Research that is cited looked only at those who were disenrolled by the 2018-2019 experience at a point in time when the waiver was ended. The research conducted on this period does not follow people over time and what happened to their coverage. In fact, more than 6,000

individuals who had been disenrolled returned to Arkansas Medicaid within 12 months. Based on national data from the Medicaid "unwind" due to the end of the COVID-19 Public Health Emergency (PHE), 75 percent of individuals found coverage from sources other than Medicaid. As the Secretary must analyze the consequences of the amendment, it is important to note that DHS estimates that 4,613 individuals in the first demonstration year, or 2.3 percent of enrollees will be suspended from coverage for an average of three months. This represents only about 25 percent of those who were disenrolled in 2018-2019.

Comment

"When uninsured people obtain Medicaid, they report that the positive impact Medicaid has on their health helps them to do a better job at work and enables them to look for better-paying positions; in turn, better employment leads to health improvement."

DHS Response

The commenter makes DHS's point precisely. Better begats better and there is no reason to believe it will not continue to raise income level to 100% FPL then 138% FPL, etc., especially for young adults just entering the workforce, except for the work disincentive presented by the "benefit cliff."

A report, *New England States Tackle Benefit Cliffs*, supported by the W.K. Kellog Foundation and the Doris Duke Foundation in collaboration with the American Public Human Services Association (APHSA), summarizes the situation as:

> The cliff effect is understood by consumers as a major obstacle to family economic success, across generations. Most parents seek upward mobility for their families and wish to be in the workforce, contributing both to their community and the economy at large. When benefits that support families are reduced or cut as the parent starts to work, a roadblock is set up. Parents often decline the job and stay where benefits uphold necessary family support. This is not a failure on the consumer's part, but a challenge that the state and federal government can together remedy.[20]

Comment

"The state claims that Medicaid expansion enrollees are incentivized to limit their work hours because individuals who work 37 hours per week at minimum wage are eligible for Medicaid expansion, while individuals who work 38 hours per week are not. However, Arkansas does not cite any evidence in support of its claim that low income workers decide how many hours to work based on whether they will continue to qualify for Medicaid."

[20] https://www.jtgfoundation.org/wp-content/uploads/2024/04/New-England-States-Tackle-Benefit-Cliffs-2024.pdf

DHS Response

The commenter and several others repeatedly emphasize the percentages of Medicaid enrollees who are working. However, most are not working full-time (2080 hours per year). The point is that working just one more hour a week can make a difference. DHS has presented several studies on the "benefit cliff." According to a September 2021 issue paper, "Risks that Come with Increasing Earnings for Low-Income Workers Receiving Safety Net Programs: Perspectives of Working Parents," "[a]lmost all focus group participants recognized the relationship between earnings increases and benefit reductions. Many participants cited personal experience. This is consistent with previous works on marginal tax rates finding that many low-income participants of public benefit programs had an understanding about benefit reductions through personal experience."[21]

Medicaid is the largest means-tested public assistance program. Therefore, most if not all of the focus group participants would have been receiving assistance through Medicaid.

Participants described four possible risk events:

1. "An earnings risk increase often leads to **benefit reductions**.
2. **Risk of subsequent earnings loss**: the earnings increase may be lost later, either due to a reduction in work hours or to a total loss of employment.
3. **Risk of being unable to regain lost benefits**: following an earnings loss, needed benefits may be difficult or impossible to get back.
4. **Risk of being unable to provide for children's basic needs**: Should this sequence of events occur, the parent would no longer be able to provide for the family's basic needs (emphasis in original).[22]

The ASPE paper continues, "[p]articipants in the study shared that the current program and employment context makes increasing earnings a risk-laden path—**even if many people still ultimately chose that path** (emphasis added)."[23]

"In spite of these risks, most participants (about 70 percent) said that they would nonetheless increase their earnings if presented with an opportunity."

In a companion paper, "Complex Rules and Barriers to Self-Sufficiency in Safety Net Programs: Perspectives of Working Parents," the focus group participants described frustrations with how benefit programs are administered:

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[21] https://aspe.hhs.gov/sites/default/files/documents/04efcaa192583caf5f53b98b80802ca6/MTR_Qual_Study_Brief_Risks.pdf

[22] Ibid.

[23] Ibid.

> The low-income parents we spoke with expressed a strong desire to be independent of the federal benefit programs they used while at the same time they saw real value in them, particularly to help support their children. Their experiences with program policies and administration, were, by and large, difficult. While they described the benefits as generally helpful, they felt interactions with the system were often frustrating or even demeaning. Many participants saw the system as disjointed, challenging to access, and indifferent to their families' stability and advancement.[24]

Providing opportunities is the foundation of the Pathway amendment. Focused care coordination will help break down barriers and indifference reflected in the status quo.

Comment

"Arkansas's proposal lacks important detail about how the program will work and what enrollees must do to maintain coverage."

DHS Response

DHS has been clear that for the vast majority of enrollees, they will need to do nothing to maintain coverage as they will be identified through data matching as "on track." For the small group of individuals who are assigned to success coaching, DHS has been clear as well—to become "on track" an individual need only cooperate with success coaching, develop an individualized PDP, and make progress on their own defined goals.

Some commenters expressed concerns with whether success coaching will be effective. At a minimum, success coaching will yield dividends by connecting individuals to local resources to address their HSRN,as expressed by an April 1, 2022 ASPE report, "Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts." ASPE concluded:

> Studies indicate that some SDOH and HRSN interventions, provided in the right settings and depending on the population, can improve health outcomes and well-being. In addition, some interventions may also decrease health care costs, though successful interventions can be cost-effective and worth undertaking even if they do not ultimately save money overall.
>
> Research on community interventions has also demonstrated health improvements with long-term impact. However, as we focus our efforts on SDOH and HRSNs, more work to assess the impact of various interventions on multiple populations is warranted. Additional research can help us better understand how interventions to address risks

[24] https://aspe.hhs.gov/sites/default/files/documents/68f0b7e5248a36dbb99a6dcdf9023910/mtr-qualitative-brief-2022.pdf

> related to SDOH and HRSNs in less medically complex individuals impact health and well-being over the life course, as well as the longer-term impacts of interventions; the impact on a wider range of populations, including rural communities and individuals without chronic illnesses; and the most appropriate 'dose' of various interventions. Further, … additional research is needed that focuses on health outcomes, in addition to health utilization, health costs, and healthy behaviors.
>
> In addition to efforts to improve SDOH and HRSNs, HHS is committed to building the evidence base and measuring success related to these efforts.[25]

The Pathway amendment will assist individuals meet their personal goals **and** provide the evidence base HHS believes is in the national interest.

14 Health/medical organizations/providers

As leading medical organizations that advocate on behalf of their patients, these commenters understand that everything in health and medicine involves a degree of risk. It is highly significant that not one of the health/medical organizations/providers challenged DHS' statements regarding the adverse affects of poverty on poor health outcomes and even premature death.

In its April 1, 2022 report, ASPE also stated:

> Social and economic factors such as socioeconomic status, income levels, poverty, and educational attainment are fundamental drivers of poor health outcomes because they facilitate or impede access to important resources that affect health outcomes directly and through multiple mechanisms. In a study of societal health burden and life expectancy, social and economic factors accounted for two of the three largest impacts on health and life expectancy. 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* … (emphasis added).[26]

Medical and scientific advancement relies on repeated experimentation; without which there would be no further improvements in treating cancer or HIV or ESRD. So why should it be acceptable to conclude that there are no benefits to work and community engagement after a single trial in a single state was conducted. DHS has been public about flaws in the 2018-2019 design and implementation and has made many changes based on lessons learned..

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[25] https://aspe.hhs.gov/sites/default/files/documents/6ba4bbb2e9c9551355a6926f023f1585/SDOH-Evidence-Review.pdf p. 17

[26] https://aspe.hhs.gov/sites/default/files/documents/6ba4bbb2e9c9551355a6926f023f1585/SDOH-Evidence-Review.pdf p.8

Comments

Commenters are “deeply concerned that the waiver does not include exemptions.” Accordingly, organizations requested that “patients with cancer who are under active treatment” and other serious medical conditions be exempted for at least one year after final treatment.

Another commenter requested exemption for pregnant and post-partum women.

DHS Response

DHS appreciates the data provided by commenters regarding the importance of screening, early diagnosis, and treatment. In calendar year 2024, the people of Arkansas invested approximately $1.8 billion in the ARHOME program. The Pathway amendment is a clear break from the past and from other state proposals regarding work requirements and community engagement. One of the lessons learned from the 2018-2019 experience is the confusion over such terms as “exemptions” and “noncompliance.” Pathway is an altogether different approach as it stresses the importance of “being healthy” and successful. Clearly individuals who are in active treatment are using their healthcare coverage, including during pregnancy and post-partum period, and therefore are “on track.” Data matching with the QHPs and Medicaid’s own FFS claims data will look over several months, mitigating the chance that active treatment will be missed. And even if missed, the individual will have the opportunity to provide such information before any adverse action is taken. Thus, DHS has eliminated the need for an exemption.

Comments

Commenter “appreciates Arkansas’ goal of addressing Health-Related Social Needs (HRSNs) through focused care coordination.”

DHS Response

DHS appreciates the comment and notes that focused care coordination is one of the significant improvements from the 2018-2019 experience.

Comments

Commenters supports expansion of Life360 Homes to all pregnant women, not just those with higher risk pregnancies.

DHS Response

DHS appreciates the support for Life360 Homes.

Comments

Commenter requested CMS require an exemption for American Indian and Alaska Native people due to the federal trust obligation.

DHS Response

DHS fully recognizes the federal trust obligation and is open to handling this issue through STC negotiations with CMS.

Comment

Commenter notes that patient visits for Medicaid recipients in QHPs are significantly higher than under Arkansas FFP and opposes policies that would decrease provider reimbursement and access to care.

DHS Response

DHS appreciates the recognition of the important design of the ARHOME program to use QHPs.

Comment

Commenter notes the importance of screening for HRSN and recommends Arkansas consider the tools, processes, referral sources, data collection, and community partnerships. Commenter further "encourages Arkansas to perform additional research, convene a technical advisory panel, and further outline a proposal for public comment."

DHS Response

DHS recognizes the importance of using the best available screening tools and processes and will consider the recommendations as part of the implementation plan.

Comment

Commenter "opposes limiting the amount of time an eligible individual can be enrolled in Medicaid.

DHS Response

DHS appreciates the opportunity to correct this misinterpretation of the Pathway amendment. To be clear, the amendment does NOT impose a limit on the amount of time and individual may be enrolled in the ARHOME program.

The amendment simply adds how long a person has been enrolled in ARHOME as a factor in assessing whether an individual may benefit from focused care coordination.

Comment

Commenter noted that data from Georgia showed "far fewer" individuals were enrolled in its Section 1115 waiver "than the state predicted."

DHS Response

DHS appreciates the opportunity to make important distinctions between the Arkansas amendment and the Georgia waiver. The two simply are not comparable as Georgia uses work and community engagement requirements criteria as a condition of eligibility to screen individuals *prior to enrollment*. Georgia uses none of the features of success coaching, PDPs, etc.

Comment

Commenter "… appreciates Arkansas's goal of addressing Health-Related Social Needs (HRSNs) through focused care coordination. HRSNs, such as food insecurity, housing instability, and lack of transportation, can significantly hinder access to timely, effective cancer care. These unmet needs can contribute to delays in diagnosis, reduced treatment adherence, and poorer survival rates." Commenter "… thanks Arkansas for the inclusion of these provisions and believes they will help to facilitate access to optimal, guideline adherent cancer care."

DHS Response

DHS appreciates the supportive comments and acknowledges the commenter's opposition to "… the provisions that tie health insurance to employment status …". The commenter noted that Arkansas ranked third among the top three states in cancer cases. Overall, the commenter provides evidence that the Pathway amendment is different from the previous experience and will provide important benefits to the ARHOME population to improve health outcomes.

Comment

Commenter "…recognizes the measured approach the state has taken to the 'work and community engagement requirements' that the pending waiver amendment will establish. The continuation of the NEMT benefit and the acknowledgement of the importance of transportation for beneficiaries seeking work or training opportunities is a key part of bridging the 'benefits cliff.' Commenter " … also recognizes the proposed 'success coaching' feature of the "Pathways (sic) to Prosperity' waiver amendment and the health-related social needs (HRSN) screening, which can address lack of transportation among other needs."

DHS Response

DHS appreciates the supportive comments and the additional evidence that the Pathway amendment significantly differs from the 2018-2019 experience.

Comment

Commenters also repeated concerns regarding the cost of implementation, unnecessary administrative hurdles, incomplete data systems and lack of details.

DHS Response

DHS continues to assert that the implementation costs are a cost-effective investment in the future of low-income, vulnerable Arkansans.

Six (6) Legal advocacy organizations

Commenters flooded CMS with footnotes of studies, many of which have nothing to do with the ARHOME population and Medicaid work and community engagement. One commenter

dismissed studies from Europe and Australia on the association between employment and health thusly: "… translating findings from mostly European studies to this Medicaid project in Arkansas can be misleading." That sums things up well and the statement of caution should be heeded. The Pathway amendment takes an unique approach that has not been tested before. Commenters challenge the Secretary's authority to approve the Pathway amendment. The fundamental question is, "does the Pathway amendment assist in promoting the objectives of Title XIX?

The affirmative answer lies deeply in the fact that Medicaid was added to the Social Security Act itself. All 21 titles of the Act are aimed at preventing poverty, alleviating the effects of poverty, or restoring someone's ability to move out of poverty.

Moreover, the Social Security Act properly expresses the reciprocal and binding social compact among us. The very financial foundation of the three trust funds of Social Security—the Old Age Survivors Insurance (OASI) trust fund, the Disability Insurance (DI), and the Hospital Insurance (HI) trust fund, all rely on working age adults to pay into the system that they themselves will rely upon in the future as beneficiaries, supported by the next generations of workers.

It is therefore inescapable that among the objectives of Medicaid, by virtue of its incorporation into the Act, is the prevention of poverty and providing for the rehabilitation of individuals to live in economic independence.

The Pathway amendment is designed to address the "root causes" of poverty. The first part of the test is to determine whether the Pathway amendment "is likely to assist in promoting the objectives of … title XIX."

This directive should be applied to the meaning of the key words that define "purpose." Therefore, the purpose of "assisting," and "promoting," and "objective to, in the words of President Kennedy, is to *create economic and social opportunities.* These words areproperly understood to be expansive and not limited to only one interpretation. The objectives include *to help them find productive, happy and independent lives*.

Comment

"Second, the project must promote the Medicaid Act's objectives."

DHS Response

DHS agrees. The purpose and therefore the objectives of the Medicaid program are found in Section 1901, "Appropriations:"

> For 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 an 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 …".

When Congress added the new adult eligibility category, also referred to as the "Section VIII group," under Affordable Care Act, it did not amend Section 1901. There was no need to amend it. The words "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care" must logically apply to the new adult group as well.

Comment

"Thus, 'the central objective' of the Medicaid Act is to 'provide medical assistance;" in other words, to provide health care coverage."

DHS Response

To turn to the issue of "medical assistance," the Pathway amendment adds a new service, focused care coordination, for which an individual will continue to be eligible even if other benefits are suspended. The Medicaid enrollee need only to affirm his/her cooperation to have all benefits restored in "real time."

Comment

"To be clear, as worded, Section 1115 does not include an independent freestanding expenditure authority. The text of the statutes must control—and limit—the actions of the federal agency, in this case limiting HHS to using federal Medicaid funding only for experimental projects …" Fourth, Section 1115 allows only 'to the extent and for the period … necessary to carry out the experiment. The Secretary cannot use Section 1115 to permit states to make long-term policy changes."

DHS Response

This extremely narrow interpretation is not consistent with the law or history. Arizona has operated its entire Medicaid program under a Section 1115 waiver since 1982. The statute clearly allows demonstration projects to be renewed and extended beyond their initial approval period.

Nor is it true Section 1115 authority can be used only to expand coverage. Again, an accurate history of states' use of 1115 authority in Tennessee, Massachusetts, Oregon, Wisconsin, and Vermont, to name a few, were state reactions to budget crises, not about expanding coverage. In the case of the Pathway amendment, the individual enrollee is in control of participation and restoration of benefits in the case of suspension.

Comment

"… the statute does not condition receipt of Medicaid benefits on any qualifications beyond those that serve to show that an individual is in need of assistance obtaining health care coverage and services."

DHS Response

This statement is not accurate. As a condition of eligibility, a parent must cooperate with the state to establish a child support medical order. A person who is enrolled in Medicaid has benefits suspended during a period of incarceration. There are circumstances in which an individual is eligible only for a limited set of benefits.

Comment

"Arkansas further assumes that when Medicaid enrollees do not work, it is a result of individual choices rather than systemic barriers.

DHS Response

On the contrary, DHS asserts that the Medicaid "benefit cliff" is indeed a systemic barrier for which the Pathway amendment is designed to assist individuals overcome.

In September 2021, the Office of the Assistant Secretary of Planning and Evaluation (ASPE) published an article, "Risks that Come with Increasing Earnings for Low-Income Workers Receiving Safety Net Programs: Perspectives of Working Parents." This research paper was based on discussions with 44 working parents receiving assistance from one or more federal programs.

In spite of these risks, about 70 percent said they would nonetheless increase their earnings if presented with an opportunity.

Conclusion

The Pathway amendment represents a balance of fiscal responsibility and personal responsibility. DHS is introducing a reasonable and balanced approach to address Arkansas's 16% poverty rate and encourage personal responsibility. It is in the best interests of ARHOME enrollees, for their own future and their families' future, to take advantage of the opportunities offered by the Pathway amendment.