STATE OF ARKANSAS
SARAH HUCKABEE SANDERS
GOVERNOR

April 30, 2026

Dear Secretary Kennedy,

As Governor of Arkansas, I submit this request to renew our Medicaid Section 1115 Demonstration Project, "Arkansas Health and Opportunity for Me" (ARHOME Waiver). The renewal includes several important changes to help Arkansans achieve economic independence, better serve pregnant women and new mothers, and bolster the fiscal sustainability of this program, which currently serves over 200,000 individuals.

This renewal establishes community engagement and work requirements for Arkansans served by ARHOME. These additions align Arkansas with the federal requirements in H.R. 1 signed into law by President Donald J. Trump last year. We intend to implement a soft launch of these requirements on July 1, 2026, and then initiate the full program under the renewed ARHOME waiver on Jan. 1, 2027.

This renewal proposes expanding the Life360 HOME program by allowing more providers to offer intensive supports to women with high-risk pregnancies enrolled in ARHOME. This expansion will provide critical resources to address maternal health deserts and the lack of birthing hospitals in Arkansas.

This renewal aligns our program with state law, which positions ARHOME to be fiscally sustainable. We look forward to working with you on the renewal of our Medicaid demonstration waiver.

Sincerely,

[redacted]

Sarah Huckabee Sanders
Governor of Arkansas

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ARHOME Section 1115 Demonstration Project Application

State of Arkansas

Department of Human Services

April 30, 2026

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Arkansas Health and Opportunity for Me (ARHOME)
Section 1115 Demonstration Project Application
January 1, 2027—December 31, 2031

Section I: Executive Summary

The Arkansas Department of Human Services (DHS) currently administers the Arkansas Health and Opportunity for Me (ARHOME) program under the authority of Section 1115(a)(2) of the Social Security Act (the Act) (Project Number 11-W-00365/4). The ARHOME program provides Medicaid coverage to individuals who are eligible under Section 1902(a)(10)(A)(i)(VIII) of the Act (new adult group). The current Demonstration expires December 31, 2026. Under this application, Arkansas requests approval for a new Demonstration for the period January 1, 2027-December 31, 2031.

Since 2014, DHS has used Medicaid funds to purchase coverage offered by a health insurer that participates in the state health insurance marketplace. This is also known as "premium assistance," which is allowable under Title XIX. DHS purchases insurance from six Qualified Health Plans (QHPs) administered by two health insurance carriers licensed by the Arkansas Insurance Department (AID) through a memorandum of understanding signed by DHS, AID, and the carriers.

With this Demonstration application, Arkansas seeks to continue covering the new adult group through the QHPs. The state also seeks to incorporate changes made by the State of Arkansas's 95th General Assembly through Act 774 of 2025 and P.L. 119-21, signed into law on July 4, 2025. Among the requested changes are the imposition of community engagement and work requirements on most of the ARHOME population, the expansion of Life360 HOMEs, an increase in the Medical Loss Ratio (MLR) to 85%, and the transfer of pharmacy rebates from the QHPs to DHS, as well as the extension of coverage through QHPs through December 31, 2031.

Section II: Background & Historical Narrative

In 2014, Arkansas began coverage of the Medicaid new adult group through a Section 1115 Demonstration Project, known as the "Arkansas Health Care Independence Program" or "Private Option." The program was amended and renamed "Arkansas Works" for the period January 1, 2017-December 31, 2021. Arkansas received federal approval for Work and Community Engagement (WCE) Requirements in March 2018. Implementation of those requirements began in June 2018. WCE requirements were discontinued in March 2019 due to federal litigation.[1] In the current version of the Waiver, for the period January 1, 2022-December 31, 2026, further modifications were made, and the program was renamed *Arkansas Health and Opportunity for Me* (ARHOME). The changes introduced under ARHOME included the imposition of cost-sharing for individuals above 20% of the federal poverty level, the implementation of performance metrics and targets, and the creation of Life360 HOMEs.

The Demonstration has reduced the uninsured population in the state. In 2013, 24.3% of Arkansans ages 19-64 were uninsured.[2] The percentage of uninsured among this age group had fallen to 12.9% in 2024.[3] However, this remains higher than the percentage of uninsured adults aged 19 to 64 for the U.S., which was 11.3% in 2024.[4]

2.1 Summary of Current ARHOME Section 1115 Demonstration

As of August 1, 2025, Arkansas provided health care coverage to more than 221,000 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 effective income is within a range that begins at approximately 14% FPL and is capped at 138% FPL.[5]

Everyone determined eligible for ARHOME begins coverage in the Medicaid Fee-For-Service (FFS) delivery system. About 13,000 individuals are "medically frail" and remain in the FFS model of care because it provides additional services, such as personal care, that the QHPs do not. Beneficiaries who are not medically frail may choose a QHP. However, if a beneficiary does not pick a plan within 42 days of enrollment, DHS auto-assigns the beneficiary to a QHP according to an auto-assignment algorithm that considers market share. A small number of individuals may be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program due to the presence of a serious mental illness or confirmation of a need for Home and Community Based Services (HCBS) through an Independent Assessment (IA).

Of the more than 221,000 adults in Medicaid expansion, approximately 191,400 individuals currently receive their benefits through QHPs under the authorities granted in the ARHOME Demonstration Project. 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

[1] *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020), found at https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1900-58.
[2] State Health Insurance Coverage: 2013, 2019, and 2023, Appendix Table B-3, p.19
[3] Health Insurance Coverage by State: 2023 and 2024, Appendix Table 3, p. 9
[4] Ibid.
[5] In 2025, 138% FPL is equal to $21,597 annually or $1,800 per month for a single individual.

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 payments to the QHPs in Calendar Year 2024 are approximately $1.3 billion for premiums and $493 million for cost sharing reduction payments for a total of $1.8 billion. These figures do not include the reconciliation for 2024, which will impact the final amount. For Calendar Year 2023, the total cost of ARHOME, inclusive of final cost share reconciliation, was approximately $2.1 billion.

The benefits for the new adult group, both in QHPs and FFS, meet the requirements of the Essential Health Benefit (EHB) package, as required by the Affordable Care Act. The ARHOME population pays cost sharing in the form of copayments for specific services allowable under federal law. Cost sharing does not apply to individuals with income at or below 20% of FPL and other exempt groups. Copayments are capped at 5% of household income on a quarterly basis.

Arkansas Medicaid purchases coverage that is equivalent to the cost of the second-lowest Silver Plan available in the state's Marketplace. Silver Plans have an actuarial value (AV) of 70%, i.e., the plan covers 70% of the cost of services. However, as the state is prohibited from charging premiums, and the cost-sharing obligation for Medicaid beneficiaries is limited to 5% of household 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), for whom there is no obligation for copayments, the AV is 100%.

QHPs form their own provider networks throughout the state separate from the Medicaid provider network.

2.2 Model Benefits

The ARHOME QHP model provides the following benefits to the state and enrollees beyond just health coverage:

1) **QHPs allow beneficiaries greater healthcare access.** While the Medicaid FFS provider network (including primary care physicians and specialists) is similar to the provider networks offered by the QHPs, some providers may limit the number of FFS Medicaid enrollees they serve due to lower FFS Medicaid reimbursement rates. Thus, QHPs provide more timely access to services, particularly among specialists.

2) **ARHOME provides beneficiaries with greater continuity of care.** According to the preliminary independent interim evaluation of ARHOME, QHP beneficiaries in 2022 and 2023 had better continuity of coverage than Medicaid FFS beneficiaries and were more likely to have a visit to a Primary Care Provider (PCP). ARHOME enrollees were more likely to have shorter gaps in coverage than those in FFS.

3) **ARHOME offers incentives to beneficiaries who engage in their healthcare.** The QHPs offer incentives to their members that are not available in FFS. These incentives reward members for engaging in healthy behaviors or activities to further economic independence. QHPs were required to provide at least two health improvement incentives to encourage the use of preventive care and two health improvement incentives for each of the following populations:

- Pregnant women, particularly those with high-risk pregnancies;
- Individuals with mental illness;
- Individuals with substance use disorder; and
- Individuals with two or more chronic conditions.

4) **ARHOME stabilizes Marketplace premiums.** ARHOME creates a larger risk pool for the individual market which helps to mitigate increases in premiums. For much of the 10-year history of premium assistance, Arkansas ranked among the states with the lowest average premiums. According to the Arkansas Center for Health Improvement (ACHI), Arkansas has the 16th lowest marketplace benchmark premium in the U.S. for 2025.[6] It has the lowest marketplace premium among surrounding states as well as the U.S. as a whole. Lower premiums reduce federal spending on pay tax credit subsidies for Marketplace plans.

2.3 Life360 HOMEs

On December 28, 2022, the ARHOME Waiver was amended to provide intensive care coordination services for certain targeted populations through three types of community bridge organizations known as Life360 HOMEs: Maternal, Rural, and Success.[4]

Under the Life360 HOME program, DHS contracts with hospitals to provide intensive care coordination for certain population groups within ARHOME. In 2024, the first Maternal Life360 HOMEs went live and began providing home visiting services to high-risk pregnant women. Home visiting services are provided during prenatal and postpartum periods and address health-related social needs and enhance life skills. The Maternal Life360 HOME hospitals coordinate with beneficiaries' medical providers, but medical services continue to be covered by the individual's QHP or fee-for-service Medicaid. Currently there are four Maternal Life360 HOMEs providing services with two more working through the application process. A total of 114 beneficiaries were enrolled in Maternal Life360 Home as of August 2025.

More information about the Life360 program can be found at **www.ar.gov/life360**.

Section III: Proposed Changes to Current Demonstration

DHS proposes several changes to the current Demonstration in response to Act 774 and P.L. 119-21. The major changes are expanding Life360 HOMEs, improving fiscal sustainability of the program, and implementing Community Engagement and Work Requirements. DHS also proposes changes to current cost sharing requirements to conform to new federal limitations under Section 71120, "Modifying Cost Sharing Requirements for Certain Expansion Populations Under the Medicaid Program."

3.1 Expanding Life360 HOMEs

The Maternal Life360 HOME program has provided strong support for high-risk pregnant women and their infants, and the state would like to continue growing the program, particularly in rural

[6] https://achi.net/publications/data-watch-arkansas-individual-marketplace-health-insurance-premiums/

areas with maternal health deserts. Act 774 expanded the Life360 HOME program by allowing new provider types to enroll as Life360 HOMEs, in addition to hospitals. The law now allows Federally Qualified Health Centers (FQHCs) or other organizations designated by DHS to enroll in the program. This change will allow the program to serve more people in more areas of the state. DHS intends to use this expansion of Life360 HOMEs to target areas of the state without birthing hospitals.

3.2 Improving ARHOME's Fiscal Sustainability

DHS understands the ARHOME program must be financially sustainable and has taken steps to manage costs. The state has taken measures to constrain overall cost increases in recent years. For example, in 2026, the final year of the current waiver, the Budget Neutrality cap is $898.69 PMPM, but DHS has held the carriers to a limit of $878.46 PMPM for the calendar year.

In the new waiver, the state will take additional measures to constrain overall cost increases. Act 774 requires the state to increase the Medical Loss Ratio (MLR) to 85% (currently 80%) through the new Demonstration period. The act also requires monthly advanced cost share reduction payments to be taxed as premium, expanding the state tax revenue generated by the program and reinvested in it. Last, Act 774 also requires the QHPs to remit pharmacy rebates to the state as is required of managed care programs.

3.3 Adopting Community Engagement and Work Requirements

On January 28, 2025, Arkansas Governor Sarah Huckabee Sanders announced her intention to seek the use of Medicaid work requirements for "able-bodied, childless adults." "Our goal is never to take services away from those who need it but to help people stand on their own two feet so they don't have to count on the government."

Section 71119 of P.L. 119-21, "Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals," provides that, "beginning not later than the first day of the first quarter that begins after December 31, 2026, or at the option of the State under a waiver or demonstration project under section 1115 or the State plan, such earlier date as the State may specify …". Accordingly, Arkansas seeks federal approval through this application to comply with Section 71119 using Section 1115 authority for all applicants and enrollees in Medicaid under the new adult group eligibility category. This request includes adoption of the Optional Exception for Short-Term Hardship Events allowable under 71119(3)(B).

Through this application, Arkansas seeks federal approval of our plan to implement this requirement. Section 71119 applies to the entire new adult group without regard to the service delivery system (QHPs, FFS, or PASSE) in which they are enrolled. DHS anticipates that the majority of medically frail individuals enrolled in FFS and individuals with serious mental illness enrolled in PASSE will be verified exempt. However, DHS must review and verify all necessary information to determine compliance/exemption at the time of application and at redetermination as a condition of eligibility. For those who are required to comply (i.e., not exempt) with the 80 hours per month community engagement and work requirements, DHS will verify compliance at time of application and at redetermination.

DHS proposes to implement the Medicaid community engagement and work requirements through the following mechanisms.

1. Data matching

   Section 71119(a)(5) requires states to use ex parte verifications where possible. The Division of County Operations (DCO) will use data matching with internal and external sources to the maximum extent possible to avoid requiring individuals to submit additional information. These efforts will be tested through an outreach and operations pilot that will take place in 2026, so that DHS will be fully prepared for successful implementation beginning January 1, 2027.

2. Verification

   Data matching will successfully connect an individual to electronically searchable information, such as for employment and payroll purposes. However, there will be activities that cannot be identified electronically, such as volunteering and caregiving, that the state must obtain through other means.

   DHS recognizes the need for different verification strategies among the four different populations:

   1. Applicants who must comply
   2. Applicants who may be exempt
   3. Enrollees who must comply
   4. Enrollees who may continue to be exempt

   When Arkansas implemented WCE requirements in 2018-2019 under the Arkansas Works Demonstration, DHS learned the importance of providing multiple ways for beneficiaries to report their compliance or exemption. DHS will improve communications with individuals applying for or enrolled in Medicaid and enhance its data matching capabilities.

   For beneficiaries whose exemption or compliance cannot be verified electronically, DHS proposes to verify through two methods. First, DHS will use an outbound contact center. DHS is currently soliciting a vendor to operate a Customer Support Center (CSC). As part of the CSC, the contractor must operate an outbound contact center to proactively contact Medicaid enrollees. DHS will provide the CSC with a list of enrollees for whom data matching was not successful, and the CSC will contact the beneficiaries to verify compliance or exemption. This “seek and find” capability will greatly improve DHS’s ability to maintain up-to-date contact information and timely communication. It will support DHS’s procedures for noticing noncompliance under Section 71119(a)(6).

   The second method of obtaining verification will be through Request for Information issued to beneficiaries requiring documentation to confirm exemption or compliance by providing proof from a third party.

   The final determination of compliance/exemption will be made by DCO.

3. Outreach

   Section 71119(a)(8) requires states to engage in an outreach campaign to support compliance. The DHS outreach campaign will consist of three strategies: 1) broad, statewide messaging; 2) community-specific communications; and 3) individual communication through the CSC system, including the Verification Unit.

4. Success Coaching Services (Start date: on or after July 1, 2028)

Arkansas proposes to go beyond the federal Community Engagement and Work requirements by actively assisting individuals most at risk of long-term poverty. DHS services will include success coaching to help connect beneficiaries to employment, education, and training opportunities, as well as local resources that meet their health-related social needs (HRSN) to attain personal and family independence.

The target populations include those at risk of losing coverage due to noncompliance with community engagement and work requirements, the reentry population (formerly incarcerated), individuals who were formerly in the child welfare system, veterans, and individuals who have been enrolled in Medicaid for more than 24 months. Individuals in these groups will be eligible for Success Coaching services provided through designated entities and paid for on a Per Member Per Month (PMPM) basis. Individuals will meet with success coaching entities and develop individualized Personal Development Plans (PDPs) with goals to be achieved over time. Participation will be voluntary, and there will be no sanction for declining the service.

3.4 Impact of Proposed Changes

3.4.1 Impact on Eligibility

The requested changes to Life360 HOMEs will have no impact on Medicaid eligibility, but DHS anticipates they will allow more health care organizations to enroll as Life360 HOME providers and more people to receive Life360 HOME services.

The measures DHS will take to improve financial sustainability (imposing a higher MLR, collecting pharmacy rebates from the QHPs, and taxing the ACSR payments like premiums) will have no impact on beneficiary eligibility.

The new Medicaid Community Engagement and Work requirements impose a new condition of eligibility on everyone in the new adult group. The requirements will apply at application and redetermination. Although the ARHOME Demonstration is targeted to the majority of the new adult group who receive their coverage through the premium assistance, the Demonstration will adopt the Medicaid Community Engagement and Work requirements for the entire new adult group regardless of service delivery system (QHP, FFS, or PASSE).

Based on information gathered from actuarial analysis and other states, DHS estimates that enrollment in ARHOME could decrease approximately twenty percent (20%) with the enforcement of the Community Engagement and Work requirement. The proposed outbound verification center will mitigate enrollment losses by giving individuals multiple opportunities to provide necessary information to maintain coverage.

Federal law also requires states to redetermine eligibility at least every six months. Although this requirement is outside the demonstration scope, DHS anticipates it will reinforce the enrollment decreases expected from the Community Engagement and Work requirements.

The anticipated change in enrollment is reflected in the new budget neutrality numbers, which reflect an average enrollment of approximately 160,000 individuals in the QHPs. The populations

that are exempt from participation are likely to be higher utilizers of medical services than the nonexempt populations. As a result, the PMPM cost will likely increase as the shift in the caseload mix changes.

The new Demonstration is designed to mitigate enrollment losses that would result from noncompliance and the ensuing provider compensation losses.

3.4.2 Impact on Delivery System

By expanding the types of providers that can become Life360 HOMEs, DHS anticipates more providers will enroll to offer these services, particularly federally qualified health centers and medical practices enrolled in DHS's patient-centered medical home program.

The measures DHS will take to improve financial sustainability (imposing a higher MLR, collecting pharmacy rebates from the QHPs, and taxing the ACSR payments like premiums) will likely result in the QHPs shifting these new costs to the plan premiums; however, this cost shift will increase the revenue earned by the state through the premium tax.

3.4.3 Impact on Covered Benefits/Cost Sharing

The requested changes to Life360 HOMEs, the fiscal sustainability measures, and implementation of the Community Engagement and Work requirements should have no impact on covered benefits.

Beginning January 1, 2028, DHS will implement cost sharing changes in conformance with Section 71120 of P.L 119-21, which will prohibit states from imposing cost sharing on certain medical services and populations.

DHS currently imposes copayments on certain adults with household income above 20% FPL. Copayments are in conformance with current federal rules that limit total cost sharing to the allowable amount per service and a total of 5% of household income per quarter. DHS does not impose premiums or deductibles which are prohibited by Section 71120. DHS exempts certain populations, such as pregnant women, the medically frail, and individuals enrolled in the PASSE program, from copayments which align with the new law.

Section 71120 further prohibits states from imposing cost sharing on certain care, items or services under Section 1916 of the Social Security Act or any primary care services, mental health care services, substance use disorder services, or services provided by a Federally Qualified Health Center, certified community behavioral clinic, or rural health clinic. These changes to cost sharing for the ARHOME population will be implemented and will likely reduce the total amount of copayments incurred by the adults subject to cost sharing.

Success coaching, beginning on or after July 1, 2028, will be a new benefit available to certain populations at risk of long-term dependency on social programs. The success coaching benefit may be delivered by Life360 HOMEs, state employees, or other entities.

Section IV: Overview of Demonstration Goals

The current ARHOME 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 for those with chronic diseases;
- Providing supports to assist beneficiaries 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 addition to the evaluation goals for ARHOME policies above, the Life360 HOMEs amendment of the Demonstration will focus on the following:

- Increasing beneficiary utilization of HRSN screening and corresponding services, including home visitation, to reduce the severity of beneficiaries' social needs
- Effectiveness of services received for mitigation of identified needs
- Reducing disparities in health care access, quality of care, or health outcomes at the beneficiary and community level through stratified analyses Increasing utilization of preventative and routine care
- Decreasing utilization of and costs associated with avoidable, high acuity health care
- Identifying beneficiary physical and mental health outcomes:
    - Improving maternal and infant health outcomes for participants in the Maternal Life360 HOME
    - Increasing utilization of behavioral health and substance use disorder treatments for beneficiaries with relevant diagnoses in Rural Life460 HOME
    - Increasing outreach and HRSN support services to assist beneficiaries in Success Life360 HOME

The evaluation will also assess the effectiveness of investments authorized through the amendment to support the development and implementation of the HRSN initiatives such as the following:

- Assess over time the local availability and investments in social services, such as housing, nutrition, and any other type of allowable HRSN services in concert with new Medicaid funding toward those services
- Assess potential improvements and barriers in the quality and effectiveness of beneficiary participation and downstream services that can be provided under the state plan authority
- Perform a cost analysis to support the development of cost estimates for providing HRSN services
- Life360 HOME cost assessment will include, but is not limited to, administrative costs of implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs
- Assess alignment of findings with other Life 360 HOME goals and cost analyses to assess the amendment's effects overall on the fiscal sustainability of the state's Medicaid program
- Assess the effective use of infrastructure investments to support the development and implementation of HRSN initiatives

Additional hypotheses have been added to evaluate success coaching, which is scheduled to begin in July 2028.

In terms of meeting the goals related to affordability and fiscal sustainability, Arkansas continues to offer the lowest Marketplace premiums in the region. The state has kept costs below the Budget Neutrality Per Member Per Month (PMPM) caps each year in the past five years.

Section V: Requested Waivers and Expenditure Authority

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

- To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers participating in the network of the beneficiary's Qualified Health Plan.

- To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers of focused care coordination services.

Payment to Providers **§§ 1902(a)(13) & 1902(a)(30)**

- To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan.

Amount, Duration, & Scope of Services & Comparability **§§ 1902(a)(10)(B) & 1902(a)(17)**

- To the extent necessary to enable DHS to provide different benefit packages for the "medically frail" and "interim" populations under the Medicaid FFS system than for those enrolled in private Qualified Health Plans.

- To the extent necessary to enable DHS to offer focused care coordination services to target populations that may vary and not otherwise be available to all beneficiaries in the same eligibility group.

Statewideness **§ 1902(a)(1)**

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

Cost Effectiveness Test **§§ 1905 & 1905(A)**

- To the extent necessary to enable DHS to require individuals to enroll in premium assistance offered by Arkansas QHPs and utilize an alternative cost effectiveness test that is not based on each individual.
-

Expenditure Authority

1. **Premium Assistance and Cost Sharing Reduction Payments**

   Expenditures for all or part of the cost of private insurance premiums in the Arkansas individual Marketplace plans and for payments to reduce cost sharing under such coverage for certain beneficiaries.
2. **Expenditures for Community Engagement Requirements Including Verification Center Unit**

   Expenditure authority is requested to support Community Engagement and Work activities including the system to verify compliance/exemption status of the ARHOME population.

3. Expenditures for Life360 HOME Infrastructure and Services

Expenditure authority is requested to support the expansion of and continued services, including non-medical transportation, for Life360 HOMEs throughout the state.

Section VI: Evaluation and Program Oversight

The ARHOME and Life360 HOMEs Interim Evaluation Report is included in the application as Attachment 4 and posted for public comment on DHS's website with the waiver application.

As stated in the Interim Evaluation Report:

> … this early evaluation highlighted sufficient provider networks, improvements in preventive and follow-up care, as well as positive beneficiary feedback. Arkansas continues to focus on improving health plan quality, enhancing communication with beneficiaries, and encouraging beneficiaries to take personal responsibility for their health through various incentives.
>
> Although the work is ongoing, Arkansas is dedicated to the opportunities that ARHOME and Life360 HOMEs present for improving the health of its citizens. These programs provide a pathway to reduce reliance on public supports, aligning with the state's motto, "The Land of Opportunity."[7]

In addition to the formal evaluation of the program's hypotheses, there are additional resources available to the public that provide insights into the ARHOME program, including monthly enrollment data that can be accessed through the DHS ARHOME website: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/arhome/.

6.1 Evaluation and Demonstration Hypotheses

DHS proposes to continue the currently approved Demonstration hypotheses and evaluation methodology in the new Demonstration period. The current approved Evaluation Design is attached as ***Attachment 4***.

In addition to the current evaluation, DHS proposes to evaluate the effectiveness of success coaching in four areas:

1. Increased income/hours worked per month/year
2. Completion of individual goals, including employment, education, and training as provided in PDPs
3. Reduced long-term dependency on Medicaid as source of health care coverage/increase private coverage
4. Reduced total cost of care by providing enrollees with resources to address unmet HRSN

While DHS has included its implementation plan for the community engagement requirements in this application, the state requests that Community Engagement and Work requirements be excluded from any evaluation requirements. In general, an evaluation is required only for elements of federal law provisions that are waived. Implementation of the community engagement requirements for the populations served through the Demonstration would not be

subject to hypotheses and evaluation because the state is following federal law. The use of Life360 HOMEs and success coaching go beyond federal requirements and thus will be evaluated.

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 through Success Coaching via this waiver renewal proposal. The evaluation of the Demonstration will assess whether Success Coaching enables enrollees to increase their income and leave Medicaid sooner compared to enrollees who do not receive this service.

Goals and Hypotheses

Goal #	Goal Description	#	Hypothesis Description	Measure #	Measure	Comparisons
1	Success Coaching Effectiveness	A	Beneficiaries engaged with Success Coaching will experience an increase in household income	1.A	Verification data	Expected Move Rate Beneficiaries not engaged with Success Coaching

Goal #	Goal Description	#	Hypothesis Description	Measure #	Measure	Comparisons
1	Success Coaching Effectiveness	B	Beneficiaries engaged with Success Coaching will increase the number of hours worked per month	1.B	Verification data	Expected Move Rate Beneficiaries not engaged with Success Coaching
		C	Beneficiaries engaged with Success Coaching will increase the number of hours worked per year	1.C	Verification data	Expected Move Rate Beneficiaries not engaged with Success Coaching

2	Success Coaching Effectiveness	A	Higher percentage of Beneficiaries engaged with Success Coaching will meet employment goals	2.A	Comparisons of expected move rate to actual move rate	Expected Move Rate Beneficiaries not engaged with Success Coaching
		B	Higher percentage of Beneficiaries engaged with Success Coaching will complete education goals	2.B	Comparisons of expected move rate to actual move rate	Expected Move Rate Beneficiaries not engaged with Success Coaching
		C	Higher percentage of Beneficiaries engaged with Success Coaching will complete training goals	2.C	Comparisons of expected move rate to actual move rate	Expected Move Rate Beneficiaries not engaged with Success Coaching

Goal #	Goal Description	#	Hypothesis Description	Measure #	Measure	Comparisons
	Success	A	Higher percentage of Beneficiaries with Success Coaching will leave Medicaid due to higher income	3.A	Comparisons of expected move rate to actual move rate	Length of stay on Medicaid among Beneficiaries not engaged with Success Coaching

3	Coaching Effectiveness	B	Beneficiaries engaged with Success Coaching will have an increased rate of private coverage	3.B	Comparisons of expected move rate to actual move rate	Comparisons of expected move rate to actual move rate
4	Success Coaching Effectiveness	A	Beneficiaries engaged with Success Coaching will receive an appropriate intervention if they screen positive for an HRSN	4.A	HRSN Screening/Intervention	Beneficiaries not engaged with Success Coaching
		B	Beneficiaries engaged with Success Coaching will have fewer unmet HSRNs	4.B	HRSN Screening/Intervention	Beneficiaries not engaged with Success Coaching

6.2 Oversight, Monitoring, and Reporting

Oversight, monitoring, and reporting protocols from the current Demonstration will be carried forward in the new Demonstration.

Section VII: Budget Neutrality

DHS proposes including the following expenditure types in the budget neutrality assessments:

1. Net payments to QHPs, including premiums, ACSR, CSR settlement, and MLR recoupments
2. Non-emergency medical transportation (NET), state-mandated non-essential health benefits, and fee-for-service expenditures (e.g., EPSDT dental and vision services) for ARHOME beneficiaries enrolled in a QHP (known as "wrap" payments)
3. Life360 HOME infrastructure payments
4. Life360 HOME service payments for all ARHOME beneficiaries (including medically frail)

DHS proposes the following expenditures are not included in the budget neutrality assessment:

1. Expenditures for medically frail beneficiaries or beneficiaries awaiting enrollment in a QHP
2. Community Engagement and Work implementation costs (as these are required by P.L. 119-21)
3. Life360 HOME service payments for targeted case management for beneficiaries who receive the service under the state plan.

DHS notes that the national trends of increasing health care costs are significant cost drivers for the ARHOME program and must be reflected in the "without waiver" projections.

The impact of the Medicaid Community Engagement and Work requirements on enrollment may be significantly different than the state's assumptions. DHS assumes that the number of people in the compliance populations and the exempt populations are roughly equal. While the state is taking a deliberate approach to mitigate enrollment loss, there is still great uncertainty about the future experience. DHS assumes that the exempt populations are likely to use services at higher rates than the compliance populations and therefore have higher average PMPM costs.

Budget projections for "with waiver" and "without waiver" expenditures account for several changes in the program, including[7]:

- The projections rely on the CY 2026 Budget Neutrality limit approved by CMS.
- There is an anticipated 20% reduction in enrollment attributable to the work requirement.
- There is an accompanying 10% increase in acuity expected.
- There is no expected material impact from the updated minimum MLR.
- The additional .9% cost increase attributable to the ACSR and pharmacy rebate changes will be negotiated in the 3.5% increase allowed for Demonstration Year 1.

Table 1 identifies the annual budget neutrality PMPMs for the expenditures for ARHOME beneficiaries enrolled in a QHP. The proposed limits are based on a 3.5% annual increase and an acuity adjustment resulting from the Community Engagement requirements and biannual redeterminations (lower cost beneficiaries losing coverage).

Table 1. Budget Neutrality for New Adult Group

[7] Please see the Letter from Milliman "ARHOME 1115 Demonstrative Waiver—Budget Neutrality Limits" dated November 19, 2025, attached here to as Attachment 1 and incorporated herein.

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030	DY 05 CY 2031
With Waiver	$1,023.16	$1,058.97	$1,096.03	$1,134.39	$1,174.10
Without Waiver	$1,045.90	$1,106.56	$1,170.74	$1,238.64	$1,310.48

Table 2 identifies the estimated annual enrollment projects for the life of the Demonstration.

Table 2. Member Month Enrollment Projections

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030	DY 05 CY 2031
With Waiver	1,913,319	1,913,319	1,913,319	1,913,319	1,913,319
Without Waiver	1,913,319	1,913,319	1,913,319	1,913,319	1,913,319

Table 3 identifies anticipated total expenditures with and without waiver, based on the information provided above.

Table 3. Total Expenditure Projections

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030	DY 05 CY 2031
With Waiver	$1,957,628,774	$2,026,145,781	$2,097,060,883	$2,170,458,014	$2,246,424,044
Without Waiver	$2,001,131,635	$2,117,197,270	$2,239,994,712	$2,236,914,405	$2,507,369,441

Table 4 contains DHS's request to support expansion of Life360 HOMEs. The HRSN services line is based on the current PMPM of $300 for Maternal Life 360 and the care coordination payments of $50,000 per year for Success Life360 HOMEs and $100,000 per year for Rural Life360 HOMEs, as well as the $50,000 for Maternal and Rural transportation costs. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed the demonstration period total. These costs do not include the cost of focused care coordination, which is allowable as a Medicaid service.

Table 4. Annual Limits in Life360 HOME Infrastructure

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030	DY 05 CY 2031
HRSN Services	$1,005,000	$1,715,000	$2,425,000	$3,135,000	$3,845,000
HRSN Infrastructure	$513,000	$739,375	$965,625	$1,191,875	$1,418,125

DHS made the following assumptions when developing these numbers:

- Maternal Life360 Home enrollment will grow by about 100 each year, and there will be two new facilities added each year.
- Rural and Success Life360 Enrollment will grow by about 25 in each program for each year of the demonstration. One new Rural and one new Success program will be added each year.

Section VIII: Public Notice & Comment Process

8.1 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 December 14, 2025, through January 12, 2026. During this time, the state held two dedicated public hearings.

At the request of CMS, the state opened a second public comment to provide the opportunity for the public to comment on the ARHOME interim evaluation project report which has been added to the application. This was a 20-day comment period beginning on February 8, 2026, and concluded February 27, 2026.

Public Notice

The state verifies that the abbreviated public notice of this Amendment application was published on December 14, 2025, in the Arkansas Democrat-Gazette, the newspaper with widest circulation in each city with a population of 100,000 or more in accordance with 42 CFR §431.408(a)(2)(ii). In addition, DHS used its standard electronic mailing list of interested parties, comprised of more than 150 individuals and organizations, to notify the public of the Amendment, the public hearings, and the opportunity to comment on the waiver Amendment draft. While there are no federally recognized tribes in the state of Arkansas, DHS proactively reached out to tribal representatives in neighboring Oklahoma to ensure all interested parties were included in the electronic mailing list and able to participate in the public comment period.

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

Public Hearings

DHS held 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 were held on the following dates and physical locations, in addition to being available for statewide virtual participation, as scheduled and as publicized in the formal notice:

Public Hearing #1	Public Hearing #2
Ad hoc meeting of the ARHOME Health & Economic Outcomes Accountability Oversight Advisory Panel Wednesday, December 17, 2025, at 1:00 p.m. at the Department of Human Services (DHS), Donaghey Plaza South Building, 700 Main Street, Little Rock, Arkansas 72203. The details for attending the online public hearing appear at ar.gov/dhspublichearings.	Friday, January 2, 2026, at 1:00 p.m. in the Community Room at St. Bernard's Medical Center, 225 East Washington Ave., Jonesboro, Arkansas 72401. The details for attending the online public hearing appear at ar.gov/dhspublichearings.

8.2 Summary of Public Comments & State Responses

The Arkansas Department of Human Services (DHS) received no public comments during the two public hearings. DHS received written comments from fourteen (14) organizations that were received timely during the first public comment period. DHS received written comments from three organizations after the close of the first comment period. DHS has included these comments because it opened the second comment period. One organization that submitted comments during the first comment period submitted comments during the second comment period as well.

DHS has carefully considered each comment. The comments are summarized below with DHS responses. Several duplicative comments have been combined. The full comments as submitted are attached.

While DHS has not made any policy changes based on the comments, it has improved the application by adding the most recent evaluation as Attachment 4. DHS also revised language to "Section IV: Overview of Demonstration Goals" to clarify the current ARHOME and Life360 goals and hypotheses will be continued.

National Council of Urban Indian Health (NCUIH)
"We appreciate that Arkansas DHS included an exemption for American Indian and Alaska Native people in the ARHOME Application by including exemptions for individuals who are Indians or Urban Indians. This exemption complies with the One Big Beautiful Bill Act (OBBA) which exempts American Indian and Alaska Native people from Community Engagement and Work requirements as a condition of Medicaid eligibility."

"NCUIH requests Arkansas DHS:

- Ensure that the work and community engagement exemption for American Indian and Alaska Native people in the ARHOME Application is implemented in a way that is inclusive of all American Indian and Alaska Native beneficiaries."

DHS Response

DHS appreciates the National Council's recognition that an exemption is explicitly included in the application. Verification applies to all persons who apply for Medicaid coverage in the new adult group (Section1902(a)(10)(A)(i)(VIII).

DHS will adopt and follow federal rules related to verification, including the use of databases and documents for the purpose of tribal identification, to be promulgated by the Centers for Medicare & Medicaid Services (CMS) no later than June 1, 2026. DHS is developing a robust communications campaign to help individuals understand their responsibilities to provide necessary information. DHS will include the exemption for American Indian and Alaska Native people in its communications campaign.

Centers for Medicare & Medicaid Services

CMS professional staff previewed the application as submitted for the 30-day state public comment period and provided comments to DHS. In light of the CMS comments, DHS opened a second comment period from February 8, 2026, to February 27, 2026, to allow public comment on the ARHOME interim evaluation project report.
As described below, DHS has also added language to provide a more cohesive linkage to

resources that are available to the public to review the ARHOME program.

CMS Comment

"The state's submission discusses the goals set forth at the time of the demonstration's approval. Please include discussion of how these goals were or were not met during the approval period."

Additionally, the application describes objectives from Arkansas's State Act 774. It is unclear if the extension application seeks to continue the existing goals of the current period and/or add the objectives under 774 to the demonstration. Relatedly, the full public notice should also include the goals and objectives to be implemented or extended under the demonstration."

DHS Response

DHS has revised language in "Section IV, Overview of Demonstration Goals" to clarify that the goals of the ARHOME program and the Life360 HOME program will be carried into the new Demonstration period.

The Application also describes the full public notice including the goals to be evaluated.

"Section III, Proposed Changes to Current Demonstration," describes the major changes to the current demonstration. "Section 3.4, Impact of Proposed Changes," describes the impact on eligibility, the impact on the delivery system, the impact on covered benefits, and the impact of changes to cost sharing in conformance with Section 71120 of P.L. 119-21.

CMS Comment

"Additionally, the attached Evaluation Design describes the quality monitoring processes used by the state but does not include whether issues have been identified and/or addressed."

DHS Response
The Interim Evaluation Report (IER) which is included in the application addresses issues that have been identified. Moreover, DHS provides a variety of detailed reports that provide data on quality and performance and are available to the public.

CMS Comment

"While we understand that the Interim Evaluation Report (IER) is not due to CMS until December 31, 2025, the IER must also be included as part of the extension request that is posted for state public comment per STC 104."

DHS Response

DHS opened a second comment period to provide the public with the opportunity to comment on the IER. DHS affirms that the IER is included in the application as required by federal rules and STC 104.

National Multiple Sclerosis Society, American Kidney Fund, Blood Cancer United, Diabetes Patient Advocacy Coalition, and Arthritis Foundation

Comments
"Given that work reporting requirements are federally mandated and the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's waiver request."

DHS Response
The state is not requesting authority to waive any part of P.L. 119-21, Section 71119, "Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals." DHS has included the provisions of Section 71119 in the Demonstration application for the sake of transparency as the majority of the new adult group receives coverage through Section 1115 Demonstration Project authority. As the current waiver expires December 31, 2026, DHS believes that not including the Community Engagement and Work Requirements would be an omission if they are not included in the waiver application.

Comment

"Furthermore, the Society urges Arkansas to not implement these requirements any earlier than January 1, 2027."

"Blood Cancer United urges Arkansas to not implement these requirements any earlier than the January 1, 2027, start date required under federal law. Work requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly result in inappropriate coverage loss."

DHS Response

DHS will not apply any sanctions to individuals prior to January 1, 2027. That is, individuals will not be denied eligibility nor terminated from coverage prior to January 1, 2027.

Section 7119 requires states to commence robust outreach activities at a date established by the Secretary prior to full implementation beginning January 1, 2027. DHS agrees with the comments that work reporting requirements are administratively complex. Given prior experience, DHS believes that a well-designed outreach campaign will help mitigate the risks to individuals and costs to the taxpayers. The campaign will include a description of the procedures DHS will use to identify individuals who will be exempt from the community engagement requirements, including those who are medically frail or otherwise have special medical needs as defined by the Secretary.

Association for Clinical Oncology

"We urge the Department to add a clear exemption for patients with cancer who are under active treatment, and for the exemption to last at least one year after final treatment.

DHS Response

DHS agrees that patients undergoing cancer treatment are likely to meet the exemptions for "medically frail" and are likely to meet the federal definition of "special medical needs."

Further, DHS is examining potential ways to verify cancer treatment through its claims data.

DHS will adopt and follow federal rules related to verification of cancer and other medical treatment apply exemptions as appropriate under guidance provided by the Centers for Medicare & Medicaid Services (CMS) no later than June 1, 2026.

EveryLife Foundation for Rare Diseases

"The EveryLife Foundation urges the state not to implement these requirements until January 1, 2027, and to provide comprehensive criteria and clear appeals processes.

DHS Response

DHS recognizes the importance of providing comprehensive criteria for exemptions and clear appeals processes and is currently reviewing all such procedures to ensure protections for vulnerable populations.

Cystic Fibrosis Foundation

"Our organization urges Arkansas to wait for additional federal guidance before crafting its work reporting requirements policies, as premature or rushed implementation could lead to significant coverage losses."

DHS Response

The Secretary of HHS is required by law to promulgate the community engagement rules not later than June 1, 2026. DHS recognizes the complexities of implementation and believes moving forward on as many elements as possible, especially a robust outreach campaign, is in the best interest of vulnerable Arkansans.

The proposed ARHOME Demonstration Project application is a request for authority. The many details of implementation, evaluation, and monitoring generally are not included in an application but rather follow federal approval. The state will adopt and implement federal rules when they are available.

Comment

"To prevent inappropriate coverage loss and ensure continuous access to care, Arkansas must design an exemption process that minimizes the administrative burden on enrollees. Specifically, the state should use all available data sources—particularly medical claims data—to identify eligible individuals and automatically apply and reverify exemptions."

DHS Response

DHS agrees and is designing processes to minimize the administrative burden on applicants and enrollees, including using claims data.

Comment

"Additionally, it is critical that enrollees can self-attest to their eligibility for exemptions, as there will always be people who are not identified through external data sources." "As such, it is critical that enrollees can self-attest as to whether they are capable of working so that vulnerable populations are not erroneously disenrolled from coverage."

DHS Response

DHS recognizes that there are gaps in information and databases. Accordingly, DHS is designing a multi-tiered approach to maximizing the collection and use of automated information.

Legal Aid of Arkansas

"Any provision of the Application that conflicts with, narrows, or attempts to waive the specific requirements of Section 71119 may not be approved."

DHS Response

DHS agrees with this statement and affirms that the application does not conflict with, narrow, or attempt to waive the requirements of Section 71119.

Comment

"Further, as detailed below in Section II, the information provided in the Application is insufficient to provide meaningful comment on critical aspects of the project and therefore does not meet Section 1115 demonstration requirements."

DHS Response

DHS strongly disagrees. DHS has again reviewed the federal requirements for the State public notice process under 42 C.F.R 431.408. DHS affirms that the application meets the requirement to provide "[a] comprehensive description of the demonstration application or extension to be submitted to CMS that contains a sufficient level of detail to ensure meaningful input from the public, …". DHS notes that the application will be posted by CMS for another 30-day public comment period.

Comment

"The Application's language regarding identifying a 'specified excluded individual' and requiring verifications calls into question the Department's plan for processing individuals *ex parte* as required." "It is unclear what the Department means when it identifies groups that will likely be specified excluded individuals, such as those who are medically frail and in Fee-For-Service (FFS) Medicaid or those enrolled in a Provider-Led Arkansas Shared Savings Entity (PASSE) but then indicates that verification will need to occur."

DHS Response

As the Cystic Fibrosis Foundation (CFF) notes in its comments, there are gaps in the information available to DHS. As the Legal Foundation notes, how DHS implements the *ex parte* verification processes cannot conflict with, narrow, or waive the processes to be promulgated by the federal government. DHS is designing a multi-tiered approach to maximize the collection and use of automated information. The Application presents no policy conflict with federal law.

Comment

"The Department may already have the necessary data to confirm eligibility *ex parte* for the populations deemed medically frail and receiving FFS Medicaid. This is because the medically frail designation indicates that the State has previously verified significant health needs that

differentiate these members from the general expansion population."

DHS Response

These statements are not accurate. Currently, DHS allows individuals to self-select the medically frail designation. DHS will comply with the federal rule to be promulgated and will use its databases to the maximum extent possible for verification and confirmation of eligibility.

Arkansas Community Organizations and Arkansas Community Institute

"Here are a few suggestions to make the federal work requirement less burdensome for ARHOME recipients who work, but do not have the means to pay for health insurance and do not receive health benefits from their employer:

1. Work to end the glitches in the current enrollment and renewal system and make it easier for Arkansans to navigate the system and to get help when they need it.

2. DHS should begin to exempt all individuals who are classified as medically frail or have a serious mental illness from the work requirements.

3. Develop a work reporting structure that is less burdensome by requiring work hours to be reported in the months just after enrollment and just before renewal.

DHS Response

Improving the current enrollment and renewal system and developing a work reporting structure that is less burdensome are consistent with and aligned with the DHS approach to implementation.

DHS will adopt and follow the policies and procedures to be promulgated by the federal government not later than June 1, 2026.

Arkansas Advocates

Comment

"To the extent the state is requesting waiver authority solely to comply with federal law, AACF urges DHS to clearly articulate the purpose and added value of using a demonstration rather than implementing the requirements directly through state plan authority."

DHS Response

To be clear, DHS is not requesting to waive any part of Section 71119, which provides for the community engagement and work requirements. The ARHOME program uses Section 1115 Demonstration authority to purchase coverage through qualified health plans for more than 180,000 low-income Arkansans. The current waiver expires December 31, 2026. Act 774 directs DHS to continue the program for another five years. Including the community engagement and work requirements in the waiver application provides transparency, which is in the public's interest.

Comment

“AACF strongly urges DHS not to implement work reporting requirements prior to [January 1, 2027].”

DHS Response

No one will be denied coverage prior to January 1, 2027, due to the community engagement requirements.

DHS is focused on the critical administrative activities cited by the AACF: “…[to] develop and test systems, coordinate across eligibility and enrollment functions, train staff, and conduct meaningful outreach to enrollees using multiple communications channels.”

Comment

“AACF urges DHS to automatically exempt all individuals determined to be medically frail and all individuals with serious mental illness …”. “Requiring these populations to separately verify exemptions introduces avoidable administrative complexity and increases the likelihood of erroneous suspensions due to paperwork barriers or data delays.”

DHS Response

DHS is exploring and developing verification strategies to maximize *ex parte* communications and data matching to reduce the potential for erroneous suspensions.

Comment

“Design choices to limit coverage losses and churn.”

DHS Response

The activities recommended by AACF are consistent with and align with DHS strategies to implement the community engagement requirements.

Comment

“AACF appreciates the proposal to offer voluntary Success Coaching services beginning in 2028 …”. These services should remain voluntary and clearly separated from eligibility determinations.

DHS Response

DHS appreciates the AACF support for success coaching and confirms that participation will be voluntary and separate from eligibility determinations.

Comments Received After Close of First Comment Period and in Second Comment Period

HIV+HEP Policy Institute, Arkansas Black Gay Men's Forum, and ViiV Healthcare

Comment

"Clarify that people with HIV are exempted from the work requirements as having a "serious or complex medical condition" and create an automatic ex parte exemption process.

DHS Response

DHS agrees that patients undergoing treatment for HIV are likely to meet the exemptions for "medically frail" and are likely to meet the federal definition of "special medical needs."

Further, DHS is examining potential ways to verify HIV treatment through data matching. DHS will adopt and follow federal rules related to verification of medical exemptions, including for the treatment of HIV, including the use of databases and the length of exemptions to be promulgated by the Centers for Medicare & Medicaid Services (CMS) no later than June 1, 2026.

Arkansas Association of Cancer Professionals and Association for Clinical Oncology

Comment

"...we urge Arkansas to use its existing flexibility to prevent barriers to timely and appropriate cancer care. These flexibilities should include:

- Establishing the expectation that cancer is a long-term disruption for patients. The duration of cancer-related exemptions should reflect medical necessity, and we continue to urge the Department to extend exemptions for at least one year after the conclusion of final treatment.
- Creating systems that do not threaten continuity of care during renewal periods or related to reporting requirements.
- Ensuring the maximum duration of retroactive eligibility allowed by law to protect patients from the devastating medical debt often associated with a new diagnosis.
- Encouraging the use of hardship exemptions to specifically support travel to and participation in clinical trials, which are often a patient's best treatment option."

DHS Response

DHS agrees that patients undergoing cancer treatment are likely to meet the exemptions for "medically frail" and are likely to meet the federal definition of "special medical needs."

Further, DHS is examining potential ways to verify cancer treatment through data matching.

DHS will adopt and follow federal rules related to verification of medical exemptions, including cancer treatment, including the use of databases and the length of exemptions to be promulgated by the Centers for Medicare & Medicaid Services (CMS) no later than June 1, 2026.

Section 71112 of P.L. 119-12, "Reducing State Medicaid Costs," amends Section 1902(a)(34) of the Social Security Act to limit retroactive coverage for medical assistance to individuals who are eligible under the new adult group for care and services furnished in or after the month before the month in which the individual made application. This is consistent with the current demonstration project. DHS does not seek to limit retroactive

coverage any further by this application.

Section IX: State Contact

Name and Title: Elizabeth Pitman, Director, Division of Medical Services, Arkansas Department of Human Services

Telephone Number: (501) 682-1001

Attachment 1: Actuarial Statement

Milliman

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November 19, 2025

Elizabeth Pitman
Director
Arkansas Department of Human Services
Division of Medical Services
700 Main Street
Little Rock, AR 72201
elizabeth.pitman@dhs.arkansas.gov

Re: ARHOME 1115 Demonstrative Waiver – Budget Neutrality Limits

Dear Elizabeth:

The Arkansas Department of Human Services (DHS) requested Milliman summarize historical information and estimate future projections (i.e., the budget neutrality limits) for DHS' 1115 Demonstration Waiver renewal application. DHS is developing a five-year extension of the current Arkansas Health and Opportunity for Me (ARHOME) program, including considerations for program changes from the 2025 legislative session and recently passed federal legislation. This letter contains the information we understand DHS must submit to CMS as part of the application followed by a detailed disclosure of our methodology and assumptions. DHS may share this letter with CMS as part of the application process.

Please note, the methodology and approach for developing the budget neutrality limits in this letter are consistent with the development of the budget neutrality limits approved by CMS for the current ARHOME waiver from CY 2022 to CY 2026.

TABLES FOR ARHOME APPLICATION

As part of the application, CMS requests historical information related to expenditures and enrollment for the covered population (actual data) and the five-year demonstration period (projected estimates).

Section B – Expenditure History for Relevant Population(s) and Services

Table 1 includes the expenditure history for the relevant populations and services requested in Section B of the application.

TABLE 1
ARKANSAS DEPARTMENT OF HUMAN SERVICES
1115 WAIVER DEVELOPMENT
HISTORICAL EXPENDITURES

CY QUARTER	ARHOME QHP POPULATION
Q01 2022	$684,911,339
Q02 2022	$600,240,802
Q03 2022	$599,780,999
Q04 2022	$532,718,237
Q01 2023	$397,341,665
Q02 2023	$833,601,901
Q03 2023	$453,584,837
Q04 2023	$426,296,513
Q01 2024	$456,868,346
Q02 2024	$442,799,320
Q03 2024	$434,363,578
Q04 2024	$418,550,958
CY 2022	**$2,417,651,377**
CY 2023	**$2,110,824,916**
CY 2024	**$1,752,582,202**

The application also requests the state to specify the source of the data provided above from the CMS-64. Below is a narrative DHS can include in the application:

> *The historical expenditure data reflects information submitted in form CMS 64.9VIII where Type of Eligibility is equal to "Newly." The data also includes prior period QHP expenditures captured in Lines 7, 8, 10A, and 10B in form CMS64.9VIIIP, also with Type of Eligibility equal to "Newly."*

Section F – Expenditure Projections for Targeted Demonstration Population(s)

Table 2a includes the expenditure projections for the ARHOME QHP population included in the demonstration waiver, under a "with waiver" and "without waiver" scenario. **Note, expenditures associated with the Life360 program are included separately in the "Health Related Social Needs" section. Life360 costs are NOT included in the budget neutrality expenditures in Table 2a or Table 2b.**

TABLE 2A
ARKANSAS DEPARTMENT OF HUMAN SERVICES
1115 WAIVER DEVELOPMENT
EXPENDITURE PROJECTIONS

	DY01 (2027)	DY02 (2028)	DY03 (2029)	DY04 (2030)	DY05 (2031)
With Waiver	$1,957,628,774	$2,026,145,781	$2,097,060,883	$2,170,458,014	$2,246,424,044
Without Waiver	$2,001,131,635	$2,117,197,270	$2,239,994,712	$2,369,914,405	$2,507,369,441

The application also requests the state to describe the analysis used to derive the above cost projections. Below is a narrative DHS can include in the application:

> *The "with waiver" projected costs for each demonstration year are calculated starting with the CY 2026 BN limit of $898.68 PMPM with a 10% upward adjustment for the estimated acuity impact of community engagement requirements projected forward at an annual PMPM trend rate of 3.5% and multiplied by the anticipated enrollment (described in the enrollment data section). The starting point of $898 reflects the State's best estimate of current expenditures based on recently observed experience and discussions with participating QHPs related to premium and cost share expectations for CY 2026. The 3.5% annual trend reflects DHS' expectations related to premium and CSR negotiation opportunity with the QHPs.*
>
> *The "without waiver" projected costs for each demonstration year are similarly calculated starting with the CY 2026 BN limit of $898.68 PMPM with a 10% upward adjustment for the estimated acuity impact of community engagement requirements projected forward at an annual PMPM trend rate of 5.8% and multiplied by the anticipated enrollment (described in the enrollment data section). The 5.8% represents the PMPM trend included in the current CY 2022 to CY 2026 ARHOME waiver and is intended to be set equal to the President's budget trend. Since community engagement requirements are part of federal regulations, its impact is included in both the "with waiver" and "without waiver" estimates.*

Table 2b includes the expenditure projections on a PMPM basis.

TABLE 2B
ARKANSAS DEPARTMENT OF HUMAN SERVICES
1115 WAIVER DEVELOPMENT
PMPM EXPENDITURE PROJECTION

	DY01 (2027)	DY02 (2028)	DY03 (2029)	DY04 (2030)	DY05 (2031)
With Waiver	$1,023.16	$1,058.97	$1,096.03	$1,134.39	$1,174.10
Without Waiver	$1,045.90	$1,106.56	$1,170.74	$1,238.64	$1,310.48

After consultation with DHS, the projected PMPM expenditures do not contain explicit adjustments for the three legislative changes enacted in the 2025 legislative session: an 85% minimum MLR, classification of ACSR payments as premium, and the pass-through of pharmacy rebates to DHS. We do not expect any material impact of the updated minimum MLR. The ACSR and pharmacy rebate changes result in an estimated 0.9% cost increase required to fund the premium tax liability on these costs. However, DHS anticipates the 3.5% trend from CY 2026 to CY 2027 to be negotiated with the QHPs will be inclusive of this additional liability.

Section I – Member Month Enrollment Data

Table 3 includes the member month enrollment projection for the ARHOME population included in the demonstration waiver. We understand the ARHOME program currently has nearly 200,000 individuals enrolled in QHPs as of 2024 H2. As a result of community engagement requirements starting January 1, 2027, DHS expects the enrollment to decrease roughly 20% from non-compliance. Therefore, the enrollment in Table 3 reflects this reduction and otherwise stable enrollment during the five year demonstration period.

TABLE 3
ARKANSAS DEPARTMENT OF HUMAN SERVICES
1115 WAIVER DEVELOPMENT
MEMBER MONTH ENROLLMENT PROJECTION

	DY01 (2027)	DY02 (2028)	DY03 (2029)	DY04 (2030)	DY05 (2031)
With Waiver	1,913,319	1,913,319	1,913,319	1,913,319	1,913,319
Without Waiver	1,913,319	1,913,319	1,913,319	1,913,319	1,913,319

Table 4 includes the member month enrollment history for the ARHOME QHP population.

TABLE 4
ARKANSAS DEPARTMENT OF HUMAN SERVICES
1115 WAIVER DEVELOPMENT
MEMBER MONTH ENROLLMENT HISTORY

CY QUARTER	ARHOME QHP POPULATION
Q01 2022	885,351
Q02 2022	905,383
Q03 2022	922,807
Q04 2022	920,541
Q01 2023	903,017
Q02 2023	788,599
Q03 2023	637,942
Q04 2023	600,466
Q01 2024	638,681
Q02 2024	620,190
Q03 2024	604,925
Q04 2024	590,899
CY 2022	**3,634,082**
CY 2023	**2,930,024**
CY 2024	**2,454,695**

The application also requests the state to describe the analysis used to derive the above membership projections. Below is a narrative DHS can include in the application:

> *The historical membership data reflects DHS' internal tracking of membership by quarter for individuals enrolled in the Qualified Health Plans (QHPs). This level of enrollment detail is not available in the CMS 64 reports, but it is consistent with the enrollment historically reported to CMS by DHS as part of the quarterly budget neutrality monitoring reports.*

Health Related Social Needs

DHS provided estimated cost and participation information for three types of care coordination Life 360 homes in the ARHOME program: Maternal, Rural, and Success. Table 5 below shows the aggregate estimated service and infrastructure expenditures associated with this program to address health related social needs (HRSN).

TABLE 5 ARKANSAS DEPARTMENT OF HUMAN SERVICES 1115 WAIVER DEVELOPMENT ESTIMATED LIFE360 EXPENDITURES					
	DY01 (2027)	DY02 (2028)	DY03 (2029)	DY04 (2030)	DY05 (2031)
HRSN Services	$1,005,000	$1,715,000	$2,425,000	$3,135,000	$3,845,000
HRSN Infrastructure	$513,125	$739,375	$965,625	$1,191,875	$1,418,125

METHODOLOGY

As noted above, we relied on the CMS 64 forms and internal enrollment tracking files provided by DHS to summarize the historical expenditures and membership, respectively. The narrative following Table 1 identifies the specific source of the claims information within the CMS 64 forms. Below we include additional information related to the adjustments included in the "with waiver" projection.

- Base Data: The budget neutrality projections rely on the CY 2026 BN limit approved by CMS. We note the observed CY 2023 and CY 2024 expenditures are below their respective budget neutrality limits. However, DHS recognizes recent healthcare trends and rate filings from the participating QHPs that indicate costs near or at the budget neutrality limits in CY 2026.
- Trend: After discussions with DHS, we included an annual trend of 3.5%, which reflects DHS' desire to have a trend consistent with expected QHP premium increases and negotiation expectations. We believe this represents a reasonable expectation of future increases in QHP premiums and wrap-around service costs, while remaining lower than recent trend experience.
- Community Engagement: We reviewed recently submitted waivers from other states related to community engagement efforts, and discussed DHS' expectations related to expectations when these requirements begin January 1, 2027. Based on these conversations, DHS expects a 20% reduction in ARHOME QHP enrollment accompanied by an estimated 10% increase in PMPM acuity.

DHS provided estimated cost and participation information related to the three Life360 programs. We did not audit this information, but we reviewed it for reasonableness. Below are the details for the three Life360 variants:

- Maternal: There are currently about 125 individuals enrolled in the Maternal Life360 program, and DHS expects the enrollment to grow by 100 each of the next five years. DHS also expects there will be two new facilities each year added to the four facilities currently operating. DHS is allocating $300 PMPM for home visits and $50,000 per facility for transportation, both classified as HRSN services. Additionally, each new facility will be funded with $100,000 in startup infrastructure costs.
- Rural: DHS expects enrollment to grow by 25 each of the next five years. DHS also expects one new facility to open each year. DHS is allocating $50,000 per facility for transportation and $100,000 per facility for care coordination, both classified as HRSN services. Additionally, each new facility will be funded with infrastructure costs for startup expenses ($100,000), equipment and training ($50,000), and ACU observation and monitoring ($120,000).
- Success: DHS expects enrollment to grow by 25 each of the next five years. DHS also expects one new facility to open each year. DHS is allocating $50,000 per facility for care coordination, classified as HRSN services. Additionally, each new facility will be funded with infrastructure costs for startup expenses ($100,000), technology ($50,000), and a success fee ($2,500 per individual completing a success plan).

DATA RELIANCE AND IMPORTANT CAVEATS

Milliman has developed certain models to estimate the values included in this letter. The intent of the models was to assist DHS in completing Section 6 of the 1115 Demonstration Waiver application. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

Milliman prepared this letter for the specific purpose of assisting DHS complete Section 6 of the 1115 Demonstration Waiver application. This letter and the models used to develop the values in this letter should not be used for any other purpose. This letter has been prepared solely for the internal business use of, and is only to be relied upon by, the

management of DHS, in accordance with its statutory and regulatory requirements. Milliman recognizes that materials it delivers may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit, or create a legal duty to, any third party recipient of its work. This letter and its exhibits should only be reviewed in their entirety.

The models rely on data and information as input to the models. We relied on data provided by DHS in the development of this letter. We also relied on public information released by CMS. If the underlying data provided are inadequate or incomplete, the results will be likewise inadequate or incomplete.

The estimates and results in this letter will certainly change as more information is known related to the Arkansas Medicaid program and the 1115 Demonstration Waiver. Additionally, future results depend on utilization trend, provider reimbursement, enrollment changes, member behavior, and general economic conditions.

I am a Principal and Consulting Actuary for Milliman, a member of the American Academy of Actuaries, and I meet the Qualification Standards of the Academy to render the actuarial communication contained herein. To the best of my knowledge and belief, this letter is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

Elizabeth, thank you again for the opportunity to work with DHS. Please let us know if you have any feedback.

Sincerely,

Greg J. Herrle, FSA, MAAA
Principal and Consulting Actuary

GJH/tm

Attachment 2: Public Notice

Public Notice

Medicaid Section 1115 Demonstration Project Application, Arkansas Health and Opportunity for Me (ARHOME) Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a Medicaid Arkansas Health and Opportunity for Me (ARHOME) Demonstration Project (Waiver) renewal application and to hold public hearings to receive comments on the proposed Demonstration application.

In accordance with 42 §CFR 431.408, this notice provides a summary of the waiver renewal request and serves to formally open the 30-day public comment period, which will begin on December 14, 2025, and conclude on January 12, 2026.

While DHS proposes to continue providing health care coverage to the adult expansion population through the purchase of private insurance on the state-based exchange, it proposes several changes to the current Demonstration in response to Act 774 and P.L. 119-21. The major changes are expanding Life360 HOMEs, improving fiscal sustainability of the program, and implementing community engagement requirements.

Program Description and Objectives

As of August 1, 2025, Arkansas provided health care coverage to more than 221,000 adults between the ages of 19 and 64 who are not enrolled in Medicare and who are either:

(3) childless adults with household income at or below 138% of the federal poverty level (FPL), or;
(4) parents with dependent children whose effective income is within a range that begins at approximately 14% FPL and is capped at 138% FPL.

Everyone determined eligible for ARHOME begins coverage in the Medicaid Fee-For-Service (FFS) delivery system. About 13,000 individuals are “medically frail” and remain in the FFS model of care because it provides additional services, such as personal care, that the QHPs do not. Beneficiaries who are not medically frail may choose a QHP. However, if a beneficiary does not pick a plan within 42 days of enrollment, DHS auto-assigns the beneficiary to a QHP according to an auto-assignment algorithm that considers market share. A small number of individuals may be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program due to the presence of a serious mental illness or confirmation of a need for Home and Community Based Services (HCBS) through an Independent Assessment (IA).

Of the more than 221,000 adults in Medicaid expansion, approximately 191,400 individuals currently receive their benefits through QHPs under the authorities granted in the ARHOME Demonstration Project. 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 payments to the QHPs in Calendar Year 2024 are approximately $1.3 billion for premiums and $493 million for cost sharing reduction payments for a total of

$1.8 billion. These figures do not include the reconciliation for 2024 which will impact the final amount. For Calendar Year 2023, the total cost of ARHOME, inclusive of final cost share reconciliation, was approximately $2.1 billion.

The benefits for the new adult group, both in QHPs and FFS, meet the requirements of the Essential Health Benefit (EHB) package, as required by the A.C.A. The ARHOME population pays cost sharing in the form of copayments for specific services allowable under federal law. Cost sharing does not apply to individuals with income at or below 20% of FPL and other exempt groups. Copayments are capped at no more than 5% of household income on a quarterly basis.

Arkansas Medicaid purchases coverage that is equivalent to the cost of the second-lowest Silver Plan available in the state's Marketplace. The state is prohibited from charging premiums, and the cost-sharing obligation for Medicaid beneficiaries is limited to 5% of household income. Those with income at or below 20% FPL (46% of ARHOME enrollees) have no obligation for copayments. Those with income between 21% and 138% FPL pay copayments of $0.00 to $9.40 for covered services. The copayment for most services is $4.70.

QHPs form their own provider networks throughout the state separate from the Medicaid provider network.

The ARHOME program seeks to allow beneficiaries greater healthcare access through QHPs, provide beneficiaries with greater continuity of care, offer incentives to beneficiaries who engage in their healthcare, and stabilize Marketplace premiums.

Hypothesis and Evaluation Parameters

Goal 1: Providing continuity of coverage for individuals

Hypothesis	Research question	Measure
A. ARHOME beneficiaries will be aware of the premium assistance model	What percentage of ARHOME beneficiaries are aware of the premium assistance model?	1. Beneficiary Premium Assistance Awareness
B. ARHOME beneficiaries and QHP contracted providers will be aware of the Health Improvement Initiative	What percentage of ARHOME beneficiaries and QHP contracted providers are aware of the Health Improvement Initiative?	1. Beneficiary and 2. Provider Health Improvement Initiative Awareness
C. The premium assistance model will lead to less unmet	Do Arkansas residents that are potentially eligible for ARHOME	1. Have a Personal Doctor

need for healthcare among Arkansas residents ages 19-64 with income up to 138% FPL compared to individuals at the same income levels in states that expanded Medicaid through existing service delivery systems	have less unmet needs related to having a personal doctor, medical costs, and routine checkups than similar residents in other comparable states that have expanded Medicaid?	2. Avoided Care Due to Cost 3. Last Routine Checkup
D. The ARHOME program will lead to QHP beneficiaries having better continuity of coverage that includes fewer and shorter gaps, while Medicaid eligible, compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have fewer and shorter coverage gaps than Medicaid FFS beneficiaries?	1. Percent of Beneficiaries with At Least One Month with a Coverage Gap 2. Average Length of Gaps in Coverage
E. The ARHOME program will lead to QHP beneficiaries having better continuity of primary care and specialty providers, while Medicaid-eligible, compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have better continuity of primary and specialty care providers then Medicaid FFS beneficiaries?	1. Continuity of PCP Care 2. Continuity of Specialist Care 3. Percent Annual PCP Visits

GOAL 2: Improving access to providers

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. The premium assistance model will lead to improved financial health among Arkansas healthcare providers compared to healthcare providers in states that expanded Medicaid through the existing service delivery system	Are Arkansas healthcare providers more satisfied with compensation of QHP beneficiaries during the ARHOME demonstration?	1. Provider Financial Health Improvement
	Are Arkansas healthcare providers less likely to close and have better operating margins during the ARHOME demonstration?	2. Hospital Financial Health Improvement 3. Provider Closure Rate
B. The ARHOME program will lead to QHP beneficiaries having better perceived access	Are ARHOME beneficiaries more satisfied with their medical appointments in terms of	1 – 10. CAHPS: Perceived Access to Care

to care over time and compared to Medicaid FFS beneficiaries	timeliness, ease of scheduling, receiving appropriate care from the appropriate providers, and having an interpreter available to them when needed than Medicaid FFS beneficiaries?	
C. The ARHOME program will lead to QHP beneficiaries having better perceived access to care compared to similar beneficiaries in states that expanded Medicaid through the existing service delivery system	Do Arkansas residents that are eligible for ARHOME have better perceived access to routine care that includes medical coverage, cost, having a personal doctor, being seen regularly, and receiving the appropriate vaccinations than similar residents in other comparable states that have expanded Medicaid?	1 – 5. BRFSS: Perceived Access to Care
D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have better access to network providers and in a timely manner?	1. Provider Patient Acceptance and 2. Time to First Appointment
	Do ARHOME beneficiaries have better access to preventive care, recommended screenings, and chronic condition management than Medicaid FFS beneficiaries?	3 – 12. Preventative Visits and Cancer Screenings
	Do ARHOME beneficiaries that were enrolled in Medicaid FFS and eligible for EPSDT services have similar if not more preventive (wellness, dental, vision) visits than when they were in Medicaid FFS?	
	What percentage of ARHOME beneficiaries use non-emergency transportation (NET) assistance and how often do they use this service compared with Medicaid FFS beneficiaries?	13 – 15. NET Utilizations and Awareness
	Do ARHOME beneficiaries have a similar, if not better network of primary care providers and specialists to choose from within 30 miles of their residence than Medicaid FFS beneficiaries?	16 – 19. PCP and Specialist Network Adequacy and Accessibility
		20. ECP Network Adequacy

GOAL 3: Improving continuity of care across the continuum of coverage

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. ARHOME beneficiaries will be aware of the shorter period of retroactive eligibility, and the time-limited premium requirements	What percentage of ARHOME beneficiaries are aware of the shorter period of retroactive eligibility and premium requirement awareness?	1. Beneficiary Retroactive Eligibility Awareness
		2. Beneficiary Premium Requirement Awareness
B. The shorter period of retroactive eligibility will not lead to a lower rate of Medicaid applications among individuals potentially eligible for ARHOME compared to individuals potentially eligible for other Medicaid programs without a reduced period of retroactive eligibility	Does the shorter period of retroactive eligibility lower the rate of ARHOME new enrollments?	1. New Enrollment
C. The shorter period of retroactive eligibility will not lead to a greater medical debt among new ARHOME beneficiaries compared to individuals newly enrolled in other Medicaid programs without a reduced period of retroactive eligibility	Do new ARHOME beneficiaries with a shorter period of retroactive eligibility have a higher rate of medical debt compared with the new Medicaid FFS beneficiaries?	1. New Beneficiary Medical Debt
D. During Year 1 of the demonstration, monthly premiums will not lead to lower take-up and retention rates among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those at or below 100% FPL	In the first year of the ARHOME demonstration, will monthly premiums lower rates of new enrollment and retention among ARHOME applicants or beneficiaries at 101-138% FPL as compared to those at or below 100% FPL?	1. New Enrollment
		2. Retention Rate

GOAL 3: Improving continuity of care across the continuum of coverage

HYPOTHESIS	RESEARCH QUESTION	MEASURE
E. During Year 1 of the demonstration, monthly premiums will not lead to more	In the first year of the ARHOME demonstration, will monthly premiums increase the number	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap

gaps in coverage among Arkansas residents age 19-64 with income at 101-138% FPL compared to those at or below 100% FPL	and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL as compared with ARHOME beneficiaries at or below 100% FPL?	2. Average Length of Gaps in Coverage
F.QHP beneficiaries will demonstrate they value QHP coverage, and the implementation of monthly premiums will not reduce QHP beneficiary enrollment	Will monthly premiums lower overall health insurance coverage among Arkansas residents between 101-138% FPL?	1. Health Insurance Coverage Status
	During Year 1 of the demonstration, will monthly premiums lower the percentage of ARHOME beneficiaries at 101-138% FPL who pay a premium?	2. Premium Payments
	Will monthly premiums lower the percentage of ARHOME beneficiaries selecting their own QHP at enrollment?	3. QHP Selections
G. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase take-up and retention rates among QHP beneficiaries with income at 101-138% FPL compared with Year 1	Will the termination of monthly premiums increase the rate of new enrollment or retention among ARHOME applicants or beneficiaries at 101-138% FPL in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. New Enrollment
		2. Retention Rate
H. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase gaps in coverage among QHP beneficiaries while still eligible for ARHOME than they did during Year 1	Will the termination of monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap
		2. Average Length of Gaps in Coverage
I. During Years 2-5 of the demonstration, the cessation of monthly premiums will lead to QHP beneficiaries having more gaps in coverage after earnings exceed Medicaid eligibility limits than they did during Year 1	Will the termination of monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL who disenroll due to high income in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap
		2. Average Length of Gaps in Coverage

GOAL 4: Furthering quality improvement and delivery system reform initiatives that are successful across population groups

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. ARHOME beneficiaries will be aware of the shorter point-of-service copayment requirements and the Economic Independence Initiative	What percentage of ARHOME beneficiaries are aware of point-of-service copayments and the Economic Independence Initiative?	1. Beneficiary Copayment and 2. EII Awareness
B. The ARHOME program will lead to QHP beneficiaries having greater satisfaction in the care provided over time and compared to Medicaid FFS beneficiaries	Are ARHOME beneficiaries more satisfied with their health plan, health care, as well as primary care providers and specialists?	1. Rating of 1 Health Plan and 2. Health Care 3. PCP and 4. Specialist
C. The ARHOME program will lead to QHP beneficiaries having lower non-emergent use of the emergency department (ED), lower potentially preventable use of the emergency department and hospital admissions, and lower hospital re-admissions over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have lower ED visits, chronic condition hospital admissions, and all-cause readmissions than Medicaid FFS beneficiaries?	1. Preventable 2. Non-Emergent and 3. Emergent ED Visits 4. Plan All Cause Readmissions 5 – 8. Preventable Hospital Admissions
	Do ARHOME beneficiaries have a higher rate of follow-up care after hospitalizations and ED visits than Medicaid FFS beneficiaries?	9. PCP Follow-Up after ED Visit 10. PCP Follow-Up after Hospitalization
D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries with a diagnosis of mental illness or substance use disorder have higher rates of treatment, medication adherence, preventive screenings, as well as follow-up after ED visits and hospitalizations than Medicaid FFS beneficiaries	1 – 20. Acute, Behavioral Health, Chronic Condition Care, Maternal and Perinatal Care, and HII Participation
	Do ARHOME beneficiaries have lower use of opioids and benzodiazepines than Medicaid FFS beneficiaries?	
	Do ARHOME beneficiaries have lower rates of C-sections than Medicaid FFS beneficiaries?	

	Do ARHOME beneficiaries have higher rates of preventive care, contraceptive care, and medical management of chronic conditions than Medicaid FFS beneficiaries?	
	What percentage of ARHOME beneficiaries are participating in a Health Improvement Initiative?	
E. Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries not subject to copays	Will copayments lower rates of treatment, medication adherence, preventive screenings, as well as follow-up after ED visits and hospitalizations among ARHOME beneficiaries with a diagnosis of mental illness or substance use disorder compared with rates of Medicaid FFS beneficiaries?	1 – 11. Acute, Behavioral Health, and Chronic Condition Care
	Will copayments increase the use of opioids and benzodiazepines among ARHOME beneficiaries compared with Medicaid FFS beneficiaries?	
F. Among QHP beneficiaries with income at or below 20% FPL, the Economic Independence Initiative will lead to an increase in income to above 20% FPL over time	Will the Economic Independence Initiative increase the percentage of ARHOME beneficiaries who had an income below 20% FPL in the prior year to at or above 20% FPL in the current measurement year?	1. Percent of Beneficiaries at or under 20% FPL at Initial Measurement That Are Above 20% FPL at Follow-Up Measurement, Among Those Still Enrolled at the Follow-Up Measurement

GOAL 4: Furthering quality improvement and delivery system reform initiatives that are successful across population groups

HYPOTHESIS	RESEARCH QUESTION	MEASURE
G. Among QHP beneficiaries with income at or below 100% FPL, the Economic Independence Initiative will lead to an increase in income to about 100% FPL over time	Will the Economic Independence Initiative increase the percentage of ARHOME beneficiaries who had an income below 100% FPL in the prior year to at least 100% FPL in the current measurement year?	1. Percent of Beneficiaries at or under 100% FPL at Initial Measurement that are Above 100% FPL at Follow-Up Measurement, Amont Those Still Enrolled at the Follow-Up Measurement

H. Among QHP beneficiaries who disenroll from ARHOME, the Economic Independent Initiative will lead to an increase in the percent that disenroll due to increased income over time	Will there be increase in the percentage of ARHOME beneficiaries that disenroll due to high income?	1. Percent of Beneficiaries That Disenroll Due to High Income
	Do a higher percentage of ARHOME beneficiaries that disenroll take up private health insurance and will that private health insurance be the same carrier as their ARHOME QHP carrier?	2. Percent of Disenrolled Beneficiaries That Take-Up Private Health Insurance
		3. Percent of Disenrolled Beneficiaries That Take-Up Private Health Insurance and Maintain the Same Health Insurance Plan they had in ARHOME
I. The Economic Independence Initiative will lead to an increase in the percent of QHP beneficiaries that enroll in education and training programs over time.	Will the Economic Independence Initiative increase the percentage of ARHOME beneficiaries that participate either through the initiative or in other education and training programs?	1. Percent of QHP Beneficiaries that Enroll in Education and Training Programs over time
		2. Percent of QHP Beneficiaries Participating in the ELL Program
J. The point-of-service copayments will lead to QHP beneficiaries subject to copays having lower overall healthcare use compared to similar QHP beneficiaries not subject to copays	Will ARHOME beneficiaries subject to copayments have lower healthcare utilization than ARHOME beneficiaries not subject to copayments?	1. Beneficiary Copayment Healthcare Use Impact
K. The shorter period of retroactive eligibility, the premium assistance model, the point-of-service copayments, the Health Improvement Initiative, and the other financial discipline components will lead to the rate of growth in per member per month (PMPM) QHP costs being no higher than the rate of growth in PMPM costs in Arkansas Medicaid FFS	Will the growth rate of PMPM QHP costs for ARHOME beneficiaries remain similar to or be lower than that of Medicaid FFS beneficiaries?	1. PMPM Growth Rate
	Will the growth rate of the ARHOME program's total health expenditures and administrative costs be similar to or lower than that of Medicaid FFS?	2. Total Health Expenditure Growth Rate
		3. Administrative Cost Growth Rate

GOAL 4: Furthering quality improvement and delivery system reform initiatives that are successful across population groups

HYPOTHESIS	RESEARCH QUESTION	MEASURE

L. QHP beneficiaries with a shorter period of retroactive eligibility will be healthier at enrollment than Medicaid FFS beneficiaries with a longer period of retroactive eligibility	Will ARHOME beneficiaries with a shorter period of retroactive eligibility have fewer comorbidities at enrollment than Medicaid FFS beneficiaries?	1. Average Charlson Comorbidity Index Score
M. The cessation of monthly premium for QHP beneficiaries at 101-138% FPL will lead to a faster rate of growth in PMPM QHP costs in Years 2-5 compared to Year 1	Will the termination of monthly premiums for QHP beneficiaries at 101-138% FPL in Years 2-5 lead to a faster rate of growth in PMPM QHP costs as compared to costs incurred by similar beneficiaries in Year1?	1. QHP PMPM Growth Rate
N. The premium assistance model will lead to a lower rate of increase of PMPM premiums in the Arkansas Marketplace compared to states that expanded Medicaid and provide coverage through means other than premium assistance	Will ARHOME's premium assistance model result in a lower rate of increase in PMPM premiums in the Arkansas marketplace compared to similar states that expanded Medicaid?	1. Arkansas Program Characteristics 2. Arkansas Regional Average Program Characteristics 3. Contiguous States' Program Characteristics 4. Arkansas Marketplace PMPM Growth Rate
O. The premium assistance model will lead to a lower rate of increase in average commercial insurance premiums in Arkansas compared to states that expanded Medicaid and provide coverage through means other than premium assistance	Will ARHOME's premium assistance model result in a lower rate of increase in average commercial insurance premiums in Arkansas compared to similar states that expanded Medicaid?	1. Arkansas Commercial Insurance Premium Rates

Expanding Life360 HOMEs

The Maternal Life360 HOME program has provided strong support for high-risk pregnant women and their infants in the areas of the state where it has been implemented, and the state would like to continue growing the program, particularly in rural areas with maternal health deserts. Act 774 expanded the Life360 HOME program by allowing new provider types to enroll as Life360 HOMEs, in addition to hospitals. The law now allows Federally Qualified Health Centers (FQHCs) or other enrolled Medicaid providers designated by DHS to enroll in the program. This change will allow the program to serve more people in more areas of the state. DHS intends to use this expansion of Life360 HOMEs to target areas of the state without birthing hospitals.

Improving ARHOME's Fiscal Sustainability

DHS understands the ARHOME program must be financially sustainable and has taken steps to manage costs. The state has taken measures to constrain overall cost increases in recent years. For example, in 2026, the final year of the current waiver, the Budget Neutrality cap is $898.69 PMPM, but DHS has held the carriers to a limit of $878.46 PMPM for the calendar year.

In the new waiver, the state will take additional measures to constrain overall cost increases. Act 774 requires the state to increase the Medical Loss Ratio (MLR) to 85% (currently 80%) through the new Demonstration period. The act also requires monthly advanced cost share reduction payments to be taxed as premium, expanding the state tax revenue generated by the program and reinvested in it. Last, Act 774 also requires the QHPs to remit pharmacy rebates to the state as is required of managed care programs.

Adopting Work and Community Engagement Requirements

Section 71119 of P.L. 119-21, "Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals," provides that, "beginning not later than the first day of the first quarter that begins after December 31, 2026, or at the option of the State under a waiver or demonstration project under section 1115 or the State plan, such earlier date as the State may specify …". Accordingly, Arkansas seeks federal approval through this application to comply with Section 71119 using Section 1115 authority for all individuals who are applying for Medicaid coverage under the new adult group eligibility category and for those individuals who are enrolled in Medicaid under the new adult group eligibility category. This request includes adoption of the Optional Exception for Short-Term Hardship Events allowable under 71119(3)(B). Criteria for exception are as follows:

- Under the age of 19;
- Is entitled to or enrolled in Medicare;
- Is medically frail or otherwise has special medical needs, including an individual with a substance use disorder who is participating in a drug addiction or alcoholic treatment and rehabilitation program;
- Is the parent, guardian, caretaker relative, or family caregiver as defined in Section 2 of the RAISE Family Caregivers Act of a disabled individual;
- Is the parent, guardian, caretaker relative, or family caregiver as defined in Section 2 of the RAISE Family Caregivers Act of a dependent child 13 years of age and under;
- Is a veteran with a disability rated as total;
- Is pregnant (after the child is born, will continue to be exempt through age of 13);
- Is an Indian or an Urban Indian;
- Is a California Indian;
- Is an Indian as determined by the Indian Health Service;
- Is blind or disabled;
- Is an individual with a physical, intellectual, or developmental disability that impairs their ability to perform one or more activities of daily living;

- Is an individual with a serious or complex medical condition;
- Is in compliance with any requirements imposed by the State;
- Is a member of a household that receives SNAP benefits and is not exempt from a SNAP work requirement;
- Is an inmate of a public institution; or
- Is a former foster care child less than 26 years of age.

Through this application, Arkansas seeks federal approval of our plan to implement this requirement. Section 71119 applies to the entire new adult group without regard to the service delivery system (QHPs, FFS, or PASSE) in which they are enrolled. DHS anticipates that the majority of medically frail individuals enrolled in FFS and individuals with serious mental illness enrolled in PASSE will be verified exempt. However, DHS must review and verify all necessary information to determine compliance/exemption at the time of application and at redetermination as a condition of eligibility. For those who are required to comply (i.e., not exempt) with the 80 hours per month community engagement requirements, DHS will verify compliance at time of application and at redetermination.

DHS proposes to implement the Medicaid community engagement requirements through the following mechanisms.

5. Data matching

   Section 71119(a)(5) requires states to use *ex parte* verifications where possible. The Division of County Operations (DCO) will use data matching with internal and external sources to the maximum extent possible to avoid requiring individuals to submit additional information. These efforts will be tested through an outreach and operations pilot that will take place in 2026, so that DHS will be fully prepared for successful implementation beginning January 1, 2027.

6. Verification

   Data matching will successfully connect an individual to electronically searchable information, such as for employment and payroll purposes. However, there will be activities that cannot be identified electronically, such as volunteering and caregiving, that the state must obtain through other means.

   DHS recognizes the need for different verification strategies among the four different populations:

   2. Applicants who must comply
   3. Applicants who may be exempt
   4. Enrollees who must comply
   5. Enrollees who may continue to be exempt

   When Arkansas implemented work requirements in 2018-2019 under the Arkansas Works Demonstration, DHS learned the importance of providing multiple ways for beneficiaries to report their compliance or exemption. DHS will improve communications with individuals applying for or enrolled in Medicaid and enhance its data matching capabilities.

For beneficiaries whose exemption or compliance cannot be verified electronically, DHS proposes to verify through two methods. First, DHS will use an outbound contact center. DHS is currently soliciting a vendor to operate a Customer Support Center (CSC). As part of the CSC, the contractor must operate an outbound contact center to proactively contact Medicaid enrollees. DHS will provide the CSC with a list of enrollees for whom data matching was not successful, and the CSC will contact the beneficiaries to verify compliance or exemption. This "seek and find" capability will greatly improve DHS's ability to maintain up-to-date contact information and timely communication. It will support DHS's procedures for noticing noncompliance under Section 71119(a)(6).

The second method of obtaining verification will be through a Request for Information issued to beneficiaries requiring documentation to confirm exemption or compliance by providing proof from a third party.

The final determination of compliance/exemption will be made by DCO.

7. Outreach

Section 71119(a)(8) requires states to engage in an outreach campaign to support compliance. The DHS outreach campaign will consist of three strategies: 1) broad, statewide messaging; 2) community specific communications; and 3) individual communication through the CSC system, including the Verification Unit.

8. Success Coaching Services (Start date: July 1, 2028)

Arkansas proposes to go beyond the federal work and community engagement requirements by actively assisting individuals most at risk of long-term poverty. DHS services will include success coaching to help connect beneficiaries to employment, education, and training opportunities, as well as local resources that meet their health-related social needs (HRSN) to attain personal and family independence.

The target populations include those at risk of losing coverage due to noncompliance with community engagement requirements, the reentry population (formerly incarcerated), individuals who were formerly in the child welfare system, veterans, and individuals who have been enrolled in Medicaid for more than 24 months. Individuals in these groups will be eligible for Success Coaching services provided through designated entities and paid for on a Per Member Per Month (PMPM) basis. Individuals will meet with success coaching entities and develop individualized Personal Development Plans (PDPs) with goals to be achieved over time. Participation will be voluntary, and there will be no sanction for declining the service.

Impact on Eligibility

The requested changes to Life360 HOMEs will have no impact on Medicaid eligibility, but DHS anticipates they will allow more health care organizations to enroll as Life360 HOME providers and more people to receive Life360 HOME services.

The measures DHS will take to improve financial sustainability (imposing a higher MLR, collecting pharmacy rebates from the QHPs, and taxing the ACSR payments like premiums) will have no impact on beneficiary eligibility.

The new Medicaid community engagement requirements impose a new condition of eligibility on everyone in the new adult group. The requirements will apply at application and redetermination. Although the ARHOME Demonstration is targeted to the majority of the new adult group who receive their coverage through the premium assistance, the Demonstration will adopt the Medicaid community engagement requirements for the entire new adult group regardless of service delivery system (QHP, FFS, or PASSE).

Based on information gathered from actuarial analysis and other states, DHS estimates that enrollment in ARHOME could decrease approximately twenty percent (20%) with the enforcement of the community engagement requirement. The proposed outbound verification center will mitigate enrollment losses by giving individuals multiple opportunities to provide necessary information to maintain coverage.

Federal law also requires states to redetermine eligibility at least every six months. Although this requirement is outside the demonstration scope, DHS anticipates it will reinforce the enrollment decreases expected from the community engagement requirements.

The anticipated change in enrollment is reflected in the new budget neutrality numbers, which reflect an average enrollment of approximately 160,000 individuals in the QHPs. The populations that are exempt from participation are likely to be higher utilizers of medical services than the nonexempt populations. As a result, the PMPM cost will likely increase as the shift in the caseload mix changes.

The new Demonstration is designed to mitigate enrollment losses that would result from noncompliance and the ensuing provider compensation losses.

Impact on Delivery System

By expanding the types of providers that can become Life360 HOMEs, DHS anticipates more providers will enroll to offer these services, particularly federally qualified health centers and medical practices enrolled in DHS's patient-centered medical home program.

The measures DHS will take to improve financial sustainability (imposing a higher MLR, collecting pharmacy rebates from the QHPs, and taxing the ACSR payments like premiums) will likely result in the QHPs shifting these new costs to the plan premiums; however, this cost shift will increase the revenue earned by the state through the premium tax.

Impact on Covered Benefits/Cost Sharing

The requested changes to Life360 HOMEs, the fiscal sustainability measures, and implementation of the community engagement requirements should have no impact on covered benefits or cost sharing.

Requested Waivers and Expenditure Authority

1. **Freedom of Choice** **§ 1902(a)(23)(A)**

- To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice

among providers participating in the network of the beneficiary's Qualified Health Plan.

- To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers of focused care coordination services.

2. Payment to Providers **§§ 1902(a)(13) & 1902(a)(30)**

- To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan.

3. Amount, Duration, & Scope of Services & Comparability **§§ 1902(a)(10)(B) & 1902(a)(17)**

- To the extent necessary to enable DHS to provide different benefit packages for the "medically frail" and "interim" populations under the Medicaid FFS system than for those enrolled in private Qualified Health Plans.

- To the extent necessary to enable DHS to offer focused care coordination services to target populations that may vary and not otherwise be available to all beneficiaries in the same eligibility group.

4. Statewideness **§ 1902(a)(1)**

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

5. Cost Effectiveness Test **§§ 1905 & 1905(A)**

- To the extent necessary to enable DHS to require individuals to enroll in premium assistance offered by Arkansas QHPs and utilize an alternative cost effectiveness test that is not based on each individual.

6. Expenditure Authority

a. Premium Assistance and Cost Sharing Reduction Payments

Expenditures for all or part of the cost of private insurance premiums in the Arkansas individual Marketplace plans and for payments to reduce cost sharing under such coverage for certain beneficiaries.

b. Expenditures for Community Engagement Requirements Including Verification Center Unit

Expenditure authority is requested to support work and community engagement activities including the system to verify compliance/exemption status of the ARHOME population.

c. Expenditures for Life360 HOME Infrastructure and Services

Expenditure authority is requested to support the expansion of and continued services, including non-medical transportation, for Life360 HOMEs throughout the state.

Budget Neutrality

DHS proposes clarifying that the following expenditure types will be included in the budget neutrality assessments:

5. Net payments to QHPs, including premiums, ACSR, CSR settlement, and MLR recoupments
6. Non-emergency medical transportation (NET) and fee-for-service expenditures (e.g., EPSDT dental and vision services) for ARHOME beneficiaries enrolled in a QHP (known as “wrap” payments)
7. Life360 HOME infrastructure payments
8. Life360 HOME service payments for all ARHOME beneficiaries (including medically frail)

DHS proposes the following expenditures are not included in the budget neutrality assessment:

3. Expenditures for medically frail beneficiaries or beneficiaries awaiting enrollment in a QHP
4. Work and community engagement implementation costs (as these are required by P.L. 119-21)

DHS notes that the national trends of increasing health care costs are significant cost drivers for the ARHOME program and must be reflected in the “without waiver” projections.

The impact of the Medicaid community engagement requirements on enrollment may be significantly different than the state’s assumptions. DHS assumes that the number of people in the compliance populations and the exempt populations are roughly equal. While the state is taking a deliberate approach to mitigate enrollment loss, there is still great uncertainty about the future experience. DHS assumes that the exempt populations are likely to use services at higher rates than the compliance populations and therefore have higher average PMPM costs.

Budget projections for “with waiver” and “without waiver” expenditures account for several changes in the program including:

- The projections rely on the CY 2026 Budget Neutrality limit approved by CMS.
- There is an anticipated 20% reduction in enrollment attributable to the work requirement.
- There is an accompanying 10% increase in acuity expected.
- There is no expected material impact from the updated minimum MLR.
- The additional .9% cost increase attributable to the ACSR and pharmacy rebate changes will be negotiated in the 3.5% increase allowed for Demonstration Year 1.

Table 1 identifies the annual budget neutrality PMPMs for the expenditures for ARHOME beneficiaries enrolled in a QHP. The proposed limits are based on a 3.5% annual increase and an acuity adjustment resulting from the community engagement requirements and biannual redeterminations (lower cost beneficiaries losing coverage).

Table 1. Budget Neutrality for New Adult Group

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030	DY 05 CY 2031
With Waiver	$1,023.16	$1,058.97	$1,096.03	$1,134.39	$1,174.10
Without Waiver	$1,045.90	$1,106.56	$1,170.74	$1,238.64	$1,310.48

Table 2 contains DHS's request to support expansion of Life360 HOMEs. The HRSN services line is based on the current PMPM of $300 for Maternal Life 360 and the care coordination payments of $50,000 per year for Success Life360 Homes and $100,000 per year for Rural Life360 HOMEs, as well as the $50,000 for Maternal and Rural transportation costs. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed the demonstration period total. These costs do not include the cost of focused care coordination, which is allowable as a Medicaid service.

Table 2. Annual Limits in Life360 HOME Infrastructure

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030	DY 05 CY 2031
HRSN Services	$1,005,000	$1,715,000	$2,425,000	$3,135,000	$3,845,000
HRSN Infrastructure	$513,000	$739,375	$965,625	$1,191,875	$1,418,125

Public Hearings and Comments

DHS intends to implement the proposed changes in the renewal application by January 1, 2027.

The proposed renewal application and full public notice are available for public review on the DHS website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/.

In addition, the draft documents are also available for hard copy review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P.O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437.

During the public comment period, the public is invited to provide written comments to DHS via US postal service or electronic mail, as well as make comments verbally during the two public hearings. DHS will hold two public hearings, with both in person and virtual attendance options, on the following dates, times, and locations:

Public Hearing #1: Ad Hoc Meeting of the ARHOME Health & Economic Outcomes Accountability Oversight Advisory Panel

Wednesday, December 17, 2025, at 1:00 p.m. in Conference Room A/B at the Department of Human Services (DHS), Donaghey Plaza South Building, 700 Main Street, Little Rock, Arkansas 72203.

The details for attending the online public hearing appear at ar.gov/dhspublichearings.

Public Hearing #2: General Public Forum

Friday, January 2, 2026, at 1:00 p.m. in the Community Room at St. Bernard's Medical Center, 225 East Washington Ave., Jonesboro, Arkansas 72401.

The details for attending the online public hearing appear at ar.gov/dhspublichearings.

Interested persons should submit all comments to DHS on the proposed amendment on or before **January 12, 2026.**

Comments can be submitted via email to ORP@dhs.arkansas.gov or by mail to Department of Human Services (DHS) Office of Rules Promulgation, 2nd Floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin.

If you need a copy of the draft amendment or public notice documents in a different format, such as large print or in hard copy, contact the Office of Rules Promulgation at 501-320-6428.

Medicaid Section 1115 Demonstration Project Application, Arkansas Health and Opportunity for Me (ARHOME) Second Public Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a Medicaid Arkansas Health and Opportunity for Me (ARHOME) Demonstration Project (Waiver) renewal application and to hold public hearings to receive comments on the proposed Demonstration application.

In accordance with 42 §CFR 431.408, this notice provides a summary of the waiver renewal request and serves to formally open a second 20-day public comment period, which will begin on February 8, 2026, and conclude on February 27, 2026. This second public comment period is initiated to allow public comment on the ARHOME interim evaluation project report, which has been added as Attachment 4 to the application.

While DHS proposes to continue providing health care coverage to the adult expansion population through the purchase of private insurance on the state-based exchange, it proposes several changes to the current Demonstration in response to Act 774 and P.L. 119-21. The major changes are expanding Life360 HOMEs, improving fiscal sustainability of the program, and implementing community engagement requirements.

Program Description and Objectives

As of August 1, 2025, Arkansas provided health care coverage to more than 221,000 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 effective income is within a range that begins at approximately 14% FPL and is capped at 138% FPL.

Everyone determined eligible for ARHOME begins coverage in the Medicaid Fee-For-Service (FFS) delivery system. About 13,000 individuals are “medically frail” and remain in the FFS model of care because it provides additional services, such as personal care, that the QHPs do not. Beneficiaries who are not medically frail may choose a QHP. However, if a beneficiary does not pick a plan within 42 days of enrollment, DHS auto-assigns the beneficiary to a QHP according to an auto-assignment algorithm that considers market share. A small number of individuals may be enrolled in the Provider-led Arkansas Shared Savings Entity (PASSE) program due to the presence of a serious mental illness or confirmation of a need for Home and Community Based Services (HCBS) through an Independent Assessment (IA).

Of the more than 221,000 adults in Medicaid expansion, approximately 191,400 individuals currently receive their benefits through QHPs under the authorities granted in the ARHOME Demonstration Project. 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 payments to the QHPs in Calendar Year 2024 are approximately $1.3 billion for premiums and $493 million for cost sharing reduction payments for a total of $1.8 billion. These figures do not include the reconciliation for 2024 which will impact the final amount. For Calendar Year 2023, the total cost of ARHOME, inclusive of final cost share reconciliation, was approximately $2.1 billion.

The benefits for the new adult group, both in QHPs and FFS, meet the requirements of the Essential Health Benefit (EHB) package, as required by the A.C.A. The ARHOME population pays cost sharing in the form of copayments for specific services allowable under federal law. Cost sharing does not apply to individuals with income at or below 20% of FPL and other exempt groups. Copayments are capped at no more than 5% of household income on a quarterly basis.

Arkansas Medicaid purchases coverage that is equivalent to the cost of the second-lowest Silver Plan available in the state's Marketplace. The state is prohibited from charging premiums, and the cost-sharing obligation for Medicaid beneficiaries is limited to 5% of household income. Those with income at or below 20% FPL (46% of ARHOME enrollees) have no obligation for copayments. Those with income between 21% and 138% FPL pay copayments of $0.00 to $9.40 for covered services. The copayment for most services is $4.70.

QHPs form their own provider networks throughout the state separate from the Medicaid provider network.

The ARHOME program seeks to allow beneficiaries greater healthcare access through QHPs, provide beneficiaries with greater continuity of care, offer incentives to beneficiaries who engage in their healthcare, and stabilize Marketplace premiums.

Hypothesis and Evaluation Parameters

Goal 1: Providing continuity of coverage for individuals

Hypothesis	Research question	Measure
A. ARHOME beneficiaries will be aware of the premium assistance model	What percentage of ARHOME beneficiaries are aware of the premium assistance model?	1. Beneficiary Premium Assistance Awareness
B. ARHOME beneficiaries and QHP contracted providers will be aware of the Health Improvement Initiative	What percentage of ARHOME beneficiaries and QHP contracted providers are aware of the Health Improvement Initiative?	1. Beneficiary and 2. Provider Health Improvement Initiative Awareness
C. The premium assistance model will lead to less unmet need for healthcare among Arkansas residents ages 19-64 with income up to 138% FPL	Do Arkansas residents that are potentially eligible for ARHOME have less unmet needs related to having a personal doctor, medical costs, and routine checkups than	1. Have a Personal Doctor 2. Avoided Care Due to Cost

compared to individuals at the same income levels in states that expanded Medicaid through existing service delivery systems	similar residents in other comparable states that have expanded Medicaid?	3. Last Routine Checkup
D. The ARHOME program will lead to QHP beneficiaries having better continuity of coverage that includes fewer and shorter gaps, while Medicaid eligible, compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have fewer and shorter coverage gaps than Medicaid FFS beneficiaries?	1. Percent of Beneficiaries with At Least One Month with a Coverage Gap 2. Average Length of Gaps in Coverage
E. The ARHOME program will lead to QHP beneficiaries having better continuity of primary care and specialty providers, while Medicaid-eligible, compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have better continuity of primary and specialty care providers then Medicaid FFS beneficiaries?	1. Continuity of PCP Care 2. Continuity of Specialist Care 3. Percent Annual PCP Visits

GOAL 2: Improving access to providers

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. The premium assistance model will lead to improved financial health among Arkansas healthcare providers compared to healthcare providers in states that expanded Medicaid through the existing service delivery system	Are Arkansas healthcare providers more satisfied with compensation of QHP beneficiaries during the ARHOME demonstration?	1. Provider Financial Health Improvement
	Are Arkansas healthcare providers less likely to close and have better operating margins during the ARHOME demonstration?	2. Hospital Financial Health Improvement 3. Provider Closure Rate
B. The ARHOME program will lead to QHP beneficiaries having better perceived access to care over time and compared to Medicaid FFS beneficiaries	Are ARHOME beneficiaries more satisfied with their medical appointments in terms of timeliness, ease of scheduling, receiving appropriate care from the appropriate providers, and having an interpreter available	1 – 10. CAHPS: Perceived Access to Care

	to them when needed than Medicaid FFS beneficiaries?	
C. The ARHOME program will lead to QHP beneficiaries having better perceived access to care compared to similar beneficiaries in states that expanded Medicaid through the existing service delivery system	Do Arkansas residents that are eligible for ARHOME have better perceived access to routine care that includes medical coverage, cost, having a personal doctor, being seen regularly, and receiving the appropriate vaccinations than similar residents in other comparable states that have expanded Medicaid?	1 – 5. BRFSS: Perceived Access to Care
D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have better access to network providers and in a timely manner?	1. Provider Patient Acceptance and 2. Time to First Appointment
	Do ARHOME beneficiaries have better access to preventive care, recommended screenings, and chronic condition management than Medicaid FFS beneficiaries?	3 – 12. Preventative Visits and Cancer Screenings
	Do ARHOME beneficiaries that were enrolled in Medicaid FFS and eligible for EPSDT services have similar if not more preventive (wellness, dental, vision) visits than when they were in Medicaid FFS?	
	What percentage of ARHOME beneficiaries use non-emergency transportation (NET) assistance and how often do they use this service compared with Medicaid FFS beneficiaries?	13 – 15. NET Utilizations and Awareness
	Do ARHOME beneficiaries have a similar, if not better network of primary care providers and specialists to choose from within 30 miles of their residence than Medicaid FFS beneficiaries?	16 – 19. PCP and Specialist Network Adequacy and Accessibility
		20. ECP Network Adequacy

GOAL 3: Improving continuity of care across the continuum of coverage

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. ARHOME beneficiaries will be aware of the shorter period of retroactive eligibility, and the time-limited premium requirements	What percentage of ARHOME beneficiaries are aware of the shorter period of retroactive eligibility and premium requirement awareness?	1. Beneficiary Retroactive Eligibility Awareness
		2. Beneficiary Premium Requirement Awareness
B. The shorter period of retroactive eligibility will not lead to a lower rate of Medicaid applications among individuals potentially eligible for ARHOME compared to individuals potentially eligible for other Medicaid programs without a reduced period of retroactive eligibility	Does the shorter period of retroactive eligibility lower the rate of ARHOME new enrollments?	1. New Enrollment
C. The shorter period of retroactive eligibility will not lead to a greater medical debt among new ARHOME beneficiaries compared to individuals newly enrolled in other Medicaid programs without a reduced period of retroactive eligibility	Do new ARHOME beneficiaries with a shorter period of retroactive eligibility have a higher rate of medical debt compared with the new Medicaid FFS beneficiaries?	1. New Beneficiary Medical Debt
D. During Year 1 of the demonstration, monthly premiums will not lead to lower take-up and retention rates among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those at or below 100% FPL	In the first year of the ARHOME demonstration, will monthly premiums lower rates of new enrollment and retention among ARHOME applicants or beneficiaries at 101-138% FPL as compared to those at or below 100% FPL?	1. New Enrollment
		2. Retention Rate

GOAL 3: Improving continuity of care across the continuum of coverage

HYPOTHESIS	RESEARCH QUESTION	MEASURE
E. During Year 1 of the demonstration, monthly premiums will not lead to more gaps in coverage among Arkansas residents age 19-64 with income at 101-138% FPL compared to those at or below 100% FPL	In the first year of the ARHOME demonstration, will monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL as compared with ARHOME beneficiaries at or below 100% FPL?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap
		2. Average Length of Gaps in Coverage

F.QHP beneficiaries will demonstrate they value QHP coverage, and the implementation of monthly premiums will not reduce QHP beneficiary enrollment	Will monthly premiums lower overall health insurance coverage among Arkansas residents between 101-138% FPL?	1. Health Insurance Coverage Status
	During Year 1 of the demonstration, will monthly premiums lower the percentage of ARHOME beneficiaries at 101-138% FPL who pay a premium?	2. Premium Payments
	Will monthly premiums lower the percentage of ARHOME beneficiaries selecting their own QHP at enrollment?	3. QHP Selections
G. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase take-up and retention rates among QHP beneficiaries with income at 101-138% FPL compared with Year 1	Will the termination of monthly premiums increase the rate of new enrollment or retention among ARHOME applicants or beneficiaries at 101-138% FPL in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. New Enrollment
		2. Retention Rate
H. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase gaps in coverage among QHP beneficiaries while still eligible for ARHOME than they did during Year 1	Will the termination of monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap
		2. Average Length of Gaps in Coverage
I. During Years 2-5 of the demonstration, the cessation of monthly premiums will lead to QHP beneficiaries having more gaps in coverage after earnings exceed Medicaid eligibility limits than they did during Year 1	Will the termination of monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL who disenroll due to high income in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap
		2. Average Length of Gaps in Coverage

GOAL 4: Furthering quality improvement and delivery system reform initiatives that are successful across population groups

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. ARHOME beneficiaries will be aware of the shorter point-of-service copayment requirements and the Economic Independence Initiative	What percentage of ARHOME beneficiaries are aware of point-of-service copayments and the Economic Independence Initiative?	1. Beneficiary Copayment and 2. EII Awareness
B. The ARHOME program will lead to QHP beneficiaries having greater satisfaction in the care provided over time and compared to Medicaid FFS beneficiaries	Are ARHOME beneficiaries more satisfied with their health plan, health care, as well as primary care providers and specialists?	1. Rating of 1 Health Plan and 2. Health Care 3. PCP and 4. Specialist
C. The ARHOME program will lead to QHP beneficiaries having lower non-emergent use of the emergency department (ED), lower potentially preventable use of the emergency department and hospital admissions, and lower hospital re-admissions over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have lower ED visits, chronic condition hospital admissions, and all-cause readmissions than Medicaid FFS beneficiaries?	1. Preventable 2. Non-Emergent and 3. Emergent ED Visits 4. Plan All Cause Readmissions 5 – 8. Preventable Hospital Admissions
	Do ARHOME beneficiaries have a higher rate of follow-up care after hospitalizations and ED visits than Medicaid FFS beneficiaries?	9. PCP Follow-Up after ED Visit 10. PCP Follow-Up after Hospitalization
D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries with a diagnosis of mental illness or substance use disorder have higher rates of treatment, medication adherence, preventive screenings, as well as follow-up after ED visits and hospitalizations than Medicaid FFS beneficiaries	1 – 20. Acute, Behavioral Health, Chronic Condition Care, Maternal and Perinatal Care, and HIT Participation
	Do ARHOME beneficiaries have lower use of opioids and benzodiazepines than Medicaid FFS beneficiaries?	
	Do ARHOME beneficiaries have lower rates of C-sections than Medicaid FFS beneficiaries?	
	Do ARHOME beneficiaries have higher rates of preventive care, contraceptive care, and medical management of chronic conditions than Medicaid FFS	

	beneficiaries?	
	What percentage of ARHOME beneficiaries are participating in a Health Improvement Initiative?	
E. Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries not subject to copays	Will copayments lower rates of treatment, medication adherence, preventive screenings, as well as follow-up after ED visits and hospitalizations among ARHOME beneficiaries with a diagnosis of mental illness or substance use disorder compared with rates of Medicaid FFS beneficiaries?	1 – 11. Acute, Behavioral Health, and Chronic Condition Care
	Will copayments increase the use of opioids and benzodiazepines among ARHOME beneficiaries compared with Medicaid FFS beneficiaries?	
F. Among QHP beneficiaries with income at or below 20% FPL, the Economic Independence Initiative will lead to an increase in income to above 20% FPL over time	Will the Economic Independence Initiative increase the percentage of ARHOME beneficiaries who had an income below 20% FPL in the prior year to at or above 20% FPL in the current measurement year?	1. Percent of Beneficiaries at or under 20% FPL at Initial Measurement That Are Above 20% FPL at Follow-Up Measurement, Among Those Still Enrolled at the Follow-Up Measurement

GOAL 4: Furthering quality improvement and delivery system reform initiatives that are successful across population groups

HYPOTHESIS	RESEARCH QUESTION	MEASURE
G. Among QHP beneficiaries with income at or below 100% FPL, the Economic Independence Initiative will lead to an increase in income to about 100% FPL over time	Will the Economic Independence Initiative increase the percentage of ARHOME beneficiaries who had an income below 100% FPL in the prior year to at least 100% FPL in the current measurement year?	1. Percent of Beneficiaries at or under 100% FPL at Initial Measurement that are Above 100% FPL at Follow-Up Measurement, Amont Those Still Enrolled at the Follow-Up Measurement
H. Among QHP beneficiaries who disenroll from ARHOME, the Economic Independent Initiative	Will there be increase in the percentage of ARHOME beneficiaries that disenroll due	1. Percent of Beneficiaries That Disenroll Due to High Income

will lead to an increase in the percent that disenroll due to increased income over time		
	Do a higher percentage of ARHOME beneficiaries that disenroll take up private health insurance and will that private health insurance be the same carrier as their ARHOME QHP carrier?	2. Percent of Disenrolled Beneficiaries That Take-Up Private Health Insurance
		3. Percent of Disenrolled Beneficiaries That Take-Up Private Health Insurance and Maintain the Same Health Insurance Plan they had in ARHOME
I. The Economic Independence Initiative will lead to an increase in the percent of QHP beneficiaries that enroll in education and training programs over time.	Will the Economic Independence Initiative increase the percentage of ARHOME beneficiaries that participate either through the initiative or in other education and training programs?	1. Percent of QHP Beneficiaries that Enroll in Education and Training Programs over time
		2. Percent of QHP Beneficiaries Participating in the ELL Program
J. The point-of-service copayments will lead to QHP beneficiaries subject to copays having lower overall healthcare use compared to similar QHP beneficiaries not subject to copays	Will ARHOME beneficiaries subject to copayments have lower healthcare utilization than ARHOME beneficiaries not subject to copayments?	1. Beneficiary Copayment Healthcare Use Impact
K. The shorter period of retroactive eligibility, the premium assistance model, the point-of-service copayments, the Health Improvement Initiative, and the other financial discipline components will lead to the rate of growth in per member per month (PMPM) QHP costs being no higher than the rate of growth in PMPM costs in Arkansas Medicaid FFS	Will the growth rate of PMPM QHP costs for ARHOME beneficiaries remain similar to or be lower than that of Medicaid FFS beneficiaries?	1. PMPM Growth Rate
	Will the growth rate of the ARHOME program's total health expenditures and administrative costs be similar to or lower than that of Medicaid FFS?	2. Total Health Expenditure Growth Rate
		3. Administrative Cost Growth Rate

GOAL 4: Furthering quality improvement and delivery system reform initiatives that are successful across population groups

HYPOTHESIS	RESEARCH QUESTION	MEASURE
L. QHP beneficiaries with a shorter period of retroactive eligibility will be healthier at enrollment than Medicaid FFS beneficiaries with a longer period of retroactive eligibility	Will ARHOME beneficiaries with a shorter period of retroactive eligibility have fewer comorbidities at enrollment than Medicaid FFS beneficiaries?	1. Average Charlson Comorbidity Index Score
M. The cessation of monthly premium for QHP beneficiaries at 101-138% FPL will lead to a faster rate of growth in PMPM QHP costs in Years 2-5 compared to Year 1	Will the termination of monthly premiums for QHP beneficiaries at 101-138% FPL in Years 2-5 lead to a faster rate of growth in PMPM QHP costs as compared to costs incurred by similar beneficiaries in Year1?	1. QHP PMPM Growth Rate
N. The premium assistance model will lead to a lower rate of increase of PMPM premiums in the Arkansas Marketplace compared to states that expanded Medicaid and provide coverage through means other than premium assistance	Will ARHOME's premium assistance model result in a lower rate of increase in PMPM premiums in the Arkansas marketplace compared to similar states that expanded Medicaid?	1. Arkansas Program Characteristics 2. Arkansas Regional Average Program Characteristics 3. Contiguous States' Program Characteristics 4. Arkansas Marketplace PMPM Growth Rate
O. The premium assistance model will lead to a lower rate of increase in average commercial insurance premiums in Arkansas compared to states that expanded Medicaid and provide coverage through means other than premium assistance	Will ARHOME's premium assistance model result in a lower rate of increase in average commercial insurance premiums in Arkansas compared to similar states that expanded Medicaid?	1. Arkansas Commercial Insurance Premium Rates

Expanding Life360 HOMEs

The Maternal Life360 HOME program has provided strong support for high-risk pregnant women and their infants in the areas of the state where it has been implemented, and the state would like to continue growing the program, particularly in rural areas with maternal health deserts. Act 774 expanded the Life360 HOME program by allowing new provider types to enroll as Life360 HOMEs, in addition to hospitals. The law now allows Federally Qualified Health Centers (FQHCs) or other enrolled Medicaid providers designated by DHS to enroll in the program. This change will allow the program to serve more people in more areas of the state. DHS intends to use this expansion of Life360 HOMEs to target areas of the state without birthing hospitals.

Improving ARHOME's Fiscal Sustainability

DHS understands the ARHOME program must be financially sustainable and has taken steps to manage costs. The state has taken measures to constrain overall cost increases in recent years. For example, in 2026, the final year of the current waiver, the Budget Neutrality cap is $898.69 PMPM, but DHS has held the carriers to a limit of $878.46 PMPM for the calendar year.

In the new waiver, the state will take additional measures to constrain overall cost increases. Act 774 requires the state to increase the Medical Loss Ratio (MLR) to 85% (currently 80%) through the new Demonstration period. The act also requires monthly advanced cost share reduction payments to be taxed as premium, expanding the state tax revenue generated by the program and reinvested in it. Last, Act 774 also requires the QHPs to remit pharmacy rebates to the state as is required of managed care programs.

Adopting Work and Community Engagement Requirements

Section 71119 of P.L. 119-21, "Requirement for States to Establish Medicaid Community Engagement Requirements for Certain Individuals," provides that, "beginning not later than the first day of the first quarter that begins after December 31, 2026, or at the option of the State under a waiver or demonstration project under section 1115 or the State plan, such earlier date as the State may specify …". Accordingly, Arkansas seeks federal approval through this application to comply with Section 71119 using Section 1115 authority for all individuals who are applying for Medicaid coverage under the new adult group eligibility category and for those individuals who are enrolled in Medicaid under the new adult group eligibility category. This request includes adoption of the Optional Exception for Short-Term Hardship Events allowable under 71119(3)(B). Criteria for exception are as follows:

- Under the age of 19;
- Is entitled to or enrolled in Medicare;
- Is medically frail or otherwise has special medical needs, including an individual with a substance use disorder who is participating in a drug addiction or alcoholic treatment and rehabilitation program;
- Is the parent, guardian, caretaker relative, or family caregiver as defined in Section 2 of the RAISE Family Caregivers Act of a disabled individual;

- Is the parent, guardian, caretaker relative, or family caregiver as defined in Section 2 of the RAISE Family Caregivers Act of a dependent child 13 years of age and under;
- Is a veteran with a disability rated as total;
- Is pregnant (after the child is born, will continue to be exempt through age of 13);
- Is an Indian or an Urban Indian;
- Is a California Indian;
- Is an Indian as determined by the Indian Health Service;
- Is blind or disabled;
- Is an individual with a physical, intellectual, or developmental disability that impairs their ability to perform one or more activities of daily living;
- Is an individual with a serious or complex medical condition;
- Is in compliance with any requirements imposed by the State;
- Is a member of a household that receives SNAP benefits and is not exempt from a SNAP work requirement;
- Is an inmate of a public institution; or
- Is a former foster care child less than 26 years of age.

Through this application, Arkansas seeks federal approval of our plan to implement this requirement. Section 71119 applies to the entire new adult group without regard to the service delivery system (QHPs, FFS, or PASSE) in which they are enrolled. DHS anticipates that the majority of medically frail individuals enrolled in FFS and individuals with serious mental illness enrolled in PASSE will be verified exempt. However, DHS must review and verify all necessary information to determine compliance/exemption at the time of application and at redetermination as a condition of eligibility. For those who are required to comply (i.e., not exempt) with the 80 hours per month community engagement requirements, DHS will verify compliance at time of application and at redetermination.

DHS proposes to implement the Medicaid community engagement requirements through the following mechanisms.

1. Data matching

   Section 71119(a)(5) requires states to use ex parte verifications where possible. The Division of County Operations (DCO) will use data matching with internal and external sources to the maximum extent possible to avoid requiring individuals to submit additional information. These efforts will be tested through an outreach and operations pilot that will take place in 2026, so that DHS will be fully prepared for successful implementation beginning January 1, 2027.

2. Verification

   Data matching will successfully connect an individual to electronically searchable information, such as for employment and payroll purposes. However, there will be activities that cannot be identified electronically, such as volunteering and caregiving, that the state must obtain through other means.

DHS recognizes the need for different verification strategies among the four different populations:

1. Applicants who must comply
2. Applicants who may be exempt
3. Enrollees who must comply
4. Enrollees who may continue to be exempt

When Arkansas implemented work requirements in 2018-2019 under the Arkansas Works Demonstration, DHS learned the importance of providing multiple ways for beneficiaries to report their compliance or exemption. DHS will improve communications with individuals applying for or enrolled in Medicaid and enhance its data matching capabilities.

For beneficiaries whose exemption or compliance cannot be verified electronically, DHS proposes to verify through two methods. First, DHS will use an outbound contact center. DHS is currently soliciting a vendor to operate a Customer Support Center (CSC). As part of the CSC, the contractor must operate an outbound contact center to proactively contact Medicaid enrollees. DHS will provide the CSC with a list of enrollees for whom data matching was not successful, and the CSC will contact the beneficiaries to verify compliance or exemption. This “seek and find” capability will greatly improve DHS’s ability to maintain up-to-date contact information and timely communication. It will support DHS’s procedures for noticing noncompliance under Section 71119(a)(6).

The second method of obtaining verification will be through a Request for Information issued to beneficiaries requiring documentation to confirm exemption or compliance by providing proof from a third party.

The final determination of compliance/exemption will be made by DCO.

3. Outreach

Section 71119(a)(8) requires states to engage in an outreach campaign to support compliance. The DHS outreach campaign will consist of three strategies: 1) broad, statewide messaging; 2) community specific communications; and 3) individual communication through the CSC system, including the Verification Unit.

4. Success Coaching Services (Start date: July 1, 2028)

Arkansas proposes to go beyond the federal work and community engagement requirements by actively assisting individuals most at risk of long-term poverty. DHS services will include success coaching to help connect beneficiaries to employment, education, and training opportunities, as well as local resources that meet their health-related social needs (HRSN) to attain personal and family independence.

The target populations include those at risk of losing coverage due to noncompliance with community engagement requirements, the reentry population (formerly incarcerated), individuals who were formerly in the child welfare system, veterans, and individuals who have been enrolled in Medicaid for more than 24 months. Individuals in these groups will be eligible for Success Coaching services provided through designated entities and paid for on a Per Member Per Month (PMPM) basis. Individuals will meet with success coaching entities and develop individualized Personal Development Plans (PDPs) with goals to be achieved over time. Participation will be voluntary, and there will be no sanction for declining the service.

Impact on Eligibility

The requested changes to Life360 HOMEs will have no impact on Medicaid eligibility, but DHS anticipates they will allow more health care organizations to enroll as Life360 HOME providers and more people to receive Life360 HOME services.

The measures DHS will take to improve financial sustainability (imposing a higher MLR, collecting pharmacy rebates from the QHPs, and taxing the ACSR payments like premiums) will have no impact on beneficiary eligibility.

The new Medicaid community engagement requirements impose a new condition of eligibility on everyone in the new adult group. The requirements will apply at application and redetermination. Although the ARHOME Demonstration is targeted to the majority of the new adult group who receive their coverage through the premium assistance, the Demonstration will adopt the Medicaid community engagement requirements for the entire new adult group regardless of service delivery system (QHP, FFS, or PASSE).

Based on information gathered from actuarial analysis and other states, DHS estimates that enrollment in ARHOME could decrease approximately twenty percent (20%) with the enforcement of the community engagement requirement. The proposed outbound verification center will mitigate enrollment losses by giving individuals multiple opportunities to provide necessary information to maintain coverage.

Federal law also requires states to redetermine eligibility at least every six months. Although this requirement is outside the demonstration scope, DHS anticipates it will reinforce the enrollment decreases expected from the community engagement requirements.

The anticipated change in enrollment is reflected in the new budget neutrality numbers, which reflect an average enrollment of approximately 160,000 individuals in the QHPs. The populations that are exempt from participation are likely to be higher utilizers of medical services than the nonexempt populations. As a result, the PMPM cost will likely increase as the shift in the caseload mix changes.

The new Demonstration is designed to mitigate enrollment losses that would result from noncompliance and the ensuing provider compensation losses.

Impact on Delivery System

By expanding the types of providers that can become Life360 HOMEs, DHS anticipates more providers will enroll to offer these services, particularly federally qualified health centers and medical practices enrolled in DHS's patient-centered medical home program.

The measures DHS will take to improve financial sustainability (imposing a higher MLR, collecting pharmacy rebates from the QHPs, and taxing the ACSR payments like premiums) will likely result in the QHPs shifting these new costs to the plan premiums; however, this cost shift will increase the revenue earned by the state through the premium tax.

Impact on Covered Benefits/Cost Sharing

The requested changes to Life360 HOMEs, the fiscal sustainability measures, and implementation of the community engagement requirements should have no impact on covered benefits or cost sharing.

Requested Waivers and Expenditure Authority

1. **Freedom of Choice** **§ 1902(a)(23)(A)**

- To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers participating in the network of the beneficiary's Qualified Health Plan.

- To the extent necessary to enable Arkansas to limit beneficiaries' freedom of choice among providers of focused care coordination services.

2. **Payment to Providers** **§§ 1902(a)(13) & 1902(a)(30)**

- To the extent necessary to permit Arkansas to provide for payment to providers equal to the market-based rates determined by the Qualified Health Plan.

3. **Amount, Duration, & Scope Of Services & Comparability** **§§ 1902(a)(10)(B) & 1902(a)(17)**

- To the extent necessary to enable DHS to provide different benefit packages for the "medically frail" and "interim" populations under the Medicaid FFS system than for those enrolled in private Qualified Health Plans.

- To the extent necessary to enable DHS to offer focused care coordination services to target populations that may vary and not otherwise be available to all beneficiaries in the same eligibility group.

4. **Statewideness** **§ 1902(a)(1)**

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

5. **Cost Effectiveness Test** **§§ 1905 & 1905(A)**

- To the extent necessary to enable DHS to require individuals to enroll in premium assistance offered by Arkansas QHPs and utilize an alternative cost effectiveness test that is not based on each individual.

6. **Expenditure Authority**

   a. **Premium Assistance and Cost Sharing Reduction Payments**

   Expenditures for all or part of the cost of private insurance premiums in the Arkansas individual Marketplace plans and for payments to reduce cost sharing under such coverage for certain beneficiaries.

b. Expenditures for Community Engagement Requirements Including Verification Center Unit

Expenditure authority is requested to support work and community engagement activities including the system to verify compliance/exemption status of the ARHOME population.

c. Expenditures for Life360 HOME Infrastructure and Services

Expenditure authority is requested to support the expansion of and continued services, including non-medical transportation, for Life360 HOMEs throughout the state.

Budget Neutrality

DHS proposes clarifying that the following expenditure types will be included in the budget neutrality assessments:

1. Net payments to QHPs, including premiums, ACSR, CSR settlement, and MLR recoupments
2. Non-emergency medical transportation (NET) and fee-for-service expenditures (e.g., EPSDT dental and vision services) for ARHOME beneficiaries enrolled in a QHP (known as "wrap" payments)
3. Life360 HOME infrastructure payments
4. Life360 HOME service payments for all ARHOME beneficiaries (including medically frail)

DHS proposes the following expenditures are not included in the budget neutrality assessment:

1. Expenditures for medically frail beneficiaries or beneficiaries awaiting enrollment in a QHP
2. Work and community engagement implementation costs (as these are required by P.L. 119-21)

DHS notes that the national trends of increasing health care costs are significant cost drivers for the ARHOME program and must be reflected in the "without waiver" projections.

The impact of the Medicaid community engagement requirements on enrollment may be significantly different than the state's assumptions. DHS assumes that the number of people in the compliance populations and the exempt populations are roughly equal. While the state is taking a deliberate approach to mitigate enrollment loss, there is still great uncertainty about the future experience. DHS assumes that the exempt populations are likely to use services at higher rates than the compliance populations and therefore have higher average PMPM costs.

Budget projections for "with waiver" and "without waiver" expenditures account for several changes in the program including:

- The projections rely on the CY 2026 Budget Neutrality limit approved by CMS.
- There is an anticipated 20% reduction in enrollment attributable to the work requirement.
- There is an accompanying 10% increase in acuity expected.
- There is no expected material impact from the updated minimum MLR.
- The additional .9% cost increase attributable to the ACSR and pharmacy rebate changes will be negotiated in the 3.5% increase allowed for Demonstration Year 1.

Table 1 identifies the annual budget neutrality PMPMs for the expenditures for ARHOME beneficiaries enrolled in a QHP. The proposed limits are based on a 3.5% annual increase and

an acuity adjustment resulting from the community engagement requirements and biannual redeterminations (lower cost beneficiaries losing coverage).

Table 1. Budget Neutrality for New Adult Group

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030		DY 05 CY 2031
With Waiver	$1,023.16	$1,058.97	$1,096.03	$1,134.39		$1,174.10
Without Waiver	$1,045.90	$1,106.56	$1,170.74	$1,238.64		$1,310.48

Table 2 contains DHS's request to support expansion of Life360 HOMEs. The HRSN services line is based on the current PMPM of $300 for Maternal Life 360 and the care coordination payments of $50,000 per year for Success Life360 Homes and $100,000 per year for Rural Life360 HOMEs, as well as the $50,000 for Maternal and Rural transportation costs. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed the demonstration period total. These costs do not include the cost of focused care coordination, which is allowable as a Medicaid service.

Table 2. Annual Limits in Life360 HOME Infrastructure

	DY 01 CY 2027	DY 02 CY 2028	DY 03 CY 2029	DY 04 CY 2030	DY 05 CY 2031
HRSN Services	$1,005,000	$1,715,000	$2,425,000	$3,135,000	$3,845,000
HRSN Infrastructure	$513,000	$739,375	$965,625	$1,191,875	$1,418,125

Public Hearings and Comments

DHS intends to implement the proposed changes in the renewal application by January 1, 2027.

The proposed renewal application, full public notice, and interim evaluation project report are available for public review on the DHS website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. In addition, the draft documents are also available for hard copy review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P.O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437.

Comments can be submitted via email to ORP@dhs.arkansas.gov or by mail to Department of Human Services (DHS) Office of Rules Promulgation, 2nd Floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. During the public comment period, the public is invited to provide written comments to DHS via US postal service or electronic mail. Interested persons should submit all comments to DHS by **February 27, 2026.**

Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated and managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin.

If you need a copy of the draft amendment or public notice documents in a different format, such as large print or in hard copy, contact the Office of Rules Promulgation at 501-320-6428.

Attachment 3: Abbreviated Public Notice

Public Notice

Medicaid Section 1115 Demonstration Project Application, Arkansas Health and Opportunity for Me (ARHOME) Abbreviated Notice

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing public notice of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a Medicaid Arkansas Health and Opportunity for Me (ARHOME) Demonstration Project (Waiver) application and to hold public hearings to receive comments on the proposed Demonstration application.

In accordance with 42 §CFR 431.408, this notice provides a summary of the waiver renewal request and serves to formally open the 30-day public comment period, which will begin on December 14, 2025 and conclude on January 13, 2026.

Specifically, DHS seeks public comment on its renewal request to include the following changes to the current ARHOME demonstration:

1. *Implementation of new federal requirements for community engagement.* The renewal application includes a description of how DHS plans to implement the new federal and state work requirements. Arkansas proposes to use the ARHOME demonstration to comply with the new community engagement requirements for all individuals who are applying for Medicaid coverage under the new adult group eligibility category and for those individuals who are enrolled in Medicaid under the new adult group eligibility category. The application also proposes to adopt the Optional Exception for Short-Term Hardship Events allowable under 71119(3)(B). DHS will redetermine eligibility at least once every six months for the new adult group beginning January 1, 2027.

2. *Expansion of Life360 HOMEs.* The renewal application proposes to expand the Life360 HOME program, particularly in areas with maternal health deserts. Act 774 expanded the Life360 HOME program by allowing new provider types to enroll as Life360 HOMEs, in addition to hospitals. The law now allows Federally Qualified Health Centers and other organizations designated by DHS to enroll in the program. This change will allow the program to serve more people in more areas of the state. DHS intends to use this expansion of Life360 HOME to target areas of the state without birthing hospitals.

3. *Improving ARHOME's fiscal sustainability.* Act 774 of 2025 requires the state to increase the Medical Loss Ratio from 80% to 85% through the new demonstration period. The Act also requires monthly advanced cost share reduction payments to be taxed as premium, expanding state tax revenue generated by the program and reinvesting it. Act 774 also requires Qualified Health Programs (QHPs) to return pharmacy rebates to the state, as is already required of managed care programs.

Continuation of the ARHOME Demonstration Model

DHS will continue the remainder of the ARHOME model as it currently exists. Of the more than 221,000 adults in Medicaid expansion, approximately 191,400 individuals currently

receive their benefits through QHPs under the authorities granted in the ARHOME Demonstration Project. 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 payments to the QHPs in Calendar Year 2024 are approximately $1.3 billion for premiums and $493 million for cost sharing reduction payments for a total of $1.8 billion. These figures do not include the reconciliation for 2024 which will impact the final amount. For Calendar Year 2023, the total cost of ARHOME, inclusive of final cost share reconciliation, was approximately $2.1 billion.

The benefits for the new adult group, both in QHPs and FFS, meet the requirements of the Essential Health Benefit (EHB) package, as required by the A.C.A. The ARHOME population pays cost sharing in the form of copayments for specific services allowable under federal law. Cost sharing does not apply to individuals with income at or below 20% of FPL and other exempt groups. Copayments are capped at no more than 5% of household income on a quarterly basis.

Arkansas Medicaid purchases coverage that is equivalent to the cost of the second-lowest Silver Plan available in the state's Marketplace. QHPs form their own provider networks throughout the state separate from the Medicaid provider network.

Implementation

DHS intends to implement the proposed changes in the renewal application by January 1, 2027.

Public Comments

The proposed renewal application and full public notice are available for public review on the DHS website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/.

In addition, the draft documents are also available for hard copy review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P.O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437.
During the public comment period, the public is invited to provide written comments to DHS via US postal service or electronic mail, as well as make comments verbally during the two public hearings. DHS will hold two public hearings on the following dates, times, and locations:

Public Hearing #1: Ad hoc Meeting of the ARHOME Health & Economic Outcomes Accountability Oversight Advisory Panel

Wednesday, December 17, 2025, at 1:00 p.m. in Conference Room A/B at the Department of Human Services (DHS), Donaghey Plaza South Building, 700 Main Street, Little Rock, Arkansas 72203.

The details for attending the online public hearing appear at ar.gov/dhspublichearings.

Public Hearing #2: General Public Forum

Friday, January 2, 2026, at 1:00 p.m. in the Community Room at St. Bernard's Medical Center, 225 East Washington Ave., Jonesboro, Arkansas 72401.

The details for attending the online public hearing appear at ar.gov/dhspublichearings.

Interested persons should submit all comments to DHS on the proposed amendment on or before **January 12, 2026.**

Comments can be submitted via email to ORP@dhs.arkansas.gov or by mail to Department of Human Services (DHS) Office of Rules Promulgation, 2nd Floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

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Elizabeth Pitman, Director
Division of Medical Services

Medicaid Section 1115 Demonstration Project Application, Arkansas Health and Opportunity for Me (ARHOME) Abbreviated Notice (Second Comment Period)

The Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) is providing a second public notice of its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a Medicaid Arkansas Health and Opportunity for Me (ARHOME) Demonstration Project (Waiver) application and to hold public hearings to receive comments on the proposed Demonstration application.

In accordance with 42 §CFR 431.408, this notice provides a summary of the waiver renewal request and serves to formally open a second public comment period, which will last 20 days, beginning on February 8, 2026, and concluding on February 27, 2026. This second public comment period is initiated to allow public comment on the ARHOME interim evaluation project report, which has been added as Attachment 4 to the application.

Specifically, DHS seeks public comments on its renewal request to include the following changes to the current ARHOME demonstration:

1. *Implementation of new federal requirements for community engagement.* The renewal application includes a description of how DHS plans to implement the new federal and state work requirements. Arkansas proposes to use the ARHOME demonstration to comply with the new community engagement requirements for all individuals who are applying for Medicaid coverage under the new adult group eligibility category and for those individuals who are enrolled in Medicaid under the new adult group eligibility category. The application also proposes to adopt the Optional Exception for Short-Term Hardship Events allowable under 71119(3)(B). DHS will redetermine eligibility at least once every six months for the new adult group beginning January 1, 2027.

2. *Expansion of Life360 HOMEs.* The renewal application proposes to expand the Life360 HOME program, particularly in areas with maternal health deserts. Act 774 expanded the Life360 HOME program by allowing new provider types to enroll as Life360 HOMEs, in addition to hospitals. The law now allows Federally Qualified Health Centers and other organizations designated by DHS to enroll in the program. This change will allow the program to serve more people in more areas of the state. DHS intends to use this expansion of Life360 HOME to target areas of the state without birthing hospitals.

3. *Improving ARHOME's fiscal sustainability.* Act 774 of 2025 requires the state to increase the Medical Loss Ratio from 80% to 85% through the new demonstration period. The Act also requires monthly advanced cost share reduction payments to be taxed as premium, expanding state tax revenue generated by the program and reinvesting it. Act 774 also requires Qualified Health Programs (QHPs) to return pharmacy rebates to the state, as is already required of managed care programs.

Continuation of the ARHOME Demonstration Model

DHS will continue the remainder of the ARHOME model as it currently exists. Of the more than 221,000 adults in Medicaid expansion, approximately 191,400 individuals currently receive their benefits through QHPs under the authorities granted in the ARHOME Demonstration Project. 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 payments to the QHPs in Calendar Year 2024 are approximately $1.3 billion for premiums and $493 million for cost sharing reduction payments for a total of $1.8 billion. These figures do not include the reconciliation for 2024 which will impact the final amount. For Calendar Year 2023, the total cost of ARHOME, inclusive of final cost share reconciliation, was approximately $2.1 billion.

The benefits for the new adult group, both in QHPs and FFS, meet the requirements of the Essential Health Benefit (EHB) package, as required by the A.C.A. The ARHOME population pays cost sharing in the form of copayments for specific services allowable under federal law. Cost sharing does not apply to individuals with income at or below 20% of FPL and other exempt groups. Copayments are capped at no more than 5% of household income on a quarterly basis.

Arkansas Medicaid purchases coverage that is equivalent to the cost of the second-lowest Silver Plan available in the state's Marketplace. QHPs form their own provider networks throughout the state separate from the Medicaid provider network.

Implementation

DHS intends to implement the proposed changes in the renewal application by January 1, 2027.

Public Comments

The proposed renewal application, full public notice, and interim evaluation project report are available for public review on the DHS website at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/.

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During the public comment period, the public is invited to provide written comments to DHS via US postal service or electronic mail. Interested persons should submit all comments to DHS by **February 27, 2026.**

Comments can be submitted via email to ORP@dhs.arkansas.gov or by mail to Department of Human Services (DHS) Office of Rules Promulgation, 2nd Floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available.

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/s/ Elizabeth Pitman, Director
Division of Medical Services 4502292178

Attachment 4: Current ARHOME Evaluation

Arkansas Health and Opportunity for Me and Life360 Amendment Interim Evaluation Project

Number II-W-00379/6

Interim Evaluation Report

Submittal Date:
December 31, 2025

GDIT

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1.0 EXECUTIVE SUMMARY

The Arkansas Health and Opportunity for Me (ARHOME) program aims to provide continued coverage and enhance services for the new adult group previously covered under Arkansas Works. Approved by the Centers for Medicare & Medicaid Services (CMS) in December 2021, the ARHOME program provides healthcare through qualified health plans (QHPs) offered on the Health Insurance Marketplace and implements new initiatives for health improvement, economic independence, and performance accountability. QHPs are required to develop annual strategic plans geared towards achieving quality and performance metrics, enhancing health outcomes, and promoting economic independence, with financial penalties for underperformance.

The program was amended in November 2022 to include the Life360 HOME amendment, which focuses on addressing health-related social needs (HRSNs) among vulnerable populations. The Life360 HOMEs program, particularly the Maternal Life360 HOMEs program, targets beneficiaries with high-risk pregnancies, aiming to address the complex medical and socio-economic challenges they encounter. This program focuses on improving maternal and infant health outcomes in Arkansas by providing intensive care coordination and connecting expectant mothers to essential medical and non-medical services, such as housing, food, and transportation.

The early stages of the ARHOME demonstration and Maternal Life360 HOME program have yielded mixed outcomes. Key findings for 2022 and 2023 reveal improvements in various health measures, yet they also highlight areas requiring additional focus and policy adjustments. This summary highlights notable differences between ARHOME beneficiaries and Arkansas's Medicaid Fee-For-Service (FFS) population, emphasizing where ARHOME has shown significant improvements.

Continuity of Coverage and Care

Despite increases in beneficiary awareness of important aspects of the premium assistance model over the two years, these differences were not statistically significant, indicating a need for better engagement strategies. During the Medicaid Public Health Emergency (PHE) unwinding, ARHOME beneficiaries experienced more frequent coverage gaps compared to comparison groups, but these gaps were generally shorter in duration, showing partial success in maintaining continuity despite disruptions. In terms of primary and specialty care, a significantly lower percentage of ARHOME beneficiaries had consistent visits with the same primary care provider compared to FFS beneficiaries, highlighting gaps in primary care continuity. However, ARHOME beneficiaries demonstrated higher rates of annual primary care physician (PCP) visits, suggesting better engagement in proactive healthcare management. For specialty care, both groups showed high visit consistency for some specialties, but significant gaps existed for ARHOME beneficiaries in specific areas like endocrinology and gastroenterology.

When comparing Arkansas to a similar expansion state, West Virginia, Arkansas residents aged 19-64 with incomes up to 138% FPL reported having significantly fewer personal doctors and

lower overall rates of routine checkups. Additionally, a significantly higher percentage of Arkansas residents avoided care due to cost, underscoring persistent financial barriers to accessing healthcare.

Improving Access to Providers

ARHOME provider focus group (PFG) participants generally provided positive feedback on reimbursement rates, and providers exhibited a greater willingness to accept ARHOME patients compared to Medicaid FFS patients. This increased willingness likely contributed to beneficiaries reporting higher satisfaction with the timeliness and accessibility of healthcare services under ARHOME compared to FFS. Specifically, beneficiaries noted better access to timely non-urgent appointments and easier access to necessary care.

Arkansas provider networks generally demonstrated adequate stability and accessibility, ensuring that beneficiaries had sustained access to primary and specialty care services. However, ensuring consistent access to specialist services remains a challenge, with a few specialty areas experiencing shortages. Despite this challenge, the program's focus on quality improvement led to higher perceived access to care among ARHOME beneficiaries. There were also notable improvements in targeted preventive measures, such as increased rates of diabetes screenings, better follow-up care after hospitalizations, and enhanced management of chronic conditions.

Improving Continuity of Care Across the Continuum of Coverage

Awareness of the shorter retroactive eligibility period and time-limited premium requirements was mixed. More beneficiaries were aware of premium requirements than retroactive eligibility, but neither awareness improved significantly over time, indicating a need for better communication and patient education. The shortened retroactive eligibility period did not deter enrollment but did result in greater medical debt among new beneficiaries compared to other Medicaid programs, as evidenced by higher percentages of unpaid medical bills.

The impact of monthly premiums paid by beneficiaries in the first year of ARHOME was also inconclusive. A lower percentage of new enrollees with higher incomes (101-138% FPL) joined in the first year, and retention rates were higher among this income group. Although bene-paid premiums led to fewer gaps among higher income beneficiaries, those who did experience gaps had longer durations of coverage gaps. Additionally, the removal of premiums did not boost take-up or retention rates, and while it reduced coverage gaps for beneficiaries exceeding Medicaid income limits >138%, overall coverage gaps and their lengths did increase, likely influenced by factors such as the PHE unwinding.

Furthering Quality Improvement

The ARHOME program has made some notable strides in improving healthcare for its beneficiaries, though there are areas that need further work. Awareness about copayment requirements and the Economic Independence Initiative (EII) increased, but not significantly enough to make a large impact. This suggests that there needs to be better communication to ensure that beneficiaries fully understand what is required of them.

Beneficiaries of ARHOME reported higher satisfaction with their health plans and overall healthcare compared to those in FFS. This demonstrates that the program is appreciated by its users. However, satisfaction with primary care providers and specialists, while higher, did not significantly surpass that of the FFS beneficiaries, showing room for improvement.

When it comes to health care utilization and quality of care, the results were mixed. There was an initial drop in non-emergency visits to the emergency department (ED) in MY22, but this did not continue into MY23. Similarly, there were some gains in follow-up care after emergency visits, but there were still higher rates of hospital admissions for certain conditions like diabetes complications and heart failure. This indicates that while the ARHOME program helps with follow-up care, more targeted strategies are needed to manage these chronic conditions better. Quality of care saw some positive developments, such as better management of depression and higher rates of follow-up care for mental illness. However, there were inconsistencies, particularly with medication adherence and the management of opioid prescriptions, highlighting the need for continued improvements in these areas.

Dropping monthly premiums for certain beneficiaries did not lead to increased healthcare costs, which is a positive sign of effective cost management. The premium assistance model also helped keep Arkansas's marketplace premiums lower than those in nearby states, although commercial insurance premiums showed similar trends to those in other states, suggesting external factors at play.

Life360 HOME Program

Physicians and hospital executives from the 2023 Provider Focus Groups (PFGs) viewed the Maternal Life360 HOME program positively, recognizing it as a crucial step towards better coordination of clinical and community support. Key informant interviews underscored the program's value in early identification of high-risk pregnancies and providing timely supportive services.

However, they also highlighted challenges, including the lengthy and complex application process, integration into hospital systems, negotiating payment rates, and patient outreach. Successful integration was aided by engagement with providers and partnerships with existing programs with experienced staff. Building trust and effective communication with eligible women remained difficult but essential for follow-up care. As the program progresses, ongoing evaluation of patient identification efficiency, data tracking, and financial reimbursement processes is needed to ensure its success and sustainability.

Recommendations

- **Enhanced Communication:** Boost beneficiary awareness and engagement with the premium assistance model by deploying more effective education and outreach strategies. Improving communication between providers, beneficiaries, and their health plan ensures beneficiaries have a clear understanding of retroactive eligibility periods, copayments, and health plan initiatives. Provide straightforward and accessible information to help beneficiaries navigate these elements more efficiently.

- **Improve Continuity and Access to Care:** Focus on reducing and minimizing coverage gaps during transitional period, such as the Medicaid PHE unwinding, and ensure that ARHOME beneficiaries have consistent and continuous access to primary care providers. Proactively identify and remove financial barriers that might prevent access to necessary healthcare services. Enhance specialty care, particularly in critical areas like endocrinology and gastroenterology, to bridge existing gaps and ensure comprehensive care for all beneficiaries.
- **Sustain Provider Relationships and Service Accessibility:** Maintain and potentially enhance positive provider feedback on reimbursement rates to sustain the willingness of providers to accept ARHOME patients. Ensure that beneficiaries have timely and reliable access to healthcare services, particularly for non-urgent appointments. Address shortages in specialist care to maintain high levels of satisfaction and accessibility in both primary and specialty care, ensuring that all areas of patient care are adequately covered.
- **Enhance Care Quality and Early Interventions:** Effectively implement and refine targeted strategies for managing chronic conditions like diabetes complications and heart failure. Boost efforts to improve and maintain high standards of follow-up care after ED visits to ensure continuity and quality of treatment. Emphasize the importance of medication adherence and the prudent management of opioid prescriptions to address inconsistencies and enhance overall patient outcomes. Invest in preventive care through early interventions, focusing on regular health screenings, vaccination drives, and workshops for chronic disease management. Early intervention can prevent complex health issues, reduce long-term healthcare costs, and markedly improve the quality of life for beneficiaries.
- **Evaluate and Enhance Program Integration:** Continuously assess and refine the Maternal Life360 HOME program to ensure efficient patient identification, robust data tracking, and effective financial reimbursement processes. Focus on building trust and improving communication with eligible women to enhance follow-up care and ensure comprehensive support throughout their healthcare journey. Engage with providers and leverage existing programs with experienced staff to facilitate successful integration and sustainability of the program.

Conclusion

Arkansas has leveraged its demonstration waiver to enhance Medicaid expansion, utilizing the Affordable Care Act's framework of private health plans to increase access and consumer choice. By enrolling the Medicaid population in the same health plans available to higher-income residents, Arkansas has reduced the stigma often associated with publicly funded healthcare. Health providers have noted that they frequently cannot distinguish ARHOME beneficiaries from non-Medicaid patients, highlighting the success of this integration.

Recognizing the need for enhanced support for certain populations, Arkansas implemented the Life360 HOMEs Amendment. This program focuses on pregnant women, ensuring they receive

the necessary support to deliver healthy newborns through the provision of community services, such as behavioral health, substance use treatment, and nutritional support.

The evaluation of the ARHOME demonstration during the COVID-19 PHE in 2022, followed by the PHE unwinding in 2023, has presented additional complexities. These unexpected policy changes had a larger impact on results than would have occurred under normal circumstances, complicating the assessment of the program's effectiveness. The disruptions caused by these events led to significant coverage gaps that may have altered healthcare utilization patterns and must be considered when interpreting the results of this report.

Despite these challenges, this early evaluation highlighted sufficient provider networks, improvements in preventive and follow-up care, as well as positive beneficiary feedback. Arkansas continues to focus on improving health plan quality, enhancing communication with beneficiaries, and encouraging beneficiaries to take personal responsibility for their health through various incentives. Additionally, the state remains committed to working with hospitals to optimize supportive services for the Life360 HOMEs program. By implementing the recently awarded Transforming Maternal Health Grant, along with initiatives from Governor Sanders and the Arkansas Legislature, the state aims to provide improved support for pregnant women.

Although the work is ongoing, Arkansas is dedicated to the opportunities that ARHOME and Life360 HOMEs present for improving the health of its citizens. These programs provide a pathway to reduce reliance on public supports, aligning with the state's motto, “The Land of Opportunity.”

2.0 GENERAL BACKGROUND INFORMATION

The Arkansas General Assembly created the **Arkansas Health and Opportunity for Me** (ARHOME) program by enacting Act 530 of 2021 to provide continued coverage and enhanced services for the new adult group previously covered under the Arkansas Works program. The Centers for Medicare & Medicaid Services (CMS) approved ARHOME in December of 2021. In November of 2022, CMS additionally approved Arkansas's **Life360 HOMEs** amendment to the ARHOME program to further address health-related social needs (HRSNs) among targeted vulnerable populations through coverage of intensive support and care coordination.

Arkansas first expanded Medicaid in 2014 under the Affordable Care Act (ACA) for the new adult group to include individuals between 19 and 64 years of age with incomes at or below 138 percent of the federal poverty level (% FPL) through the Arkansas Health Care Independence Program (HCIP). Beneficiaries received healthcare coverage through qualified health plans (QHPs) offered on the Health Insurance Marketplace. Further improvements under the program, renamed Arkansas Works, included beneficiary paid premiums, job referrals, and community engagement requirements for beneficiaries who met certain criteria, as allowed by Medicaid. ARHOME introduced new health improvement initiatives, economic independence initiatives, and performance measurement accountability for QHPs. **Table 1** provides an overview of key information and dates for the Arkansas Section 1115 Demonstration Project.

Table 1: Arkansas Medicaid Section 1115 Demonstration Project Key Information

ARKANSAS MEDICAID SECTION 1115 DEMONSTRATION PROJECT KEY INFORMATION	
HCIP Waiver Application Approved by CMS	September 27, 2013
HCIP Waiver Period	October 1, 2013 – December 31, 2016
Arkansas Works Waiver Application Approved by CMS	December 8, 2016
Arkansas Works Waiver Period	January 1, 2017 – December 31, 2021
ARHOME Waiver Application Approved by CMS	December 21, 2021
ARHOME Waiver Period	January 1, 2022 – December 31, 2026
ARHOME Evaluation Design Approved by CMS	April 7, 2025
ARHOME Life360 HOMEs Amendment Approved by CMS	November 1, 2022
ARHOME Life360 HOMEs Evaluation Design Approved by CMS	January 17, 2025
ARHOME Amendment for NMT Approved by CMS	December 20, 2024

2.1 ARHOME

Under the new ARHOME program, the state continued with the same new adult group, benefit packages, and service delivery systems (QHPs and Fee-For-Service [FFS]) that were applicable under the Arkansas Works program. The monthly premiums for beneficiaries with incomes above 100 percent of the FPL continued under ARHOME, but only through calendar year 2022. From May 1, 2018, to March 27, 2019, during the Arkansas Works program, new enrollees were limited to 30 days of retroactive coverage prior to an application. This policy was reimplemented for use in the ARHOME program beginning July 1, 2022. Additionally, the Provider-led Arkansas Shared Savings Entity (PASSE) program became an available service delivery system for individuals in the new adult group with serious mental illness (SMI) and substance use disorder (SUD).

New program provisions require QHPs to submit an annual strategic plan that includes activities to meet quality and performance metrics selected by the Department of Human Services (DHS), as well as activities to improve health outcomes and economic independence goals.

Quality and Performance

In 2021, DHS established 26 Medicaid Core Set Measures related to maternal and infant health, chronic diseases, and other health indicators. DHS measures and evaluates each QHP's performance on selected health care quality metrics against established annual benchmarks. DHS may require a corrective action plan or levy financial penalties for any demonstration year in which a QHP fails to meet performance targets.

Health Improvement

To encourage the use of preventive care, QHPs must provide at least one Health Improvement Initiative (HII) incentive in 2022 and two HII incentives in 2023 and beyond for each of the following populations:

- Pregnant women, particularly those with high-risk pregnancies
- Individuals with mental illness
- Individuals with substance use disorder
- Individuals with two or more chronic conditions
- Individuals living in rural areas

Economic Independence

To encourage advances in a beneficiary's economic status or employment prospects through participation in employment, education, and training programs, QHPs were required to offer one Economic Independence Initiative (EII) incentive in 2022 and two EII incentives in 2023 and beyond.

2.1.1 ARHOME PROGRAM DIAGRAMS

Figure 1 provides a visual representation of how the ARHOME program aims and key drivers contribute to the achievement of overarching goals.

Figure 1: ARHOME Driver Diagram

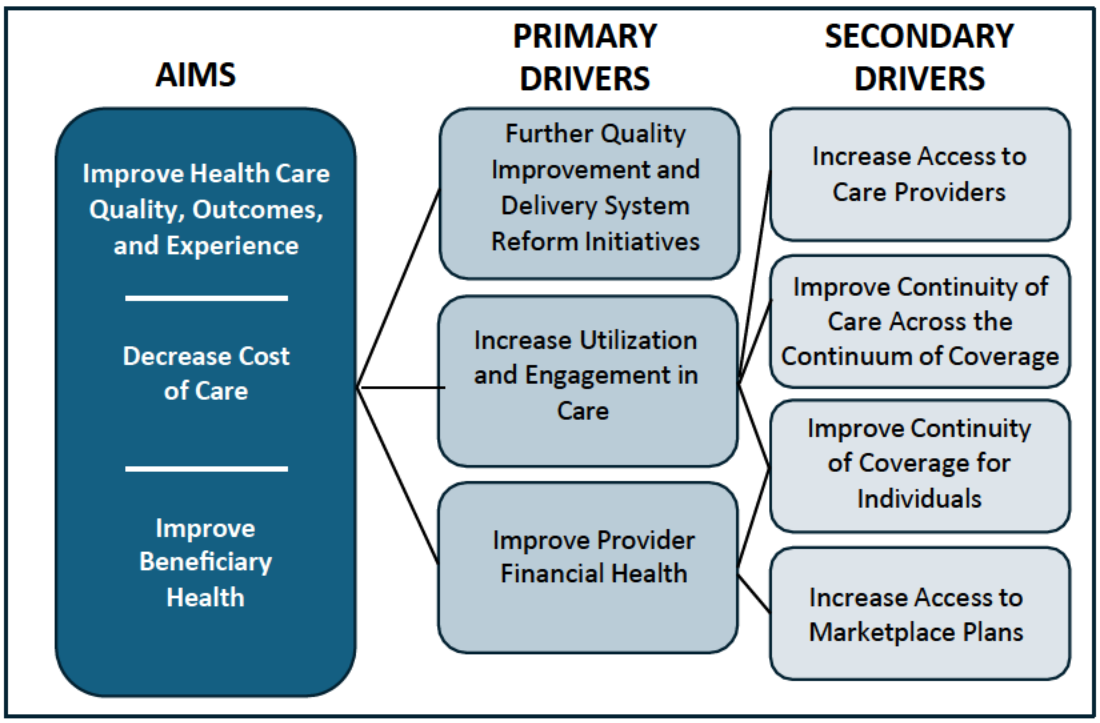
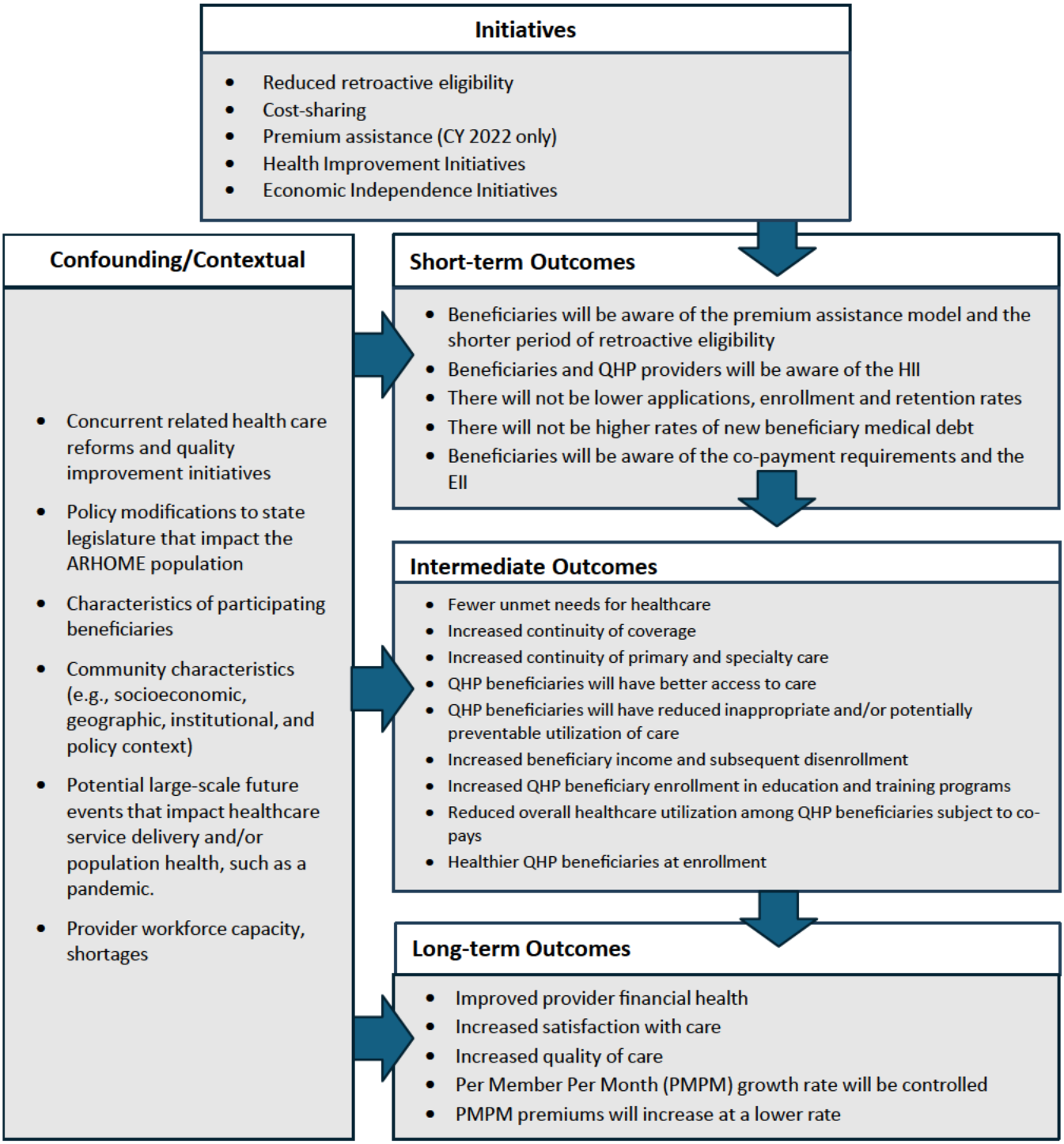


Figure 2 demonstrates how the ARHOME program's initiatives interact with contextual factors to support the following short-term, intermediate, and long-term outcomes to provide necessary healthcare coverage to qualified individuals.

Figure 2: ARHOME Evaluation Logic Model



NOTE: All outcomes are intended to be realized over the course of the ARHOME demonstration period and when applicable, compared with Medicaid FFS beneficiaries or similar residents in other expansion or non-expansion states.

2.2 LIFE360 HOMES

The **Life360 HOMEs** amendment (also referred to as **Life360s**) addresses complex medical and socioeconomic challenges facing many of Arkansas's most vulnerable residents. These include beneficiaries with high-risk pregnancies, beneficiaries in rural areas with SMI or SUD diagnoses, and as young adults identified as most at risk for long-term poverty and poor health outcomes.

Through the amendment, Arkansas is able to provide certain services that address HRSNs for Medicaid beneficiaries enrolled in Life360 HOMEs, as evidence indicates that HRSNs are a critical driver in health outcomes and beneficiaries' access to health services that help to keep them well.[1,2] Life360 HOMEs aim to reduce maternal and infant mortality rates around the state, fill gaps in the continuum of care for beneficiaries with SMI or SUD diagnoses in rural areas, and increase active participation among young-adult high-risk beneficiaries in improving their health and addressing HRSNs.

The three intended target populations of the Life360 HOMEs program are listed below:

1. **Maternal Life 360 HOME** supports beneficiaries with high-risk pregnancies, as identified by their physician.
2. **Rural Life360 HOME** supports beneficiaries with SMI or SUD diagnosis who live in rural areas.
3. **Success Life360 HOME** supports young adults at high-risk for long-term poverty due to prior incarceration or involvement with the juvenile justice system (ages 19-24), involvement with the foster care system (ages 19-27), and veterans (ages 19-30) who are at high risk of homelessness.

The Life360 HOMEs program is designed to provide beneficiaries with intensive care coordination by connecting them to medical services and nonmedical support in their communities that address their HRSNs as well as actively engage beneficiaries in promoting their own health care. Hospitals approved to participate as a Life360 HOME provider create infrastructure and partnerships with other providers to make referrals to the Life360 HOME, conduct HRSN screenings, and deliver care coordination through referral networks with community entities to support beneficiaries with housing, food, education, and other social services.[3]

In December 2024, CMS approved a waiver amendment to provide funding to the Life360 HOMEs program for non-medical transportation (NMT), allowing the state to expand transportation benefits to improve beneficiaries' access to the HRSN services they are eligible to

[1] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf.
[2] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment." The Commonwealth Fund, 2014, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.
[3] Life360. Arkansas Department of Human Services. https://humanservices.arkansas.gov/divisions-shared-services/medical-services/healthcare-programs/arhome/life360/. Accessed 20 September 2024.

receive. This creates a significant opportunity for qualified Life360 HOMEs beneficiaries who report difficulties obtaining transportation to and from covered HRSN services.

This current report focuses on the **Maternal Life360 HOME** population as this was the only type of Life360 HOME implemented to date. Results largely consist of qualitative data from provider and stakeholder surveys and interviews due to Maternal Life360 provider enrollment beginning in the summer of 2024. Survey results assess provider perspectives of the Life360 HOME program and investments enabled through the ARHOME waiver supporting the development and implementation of HRSN services.

Results of this interim evaluation related to Maternal Life360 HOME summarize the following:

- Awareness and likeliness to participate in a Life360 HOME;
- Potential facilitators and barriers in the quality and effectiveness of beneficiary participation, infrastructure support, and downstream services that can be provided under the state plan authority;
- The local availability of and investments in social services, such as housing, nutrition, and any other type of HRSN services; and
- Effective use of infrastructure investments to support the development, implementation, and sustainability of HRSN services.

Beyond this interim evaluation, the Life360 HOMEs summative report will further evaluate beneficiary focused aims such as, 1) HRSN screening and utilization of corresponding services; 2) health care access, quality of care, and health outcomes; 3) utilization of preventive and routine care; 4) utilization and costs associated with potentially avoidable, high acuity health care; as well as 5) mental and physical health outcomes. Continued programmatic performance and sustainability will be captured through surveys as well as annual quality and performance metrics.

Due to unforeseen circumstances between the approval of the Life360 HOMEs amendment and the start-up of the program, operationalization of both Rural and Success Life360 HOMEs was suspended. Rural Life360 HOME was suspended due to a lack of approval for several reimbursement mechanisms needed by potential participating hospitals. Success Life360 HOME's proposed eligible beneficiary population was too narrowly defined to be considered viable by possible participating providers, which may have led to less interest in the program from providers.

2.2.1 MATERNAL LIFE360 HOME PROGRAM DIAGRAMS

Figure 3 provides a visual process of how a provider becomes a Maternal Life360 HOME and how a beneficiary becomes a patient in a Maternal Life360 HOME.

Figure 3: Maternal Life360 HOME Participation Process Diagram

Figure 4 provides a visual representation of how the Maternal Life360 HOME program aims and key drivers contribute to the achievement of overarching goals.

Figure 4: Life360 HOMEs Driver Diagram

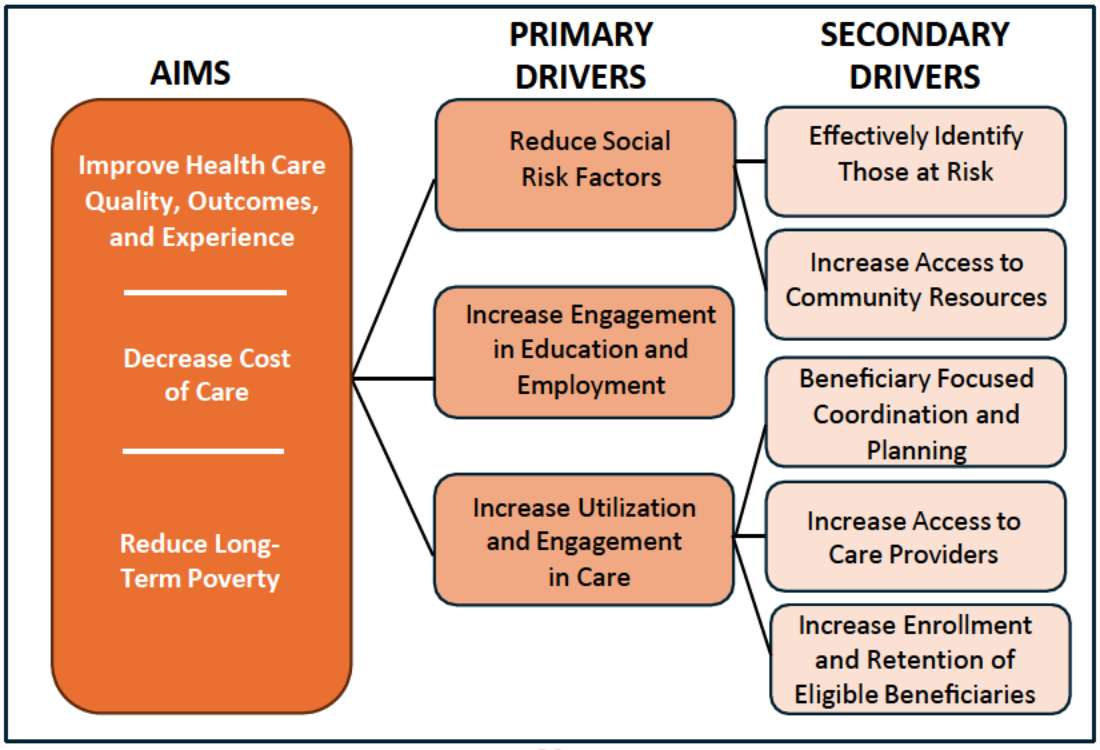
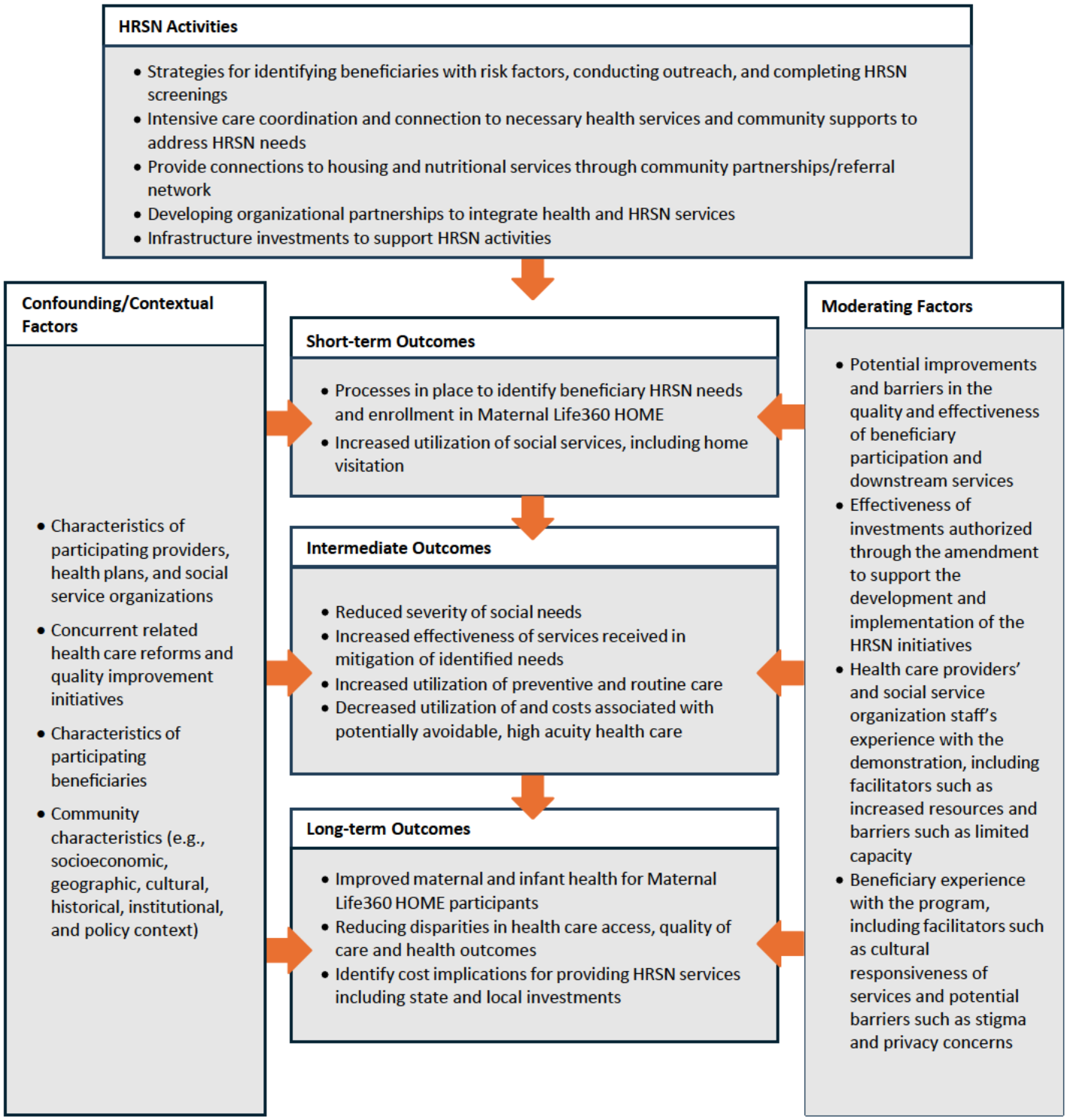


Figure 5 demonstrates how the program's initiatives interact with contextual and moderating factors to support the following short-term, intermediate, and long-term outcomes through the provision of additional support to qualified individuals in Maternal Life360 HOME.

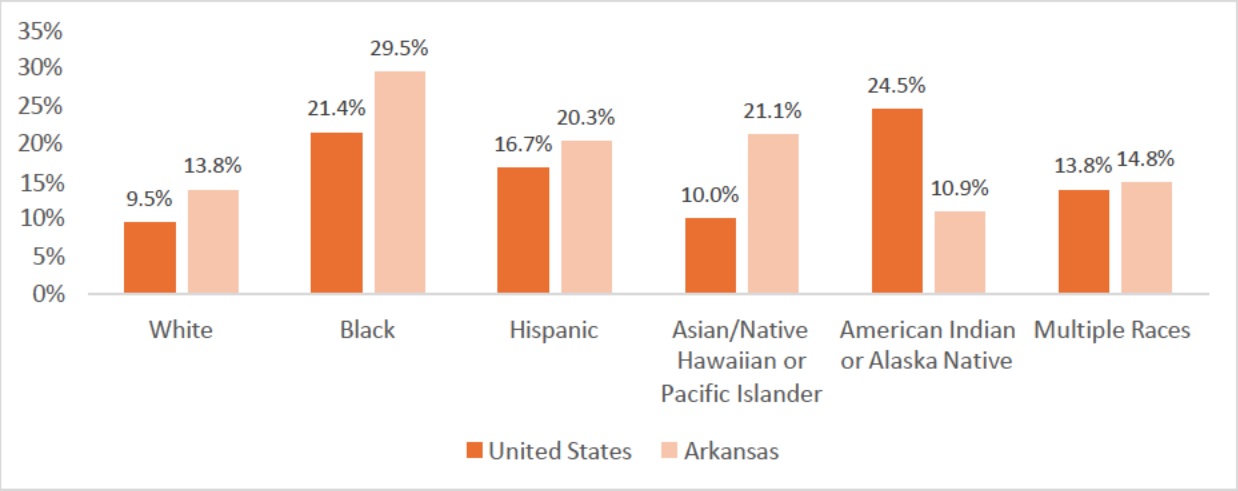
Figure 5: Maternal Life360 HOME Logic Model



2.2.2 ARKANSAS'S HEALTH RELATED SOCIAL NEEDS

HRSNs are "the social and economic needs that beneficiaries experience that affect their ability to maintain their health and well-being. They include things such as housing instability, housing quality, food insecurity, employment, personal safety, lack of transportation and affordable utilities, and more."[4] As a result, factors such as household income, educational attainment, race and ethnicity, as well as adequate food can have a significant impact on health-related outcomes and access to care. In 2022, results from the American Community Survey (ACS) of the U.S. Census Bureau ranked Arkansas 46th in overall poverty rate at 16.8% compared to the national poverty rate of 12.6%. Arkansas fell behind the U.S. average poverty rate in almost every racial category (**Figure 6**).[5]

Figure 6: Arkansas vs. U.S. Poverty Rate by Race



According to the Census Bureau, approximately 25.4% of the population 25 years or older in Arkansas held a bachelor's degree or higher in 2022 compared with the national average of 35.7%.[6] Between 2018 and 2022, Arkansas also reported lower median income at $56,335 compared to the national median income at $75,149.[7] Lower household income can result in sacrificing quality of housing, food, and other necessities. The National Low Income Housing Coalition (NLIHC) reported that 69% of extremely low-income renter households in 2024 (those spending more than half of their income) lived with severe cost burden.[8] In 2023, the U.S. Department of Agriculture (USDA) ranked Arkansas the hungriest state in the county with 18.9%

[4] Oregon Health Authority. Patient Centered Primary Care Home Program. Accessed July 31, 2024. https://www.oregon.gov/oha/HPA/dsi-pcpch/AdditionalResources/Health-related%20Social%20Needs%20vs%20the%20Social%20Determinants%20of%20Health.pdf
[5] Poverty Rate by Race and Ethnicity. Kaiser Family Foundation. Accessed July 8, 2024. https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[6] S1501 Educational Attainment. American Community Survey. Accessed July 8, 2024. https://data.census.gov/table?g=040XX00US05&tid=ACSST1Y2021.S1501
[7] U.S. Census Bureau Quick Facts. U.S. Census Bureau. Accessed July 8, 2024. https://www.census.gov/quickfacts/fact/table/AR/EDU685221
[8] 2024 Arkansas Housing Profile. National Low Income Housing Coalition. Accessed September 10, 2024. https://nlihc.org/sites/default/files/SHP_AR.pdf.

of households experiencing low or very low food security.[9] Moreover, 8.5% of the Arkansas population was uninsured in 2022 compared with the national average of 8.0%.[10]

For expecting mothers with Medicaid coverage, the burden of meeting social and economic needs may be even greater. Mothers with a positive postpartum depression screen were more likely to report a social need compared to those not reporting a social need.[11] The Strong Start for Mothers and Newborns II Initiative highlighted the importance of continuity of care across prenatal, delivery, and postpartum visits as well as addressing information gaps and barriers to transportation and childcare in enhancing maternal and infant health.[12]

2.2.3 MATERNAL AND INFANT HEALTH IN ARKANSAS

According to a 2021 report from the Centers for Disease Control and Prevention (CDC), the United States saw a 40% increase in deaths due to maternal causes from the previous year (2020). Compilation of state committee review data by the CDC suggests that 84% of these deaths were preventable.[13]

According to the Kaiser Family Foundation, between 2018 and 2022, Arkansas had the 4th highest maternal mortality rate across all states in the United States (38 maternal deaths per 100,000 live births).[14] The top underlying causes of pregnancy-related deaths between 2018-2022 in Arkansas included infection, cardiomyopathy, cardiovascular conditions, hypertensive disorders, hemorrhage, and mental health conditions and injury.[15,16]

Additionally, Arkansas scored 96 on a scale of 100 on the Maternal Vulnerability Index (MVI) in 2020, an open-source, national-scale and county-level index developed by the March of Dimes organization to identify areas in the United States where mothers are at highest risk during pregnancy due to clinical, social, environmental, and contextual factors. Higher scores on the

[9] USDA Ranks Arkansas Worst State for Food Insecurity; 3 of every 16 households went hungry in 2023. Arkansas Democrat. Accessed September 10, 2024. https://edition.arkansasonline.com/article/7995657163946000.
[10] Health Insurance Coverage of the Total Population. Kaiser Family Foundation. Accessed July 8, 2024. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[11] Chavez LJ, Tyson DP, Davenport MA, Kelleher KJ, Chisolm DJ. Social Needs as a Risk Factor for Positive Postpartum Depression Screens in Pediatric Primary Care. Acad Pediatr. 2023 Sep-Oct;23(7):1411-1416. doi: 10.1016/j.acap.2023.03.007. Epub 2023 Mar 22. PMID: 36958532.
[12] Rodin D, Silow-Carroll S, Cross-Barnet C, Courtot B, Hill I. Strategies to Promote Postpartum Visit Attendance Among Medicaid Participants. J Womens Health (Larchmt). 2019 Sep;28(9):1246-1253. doi: 10.1089/jwh.2018.7568. Epub 2019 Jun 28. PMID: 31259648.
[13] Maternal Deaths in the U.S. Spiked in 2021, CDC Reports. National Public Radio (NPR). Accessed March 30, 2023. https://www.npr.org/sections/health-shots/2023/03/16/1163786037/maternal-deaths-in-the-u-s-spiked-in-2021-cdc-reports
[14] Maternal Deaths and Mortality Rates per 100,000 Live Births. Kaiser Family Foundation. Accessed July 8, 2024. https://www.kff.org/other/state-indicator/maternal-deaths-and-mortality-rates-per-100000-live-births/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[15] Arkansas Maternal Mortality, 2018-2021 Deaths: 2024 AMMRC factsheet. Arkansas Maternal Mortality Review Committee (AMMRC). Accessed December 2025. https://healthy.arkansas.gov/wp-content/uploads/ADH-AMMRC-2024-Legislative-Report-FINAL.pdf.

[16] Arkansas Maternal Mortality, 2018-2022 Deaths: 2025 AMMRC factsheet. Arkansas Maternal Mortality Review Committee (AMMRC). Accessed December 2025. https://healthy.arkansas.gov/wp-content/uploads/Factsheet-MMRC-2025-for-web.pdf

MVI scale indicate greater vulnerability to poor pregnancy outcomes.[17] According to the March of Dimes report card for Arkansas in 2022, more than 1 out of 5 (or 20.1%) infants were born to a woman who received inadequate prenatal care in the state. Nationally, this percentage stands at 1 out of 7 (15.5%) infants.[18]

Furthermore, Arkansas had the 3rd highest infant mortality rate in 2022 at 7.7 infant deaths per 1,000 live births in Arkansas[19] compared to 5.6 infant deaths per 1,000 live births nationally.[20] According to the March of Dimes 2023 Maternity Care Deserts Report, 45.3% of counties in Arkansas vs. 32.6% of counties in the U.S. are “maternity care deserts,” defined by March of Dimes as "as any county without a hospital or birth center offering obstetric care and without any obstetric providers."[21]

[17] The U.S. Maternal Vulnerability Index: Maternal Vulnerability in the United States. Surgo Ventures. Accessed March 30, 2023. https://mvi.surgoventures.org/
[18] March of Dimes PeriStats: Inadequate Prenatal Care: for Arkansas 2017-2022. March of Dimes. Accessed July 18, 2024. https://www.marchofdimes.org/peristats/data?top=5&lev=1&stop=34&reg=99&obj=1&slev=1
[19] Infant Mortality Rates by State. National Center for Health Statistics. Accessed September 11, 2024. https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.
[20] Infant Mortality Rate Sees First Rise in 20 Years. NCHS: A Blog of the National Center for Health Statistics. Accessed September 11, 2024. https://blogs.cdc.gov/nchs/2023/11/01/7479/.
[21] 2023 Maternity Care Deserts Report for Arkansas. March of Dimes PeriStats. Accessed October 9, 2024. https://www.marchofdimes.org/peristats/reports/arkansas/maternity-care-deserts

3.0 EVALUATION QUESTIONS AND HYPOTHESES

The ARHOME demonstration and Life360 HOMEs evaluation designs both include measure diagrams to depict the fundamental relationship between the aims, hypotheses, and identified measures used to analyze performance. Measure diagrams are presented separately below for ARHOME (**Section 3.1**) and Life360 HOMEs (**Section 3.2**). Each aim represents how the demonstration or amendment positively affects its beneficiaries relative to a comparison population, when applicable. The hypotheses associate specific Special Terms and Conditions (STCs) from CMS to guide the comparison. The measures stipulate the metrics applied to each hypothesis to assess and validate the performance of both the ARHOME demonstration and Life360 HOMEs amendment. For select measures, stratification of results by key demographic or geographic features are explored.

On August 16, 2024, DHS informed CMS that the state had suspended implementation of the Success and Rural Life360 HOME programs. Therefore, the state is currently seeking to focus solely on implementation of the Maternal Life360 HOME program. Due to Maternal Life360 HOME launching in 2024, the majority of measures outlined in the evaluation design for the Maternal Life360 HOME program are not reported until the final summative report is published. In this interim report, the Maternal Life360 HOME results mainly describe implementation activities. Please note that numbering of goals, hypotheses, and measures will remain as reported in the evaluation designs for consistency, but only a subset of these will be presented in results for this report.

3.1 ARHOME DEMONSTRATION MEASURE DIAGRAMS

Table 2: Measure Diagram Goal 1

GOAL 1: PROVIDING CONTINUITY OF COVERAGE FOR INDIVIDUALS		
HYPOTHESIS	**RESEARCH QUESTION**	**MEASURE**
A. ARHOME beneficiaries will be aware of the premium assistance model	What percentage of ARHOME beneficiaries are aware of the premium assistance model?	1. Beneficiary Premium Assistance Awareness
B. ARHOME beneficiaries and QHP contracted providers will be aware of the HII	What percentage of ARHOME beneficiaries and QHP contracted providers are aware of the HII?	1. Beneficiary and 2. Provider HII Awareness
C. The premium assistance model will lead to less unmet need for healthcare among Arkansas residents ages 19-64 with income up to 138% FPL compared to individuals at the same income levels in states that expanded Medicaid through existing service delivery systems	Do Arkansas residents that are potentially eligible for ARHOME have less unmet needs related to having a personal doctor, medical costs, and routine checkups than similar residents in other comparable states that have expanded Medicaid?	1. Have a Personal Doctor 2. Avoided Care Due to Cost 3. Last Routine Checkup
D. The ARHOME program will lead to QHP beneficiaries having better continuity of coverage that includes fewer and shorter gaps, while Medicaid eligible, compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have fewer and shorter coverage gaps than Medicaid FFS beneficiaries?	1. Percent of Beneficiaries with At Least One Month with a Coverage Gap 2. Average Length of Gaps in Coverage
E. The ARHOME program will lead to QHP beneficiaries having better continuity of primary care providers (PCP) and specialty providers, while Medicaid-eligible, compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have better continuity of PCP and specialty care providers then Medicaid FFS beneficiaries?	1. Continuity of PCP Care 2. Continuity of Specialist Care 3. Percent Annual PCP Visits

Table 3: Measure Diagram Goal 2

GOAL 2: IMPROVING ACCESS TO PROVIDERS

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. The premium assistance model will lead to improved financial health among Arkansas healthcare providers compared to healthcare providers in states that expanded Medicaid through the existing service delivery system	Are Arkansas healthcare providers more satisfied with compensation of QHP beneficiaries during the ARHOME demonstration?	1. Provider Financial Health Improvement
	Are Arkansas healthcare providers less likely to close and have better operating margins during the ARHOME demonstration?	2. Hospital Financial Health Improvement
		3. Provider Closure Rate
B. The ARHOME program will lead to QHP beneficiaries having better perceived access to care over time and compared to Medicaid FFS beneficiaries	Are ARHOME beneficiaries more satisfied with their medical appointments in terms of timeliness, ease of scheduling, receiving appropriate care from the appropriate providers, and having an interpreter available to them when needed than Medicaid FFS beneficiaries?	1 – 10. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Perceived Access to Care
C. The ARHOME program will lead to QHP beneficiaries having better perceived access to care compared to similar beneficiaries in states that expanded Medicaid through the existing service delivery system	Do Arkansas residents that are potentially eligible for ARHOME have better perceived access to routine care that includes medical coverage, cost, having a personal doctor, being seen regularly, and receiving the appropriate vaccinations than similar residents in other comparable states that have expanded Medicaid?	1 – 5. Behavioral Risk Factor Surveillance System (BRFSS): Perceived Access to Care

Table 4: Measure Diagram Goal 2 Continued

HYPOTHESIS	RESEARCH QUESTION	MEASURE
D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have better access to network providers and in a timely manner?	1. Provider Patient Acceptance and 2. Time to First Appointment
	Do ARHOME beneficiaries have better access to preventive care, recommended screenings, and chronic condition management than Medicaid FFS beneficiaries?	3 – 12. Preventative Visits and Cancer Screenings
	Do ARHOME beneficiaries that were enrolled in Medicaid FFS and eligible for Early and Periodic Screening Diagnostic and Treatment (EPSDT) services have similar if not more preventive (wellness, dental, vision) visits than when they were in Medicaid FFS?	
	What percentage of ARHOME beneficiaries use non-emergency transportation (NET) assistance and how often do they use this service compared with Medicaid FFS beneficiaries?	13 – 15. NET Utilizations and Awareness
	Do ARHOME beneficiaries have a similar, if not better network of PCPs and specialists to choose from within 30 miles of their residence than Medicaid FFS beneficiaries?	16 – 19. PCP and Specialist Network Adequacy and Accessibility
		20. Essential Community Providers (ECP) Network Adequacy

Table 5: Measure Diagram Goal 3

GOAL 3: IMPROVING CONTINUITY OF CARE ACROSS THE CONTINUUM OF COVERAGE		
HYPOTHESIS	**RESEARCH QUESTION**	**MEASURE**
A. ARHOME beneficiaries will be aware of the shorter period of retroactive eligibility, and the time-limited premium requirements	What percentage of ARHOME beneficiaries are aware of the shorter period of retroactive eligibility and premium requirement awareness?	1. Beneficiary Retroactive Eligibility Awareness 2. Beneficiary Premium Requirement Awareness
B. The shorter period of retroactive eligibility will not lead to a lower rate of Medicaid applications among individuals potentially eligible for ARHOME compared to individuals potentially eligible for other Medicaid programs without a reduced period of retroactive eligibility	Does the shorter period of retroactive eligibility lower the rate of ARHOME new enrollments?	1. New Enrollment
C. The shorter period of retroactive eligibility will not lead to greater medical debt among new ARHOME beneficiaries compared to individuals newly enrolled in other Medicaid programs without a reduced period of retroactive eligibility	Do new ARHOME beneficiaries with a shorter period of retroactive eligibility have a higher rate of medical debt compared with the new Medicaid FFS beneficiaries?	1. New Beneficiary Medical Debt
D. During Year 1 of the demonstration, monthly premiums will not lead to lower take-up and retention rates among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those at or below 100% FPL	In the first year of the ARHOME demonstration, will monthly premiums lower rates of new enrollment and retention among ARHOME applicants or beneficiaries at 101-138% FPL as compared to those at or below 100% FPL?	1. New Enrollment 2. Retention Rate
E. During Year 1 of the demonstration, monthly premiums will not lead to more gaps in coverage among Arkansas residents age 19-64 with income at 101-138% FPL compared to those at or below 100% FPL	In the first year of the ARHOME demonstration, will monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL as compared with ARHOME beneficiaries at or below 100% FPL?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap 2. Average Length of Gaps in Coverage

Table 6: Measure Diagram Goal 3 Continued

HYPOTHESIS	RESEARCH QUESTION	MEASURE
F. QHP beneficiaries will demonstrate they value QHP coverage, and the implementation of monthly premiums will not reduce QHP beneficiary enrollment	Will monthly premiums lower overall health insurance coverage among Arkansas residents between 101-138% FPL?	1. Health Insurance Coverage Status
	During Year 1 of the demonstration, will monthly premiums lower the percentage of ARHOME beneficiaries at 101-138% FPL who pay a premium?	2. Premium Payments
	Will monthly premiums lower the percentage of ARHOME beneficiaries selecting their own QHP at enrollment?	3. QHP Selections
G. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase take-up and retention rates among QHP beneficiaries with income at 101-138% FPL compared with Year 1	Will the termination of monthly premiums increase the rate of new enrollment or retention among ARHOME applicants or beneficiaries at 101-138% FPL in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. New Enrollment
		2. Retention Rate
H. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase gaps in coverage among QHP beneficiaries while still eligible for ARHOME than they did during Year 1	Will the termination of monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap
		2. Average Length of Gaps in Coverage
I. During Years 2-5 of the demonstration, the cessation of monthly premiums will lead to QHP beneficiaries having more gaps in coverage after earnings exceed Medicaid eligibility limits than they did during Year 1	Will the termination of monthly premiums increase the number and length of coverage gaps among ARHOME beneficiaries at 101-138% FPL who disenroll due to high income in Years 2-5 of the ARHOME demonstration period as compared to the first year?	1. Percent of Beneficiaries with at Least One Month with a Coverage Gap
		2. Average Length of Gaps in Coverage

Table 7: Measure Diagram Goal 4

GOAL 4: FURTHERING QUALITY IMPROVEMENT AND DELIVERY SYSTEM REFORM INITIATIVES THAT ARE SUCCESSFUL ACROSS POPULATION GROUPS

HYPOTHESIS	RESEARCH QUESTION	MEASURE
A. ARHOME beneficiaries will be aware of the shorter point-of-service copayment requirements and the EII	What percentage of ARHOME beneficiaries are aware of point-of-service copayments and the EII?	1. Beneficiary Copayment and 2. EII Awareness
B. The ARHOME program will lead to QHP beneficiaries having greater satisfaction in the care provided over time and compared to Medicaid FFS beneficiaries	Are ARHOME beneficiaries more satisfied with their health plan, health care, as well as PCPs and specialists?	1 – 2. Rating of Health Plan and Health Care
		3 – 4. Rating of PCP and Specialist
C. The ARHOME program will lead to QHP beneficiaries having lower non-emergent use of the emergency department (ED), lower potentially preventable use of the emergency department and hospital admissions, and lower hospital re-admissions over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have lower ED visits, chronic condition hospital admissions, and all-cause readmissions than Medicaid FFS beneficiaries?	1. Preventable 2. Non-Emergent and 3. Emergent ED Visits
		4. Plan All Cause Readmissions
		5 – 8. Preventable Hospital Admissions
	Do ARHOME beneficiaries have a higher rate of follow-up care after hospitalizations and ED visits than Medicaid FFS beneficiaries?	9. PCP Follow-Up after ED Visit
		10. PCP Follow-Up after Hospitalization
D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries with a diagnosis of mental illness or substance use disorder have higher rates of treatment, medication adherence, preventive screenings, as well as follow-up after ED visits and hospitalizations than Medicaid FFS beneficiaries	1 – 17. Acute, Behavioral Health, Chronic Condition Care, Maternal and Perinatal Care, and HII Participation
	Do ARHOME beneficiaries have lower use of opioids and benzodiazepines than Medicaid FFS beneficiaries?	
	Do ARHOME beneficiaries have lower rates of C-sections than Medicaid FFS beneficiaries?	

Table 8: Measure Diagram Goal 4 Continued

HYPOTHESIS	RESEARCH QUESTION	MEASURE
(Continued) D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	Do ARHOME beneficiaries have higher rates of preventive care, contraceptive care, and medical management of chronic conditions than Medicaid FFS beneficiaries?	1 – 17. Acute, Behavioral Health, Chronic Condition Care, Maternal and Perinatal Care, and HII Participation
	What percentage of ARHOME beneficiaries are participating in a HII?	
E. Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries not subject to copays	Will copayments lower rates of treatment, medication adherence, preventive screenings, as well as follow-up after ED visits and hospitalizations among ARHOME beneficiaries with a diagnosis of mental illness or substance use disorder compared with rates of Medicaid FFS beneficiaries?	1 – 11. Acute, Behavioral Health, and Chronic Condition Care
	Will copayments increase the use of opioids and benzodiazepines among ARHOME beneficiaries compared with Medicaid FFS beneficiaries?	
F. Among QHP beneficiaries with income at or below 20% FPL, the EII will lead to an increase in income to above 20% FPL over time	Will the EII increase the percentage of ARHOME beneficiaries who had an income below 20% FPL in the prior year to at or above 20% FPL in the current measurement year?	1. Percent of Beneficiaries at or under 20% FPL at Initial Measurement That Are Above 20% FPL at Follow-Up Measurement, Among Those Still Enrolled at the Follow-Up Measurement
G. Among QHP beneficiaries with income at or below 100% FPL, the EII will lead to an increase in income to about 100% FPL over time	Will the EII increase the percentage of ARHOME beneficiaries who had an income below 100% FPL in the prior year to at least 100% FPL in the current measurement year?	1. Percent of Beneficiaries at or under 100% FPL at Initial Measurement that are Above 100% FPL at Follow-Up Measurement, Amont Those Still Enrolled at the Follow-Up Measurement

Table 9: Measure Diagram Goal 4 Continued

HYPOTHESIS	RESEARCH QUESTION	MEASURE
H. Among QHP beneficiaries who disenroll from ARHOME, the EII will lead to an increase in the percent that disenroll due to increased income over time	Will there be an increase in the percentage of ARHOME beneficiaries that disenroll due to high income?	1. Percent of Beneficiaries That Disenroll Due to High Income
	Do a higher percentage of ARHOME beneficiaries that disenroll take up private health insurance and will that private health insurance be the same carrier as their ARHOME QHP carrier?	2. Percent of Disenrolled Beneficiaries That Take-Up Private Health Insurance
		3. Percent of Disenrolled Beneficiaries That Take-Up Private Health Insurance and Maintain the Same Health Insurance Plan they had in ARHOME
I. The EII will lead to an increase in the percent of QHP beneficiaries that enroll in education and training programs over time	Will the EII increase the percentage of ARHOME beneficiaries that participate either through the initiative or in other education and training programs?	1. Percent of QHP Beneficiaries that Enroll in Education and Training Programs over time
		2. Percent of QHP Beneficiaries Participating in the EII Program
J. The point-of-service copayments will lead to QHP beneficiaries subject to copays having lower overall healthcare use compared to similar QHP beneficiaries not subject to copays	Will ARHOME beneficiaries subject to copayments have lower healthcare utilization than ARHOME beneficiaries not subject to copayments?	1. Beneficiary Copayment Healthcare Use Impact
K. The shorter period of retroactive eligibility, the premium assistance model, the point-of-service copayments, the HII, and the other financial discipline components will lead to the rate of growth in per member per month (PMPM) QHP costs being no higher than the rate of growth in PMPM costs in Arkansas Medicaid FFS	Will the growth rate of PMPM QHP costs for ARHOME beneficiaries remain similar to or be lower than that of Medicaid FFS beneficiaries?	1. PMPM Growth Rate
	Will the growth rate of the ARHOME program's total health expenditures and administrative costs be similar to or lower than that of Medicaid FFS?	2. Total Health Expenditure Growth Rate
		3. Administrative Cost Growth Rate

Table 10: Measure Diagram Goal 4 Continued

HYPOTHESIS	RESEARCH QUESTION	MEASURE
L. QHP beneficiaries with a shorter period of retroactive eligibility will be healthier at enrollment than Medicaid FFS beneficiaries with a longer period of retroactive eligibility	Will ARHOME beneficiaries with a shorter period of retroactive eligibility have fewer comorbidities at enrollment than Medicaid FFS beneficiaries?	1. Average Charlson Comorbidity Index (CCI) Score
M. The cessation of monthly premium for QHP beneficiaries at 101-138% FPL will lead to a faster rate of growth in PMPM QHP costs in Years 2-5 compared to Year 1	Will the termination of monthly premiums for QHP beneficiaries at 101-138% FPL in Years 2-5 lead to a faster rate of growth in PMPM QHP costs as compared to costs incurred by similar beneficiaries in Year 1?	1. QHP PMPM Growth Rate
N. The premium assistance model will lead to a lower rate of increase of PMPM premiums in the Arkansas Marketplace compared to states that expanded Medicaid and provide coverage through means other than premium assistance	Will ARHOME's premium assistance model result in a lower rate of increase in PMPM premiums in the Arkansas marketplace compared to similar states that expanded Medicaid?	1. Arkansas Program Characteristics 2. Arkansas Regional Average Program Characteristics 3. Contiguous States' Program Characteristics 4. Arkansas Marketplace PMPM Growth Rate
O. The premium assistance model will lead to a lower rate of increase in average commercial insurance premiums in Arkansas compared to states that expanded Medicaid and provide coverage through means other than premium assistance	Will ARHOME's premium assistance model result in a lower rate of increase in average commercial insurance premiums in Arkansas compared to similar states that expanded Medicaid?	1. Arkansas Commercial Insurance Premium Rates

3.2 LIFE360 HOMES AMENDMENT MEASURE DIAGRAMS

Please note that the Life360 HOMEs amendment measures in this interim report focus on implementation and start up activities, which include only the hypothesis and measures related to Hypothesis 4.E for Maternal Life360 HOME. Hypotheses and measures for Goal 1 and the rest of Goal 4 will be evaluated in the final summative report. Hypotheses and measures not evaluated in this report are shown in gray. Full detailed measure diagrams for Goal 1 and the rest of Goal 4 can be found in the attached Life360 HOMEs Evaluation Design. Rural and Success Life360 HOMEs goals are not included due to their implementation suspension on August 16, 2024.

Table 11: Measure Diagram Goal 4

GOAL 4: LIFE360 HOME COSTS AND EFFORTS WILL MEET OR EXCEED PROGRAM EXPECTATIONS		
HYPOTHESIS	**RESEARCH QUESTION**	**MEASURE**
A – D. (Not evaluated in this report and will be presented in the final summative report)		
E. Key entities during the start of Life360 HOME program will report on implementation activities, infrastructure development, overcoming barriers in the facilitation of Life360 HOME, and on adopted strategies that identify and provide services to beneficiaries with HRSN needs	**For each participating Life360 HOME provider, what are the characteristics related to key entities and their roles as well as types of HRSN services provided?**	**1. Key Entities** **2. HRSN Services**
	How are participating Life360 HOME providers integrating with existing programs and infrastructure? How are Life360 HOMEs maintaining organizational partnerships?	**3. Integration with Existing Programs and Infrastructure** **4. Maintenance of Organizational Partnerships**
	What are the key barriers in program implementation and beneficiary participation?	**5 – 6. Barriers in Implementation, Beneficiary Outreach, and Beneficiary Participation**
	What strategies have been successful in resolving key barriers to program implementation and beneficiary participation?	**7 – 8. Strategies Adopted to Facilitate and Reduce Barriers in Implementation and Beneficiary Experience**
		9. (Not evaluated in this report and will be presented in the final report)

4.0 METHODOLOGY

4.1 METHODOLOGICAL DESIGN

This evaluation tests hypotheses of coverage, access, care, quality, health outcomes, and cost-effectiveness for the ARHOME demonstration (2022-2026) using Arkansas's administrative and claims data, commercial insurance, beneficiary and provider feedback, as well as cost reporting. The Life360 HOMEs amendment (2023-2026) also assesses research questions related to HRSNs for ARHOME beneficiaries with high-risk pregnancies receiving services from a Maternal Life360 HOME.

For this interim report, measures are evaluated for demonstration years 2022 and 2023 of the ARHOME demonstration period. Where applicable, comparisons of outcomes are made with the Medicaid FFS population in client-level weighted models or with other Medicaid expansion and non-expansion states in Difference-in-Difference (DiD) analyses. Additionally, longitudinal analyses, such as pre-post and DiD analyses are performed for select metrics to observe time and treatment group interactions on healthcare utilization and cost outcomes. Since the Life360 HOMEs program is in the early stages of beneficiary recruitment at the time of this report, measures related to implementation and characteristics of participating providers are reported. The summative report will include all measures outlined in the evaluation design for the entire ARHOME demonstration period, including Life360 HOMEs, with additional data from screening tools, provider referrals, and home visiting information.

4.1.1 ARHOME

Goal 1

Continuity of coverage for ARHOME beneficiaries includes high levels of beneficiary and provider awareness of the program and its goals, few gaps in coverage, as well as having consistent care providers. Results from surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS) and ACS, are used to understand healthcare access and utilization in Arkansas compared with other Medicaid expansion states (Kentucky and West Virginia) and health insurance coverage compared with other non-Medicaid expansion states (Alabama, Mississippi, and South Carolina). The Beneficiary Engagement Satisfaction Survey (BESS) is administered to the ARHOME population three times during the demonstration period to assess beneficiary experience while enrolled in the program, which includes awareness of program goals. Arkansas's administrative and claims data additionally provide insight into the frequency and length of coverage gaps as well as continuity of care in comparison to the Medicaid FFS population.

Goal 2

Better access to providers is assessed through network adequacy and accessibility, provider financial health, and beneficiary access to non-emergency transportation and preventive screenings. Arkansas is compared to other expansion states by examining providers' financial sustainability with the premium assistance model using the CMS Provider of Service (POS) file

and the National Academy for State Health Policy (NASHP) Hospital Cost Tool. Beneficiary satisfaction related to provider accessibility in appointment scheduling, referrals to specialists, and receiving appropriate care when needed are captured using the BESS and BRFSS surveys. Claims-based measures are used to assess routine preventive screenings (e.g., cervical and breast cancer screenings) compared with the Medicaid FFS population, to assess diabetes care and Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, and to classify emergency department (ED) utilization/visits as emergent or non-emergent using the New York University (NYU) ED algorithm.[22] This algorithm is used to classify ED utilization/visits as emergent (i.e., requiring immediate medical care within 12 hours) or non-emergent, and to further classify emergent ED utilization/visits as preventable (i.e., the emergent nature could have been prevented or avoided with more timely or effective ambulatory care) or non-preventable.

Goal 3

Potential impacts of a shorter period of retroactive eligibility (90 days in the Medicaid FFS population and 30 days in ARHOME) and the cessation of monthly premiums at the end of 2022 are further evaluated for beneficiaries between 100% FPL and 138% FPL. Beneficiary awareness concerning the retroactive eligibility period, impact to medical debt, and new enrollment are analyzed using the BESS as well as state eligibility and enrollment data and compared to the Medicaid FFS population. To understand the effect of monthly premium cessation at the end of 2022, ARHOME beneficiaries above and below 100% FPL are compared as well as ARHOME beneficiaries between 100-138% FPL in the first year compared with other years for measures, such as new enrollment, retention, and continuity of coverage.

Goal 4

The last ARHOME goal seeks to further quality improvement and provider delivery system reform initiatives, which are assessed through 1) claims-based healthcare utilization measures related to preventive, acute, chronic and behavioral health, 2) beneficiary satisfaction ratings of their health care and providers, and 3) program cost characteristics compared at the regional and state levels in relation to Arkansas Medicaid FFS costs and the budget neutrality cap. Data from the HII and EII are tracked each year for beneficiary participation through QHP-reported activities and awareness through survey results with the goal of aiding beneficiaries in increasing their income, eventually disenrolling from ARHOME and enrolling in private insurance.

4.1.2 MATERNAL LIFE360 HOME

The main goal of the Maternal Life360 HOME program is to support expecting mothers with high-risk pregnancies during pregnancy and up to two years post-partum through the provision of home visits and referrals to housing, nutrition, transportation, and other resources. This report focuses on Maternal Life360 HOME program characteristics and implementation activities that include beneficiary recruitment, infrastructure development, and strategies

[22] "Faculty & Research." *NYU Wagner*, https://wagner.nyu.edu/faculty/billings/nyued-background/. Accessed 17 Oct 2025.

adopted to facilitate and reduce barriers in implementation using Life360 HOMEs program and cost data.

4.2 DATA SOURCES

The ARHOME and Life360 HOMEs evaluations leverage multiple sources of primary and secondary data to assess research hypotheses for each goal. These include claims-based administrative data, state insurance data, enrollment files, survey-based scores, and publicly available information. Administrative data sources include information extracted from the Arkansas Division of Medical Services' (DMS) Medicaid Management Information System (MMIS) and information sent from the QHPs. The carriers, Blue Cross Blue Shield and Centene, transmit administrative QHP data on a quarterly basis to the Arkansas Decision Support System (DSS) in a single standardized file. There are currently six ARHOME QHPs: Blue Cross Blue Shield (BCBCS), Health Advantage, Octave (starting in 2024), Ambetter, QCA, and QualChoice Life.

Figure 7: Data Sources

Figure 7 depicts the full list of data sources utilized for metrics in both ARHOME and Life360 HOMEs.

Public Use Files

Public Use Files supplement Arkansas State data with broader community-wide statistics that add context to population outcomes. Both the ACS and BRFSS provide additional insurance coverage and quality of care information for beneficiaries that are comparable to ARHOME. The Kaiser Family Foundation (KFF) and Medical Expenditure Panel Survey (MEPS) provide additional marketplace indicators and program characteristics for Arkansas in relation to other states. Social Determinants of Health (SDOH) data sources, such as County Health Rankings & Roadmaps (CHR&R), Map the Meal Gap, and Food Environmental Atlas, will allow for the comparison of food and housing insecurities present in the greater community with what is perceived among Life360 HOME beneficiaries in the summative evaluation.

Arkansas State Resources

Administrative data sources include information extracted from MMIS, which is used to collect, manage, and maintain Medicaid beneficiary files (i.e. eligibility, enrollment, and demographics) and FFS claims. Applicable claim types, such as institutional, professional, and pharmacy claims, are used to calculate the health utilization metrics while beneficiary demographic files identify beneficiary age, gender, and other demographic information. Eligibility files are used to verify a beneficiary's enrollment in the State's Medicaid programs. To ensure accurate and complete data, the contractor's Arkansas Medicaid Data Warehouse utilizes a snapshot process that identifies claims using a specific beneficiary finder file for maximum efficiency and requires a minimum six-month lag to allow time for most claims to be processed through the MMIS.

The Arkansas All Payer Claims Database (APCD) is a large-scale medical claims database used primarily to identify beneficiary insurance coverage information outside of the ARHOME program. Arkansas Insurance Department (AID) QHP provider network data is used to assess network adequacy measures while QHP claims data are used alongside MMIS claims data to evaluate claims-based metrics. The Arkansas Integrated Eligibility System (ARIES) provides monthly closure and renewal data for enrollment measures. Information from the Statewide Longitudinal Data System (SLDS) contains wage, training, and educational attainment data accessed through the Administrative Data Research Facility (ADRF) to evaluate economic initiatives of the ARHOME program. Immunization and birth certificate (vital statistics) data is obtained through Arkansas's Department of Health (ADH).

The University of Arkansas for Medical Sciences (UAMS) SDOH Survey is a state-wide effort led by Arkansas's Office of Health Information Technology (OHIT) in partnership with UAMS College of Public Health and the University of Arkansas. This survey consists of responses from hospitals, provider care organizations, and behavioral health providers and assesses how healthcare providers and organizations across Arkansas are screening for and addressing non-medical factors in the patient population that impact health outcomes, such as access to food, housing stability, transportation, social support, and financial barriers.

Life360 Program Data

Each of the Maternal Life360 HOME providers maintain their own software platforms to collect and store data related to beneficiary enrollment, high-risk screening, home visiting services, and Life360 program data. All relevant Life360 HOME metric data are transferred and standardized in the Life360 HOME QualityCare Insight (QCI) Portal. It is important to note that Life360program data will be evolving throughout the implementation of Life360 HOMEs as different providers are approved and enrolled in the program and will be further detailed in the summative evaluation.

Surveys, Focus Groups, and Interviews

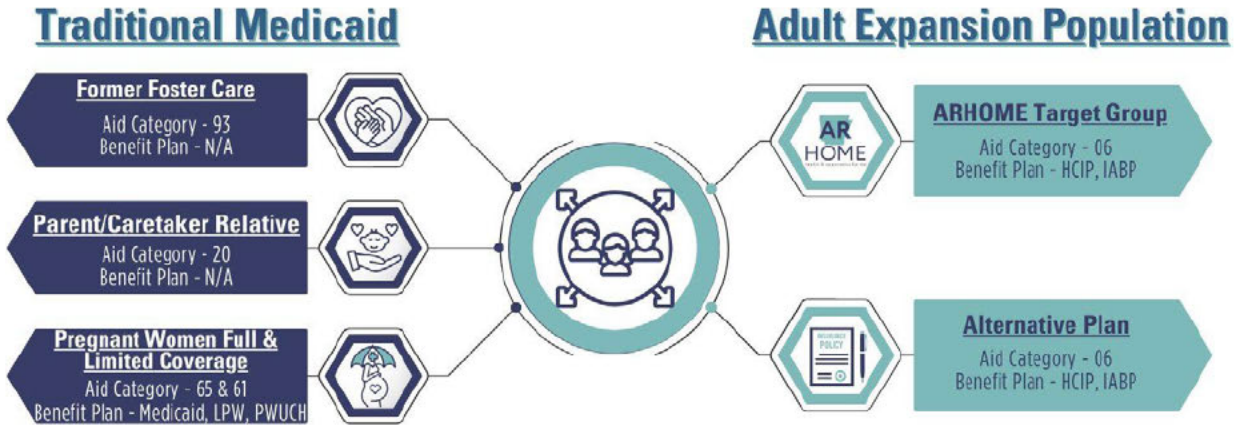
Provider and beneficiary feedback are collected through interviews, focus groups and surveys to obtain fundamental perceptions concerning the ARHOME and the Life360 HOME program. While ARHOME feedback is focused on awareness and acceptance of and satisfaction with the program, the Life360 HOME feedback also includes provider perceptions of implementation and sustainability with the program. The BESS survey primarily collects data on beneficiary satisfaction and experience in the ARHOME program while provider focus groups (PFGs) provide insight into the physician and stakeholder experience. Additional Maternal Life360 HOME provider interviews and non-provider surveys gathered responses from key informants about the Life360 program, specifically surrounding implementation activities, barriers, and lessons learned.

4.3 TARGET AND COMPARISON POPULATIONS

4.3.1 ARHOME

The ARHOME target population consists of Medicaid expansion beneficiaries (aid category 06, ≤133% FPL, 138% FPL with 5% disregard) with a QHP from a private insurance carrier (benefit plan HCIP) or those awaiting enrollment into a QHP (interim alternative benefit plan [IABP]). During the interim period, beneficiaries enrolled in ARHOME have services paid by Medicaid FFS before a QHP is chosen or assigned. The in-state Medicaid FFS comparison population consists of non-disabled adults eligible for Arkansas Medicaid pre-expansion, which includes the parent/caretaker relative (<17% FPL) and former foster care (no income limit) aid categories (**Figure 8**). These two aid categories offer the most comparable population to our target population in terms of key demographic characteristics. Other categories included children and adults outside of ARHOME's age range and beneficiaries with disabilities that may confound results due to higher utilization of healthcare services and lower quality of health and/or comorbidities related to their disabilities.

Figure 8: Aid Categories and Benefit Plans in ARHOME



NOTE: Target and Traditional Medicaid FFS Comparison groups are exclusive of other combinations of aid category and benefit plan. Pregnancy groups are Inclusive of other combinations of aid category and benefit plan. The interim, fee-for-service plan IABP is not included in the minimum eligibility period.

In 2022 and 2023, the ARHOME target population had a higher percentage of beneficiaries who were female, 50-64 years of age, and a higher average income compared with those in the comparison group (**Table 12**).

Table 12: ARHOME and Medicaid FFS Comparison Population Characteristics Based on at Least One Day Total Enrollment

	In-State Comparison Population		Target Population	
	2022 (N=84,832)	2023 (N=74,370)	2022 (N=301,429)	2023 (N=304,633)
Age Groups (%)				
19-29	30,892 (36.4%)	26,646 (35.8%)	95,531 (31.7%)	93,090 (30.6%)
30-49	46,147 (54.4%)	40,977 (55.1%)	130,715 (43.4%)	133,598 (43.9%)
50-64	3,395 (4.0%)	3,048 (4.1%)	61,763 (20.5%)	64,546 (21.2%)
Average Income				
100% FPL or Lower	78,872 (93.0%)	69,208 (93.1%)	234,793 (77.9%)	240,550 (79.0%)
Greater than 100% FPL	5,960 (7.0%)	5,162 (6.9%)	66,636 (22.1%)	64,083 (21.0%)
Gender (%)				
Female	67,514 (79.6%)	57,970 (77.9%)	164,994 (54.7%)	161,060 (52.9%)
Male	17,318 (20.4%)	16,400 (22.1%)	136,435 (45.3%)	143,573 (47.1%)
Race (%)				
Non-Hispanic White	47,614 (56.1%)	40,342 (54.2%)	174,662 (57.9%)	174,978 (57.4%)
Non-Hispanic Black	20,770 (24.5%)	18,257 (24.5%)	58,294 (19.3%)	57,691 (18.9%)
Hispanic	3,412 (4.0%)	3,552 (4.8%)	11,260 (3.7%)	13,695 (4.5%)
Other*	13,036 (15.4%)	12,219 (16.4%)	57,213 (19.0%)	58,269 (19.1%)

*Other includes American Indian, Alaska Native, Asian, Native Hawaiian, other Pacific Islander, and more than one race
Note: not all columns will sum to 100% due to rounding

A subpopulation of interest includes beneficiaries who were eligible for Medicaid Early and Periodic Screening Diagnostic and Treatment (EPSDT) services as 17- or 18-year-olds and then became eligible for a QHP as 19- or 20-year-olds. These beneficiaries are defined as the EPSDT

population to test the hypothesis that QHP beneficiaries will have at least as satisfactory access to EPSDT benefits as the Medicaid FFS group. These beneficiaries could also be included in the target population in the year(s) that they were in a QHP.

The following beneficiary exclusions apply to each measurement year:

- Less than 19 years of age on January 1
- 65 years of age or older on December 31
- Medicare or third-party liability claims
- Participation in a PASSE, an Arkansas created Medicaid managed care program, on or after the implementation date of March 1, 2019
- Death during the measurement year

Operationally, beneficiaries are assigned to the ARHOME target group based on having at least 180 days of eligibility in qualifying segments and no segments qualifying for traditional Medicaid FFS. The pregnant group is defined as beneficiaries having one or more days of coverage in qualifying segments and at least 180 days of total coverage in the measurement year. IABP coverage is allowed but does not contribute towards the 180-day minimum.

The target and comparison populations in each measurement year had approximately a 4:1 ratio, necessitating weighting to construct comparably sized groups for each measure that is described further in **Section 4.6** (**Analytic Methods**). The study populations based on at least 1 and 180 days of enrollment in 2022 and 2023 are summarized in **Table 13**.

Table 13: ARHOME Analytic Population Sample Sizes by Year

Study Population	2022		2023	
	Total (%)	180 days of enrollment (%)	Total (%)	180 days of enrollment (%)
Target	301,429 (76.3)	281,869 (76.7)	304,633 (78.0)	224,306 (77.6)
Comparison	84,832 (21.5)	79,309 (21.6)	74,370 (19.0)	56,940 (19.7)
Pregnancy	9,044 (2.3)	6,190 (1.7)	11,633 (3.0)	7,881 (2.7)

While the IABP benefit plan is considered part of the ARHOME program as a separate health plan from the QHPs, **Table 14** specifies how IABP segments were addressed at several levels: populations, measures for gaps in coverage, measure of health plan continuity, and claims-based measures. Beneficiaries with eligibility segments qualifying for the comparison population and who also have an IABP segment are excluded from the comparison population. In the other populations (target and pregnancy), IABP segments are considered insurance coverage and not gaps in coverage.

Table 14: IABP Segment Details

Analysis Level	IABP Segment Treatment
Populations	Exclude beneficiaries with IABP from the comparison population
Gaps in insurance coverage	Include IABP segments as insurance coverage
Claims-based measures, measurement period	Include claims during IABP segments
Claims-based measures, prior year diagnoses	Include claims during IABP segments, all populations

For claims-based measures, claims from IABP segments are included to ensure that diagnoses and medical services from the interim period contribute to a complete picture of the beneficiary's experience in ARHOME. Similarly, the evaluation will include claims from IABP segments prior to the measurement year(s) if a claims-based measure specifies a lookback period for prior diagnoses.

4.3.2 MATERNAL LIFE360 HOME

Providers who choose to become a Maternal Life360 HOME must be a birthing hospital in Arkansas Medicaid and provide services within their designated service area. Life360 HOME beneficiaries are enrolled in ARHOME[23], live in a county or service area served by a Life360 HOME provider, and have a high-risk pregnancy diagnosis.

Comparison populations include ARHOME beneficiaries who are representative of beneficiaries residing in non-Life360 HOME service areas that would have otherwise been eligible for services had they resided in a Life360 HOME service area. To account for geographic and socio-demographic differences between Life360 HOME service areas as compared to non-Life360 HOME service areas, county-level matching on variables/themes in the CDC/Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index (SVI) and urban/rural status consider factors that may influence comparability of outcomes. The SVI is a weighted index that includes county-level information for the following themes: socioeconomic status, household characteristics, racial and minority status, as well as housing type and transportation. These characteristics, along with urban-rural classification from the Federal Office of Rural Health Policy (FORHP), serve as baseline covariates in a propensity score model (PSM) to adjust for potential bias in the selection and assignment of beneficiaries into the comparison population. Since not all non-Life360 HOME counties are a suitable match for a Life360 HOME county, included counties will have a covariate balance that most closely matches the target counties for analytics. Ideally, analytics cohorts have at least one comparison county per target county with aggregate baseline characteristics being comparable across groups.

Currently, there are four enrolled and active hospitals (St. Bernards Medical Center, White River Health, Baptist Health Medical Center Little Rock, Baptist Health Medical Center North Little Rock), one hospital in startup phase (Mercy Hospital Northwest Arkansas) and two hospitals in the application phase (UAMS and CHI St. Vincent Hot Springs). Life360 HOME target and

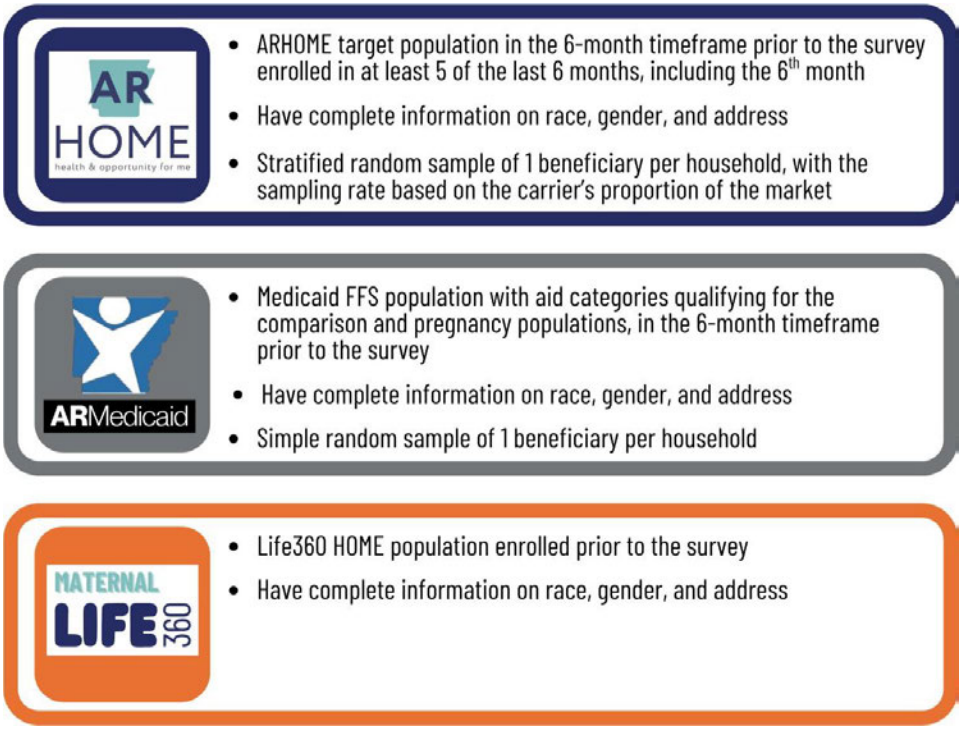
[23] All Medicaid programs are allowable for Maternal Life360 HOME, but the demonstration evaluation focuses only on the ARHOME group.

comparison populations will be a subgroup of ARHOME beneficiaries. While traditional Medicaid FFS beneficiaries are also eligible for Maternal Life360 HOME, only pregnant women who are eligible for ARHOME will be included in our Maternal Life360 HOME target population.

4.3.3 BENEFICIARY ENGAGEMENT SATISFACTION SURVEY

The BESS is administered to beneficiaries enrolled in ARHOME or Maternal Life360 HOMEs. The ARHOME BESS survey was conducted in the fall of 2022 and spring of 2024 and will be conducted again in the spring of 2026. The Life360 HOMEs survey will also be conducted in 2026 after beneficiary enrollment is well underway. This survey is based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Adult Medicaid 5.1 core questions with the addition of supplemental items and questions specific to the ARHOME and Life360 HOMEs evaluation. The survey population criteria are as follows in **Figure 9**.

Figure 9: Survey Populations



4.3.4 PROVIDER FOCUS GROUPS

The evaluator engaged specific PFGs to gather their feedback for awareness, acceptance, and satisfaction with the ARHOME program in years 2023 and 2025 of the demonstration. Target populations include members from the following organizations:

- **Arkansas Medical Society (AMS)**: Association for physicians in specialties, including OB/GYN, substance abuse treatment, practice management, urgent care, hospital medical officers, emergency medicine, family medicine, and internal medicine

- **Arkansas Academy of Family Physicians (AAFP)**: A large multi-specialty group practice with the following specialties: rehabilitation, emergency medicine, family medicine, internal medicine, and hospital medical practitioners
- **Arkansas Hospital Association (AHA)**: Association representing hospitals. Focus group members included business office director, case manager/discharge planner, CEOs, CFOs, clinical administrator, operations coordinator, vice president, and the ARHOME Program Director

Due to a lack of provider participation in 2025, PFGs were not conducted for AMS or AAFP. The AMS in-person PFG session was cancelled due to a lack of accommodations at the AMS annual conference and was not rescheduled. AAFP providers showed a lack of initial interest in attending the in-person PFG sessions at the AAFP annual conference. Thus, the in-person sessions were later converted to virtual sessions to increase attendance. However, those were cancelled as well due to lack of participation.

4.3.5 PUBLIC USE FILES

Publicly available data sets bridged the gaps in the available data and provided community-level context for ARHOME healthcare access, cost, and HRSN outcome measures. The analytic population for the interim report varied by source and is briefly described below.

The BRFSS is an annual survey conducted by states with assistance from the CDC. The core survey includes questions on health care access and immunization. This evaluation compares survey responses from Arkansas residents with responses from Kentucky and West Virginia (Medicaid expansion states) because these states performed similarly to Arkansas on socioeconomic indicators, such as the Human Development Index (HDI), unemployment rate, and percentage of population in poverty.

The BRFSS analytic sample represents adults ages 19–64 at or under ≤138% FPL who were likely to have been eligible for Medicaid after expansion. Imputed FPL was calculated as the midpoint of a respondent's income category divided by the household size according to annual federal poverty guidelines.[24] BRFSS weighting methodology provides state-level weights that allow for cross-year comparisons back to 2011.[25] The weights incorporate design weighting to adjust for nonresponse and noncoverage, as well as ranking to adjust for demographic differences between the persons sampled within each state.

The ACS, sponsored jointly by the U.S. Census Bureau and the U.S. Department of Commerce, is a nationwide survey that collects and produces information on demographic, social, economic, and health insurance coverage characteristics for a representative sample of the U.S. population

[24] Hest, R. Four Methods for Calculating Income as a Percent of the Federal Poverty Guideline (FPG) in the Behavioral Risk Factor Surveillance System (BRFSS). May 2019. State Health Access Data Assistance Center (SHADAC). Accessed at https://www.shadac.org/sites/default/files/publications/Calculating_Income_as_PercentFPG_BRFSS.pdf

[25] BRFSS Complex Sampling Weights and Preparing 2019 BRFSS Module Data for Analysis. July 2020. Accessed at https://www.cdc.gov/brfss/annual_data/2019/pdf/Complex-Smple-Weights-Prep-Module-Data-Analysis-2019-508.pdf

each year. In the ARHOME health coverage measure, comparisons are made between residents of Arkansas and residents of non-expansion states (Alabama, Mississippi, and South Carolina) who are between ages 19 and 64 at 100-138% FPL. Selected states perform similarly to Arkansas on socioeconomic indicators. Maternal Life360 HOME measures that utilize ACS data require only county-level outcomes within the state of Arkansas. When available, 5-year estimates are used unless otherwise specified.

The CMS POS files[26] are nation-wide provider-level datasets that include a comprehensive list of provider characteristics for CMS accredited facilities. The NASHP Hospital Cost Tool provides additional cost information from Medicare Cost Reports. This evaluation investigates financial health defined through measures of closure rate and positive operating margins using financial characteristics of Arkansas providers.

4.3.6 LIFE360 HOMES KEY INFORMANTS & PROVIDERS

Key informant interviews (KIIs) focus primarily on implementation activities and sustainability planning of the Maternal Life360 HOME program. The objective of these interviews is to identify and interview key individuals that can help inform our understanding of how the Life360 HOME program implementation is progressing during the amendment period. Key informants include individuals from the Maternal Life360 HOME program staff and leadership, state officials and policymakers as well as other stakeholders (i.e., providers, HRSN providers, case managers).

4.3.7 LIFE360 HOMES NON-PARTICIPATING PROVIDERS

To better understand some of the immediate concerns that prevented hospitals in Arkansas from participating in the Life360 HOMEs program, a short survey was sent to hospitals who chose not to participate in Maternal Life360 HOME. These hospitals were determined by the State to be eligible for participation but did not start or complete the enrollment process.

4.4 EVALUATION PERIOD

The evaluation period for the ARHOME demonstration is January 1, 2022 through December 31, 2026. The Life360 HOMEs program period is from January 1, 2023 through December 31, 2026.

Figure 10 displays key events that occurred during the evaluation period, such as the removal of premium requirements at the end of 2022 and the reduction in retroactive eligibility from 90 days to 30 days. Other events, such as the COVID-19 public health emergency (PHE) and Medicaid unwinding may potentially have a direct or indirect impact on results. During the COVID-19 PHE, disenrollment based on disqualifying characteristics was suspended leading to a larger ARHOME population during the pandemic. Both Medicaid unwinding and the suspension of auto-enrollment into a QHP resulted in a decrease in the eligible ARHOME population, resulting in a larger number of beneficiaries being excluded from some measures. Implications of these events are described in the **Methodological Limitation** (**Section 5**).

[26] Includes the Provider of Service Files, Hospital & Non-Hospital Facilities and Internet Quality Improvement and Evaluation System – Home Health Agency, Ambulatory Surgical Center, and Hospice Providers.

Figure 10: Key Events Coinciding with the ARHOME and Life360 HOMEs Program

4.5 EVALUATION MEASURES

This section describes the metrics by which the evaluation will measure each goal and hypothesis, separately for ARHOME and Life360 HOMEs. While a summary of metrics included in this report are listed below, a full list of detailed specifications is listed in the respective evaluation designs.

4.5.1 ARHOME SUMMARY INFORMATION BY MEASURE

Table 15: HOME Goal 1 Measure Summary

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Goal 1: Providing Continuity of Coverage for Individuals					
Hypothesis A. ARHOME beneficiaries will be aware of the premium assistance model					
1.A.1	Beneficiary Premium Assistance Awareness	Refer to survey population definition	N/A	Descriptive statistics	CAHPS Health Plan Survey, supplemental
Hypothesis B. ARHOME beneficiaries and QHP contracted providers will be aware of the Health Improvement Initiative					
1.B.1	Beneficiary Health Improvement Initiative Awareness	Refer to survey population definition	N/A	Descriptive statistics	CAHPS Health Plan Survey, supplemental
1.B.2	Provider Health Improvement Initiative Awareness	Refer to survey population definition	N/A	Descriptive statistics	Provider Survey

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Hypothesis C. The premium assistance model will lead to less unmet need for healthcare among Arkansas residents ages 19-64 with income up to 138% FPL compared to individuals at the same income levels in states that expanded Medicaid through existing service delivery systems					
1.C.1	Have a Personal Doctor	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS
1.C.2	Avoided Care Due to Cost	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS
1.C.3	Last Routine Checkup	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS
Hypothesis D. The ARHOME program will lead to QHP beneficiaries having better continuity of coverage that includes fewer and shorter gaps, while Medicaid eligible, compared to Medicaid FFS beneficiaries					
1.D.1	Beneficiaries with ≥1 Month with a Coverage Gap	ARHOME beneficiaries with ≥1 day enrollment	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS eligibility data
1.D.2	Average Length of Gaps in Coverage	ARHOME beneficiaries with ≥1 day enrollment	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS eligibility data
Hypothesis E. The ARHOME program will lead to QHP beneficiaries having better continuity of primary care and specialty providers, while Medicaid-eligible, compared to Medicaid FFS beneficiaries					
1.E.1	Continuity of PCP Care	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
1.E.2	Continuity of Specialist Care	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
1.E.3	QHP beneficiaries Seeing a PCP on an Annual Basis	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data

Table 16: ARHOME Goal 2 Measure Summary

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
GOAL 2: Improving Access to Providers					
Hypothesis A. The premium assistance model will lead to improved financial health among Arkansas healthcare providers compared to healthcare providers in states that expanded Medicaid through the existing service delivery system					
2.A.1	Provider Financial Health Improvement	ARHOME providers	N/A	Descriptive statistics	Survey/focus groups
2.A.2	Hospital Financial Health Improvement	ARHOME providers	Other Medicaid Expansion States	Descriptive statistics	NASHP Hospital Cost Tool
2.A.3	Provider Closure Rate	ARHOME providers	Other Medicaid Expansion States	Descriptive statistics	CMS Provider of Service Files
Hypothesis B. The ARHOME program will lead to QHP beneficiaries having better perceived access to care over time and compared to Medicaid FFS beneficiaries					
2.B.1	Got Care for Illness/Injury as Soon as Needed	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.2	Got Non-Urgent Appointment as Soon as Needed	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.3	How Often It Was Easy to Get Necessary Care, Tests, or Treatment	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.4	Have a Personal Doctor	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.5	Got Appointment with Specialists as Soon as Needed	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.6	Days Wait Time Between Making Appointment and Seeing Provider	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
2.B.7	How Often Had to Wait for Appointment Because of Provider's Lack of Hours/Availability	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.8	Ease to Get a Referral to a Specialist	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.9	Needed Interpreter to Help Speak with Doctors or Other Health Providers	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
2.B.10	How Often Got an Interpreter When Needed One	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey
Hypothesis C. The ARHOME program will lead to QHP beneficiaries having better perceived access to care compared to similar beneficiaries in states that expanded Medicaid through the existing service delivery system					
2.C.1	Have Health Care Coverage	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS
2.C.2	Have a Personal Doctor	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS
2.C.3	Last Routine Checkup	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS
2.C.4	Avoided Care Due to Cost	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS
2.C.5	Flu Vaccine	Adults 19-64 w/income ≤138% FPL in Arkansas	Adults 19-64 w/income ≤138% FPL in comparison states	Comparative ITS; DiD	BRFSS

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Hypothesis D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries					
2.D.1	Provider Patient Acceptance	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey; Supplemental
2.D.2	Time to First Appointment	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey; Supplemental
2.D.3	Breast Cancer Screening	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
2.D.4	Cervical Cancer Screening	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
2.D.5	Chlamydia Screening in Women Ages 21-24	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
2.D.6	Statin Therapy for Patients with Diabetes	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
2.D.7	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
2.D.8	Adults' Access to Preventive/Ambulatory Health Services	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
2.D.9	Asthma Medication Ratio: Ages 19–64	Refer to ARHOME population definition	In-State Medicaid FFS Population	IPTW weighted regression; ATE	MMIS and QHP claims data
2.D.10	Adolescent Well-Care Visits	Beneficiaries enrolled in ARHOME at ages 19–20 and eligible for EPSDT services at ages 17–18 in Medicaid FFS	Same beneficiaries in Medicaid FFS 1-2 years prior to ARHOME enrollment	Repeated measures ANOVA; pre-post comparison	MMIS and QHP claims data

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
2.D.11	EPSDT screening - Preventive Dental Visits	Beneficiaries enrolled in ARHOME at ages 19–20 and eligible for EPSDT services at ages 17–18 in Medicaid FFS	Same beneficiaries in Medicaid FFS 1-2 years prior to ARHOME enrollment	Repeated measures ANOVA; pre-post comparison	MMIS and QHP claims data
2.D.12	EPSDT screening - Preventive Vision	Beneficiaries enrolled in ARHOME at ages 19–20 and eligible for EPSDT services at ages 17–18 in Medicaid FFS	Same beneficiaries in Medicaid FFS 1-2 years prior to ARHOME enrollment	Repeated measures ANOVA; pre-post comparison	MMIS and QHP claims data
2.D.13	Any Utilization of Non-Emergency Transportation Services	Refer to ARHOME population definition	In-State Medicaid FFS Population	Logistic regression	MMIS and QHP claims data
2.D.14	Utilization Counts of Non-Emergency Transportation Services	Refer to ARHOME population definition	In-State Medicaid FFS Population	Zero inflated Poisson	MMIS and QHP claims data
2.D.15	Non-Emergency Transportation Program Awareness	Refer to survey population definition	In-State Medicaid FFS Population	Logistic regression with case-mix adjustment; F-Test Type III	CAHPS Health Plan Survey; Supplemental
2.D.16	PCP Network Adequacy	ARHOME provider network	Arkansas Medicaid provider network	Geospatial analysis	MMIS claims data
2.D.17	PCP Network Accessibility	Refer to ARHOME population definition	In-State Medicaid FFS Population	Geospatial analysis	MMIS claims data
2.D.18	Specialist Network Adequacy	ARHOME provider network	Arkansas Medicaid provider network	Geospatial analysis	MMIS claims data
2.D.19	Specialist Network Accessibility	Refer to ARHOME population definition	In-State Medicaid FFS Population	Geospatial analysis	MMIS claims data
2.D.20	ECP Network Adequacy	ARHOME provider network	Arkansas Medicaid provider network	Geospatial analysis	MMIS claims data

Table 17: ARHOME Goal 3 Measure Summary

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
GOAL 3: Improving Continuity of Care Across the Continuum of Coverage					
Hypothesis A. ARHOME beneficiaries will be aware of the shorter period of retroactive eligibility, and the time-limited premium requirements					
3.A.1	Beneficiary Retroactive Eligibility Awareness	Refer to survey population definition	N/A	Descriptive statistics	CAHPS Health Plan Survey, supplemental
3.A.2	Beneficiary Premium Requirement Awareness	Refer to survey population definition	N/A	Descriptive statistics	CAHPS Health Plan Survey, supplemental
Hypothesis B. The shorter period of retroactive eligibility will not lead to a lower rate of Medicaid applications among individuals potentially eligible for ARHOME compared to individuals potentially eligible for other Medicaid programs without a reduced period of retroactive eligibility					
3.B.1	New Enrollment	Refer to survey population definition	N/A	Descriptive statistics	CAHPS Health Plan Survey, supplemental
Hypothesis C. The shorter period of retroactive eligibility will not lead to a greater medical debt among new ARHOME beneficiaries compared to individuals newly enrolled in other Medicaid programs without a reduced period of retroactive eligibility					
3.C.1	New Beneficiary Medical Debt	All new ARHOME applicants	In-State Medicaid FFS Population	IPTW weighted regression; ATE	Application for SNAP, Health Care, and TEA/RCA Benefits
Hypothesis D. During Year 1 of the demonstration, monthly premiums will not lead to lower take-up and retention rates among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those at or below 100% FPL					
3.D.1	New Enrollment	ARHOME beneficiaries at 100-138% FPL	ARHOME beneficiaries at or below 100% FPL	IPTW weighted regression; ATE	MMIS eligibility data
3.D.2	Retention Rate	ARHOME beneficiaries at 100-138% FPL due for renewal	ARHOME beneficiaries at or below 100% FPL due for renewal	IPTW weighted regression; ATE	Renewal data
Hypothesis E. During Year 1 of the demonstration, monthly premiums will not lead to more gaps in coverage among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those at or below 100% FPL					
3.E.1	Beneficiaries with at Least One Month with a Coverage Gap	ARHOME beneficiaries at 100-138% FPL	ARHOME beneficiaries at or below 100% FPL	IPTW weighted regression; ATE	MMIS eligibility data
3.E.2	Average Length of Gaps	ARHOME beneficiaries at 100-138% FPL	ARHOME beneficiaries at or below 100% FPL	IPTW weighted regression; ATE	MMIS eligibility data

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Hypothesis F.QHP beneficiaries will demonstrate they value QHP coverage, and the implementation of monthly premiums will not reduce QHP beneficiary enrollment					
3.F.1	Health Insurance Coverage Status	Residents of Arkansas	Non-Medicaid expansion states	Comparative ITS; DiD	ACS
3.F.2	Beneficiaries Who Paid a Premium	ARHOME beneficiaries at 101-138% FPL	N/A	Descriptive statistics	State Monitoring Reports
3.F.3	QHP Beneficiaries Selecting Their Own QHP	Newly enrolled ARHOME beneficiaries	N/A	Descriptive statistics	MMIS eligibility data
Hypothesis G. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase take-up and retention rates among QHP beneficiaries with income at 101-138% FPL compared with Year 1					
3.G.1	New Enrollment	ARHOME beneficiaries with income at 101-138% FPL	ARHOME MY22 beneficiaries with income at 101-138% FPL	IPTW weighted regression; ATE	MMIS eligibility data
3.G.2	Retention Rate	ARHOME beneficiaries with income at 101-138% FPL	ARHOME MY22 beneficiaries with income at 101-138% FPL	IPTW weighted regression; ATE	Renewal data
H. During Years 2-5 of the demonstration, the cessation of monthly premiums will not increase gaps in coverage among QHP beneficiaries while still eligible for ARHOME than they did during Year 1					
3.H.1	Beneficiaries with at Least One Month with a Coverage Gap	ARHOME beneficiaries with income at 101-138% FPL	ARHOME MY22 beneficiaries with income at 101-138% FPL	IPTW weighted regression; ATE	MMIS eligibility data
3.H.2	Average Length of Gaps in Coverage	ARHOME beneficiaries with income at 101-138% FPL	ARHOME MY22 beneficiaries with income at 101-138% FPL	IPTW weighted regression; ATE	MMIS eligibility data
Hypothesis I. During Years 2-5 of the demonstration, the cessation of monthly premiums will lead to QHP beneficiaries having more gaps in coverage after earnings exceed Medicaid eligibility limits than they did during Year 1					
3.I.1	Beneficiaries with at Least One Month with a Coverage Gap	ARHOME beneficiaries with income at 101-138% FPL that disenroll due to high income	ARHOME MY22 beneficiaries with income at 101-138% FPL that disenroll due to high income	IPTW weighted regression; ATE	MMIS eligibility data
3.I.2	Average Length of Gaps in Coverage	ARHOME beneficiaries with income at 101-138% FPL that disenroll due to high income	ARHOME MY22 beneficiaries with income at 101-138% FPL that disenroll due to high income	IPTW weighted regression; ATE	MMIS eligibility data

Table 18: ARHOME Goal 4 Measure Summary

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Goal 4: Furthering Quality Improvement and Delivery System Reform Initiatives that are Successful Across Population Groups					
Hypothesis A. ARHOME beneficiaries will be aware of the shorter point-of-service copayment requirements and the Economic Independence Initiative					
4.A.1	Beneficiary Copayment Awareness	Refer to survey population definition	N/A	Descriptive statistics	CAHPS Health Plan Survey, supplemental
4.A.2	Beneficiary EII Awareness	Refer to survey population definition	N/A	Descriptive statistics	CAHPS Health Plan Survey, supplemental
Hypothesis B. The ARHOME program will lead to QHP beneficiaries having greater satisfaction in the care provided over time and compared to Medicaid FFS beneficiaries					
4.B.1	Average Rating of Health Plan	Refer to survey population definition	In-State FFS Medicaid Population	Chi-square	CAHPS Health Plan Survey
4.B.2	Average Rating of Health Care	Refer to survey population definition	In-State FFS Medicaid Population	Chi-square	CAHPS Health Plan Survey
4.B.3	Average Rating of PCP	Refer to survey population definition	In-State FFS Medicaid Population	Chi-square	CAHPS Health Plan Survey
4.B.4	Average Rating of Specialist	Refer to survey population definition	In-State FFS Medicaid Population	Chi-square	CAHPS Health Plan Survey
Hypothesis C. The ARHOME program will lead to QHP beneficiaries having lower non-emergent use of the emergency department (ED), lower potentially preventable use of the emergency department and hospital admissions, and lower hospital re-admissions over time and compared to Medicaid FFS beneficiaries					
4.C.1	Preventable ED Visits	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.2	Non-emergent ED Visits	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.3	Emergent ED Visits	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.4	Plan All-Cause Readmissions (PCR)	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
4.C.5	Diabetes Short-Term Complications Admission Rate	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.6	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.7	Heart Failure Admission Rate	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.8	Asthma in Younger Adults Admission Rate	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.9	PCP Follow-Up after ED Visit	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.C.10	PCP Follow-Up after Hospitalization	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
Hypothesis D. The ARHOME program will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries					
4.D.1	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.2	Antidepressant Medication Management	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.3	Follow-Up After Hospitalization for Mental Illness	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.4	Adherence to Antipsychotics for Individuals with Schizophrenia	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
4.D.6	Use of Opioids at High Dosage in Persons Without Cancer	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.7	Concurrent Use of Opioids and Benzodiazepines	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.8	Use of Pharmacotherapy for Opioid Use Disorder	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.9	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.10	Follow-Up After Emergency Department Visit for Mental Illness	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.11	Persistence of Beta-Blocker Treatment After a Heart Attack	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.12	Annual Monitoring for Patients on Persistent Medications	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.13	Annual HIV/AIDS Viral Load Test	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.14	C-Section Rate	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.15	Contraceptive Care – Postpartum Women Ages 21–44	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.16	Contraceptive Care – All Women Ages 21–44	Refer to ARHOME population definition	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
4.D.17	QHP Beneficiaries Participating in the HII Program	Refer to ARHOME population definition	N/A	Descriptive statistics	MMIS and QHP claims data

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Hypothesis E. Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries not subject to copay					
4.E.1	Antidepressant Medication Management	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.2	Follow-Up After Hospitalization for Mental Illness	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.3	Adherence to Antipsychotics for Individuals with Schizophrenia	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.4	Use of Opioids at High Dosage in Persons Without Cancer	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.5	Concurrent Use of Opioids and Benzodiazepines	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.6	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.7	Follow-Up After Emergency Department Visit for Mental Illness	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.8	Persistence of Beta-Blocker Treatment After a Heart Attack	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.9	Annual Monitoring for Patients on Persistent Medications	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.10	Annual HIV/AIDS Viral Load Test	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data
4.E.11	Statin Therapy for Patients with Diabetes	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Hypothesis F. Among QHP beneficiaries with income at or below 20% FPL, the Economic Independence Initiative will lead to an increase in income to above 20% FPL over time					
4.F.1	Beneficiaries initially at 20% FPL who are above 20% FPL at follow-up	Refer to ARHOME population definition	N/A	Pre-post comparison; Paired t-test	MMIS and QHP claims data
Hypothesis G. Among QHP beneficiaries with income at or below 100% FPL, the Economic Independence Initiative will lead to an increase in income to about 100% FPL over time					
4.G.1	Beneficiaries initially at or under 100% FPL who are above 100% FPL at follow-up	Refer to ARHOME population definition	N/A	Pre-post comparison; Paired t-test	MMIS and QHP claims data
Hypothesis H. Among QHP beneficiaries who disenroll from ARHOME, the Economic Independent Initiative will lead to an increase in the percent that disenroll due to increased income over time					
4.H.1	Beneficiaries That Disenroll Due to High Income	ARHOME beneficiaries with ≥1 day enrollment	N/A	Descriptive statistics	Closure and Renewal lists
4.H.2	Disenrolled Beneficiaries That Take-Up Private Health Insurance	ARHOME beneficiaries with ≥1 day enrollment	N/A	Descriptive statistics	APCD data
4.H.3	Disenrolled Beneficiaries That Take-Up Private Health Insurance and Maintain the Same Health Insurance Plan They Had in ARHOME	ARHOME beneficiaries with ≥1 day enrollment	N/A	Descriptive statistics	APCD data
Hypothesis I. The Economic Independence Initiative will lead to an increase in the percent of QHP beneficiaries that enroll in education and training programs over time4					
4.I.1	Beneficiaries That Enroll in Education and Training Programs over Time	Refer to ARHOME population definition	N/A	Descriptive statistics	SLDS data
4.I.2	Beneficiaries Participating in the EII Program	Refer to ARHOME population definition	N/A	Descriptive statistics	Carrier data
4.J.1	Beneficiary Copayment Healthcare Use Impact	ARHOME beneficiaries subject to copay	ARHOME beneficiaries not subject to copay	IPTW weighted regression; ATE	MMIS and QHP claims data

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Hypothesis K. The shorter period of retroactive eligibility, the premium assistance model, the point-of-service copayments, the Health Improvement Initiative, and the other financial discipline components will lead to the rate of growth in per member per month (PMPM) QHP costs being no higher than the rate of growth in PMPM costs in Arkansas Medicaid FFS					
4.K.1	PMPM Growth Rate	ARHOME expenditure costs	Arkansas Medicaid FFS expenditure costs	Descriptive statistics	Program monthly reports
4.K.2	Total Health Expenditure Growth Rate	ARHOME expenditure costs	Arkansas Medicaid FFS expenditure costs	Pre-post comparison; t-test	DMS financial data
4.K.3	Administrative Cost Growth Rate	ARHOME administrative costs	Arkansas Medicaid FFS administrative costs	Pre-post comparison; t-test	DMS financial data
Hypothesis L. QHP beneficiaries with a shorter period of retroactive eligibility will be healthier at enrollment than Medicaid FFS beneficiaries with a longer period of retroactive eligibility					
4.L.1	Average CCI Score	ARHOME new enrollees	In-State FFS Medicaid Population	IPTW weighted regression; ATE	MMIS and QHP claims data
Hypothesis M. The cessation of monthly premium for QHP beneficiaries at 101-138% FPL will lead to a faster rate of growth in PMPM QHP costs in Years 2-5 compared to Year 1					
4.M.1	QHP PMPM Growth Rate	ARHOME beneficiaries with income from 101-138% FPL	ARHOME MY22 beneficiaries with income from 101-138% FPL	IPTW weighted regression; ATE	DMS financial data
Hypothesis N. The premium assistance model will lead to a lower rate of increase of PMPM premiums in the Arkansas Marketplace compared to states that expanded Medicaid and provide coverage through means other than premium assistance					
4.N.1	Arkansas Program Characteristics	Arkansas Health insurance exchange programs	N/A	Descriptive statistics	AID
4.N.2	Arkansas Regional Average Program Characteristics	Arkansas Health insurance exchange programs	N/A	Descriptive statistics	AID
4.N.3	Other Medicaid Expansion States Program Characteristics	Health insurance exchange programs	N/A	Descriptive statistics	AID
4.N.4	Arkansas Marketplace PMPM Growth Rate	Arkansas	Other Medicaid expansion states	Descriptive statistics	KFF

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Hypothesis O. The premium assistance model will lead to a lower rate of increase in average commercial insurance premiums in Arkansas compared to states that expanded Medicaid and provide coverage through means other than premium assistance					
4.O.1	Arkansas Commercial Insurance Premium Rates	Arkansas	Other Medicaid expansion states	Descriptive statistics	KFF

4.5.2 LIFE360 HOMES SUMMARY INFORMATION BY MEASURE

The Life360 HOMEs amendment measures in this interim report focus on implementation and start up activities, which only include hypotheses and measures related to Goal 4.E for Maternal Life360 HOME. Hypotheses and measures for Goal 1 and the rest of Goal 4 will be evaluated in the final summative report.

Table 19: Life360 HOMEs Goal 4 Measure Summary

Measure #	Measure Name	Target Population	Comparison Population	Statistical Test	Data Source
Goal 4: Life360 HOME costs and efforts will meet or exceed program expectations					
Hypothesis E. The key entities during the start of Life360 HOME program will report on implementation activities, infrastructure development, overcoming barriers in the facilitation of Life360 HOME, and on adopted strategies that identify and provide services to beneficiaries with HRSN needs					
4.E.1	Key Entities	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews
4.E.2	Types of HRSN Services	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews
4.E.3	Integration of the Amendment with Existing Programs and Infrastructure	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews
4.E.4	Maintenance of Organizational Partnerships	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews
4.E.5	Key Entity Barriers in Implementing Amendment	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews
4.E.6	Barriers in Beneficiary Outreach and Participation	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews
4.E.7	Strategies Adopted to Facilitate and Reduce Barriers in Implementation	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews
4.E.8	Strategies Adopted to Improve Beneficiary Experience	Life360 HOMEs Hospitals	N/A	Qualitative analyses	Key informant interviews

4.6 ANALYTIC METHODS

The following sections summarize analytical methods for the following:

- Beneficiary Engagement Satisfaction Surveys
- Provider Focus Groups
- Eligibility and Claims-Based Metrics
- Network Adequacy
- Public Use Files
- Key Informant Interviews
- Life360 HOMEs Non-Participating Provider Survey
- Multi-Year Analysis

4.6.1 BENEFICIARY ENGAGEMENT SATISFACTION SURVEY (BESS)

The BESS is based on the CAHPS Adult Medicaid Health Plan Survey 5.1. and administered in 2022, 2024, and 2026 of the ARHOME demonstration period. This report summarizes 2022 and 2024 BESS survey results while the final 2026 survey will be evaluated in the summative report. The survey sample, structure, questions, and analytic methods follow National Committee for Quality Assurance (NCQA) CAHPS guidance and focus on comparing ARHOME QHP performance with that of traditional Medicaid FFS.

Technical specifications and protocols for administering the surveys (including selection of survey questions, selection of eligible recipients to participate in the survey, calculation of survey metrics, and statistical analysis) are summarized in the HEDIS Volume 3 2024 Sections 1-5 document.[27]

Beneficiary Eligibility

Eligible beneficiaries consisted of adults 19-64 years of age, enrolled for at least 5 of the last 6 months prior to the survey (with no more than one 30-day coverage gap), and had complete demographic information based on Arkansas's MMIS eligibility data as of the 6-month period prior to the survey.

Sampling Protocol

Beneficiaries were selected for survey participation using systematic sampling in accordance with standard NCQA sampling methods (simple/stratified random sampling used for the 2022 BESS survey). Survey questionnaires were sent via mail, email, and/or text with the goal of obtaining at least 411 returned surveys for each year and population group. This is the minimum sample size required to conduct a robust statistical regression analysis to evaluate

[27] HEDIS® Measurement Year 2024 Volume 3: Specifications for Survey Measures

various survey metric rates. Surveys were sent in multiple mailing rounds in English and Spanish, and follow up with non-respondents was attempted for each survey administration.

An initial sample of 3,600 Medicaid FFS and 2,000 QHP beneficiaries were selected for the 2022 survey. Since the number of returned surveys fell short of the required 411 responses needed for robust statistical analysis, only descriptive analyses of results are provided. Due to the low 2022 BESS Survey response, a larger number of FFS and QHP beneficiaries were sampled in 2024 (6,270 Medicaid FFS and 5,220 QHP beneficiaries) that resulted in an adequate sample size for more sophisticated analyses.

Survey Metrics

Survey questions for each year and population group follow NCQA guidelines and quantitatively assess the performance of the ARHOME program relative to the traditional Medicaid FFS program.[28] It is important to note that survey questions are not identical between the QHP and FFS groups, nor are they identical among different years in which the surveys were administered due to refinement of questions and accreditation by NCQA for survey administration. Some differences include the following:

- Non-Emergency Transportation (NET) questions were included in both the QHP and FFS surveys in 2022 but were included in only the QHP survey in 2024. A separate BESS NET survey with only NET questions were administered electronically to Medicaid FFS eligible participants who returned the previous BESS survey earlier in 2024.
- Questions related to knowledge of premiums/copays, retroactive eligibility, and health plan incentives were included in the 2024 QHP surveys only as they were not relevant to the Medicaid FFS population.

Additionally, composite metrics of two or more individual survey questions where a broader scale of responses beyond what was included in any individual survey question was used. Metric findings that are the result of two or more survey questions, such as getting needed care, provider communication, and knowledge of premiums and copays, are described in more detail in the results section.

Due to our population and measure intent, responses for some questions were combined for easier reporting. For example, eight possible race codes were combined into four due to few responses in categories of Asian, Native Hawaiian or Pacific Islander, American Indian or Alaskan Native, Mixed, and Other. Additionally, the highest categories of education were combined because of interest in understanding whether beneficiaries had education of 8th grade or less, had some high school education but they did not graduate, were a high school graduate or had a GED, had some college or 2-year degree, or had a 4-year college degree or more.

[28] The BESS survey questions represent a total of 23 survey metrics (Appendix X, Table C). Specific questions in the BESS surveys (excluding ARHOME supplemental questions) are NCQA proprietary copyrighted material and are thus not reiterated here.

Rurality was based on the respondent's residence zip code information. Urban-rural classification information for Arkansas counties obtained from the FORHP[29] was linked to the respondent's zip code through identification of the county of residence. A total of 75 Arkansas counties were identified as either Rural or Urban, and also geographically as either Central, Northeast, Southeast, Northwest, or Southwest.

Survey Disposition Analysis

Survey disposition and frequency analysis were conducted for each metric on eligible and complete survey answers, in accordance with NCQA protocol. Characteristics of the survey disposition analysis include total sample size (TS), bad addresses (BA), non-responses (NR), returned surveys (RS), ineligible surveys (IES), incomplete (but eligible) surveys (ICS), analyzable sample size (AS), and analyzable surveys.

Calculations:

- **Survey Return Rate (SRR)** = TS - BA - NR
- **Analyzable Survey Rate (ASR)** = AS - NR - ICS
- **Total Response Rate (TRR)** = AS/TS

For a survey to be eligible, the beneficiary needed a valid health plan and be between the ages 18 and 64 at the time the survey was administered. Otherwise, the survey was deemed ineligible and included in the calculation of IES.

An additional requirement included a response to at least 3 of the following 5 NCQA-required questions. Otherwise, the survey was deemed incomplete (but eligible) and included in the calculation of ICS.

- Having a condition that needed immediate care
- Having a personal doctor
- Making an appointment to see a specialist
- Getting information from health plan's customer service
- Rating of health plan on a 0-10 scale

If the eligibility criteria were not met, the survey was deemed ineligible (regardless of the number of NCQA-required survey questions answered) and included in the calculation of IES. Only eligible, complete, and analyzable surveys were used in further analysis.

For the 2022 BESS Survey, ARHOME beneficiaries were more engaged with a 3.67% higher return rate and a 4.40% higher analyzable survey rate compared to traditional Medicaid FFS beneficiaries.

[29] "Federal Office of Rural Health Policy (FORHP) Data Files." *Health Resources & Services Administration*, Feb. 2025, https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

Table 20: Survey disposition analysis, 2022

Survey Return Rate	Target		Comparison	
	Count	Rate	Count	Rate
Total Sample Size	2,000	.	3,600	.
*Bad address	341	17.05%	638	17.72%
**Nonresponse	1,444	72.20%	2,707	75.19%
Refusal	0	0.00%	0	0.00%
Survey Return Rate	215	10.75%	255	7.08%
Analyzable Sample Size	**Target**		**Comparison**	
	Count	**Rate**	**Count**	**Rate**
Total Sample Size	2,000	.	3,600	.
*Bad address	341	17.05%	638	17.72%
*Ineligible survey	6	0.30%	11	0.31%
Analyzable sample size (removing bad addresses and ineligibles)	1,653	82.65%	2,951	81.97%
Total Response Rate	**Target**		**Comparison**	
	Count	**Rate**	**Count**	**Rate**
Analyzable sample size (removing bad addresses and ineligibles)	1,653	.	2,951	.
**Nonresponse	1,444	87.36%	2,707	91.73%
***Incomplete survey (but eligible)	4	0.24%	8	0.27%
Analyzable Surveys (surveys for analyzable response rate)	205	12.40%	236	8.00%
Total Response Rate (removing ineligibles)		10.28%		6.58%
Total Response Rate		10.25%		6.56%

* Bad addresses and ineligibles are excluded from analyzable sample size.
** Nonresponse count does not include refusal or bad address.
*** An incomplete survey satisfies the enrollment and age eligibility requirements but does not have at least 3 of the 5 required survey questions answered, as indicated in Preparing Data from CAHPS® Surveys for Analysis. Incomplete surveys are not included in the analysis.

For the 2024 BESS survey, ARHOME beneficiaries were more engaged with a 3.41% higher return rate and a 3.82% higher analyzable survey rate compared to traditional Medicaid FFS beneficiaries.

Table 21: Survey disposition analysis, 2024

Survey Return Rate	Target		Comparison	
	Count	Rate	Count	Rate
Total Sample Size	5,220	.	6,270	.
*Bad address	657	12.59%	789	12.58%
**Nonresponse	3,951	75.69%	4,960	79.11%
Refusal	0	0.00%	0	0.00%
Survey Return Rate	612	11.72%	521	8.31%
Analyzable Sample Size	**Target**		**Comparison**	
	Count	**Rate**	**Count**	**Rate**
Total Sample Size	5,220	.	6,270	.
*Bad address	657	12.59%	789	12.58%

*Ineligible survey	23	0.44%	29	0.46%
Analyzable sample size (removing bad addresses and ineligibles)	4,540	86.97%	5,452	86.95%
Total Response Rate	**Target**		**Comparison**	
	Count	**Rate**	**Count**	**Rate**
Analyzable sample size (removing bad addresses and ineligibles)	4,540	.	5,452	.
**Nonresponse	3,951	87.03%	4,960	90.98%
***Incomplete survey (but eligible)	6	0.13%	0	0.00%
Analyzable Surveys (surveys for analyzable response rate)	583	12.84%	492	9.02%
Total Response Rate (removing ineligibles)		11.22%		7.88%
Total Response Rate		11.17%		7.85%

* Bad addresses and ineligibles are excluded from analyzable sample size.

** Nonresponse count does not include refusal or bad address.

*** An incomplete survey satisfies the enrollment and age eligibility requirements but does not have at least 3 of the 5 required survey questions answered, as indicated in Preparing Data from CAHPS® Surveys for Analysis. Incomplete surveys are not included in the analysis.

Analytics

Frequency analysis described favorable and total responses for each survey question. Favorable response rates for each survey question and each composite were compared between the target and comparison groups. Satisfaction of the ARHOME program relative to traditional Medicaid FFS was assessed by comparing differences in favorable response rates between the two groups via chi-square analysis ($p<0.05$).

Urban-Rural and region-specific analyses using a DiD approach that assessed geographic variability. Regions include Central, Northeast, Southeast, Northwest, and Southwest counties. Each region was compared to all regions.

Logistic regression analysis with case-mix adjustment (CMA) and adjustment for sample weights based on the original sample frame was performed for 2024 BESS survey metrics by regressing favorable response rates on demographic covariates found to be significantly different between the two groups.[30] A favorable response rate is the ratio of favorable responses to total responses for each question. Demographic covariates for case CMA included gender, age group, race, education, urban-rural status, region status, overall health status, mental health status, getting health care at least three times for the same condition (2022 BESS survey only), condition lasting at least three months (2022 BESS survey only), taking prescribed medication, and medicine treating condition lasting at least three months.

[30] The following covariates were significant in favorable response rates between the target and comparison groups: gender, age group, race, urban-rural status, mental health status, and taking prescribed medication.

4.6.2 PROVIDER FOCUS GROUPS (PFG)

The PFGs conducted for the ARHOME program in 2023 and 2025 assessed the attitudes, opinions, and experiences of providers regarding specific program components of the ARHOME and Life360 HOME program. The primary focus areas of the 2023 PFGs included financial impact, incentive awareness, Life360 HOMEs, and primary care. The 2025 PFG sessions additionally focused on implementation and sustainability. Questions asked in each of the PFG sessions are listed in **Table B** in **Appendix 10.3**.

Eligibility of focus group participants included experience as ARHOME and Medicaid providers as well as representation from various professionals, medical specialties, and practice settings to enhance the diversity, validity, and reliability of the findings. The 2023 PFG sessions gathered feedback from 13 members of the AMS, 11 physicians of the AAFP, and 9 healthcare executives of AHA. The 2025 PFG sessions included 9 healthcare executives of the AHA. Due to lack of participation, PFG sessions were not conducted for AMS or AAFP in 2025 (as discussed in **Section 4.3.4**).

Descriptive Analysis

Frequency analysis was conducted to describe the favorable response rate for each question in each PFG session (AMS, AAFP, AHA) and in each focus area (Financial Impact, Incentive Awareness, Life360 HOME, and/or Primary Care). The denominator included the number of individuals who answered the given question, whereas the numerator included the number of favorable responses. Favorable response rate results were plotted for each question in each PFG session and focus area with standard error bars to show variability of individual data points around the mean.

4.6.3 ELIGIBILITY AND CLAIMS-BASED METRICS

For eligibility and claims-based measures in both ARHOME and Life360 HOMEs, weighted target and comparison populations ensured that the distributions of baseline characteristics were not significantly different while adjustment of measure results for pre- and post-treatment effects considered additional confounding effects. Measures addressing provider networks, program characteristics, or cost did not require adjustment to compare plans and programs.

The following section describes the process of matching the target and comparison groups via the PSM, model selection based on covariate balance and sample size limitations, as well as adjustments made for post-treatment effects.

Identify Eligible Beneficiaries

After identifying target and comparison populations, some metrics required additional restrictions based on factors, such as enrollment days and age. Most claims-based measures have a continuous enrollment requirement during the measurement year that is more restrictive than that used to identify the analytic populations. This ensures sufficient time for events, diagnoses, or procedures to appear in claims.

Each analysis follows metric-specific eligibility requirements to identify the numerator-to-denominator ratio that expresses a quantitative rate for which a given metric is evaluated with respect to relative performance between the two groups.

Adjust for Beneficiary Selection

The PSM is a group selection adjustment treatment (GSAT) model that adjusts for beneficiary selection to minimize potential bias in the selection and assignment of metric-eligible beneficiaries to the two groups. To maintain statistical unbiased robustness, the underlying baseline covariates describing the metric-eligible beneficiaries should not be statistically different between the two groups.

In PSM, a propensity score is the predicted probability of a beneficiary being assigned to the treatment group, given their observed baseline characteristics. Logistic regression estimated each beneficiary's predicted probability, and the inverse probability of treatment weight (IPTW) was calculated as 1/PS for a beneficiary in the treatment group and 1/(1–PS) for a beneficiary in the control group.[31]

Final PSM models for all measures included the following covariates: age, gender, FORHP Zip Code Tabulation Areas (ZCTA)-level urban-rural status[32], ZCTA-level minority population from the ACS, as well as interactions of age with gender, urban-rural status, and minority population. Additional covariates were included if sample size allowed[33], such as baseline income category and its interaction with age as well as the following ZCTA-level covariates sourced from the ACS and BRFSS: under poverty level, less than high school education, age 65 or older, adults with no usual source of care, adults who are obese, adults who smoke, and low birth weight rate. ZCTA-level covariates were linked to each beneficiary's earliest address in the ARHOME measurement year and reported as proportions of the total population in the ZCTA.

Check for Covariate Balance Across Groups

For each measure that underwent PSM modeling, covariate balance tables attributed to the two weighted groups were assessed for balance using the standardized difference and variance ratio of each covariate across the groups. The standardized difference is the difference in group means between the treatment and comparison groups expressed in units of standard deviation. This accounts for differences in sample size between the two groups, since the ARHOME target group is typically much larger than the comparison group. The variance ratio is a ratio of the treatment group's covariate values to the variance in the control group's covariate values.

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[31] Austin, P.C. and E.A. Stuart. 2015. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. *Statistics in Medicine* 34(28):3661–79. DOI: 10.1002/sim.6607

[32] Federal Office of Rural Health Policy (FORHP) Data Files. Health Resources & Services Administration (HRSA). Accessed on February 21, 2025: https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

[33] Baseline income not included for small-denominator measures BCS, HIV, PBH, SAA, SPD. Additional ZCTA-level covariates were not included for small-denominator measures BCS, HIV, MPM, PBH, SAA, SPD, and Continuity of Specialist Care.

A standardized difference of greater than 0.10 or a variance ratio of <0.5 or >2.0 was considered to show residual imbalance between the two groups.[34] Graphical methods for assessing imbalance included comparing side-by-side boxplots, empirical cumulative distribution functions (CDFs), and bar charts, among other standard graphical output from the Statistical Analysis System (SAS) procedures PSMatch and CausalTrt.[35]

To achieve covariate balance, most measure denominators were trimmed of observations beyond extreme percentiles of the propensity score (1^{st}–99^{th} or 5^{th}–95^{th} percentiles, depending on denominator size), and age interactions were added to the PSM model. For the measures with small denominators that still had residual imbalance in one or more covariates, either the outcome model included the covariate(s) for further adjustment, or the population was considered too imbalanced for valid causal inference.

An automated balance table test for each covariate in the PSM model assessed whether each covariate passed the standardized difference and variance ratio test. Unweighted and weighted means were calculated for each covariate for the two groups, and the standardized difference and variance ratio values were then calculated with respect to these two groups. Failure of either test excluded the covariate from the original PSM model in order to develop a refined covariate list that includes only covariates that pass both balance table tests. A refined PSM model is developed which includes only those covariates that pass both tests (with the exception of core covariates[36]), which is then incorporated into the outcome model to continue the modeling analysis.

Adjust for County Selection (Maternal Life360 HOME only)

The following county selection adjustments are based on anticipated statistical adaptations according to current program specifications as Maternal Life360 HOME is not ready for eligibility and claims-based analyses. Methods may evolve with full program implementation and will be finalized in the summative evaluation.

Prior to beneficiary selection adjustments described above, it is necessary for Maternal Life360 HOME service areas to be matched at the county-level using PSM with the goal of creating Life360 HOME and non-Life360 HOME service areas that are similar in the distribution of their baseline county-level characteristics. Since Life360 HOME counties are determined by the providers who choose to enroll in the program, this method reduces potential bias in the selection and assignment of comparison counties. To maintain statistical unbiased robustness, underlying baseline characteristics describing the eligible comparison counties should not be statistically different when compared to the Life360 HOME counties.

Baseline covariates sourced from the CDC/ATSDR SVI contain zip-code level socio-demographic characteristics that include socioeconomic status, household characteristics, racial and ethnic

[34] Austin, P.C. 2009. Using the standardized difference to compare the prevalence of a binary variable between two groups in observational research. *Communications in Statistics - Simulation and Computation* 38(6):1228–1234. DOI: 10.1080/03610910902859574

[35] Austin, P.C. and E.A. Stuart. 2015. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. *Statistics in Medicine* 34(28):3661–3679. DOI: 10.1002/sim.6607

[36] Core covariates include age, gender, race, and income.

minority status, and housing type and transportation. Overall county population and metropolitan status is identified using the FORHP urban-rural classifications.

The eligible comparison population resides in counties that closely resemble each Life360 HOME county population and as a whole. Covariate balance is assessed by looking at the standardized difference of each variable across Life360 HOME target counties and matched comparison counties. Standardized mean differences between -0.1 to 0.1 for all baseline covariates is established as the criteria for covariate balance.[37] Balance plots offer another method to visualize covariate balance by graphing the numeric values of the standardized mean differences among weighted matched counties. Additional qualitative graphical methods to compare the distribution of continuous baseline covariates in the weighted sample include empirical CDFs and side-by-side boxplots. The resulting eligible beneficiaries residing in Life360 HOME target and matched comparison counties are then used in beneficiary-level weighted models for each metric.

Annual balance checks are necessary to ensure that the target and comparison groups remain balanced each measurement year due to the approval of new providers, expansion of existing service areas, and providers who may choose not to stay in the program. Additional flags consider time enrolled and active during the measurement year to identify staggered adoption and exit events both in annual and in longitudinal analyses. Sensitivity analysis will provide insight into the providers who remained enrolled for the entire measurement year compared with those that were newly enrolled and those that exited at some point during the measurement year. Providers who choose not to stay in the program will not be eligible to be matched as comparison counties in future years due to the potential confounding effects of previous participation in Life360 HOME.

Even though comparable Life360 HOME and comparison counties will be determined for analytics, provider participation in the Life360 HOME program is voluntary. Providers who participate in the program may be different than providers who do not choose to participate. Descriptive statistics looking at characteristics of Life360 HOME providers (i.e. provider size, geographical location, patient population etc.) compared with providers that choose not to participate in Life360 HOME allow for the speculation of whether there are provider attributes that affect participation. Provider characteristics that are significantly associated with participating or non-participating providers will be adjusted for appropriately in the county matching process. Additional results from PFGs, surveys, and interviews that address willingness to participate in the Life360 HOMEs program will also be taken into consideration.

Model Measure Outcomes, Adjusted for Selection

The beneficiary-level outcome is defined as the numerator-to-denominator ratio. Most metrics have an outcome that is binary (0/1) or a continuous integer (i.e., count of events, number of months, or number of gaps).

[37] Austin, P.C. 2009. Balance diagnostics for comparing the distribution of baseline covariates between treatment groups in propensity-score matched samples. *Statistics in Medicine* 28:3083-3107. DOI: 10.1002/sim.3697

Metrics with a binary outcome were modeled using logistic regression, whereas Poisson or negative binomial (depending on variance) was used to model those metrics with a count outcome. The IPTW values from each measure's PSM model were coupled with the outcome model to adjust for selection bias. The average treatment effect (ATE) is defined as the difference in weighted group means of the outcome between the two groups or the average effect of being in ARHOME QHP compared with traditional Medicaid FFS.[38] For measures with a bene-level outcome of 0 or 1, the weighted group mean is equal to the effective percentage of the group meeting the measure.[39] Statistical significance of the coefficient of the treatment variable was set at $p<0.05$.

Models with small sample size adjust for only beneficiary selection and are referred to as Inverse Probability Weighted Score (IPWS) models. For models that could not be weighted using PSM modeling, an alternative regression outcome model described below was performed.

Adjust Measures for Post-Treatment Effects

In addition to adjustment for beneficiary selection, outcome models also include other covariates, such as demographic characteristics, prior enrollment in the Medicaid expansion program, risk scores, and enrollment region.

The post-treatment (outcome) model covariates include age, gender, age-by-gender interaction, race/ethnicity, minority status, and rurality. All measures except those with small sample size also include baseline income category and its interaction with age. Since the ARHOME evaluation period begins in the fourth year of Arkansas's 1115 waiver demonstration, measure results adjust for each beneficiary's time in the program prior to 2022, which includes the HCIP (2014-2016) and Arkansas Works (2017-2021) evaluation period. Adjustment for clinical severity using the Department of Health and Human Services' (HHS) Hierarchical Condition Category (HCC) risk adjustment algorithm[40] considered potential effects of expensive chronic conditions that may affect utilization measure outcomes.

A sensitivity analysis conducted for each measure determined whether results changed when different sets of covariates were included in the outcome model. In addition, "doubly robust" estimators determined the sensitivity of results due to misspecification of either the treatment model or the outcome model.

- Misspecification of the GSAT model (PSM) or outcome model (IPWREG, IPWS, REGADJ) can impact results. Testing both models and comparing their results ensures statistical robustness of model estimates.

[38] Austin, P.C. 2011. An introduction to propensity score methods for reducing the effects of confounding in observational studies. *Multivariate Behavioral Research* 46(3):399–424. DOI: 10.1080/00273171.2011.568786
[39] Austin, P.C. 2010. The performance of different propensity-score methods for estimating differences in proportions (risk differences or absolute risk reductions) in observational studies. *Statistics in Medicine* 29(20):2137–2148. DOI:10.1002/sim.3854
[40] "Risk Adjustment." *Centers for Medicare & Medicaid Services*, 2024, https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment.

- Combining GSAT with outcome models facilitates doubly robust estimates of treatment effects, accounting for both selection and outcome misspecification.

Doubly robust results from models adjusted for selection, confounders, and post-treatment covariates are referred to as inverse probability weighted with regression adjustment (IPWREG). An alternative model for smaller sample sizes like the regression adjustment (REGADJ) omits the PSM, involves no trim to remove outliers. The IPWREG (95% trim) model was the golden standard when sample sizes were adequate to allow for balancing of target and comparison groups while adjusting for confounders and post-treatment effects.

Each metric calculates a predicted outcome metric (POM) for each group and year along with the standard errors resulting from the most parsimonious outcome regression model. The ATE was calculated as the difference in POM between the two groups. A chi-square statistical analysis assessed significance at the 95% confidence level ($p<0.05$). When sample size allows, Life360 HOME metric results are further stratified by age, race/ethnicity, and geography.

For 26 quality and performance metrics determined by DMS to be a part of ARHOME's strategic plan to encourage use of preventive care and improve beneficiary health, performance targets starting in 2022 were reported alongside metric results as a benchmark for performance.

Transportation Services

NET service utilization in the target and comparison populations was analyzed using descriptive analysis, cross-sectional logistic and count regression models. Descriptive analysis reported the percentage of beneficiaries with any NET utilization and the mean and standard deviation of NET services stratified by age, gender, risk score, and NET service region. Regression analysis estimated the average marginal treatment effect, controlling for age, gender, risk score, and NET service region. Additionally, descriptive statistics of NMT service utilization are reported for beneficiaries enrolled in the Life360 HOME program and receiving HRSN services.

EPSDT Benefits

The Medicaid Core Set Measures, Adolescent Well-Care Visits, Preventive Dental Visits, and Preventive Vision Screenings, assessed beneficiary access to the Medicaid EPSDT benefits while enrolled in ARHOME. Eligible EPSDT beneficiaries were between 1 and 20 years of age, enrolled in a QHP during the measurement year, had previous enrollment in Medicaid FFS, and were eligible for EPSDT benefits in the two years prior to the measurement year. Since the EPSDT population serves as their own control group, pre- and post-enrollment in ARHOME, they do not require further adjustment.

Continuous enrollment required beneficiaries to have no more than 1 gap in coverage of 45 days. Logistic regression modeling of bene-level measure outcomes included the period as a 3-level predictor variable (R1=MY, R2=MY-1, R3=MY-2) to assess age and QHP effects while accounting for within-beneficiary correlations. For example, comparing R3 (17-18-year-olds enrolled in FFS) and R2 (18-19-year-olds enrolled in FFS) assessed the age effect on the EPSDT outcome metrics, whereas comparing R2 and R1 (19–20-year-olds enrolled in QHP) assessed the combined impacts of age and transition from FFS to QHP.

4.6.4 NETWORK ADEQUACY

Network adequacy metrics were assessed with geospatial analyses conducted using Geographic Information Systems (GIS) software. Input data was sourced from AID QHP provider network data as well as MMIS Medicaid FFS provider and demographic data. A beneficiary's address was defined as the first address in a qualifying ARHOME segment during the measurement year.

Primary Care Provider, for the purposes of network adequacy, is defined as the following provider types and provider specialty codes:

- Physician (solo or group) with a specialty in general practice, family practice, internal medicine or geriatrics
- Area Health Education Center (AHEC) PCP Group
- Rural Health Clinic with a specialty of rural health clinic or rural health freestanding
- Federally Qualified Health Center
- Nurse Practitioner (solo or group) with a specialty of Advanced Practice Nurse
- Physician Assistant

Geospatial analyses were performed separately for Medicaid FFS and QHP data, by provider type, and plan year. Providers were mapped based on primary address, and service areas were defined for each provider based on geographic access standards for the provider type.

1. **Network adequacy:** Map provider addresses and establish the appropriate radius based on provider type (30 miles for PCP, 60 miles for specialists) to create circles around the addresses. After subtracting the area that is completely covered by the circles from the total area of Arkansas, the remainder represents the number of square miles without adequate coverage. The proportion of the state of Arkansas that lacks adequate coverage is defined as the number of square miles without adequate coverage divided by the total square miles of Arkansas.
2. **Network access:** Map the provider and beneficiary addresses and establish a 30-mile radius around each client address. Determine the number of beneficiaries that have a PCP within their circle (repeat using 60 miles for specialists). The proportion of beneficiaries lacking access for each provider type is defined as the number of beneficiaries who were not able to access a provider divided by the total number of beneficiaries.

Essential Community Providers (ECP) are defined as providers that serve predominantly low-income, medically underserved individuals, and specifically include providers described in section 340B of the Public Health Service (PHS) Act and the Social Security Act. The ACA stipulates that QHPs are required to have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the plans' service area, in accordance with federal network adequacy standards described in 45 CFR §156.235(e). CMS has established two ECP standards: the general ECP standard and the alternate ECP standard.

The AID is responsible for reviewing the plan's compliance with Essential Community Provider Standards as set forth by CMS and outlined in annual Notice of Benefit and Payment Parameter regulations and the Letter to Issuers in the Federally Facilitated Marketplace (FFM). AID is responsible for ensuring QHP issuers offer provider network of each of its QHPs that includes ECPs in sufficient number and geographic distribution to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service areas. Additionally, this standard ensures issuers complying with 45 CFR §156.235(e), which requires that QHP issuers must pay an amount to FQHCs that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Social Security Act for such item or service, as specified in section 1302(g) of the ACA.

CMS defines the ECP Categories and Provider Types as outlined below in **Table 22.**

Table 22: Key Informant Analytic Process

Major ECP Category	ECP Provider Types
Federally Qualified Health Centers (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Providers	Ryan White HIV/AIDS Program Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Health Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Hospitals	Disproportionate Share Hospital (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals.

To satisfy the general ECP standard as outlined by CMS,[41] QHP issuers must:

1. Contract with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network.
2. Offer contracts in good faith to all available Indian health care providers in the plan's service area for the respective QHP certification plan year.
3. Offer contracts in good faith to at least one ECP in each ECP category in each county in the service area for the respective QHP certification plan year, where an ECP in that category is available.

[41] Centers for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services. "2018 Letter to Issuers in the Federally-facilitated Marketplaces and Addendum." *Department of Health & Human Services*, 16 December 2016 & 17 February 2017, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-marketplaces-and-February-17-Addendum.pdf

The standard for meeting requirements that contracts be offered in "good faith" is health plans offering contract terms comparable to those that it offers to similarly situated non-ECP providers, except for terms that would not be applicable to an ECP (such as based on the services the ECP provides).

To satisfy the alternate ECP standard, QHP issuers must:

1. Contract with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network.
2. Offer all the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard or otherwise offer a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area.

To assess ECPs network adequacy, information was extracted from each issuer's annually filed and reviewed ECP Network Adequacy Templates to determine compliance with the standard of contracting with at least 20% of available ECPs.

To determine the number of ECPs available in any given year, we relied on the list of ECPs in the "select ECPs" tab of the ECP Network Adequacy Template[42]. Note that the number of ECPs available in the template is not exhaustive, additional ECPs may be available during the reporting year. Therefore, the proportions calculated using Total ECPs extracted from the templates should be considered an estimate.

ECP adequacy represented the ratio of the number of ECPs in each network from the Carrier and QHP Templates (numerator) compared to the total number of providers in the Arkansas essential community provider list for each year[43] (denominator).

4.6.5 PUBLIC USE FILES

Core questions from the BRFSS on Health Care Access (any coverage, personal doctor, routine checkup, medical cost) and Immunization (flu shot/spray) were analyzed for Arkansas and comparison states with traditional Medicaid expansions (Kentucky and West Virginia) pre- and post- Medicaid expansion. Annual means were computed for each measure for Arkansas and comparison states and were plotted across the baseline years to verify that pre-expansion trends in the measures were similar for Arkansas and control states. Means were calculated for three time periods: Baseline, 2017–2021, Early expansion, 2022–2023, Late expansion, 2024–2026. DiD models were then estimated to assess changes in outcomes attributable to Medicaid expansion. DiD estimators represent the interactions of time-period with location (Arkansas vs. comparison states).

[42] The AID operates the Network Adequacy Regulation Program. Filing instructions and templates are available here: "Network Adequacy Regulation Program." *Arkansas Insurance Department*, https://rhld.insurance.arkansas.gov/NetworkAdequacy.
[43] "HHS Rolling Draft Essential Community Provider (ECP) List for the Federally-facilitated Marketplace." Data.HealthCare.Gov. https://data.healthcare.gov/rolling-draft-list.

DiD models included demographic covariates for race/ethnicity, age, education, employment, household size, veteran status, sex, income, renting status, and mode of survey administration (cellphone versus landline). Survey responses were dichotomized yes/no. All models were estimated as linear probability models using BRFSS sampling weights.

Health insurance status of adults ages 19-64 with income at 101-138% FPL in Arkansas were compared with non-expansion states (Alabama, Mississippi, and South Carolina) using current ACS weighting methodology that provides state-level weights to allow for cross-year comparisons. The weights incorporate design weighting to adjust for nonresponse and noncoverage, as well as ranking to adjust for demographic differences between the persons sampled within each state.

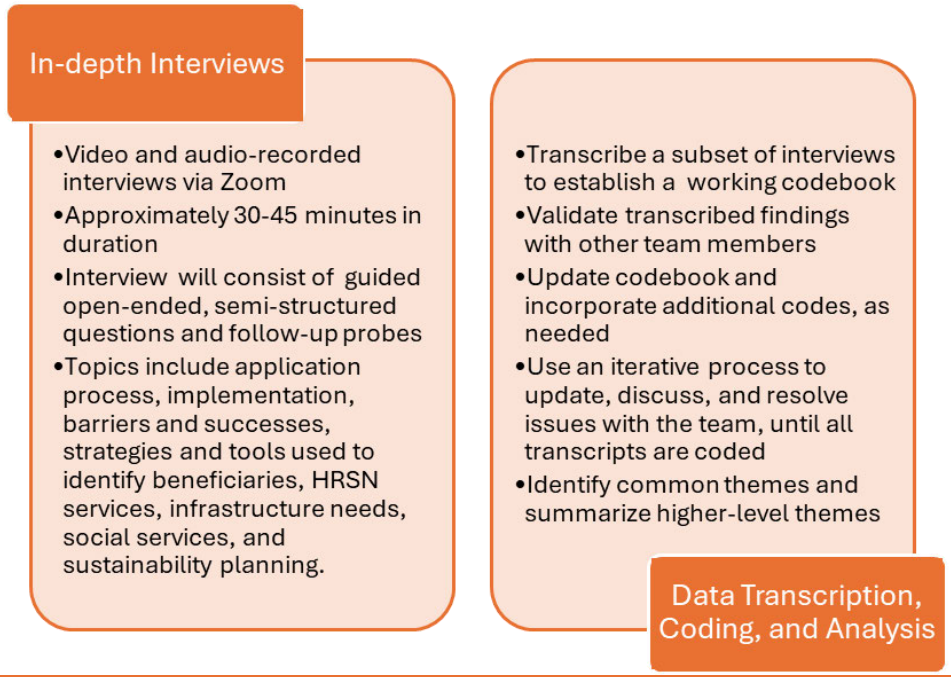
Hospital financial health was analyzed using data from NASHP's Hospital Cost Tool and interrupted time series (ITS)/DiD estimates for the changes in the ratio of hospitals' uninsured/bad debt costs to either net patient revenue or operating expenditures from baseline (2020-2021) to early demonstration (2022-2023). Regression analyses were adjusted for bed category and included hospital fixed effects. Facility type, owner type, and independent status were not included due to collinearity concerns. Standard errors in difference-in-difference models were adjusted for clustering at the hospital level.

4.6.6 KEY INFORMANT INTERVIEWS

KIIs consist of two rounds of interviews where round 1 interviews occur within 6 months of application approval/program implementation and round 2 interviews occur approximately 12-18 months after round 1 interviews. Sustainability results from round 2 will be reported in the summative evaluation. Dates vary based on the program start date and individual stakeholders interviewed may not be the same between the 2 rounds (depending on job position retention). Interview results were evaluated qualitatively through transcription of interviews and identifying high-level themes (**Figure 11**).

Maternal Life360 HOME provider interviews gather information from stakeholders engaged directly with the Life360 HOME program to understand their perspective on start-up activities, implementation progress and challenges, collaboration with community partners, lessons learned, and sustainability. Recruited individuals were involved with ongoing activities at each of the approved Life360 HOME maternal programs and at the State.

Figure 11: Key Informant Analytic Process



4.6.7 LIFE360 HOMES NON-PARTICIPATING PROVIDER SURVEY

In October of 2024, a survey was sent to key personnel at 25 non-participating hospitals that the State determined to be eligible for Maternal Life360 HOME program but chose not to enroll. Questions asked whether providers were aware of the Life360 HOMEs program, interested in applying to become a Life360 HOME provider, observed any strengths and/or barriers to the program in their hospital, and whether they had a similar referral program already established in their hospital for pregnant women. A full list of questions is available in **Table A** in **Appendix 10.3**. Due to the small sample size of returned surveys (N=5), descriptive statistics were not performed, and responses were instead summarized.

4.6.8 MULTI-YEAR ANALYSIS

To evaluate ARHOME and Maternal Life360 HOMEs programs over the course of the demonstration period, time-series analyses were performed for select metrics. Since data is available only for years 2022 and 2023, not all multi-year analyses described in **Table 22** were explored. This section describes all time-series analyses intended for the ARHOME evaluation and Life360 HOMEs program.

There will generally be two periods of study – the ARHOME demonstration period, which includes Life360 HOMEs (2022-2026), and a pre-policy baseline period that includes the prior Arkansas Works demonstration period (2017-2021). PSM weights were used for each calendar year and each measure to achieve similar distributions in measured characteristics between target and comparison populations while considering serial correlation over the program period. This allows intermediate and longer-term measure outcomes to be analyzed. Multi-year analysis methods that are considered include pre-post, DiD, ITS, and Regression Discontinuity

Design (RDD).[44,45] **Table 23** describes the time frame for multi-year analyses as well as the measures that will be evaluated for ARHOME and Life360 HOMEs.

Table 23: ARHOME and Maternal Life360 HOMEs time-series analyses

	Analytic Period	Baseline Period	Claims-Based Measures
ARHOME	2022-2026	2017-2021	• Primary care adult access to preventive/ambulatory health services (2.D.8) • Total emergency department visits/utilization • Continuity of coverage measures and coverage gaps (1.D.1, 1.D.2, 3.E.1, 3.E.2, 3.H.1, 3.H.2, 3.I.1, 3.I.2) • Health care access (1.C.1, 1.C.2, 1.C.3, 2.C.1, 2.C.2, 2.C.3, 2.C.4, 2.C.5)
Maternal Life360 HOME	2025-2026	2017-2023	• Adult access to preventive/ambulatory health services (1.A.1, 2.A.6, 3.A.5) • Total emergency department visits/utilization • All-cause readmissions (1.C.2, 2.D.2, 3.D.2) • Medicaid costs 1.H.1-3, 2.G.1-3, 3.G.1-3) • HRSN screening and interventions (1.I.1-1.I.6, 2.H.1-6, 3.H.1-6)

Pre/Post Analysis

Pre-post analysis measures the change in the metric outcome between two periods without requiring multiple (i.e., annual) measurements within both periods. The two periods are directly compared by calculating the difference in slope of the outcome POM estimates for target and comparison populations. In this report, a pre-/post analysis of the first year of ARHOME (2022) and the second year (2023) was performed for selected claims-based measures (2.D.8, 1.D.1, 1.D.2, 3.E.1, 3.E.2, 3.H.1, 3.H.2, 3.I.1, 3.I.2) to observe temporal effects related to the PHE unwinding in 2023 and the termination of the premium requirement in 2022 occurring within the first two years of the ARHOME demonstration period. The summative evaluation will assess differences between the baseline period (pre-period) and the ARHOME demonstration period (post-period).

Differences-in-Difference Analysis

DiD is a 2-dimensional analysis that measures the change in the metric outcome between two periods and between two levels of a second covariate (i.e., treated versus untreated) without requiring multiple measurements within both levels of each covariate. The DiD analysis involves incorporation of interaction terms in each regression model, which quantifies the impact of the variation of one covariate on the outcome metric of the second covariate (such as time period and one additional treatment covariate, county or age). Thus, incorporation of the

[44] Contreary K, Bradley K, and Chao S. Best Practices in Casual Inference for Evaluations of Section 1115 Eligibility and Coverage Demonstrations. Mathematica Policy Research. Released June 2018. Accessed on February 24, 2025: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/causal-inference.pdf.
[45] Bradley K, Heeringa JR, Pohl V, et al. Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations. Released June 2018. Accessed on February 24, 2025: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/comparison-grp-eval-dsgn.pdf.

time*treatment interaction into the outcome model provides a DiD estimate of the demonstration period's effects on the outcome metric.

Pre-post analysis was conducted to assess temporal effects across years between the pre-period and demonstration period to assess interaction effects between two covariates on the least squares means (LSM) POM estimates of the outcome variable across the ranges of both covariates. The DiD interaction calculates the difference in slopes as a quantitative assessment of the interaction effect between the covariates on the POM estimate of the outcome variable.

Interrupted Time Series Analysis

An advantage of the ITS is that it allows an estimate of differences in pre- and post- interruption outcomes for just the target population (single group ITS) or both the target and comparison population (multiple/robust ITS), for a more robust comparison analysis. For single ITS, a dynamic cohort will be constructed in which clients could enter in any year based on assignment to the target group. The multiple ITS cohort additionally requires a client to have not changed their income category throughout the study period.

A potential limitation of the ITS analysis is the requirement of a large sample size or number of data points to establish a statistically robust regression line. However, both the 5-year pre-period (2017-2021) and 5-year demonstration period (2022-2026) should provide an adequate temporal sample size. Other limitations include treatments that are introduced gradually, where pre-implementation trends are seasonal or non-linear, or where the baseline population changes over time. If ITS is not possible, a pre-post analysis will be conducted as described above.

Regression Discontinuity Design

RDD enables assessment of differences in an outcome based on differences in a covariate on either side of a threshold discontinuity level in the presence of a policy implementation at the threshold level. The resulting impact estimate of RDD applies to only a small subset of the overall population (i.e., those just above and just below the eligibility threshold) because it is important to capture very similar population characteristics on both sides of the discontinuity. In an RDD pre-post comparison analysis, logistic regression (for binary measures) or Poisson/negative binomial regression (for integral/count measures) will be performed separately on the "before" (baseline period) and "after" (demonstration period) datasets.

At the conclusion of ARHOME, RDD applies to measures relating to the ARHOME policy of required copays for beneficiaries with incomes greater than 20% FPL. Where permitted by sample size requirements, eligible beneficiary populations with incomes just below and above the 20% FPL threshold (e.g., 18-22% FPL) will be included in the RDD analysis to isolate the treatment effect while minimizing the potential confounding effects of the income covariate on the outcome variables. POM estimates will be plotted and regressed vs. beneficiary income level (%FPL) on either side of the specified income discontinuity. Regression slopes, intercepts, and vertical gap between the two regression lines at the income discontinuity will be calculated and compared to assess impacts of copay requirements on the outcome.

An unbiased estimate of the local treatment effect requires accurate, robust RDD modeling between the treatment and outcome variables, which can be potentially confounded by inherent non-linearity in the data. To address such non-linearities, regression analysis can be conducted not only on the two separate sections on either side of the discontinuity, but also on the combined (total) sections. Any variations in the regression slope in the vicinity of the discontinuity region (20% FPL) will be noted, to distinguish between the discontinuity and any inherent non-linearities in the data.

5.0 METHODOLOGICAL LIMITATIONS

As with other evaluations of this nature, there are limitations related to our population, analytics, and subsequent interpretations that are discussed in this section.

5.1 ARHOME

The main limitation of this evaluation is that before the Arkansas's 1115 waiver period began in 2014, there were very few ways in which adults were eligible for traditional Medicaid. Therefore, a large majority of the population enrolled in ARHOME or its predecessors, HCIP and Arkansas Works, do not have a truly comparable population in traditional Medicaid. Finding exact demographic comparability between the ARHOME and other in-state populations could not be reasonably achieved, but incorporating in-state Medicaid groups allowed the evaluation to highlight differences and similarities in coverages especially within the state. Health status similarities were also a reason for the comparison group selection, although it is acknowledged that this demonstration opened a specific coverage category for a relatively healthy adult population that previously had limited to no coverage options. Comparability in underlying demographic, socioeconomic, and health-related characteristics between the target and comparison populations is important in ensuring that results are not adversely affected by other factors that could influence our measure outcomes. To account for limitations in both numbers and comparability, models evaluating the target and comparison populations adjust for differences in key sociodemographic factors through PSM weighting. In the event that differences persist, further adjustments to outcome models also account for additional covariates on a measure-by-measure basis.

Factors used for beneficiary-level weighting are derived from the eligibility determination process. Since causal analysis requires that the baseline variables are known before assignment to the treatment or comparison group and that they are not affected by the assignment, we assume baseline covariates for each beneficiary did not change during the calendar year.

There were coverage changes that occurred during the ARHOME evaluation period that may directly or indirectly impact results. The ARHOME retroactive eligibility period was shortened from 90 to 30 days starting on July 1, 2022, through December 31, 2026. Additionally, monthly premium payments for beneficiaries over 100% FPL were terminated at the end of 2022. While we directly assess the impacts of these changes in measures (i.e., enrollment, retention, coverage gaps and medical debt) there may be indirect effects to other measures in 2022. Suspension of ARHOME auto assignment of a QHP between September 1, 2022, and May 31, 2023 may exclude beneficiaries from the analytic sample of certain measures that require continuous enrollment of a beneficiary in a QHP health plan and diminish the observed effects of measure outcomes due to smaller sample sizes (i.e., EPSDT measures). While there were changes in ARHOME coverage requirements, this is an inevitable aspect of the evolving transformation of the state healthcare system that we addressed in measure development and analytical methods to the best of our ability.

Due to the COVID-19 PHE that started in early 2020 and ended on May 30th, 2023, there was a pause in ARHOME disenrollment. A lack of beneficiary determinations during this time made it possible for beneficiaries who would have become ineligible for the ARHOME program to be retained. Beneficiaries that would have been ineligible under non-PHE circumstances may be inherently different than those that continued to be eligible during that time frame. This has the potential to mask the actual performance of the ARHOME QHP program relative to traditional Medicaid FFS across the first two years of the demonstration. While we cannot determine the beneficiaries who may have become ineligible during this period due to lack of determination processes, we expect that the number of retained ineligible beneficiaries will be small.

Conversely, at the end of the COVID-19 PHE, Medicaid unwinding occurred during a 6-month period (April – September 2023) that resulted in a much higher rate of disenrollment due to eligibility redeterminations. This resulted in a drastic reduction in the ARHOME population, an observed increase in the rate of disenrollment, as well as coverage gaps in 2023 compared to 2022. Differences in eligible-beneficiary sample sizes between the target and comparison groups and between/within measurement years, 2022 and 2023, are accounted for using concurrent PSM and outcome modeling adjustments. This helped correct for differences in underlying sociodemographic covariates. We are aware that decreases in sample size over time can lead to covariate imbalances and model convergence, such that an outcome model that is statistically robust in one year may not be as statistically robust in another year. Approaches to outcome modeling are evaluated each year and refitted as needed to ensure the most statistically robust findings.

Since the ARHOME analytic time frame began on January 1, 2022 and the COVID-19 PHE did not officially end until mid-2023, it is possible that there are residual effects of the pandemic that may have impacted healthcare utilization even though the demonstration began after the peak of the PHE. However, we do not believe this impact differentially affected the two groups. Based on the results of county-to-beneficiary-level COVID-19 sensitivity analyses conducted during the Arkansas Works demonstration (2017-2021), we decided to move forward without COVID-19 model adjustments for ARHOME. County-level COVID-19 statistics[46] (cases, deaths, population) in 2022 and later did not show sufficiently large gradients across the Arkansas counties to justify attributing COVID-19 risk levels to beneficiaries based on county of residence. By 2022, overall COVID risk was very low compared to previous years (2020-2021). Thus, incorporating a COVID-19 risk score into outcome models for 2022 and beyond was not expected to greatly impact findings. While the baseline period (2017-2021) for longitudinal analyses overlaps peak pandemic activity, we similarly did not include a COVID-19 risk score in our models due to non-significant changes in outcome measures during Arkansas Works.

Some publicly available data sources used for model adjustments and measure outcomes are not updated annually and may be unavailable for a given measurement year. While we used the most current information available at the time of analysis, it is possible that the most recent data does not reflect the characteristics of the population for the measurement year of interest. Since publicly available information is aggregated to the zip-code level at the smallest unit, we

[46] "Arkansas coronavirus cases and deaths." *USA Facts*, July 2023, https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/state/arkansas.

expected year-to-year changes to generally not be large enough to invalidate our use of the data. When reporting results, the lag in availability of data is noted for awareness. There are also limitations within the context of self-reported survey data due to self-selection bias and social-desirability bias. Additionally, literacy levels may impact survey participation and responses. Evaluation results utilizing cross-sectional survey data should be interpreted as associations and may not necessarily be directly attributed to the demonstration.

When interpreting findings based on publicly available data, it's important to note that the population may not be representative of the ARHOME population for comparisons that are made within the State, but this population is nonetheless presented to gain community-level insight of measure outcomes that we do not capture within the ARHOME program. When creating comparison groups with publicly sourced data, we include survey responses from individuals between 19 to 64 years of age and an imputed FPL of less than 138% to simulate ARHOME eligibility. It is possible that the inclusion of respondents who may not be part of the demonstration group attenuates the true effect estimates.

We are also limited by the responses of a given survey instrument where variable manipulation was necessary. One limitation to the income measurement in BRFSS is that it is not precise. Respondents self-report household income in ranges of several thousand dollars. A continuous value for household income was imputed using the midpoint of the BRFSS income category. Using imputed income with household size allowed the ability to link to annual thresholds for 138% FPL in each state. This imputed household income measure is a proxy of eligibility for Medicaid, and there may be some non-differential misclassification of households with incomes below or above 138% of the FPL that may bias results toward the null. Furthermore, our BRFSS insurance coverage outcome does not allow determination of the source of coverage (e.g., Medicaid, Medicare, or private insurance). As a result, it is not possible to identify individuals enrolled in Medicaid. Thus, it is also not possible to determine if respondents fall into the ARHOME demonstration group.

As noted in the **Analytic Methods** (**Section 4.6.1**), a logistic regression analyses could not be performed on the 2022 BESS survey due to insufficient sample size. The number of surveys returned for each population group was below the threshold of the number of surveys required to conduct a robust statistical analysis with enough power to detect differences in outcomes between the target and comparison groups.

Out-of-state comparators are limited in use in eligibility and claims-based analyses for several reasons, including but not limited to the cost to obtain records, programmatic and policy differences, variation in documentation and claims structure, and potential issues in obtaining pre- and post-intervention data.

MATERNAL LIFE360 HOMES

The main considerations of Life360 HOMEs relate to the final analytic sample and comparability of the target and comparison populations, which are dependent on the number and geographic spread of participating providers, number of enrolled beneficiaries, and associated service areas. Currently, Maternal Life360 HOME hospitals that intend to participate are in various

stages of application, approval, program start-up, and early stages of participant recruitment. Thus, considerations to the analytic sample for a given measurement year will need to be evaluated at the time of analysis. To account for potential limitations associated with participating hospitals, models evaluating the target and comparison populations will be adjusted for differences in sociodemographic factors by using propensity score matching to balance and make the target and comparison groups more comparable.

Matching by a Life360 HOME's county or service area can be done only with observable and identifiable characteristics. For those factors that are unobservable, weighted beneficiary-level regression models will attempt to minimize all factors, observed and unobserved, by using weights that represent the likelihood of an eligible beneficiary being in the target and comparison populations.

Comparison counties chosen for matching will not necessarily be representative of all counties that may be eligible for Maternal Life360 HOME but did not choose to participate. While overall representation is ideal, it is more important to assess the potential benefits of the Life360 HOME program using comparison counties that consist of an eligible population similar to the beneficiaries residing in a Life360 HOME county, so that other factors are not driving any observed differences in outcomes. Since the number of providers that choose to participate in Maternal Life360 HOME may change from year to year and there may be gradual expansion in service areas, the effectiveness of identifying matched comparison counties will be evaluated prior to analytics for each measurement year. It is possible that many of the Maternal Life360 HOME counties have similar population or geographic characteristics and that there is not enough available comparison counties defined as a close match for a 1:1 ratio. There is also the possibility that a greater than expected number of counties fall under Life360 HOME providers so that we have a limited number of comparison counties to choose from during the matching process. In this case, matching by county may not be feasible, and we will instead consider performing concurrent beneficiary-level PSM and model adjustments with county-level sociodemographic and provider characteristics.

Additionally, beneficiaries participating in Maternal Life360 HOME may seek HRSN-related services outside of the provider service area that are not associated with Life360 HOME referrals. While this may happen, we expect the number of beneficiaries who do this to be relatively small due to the working relationship that will be established between the beneficiary, provider, and Life360 HOME case manager. The number of Life360 HOME beneficiaries who seek HRSN-related services outside the Life360 region will also likely be small compared to beneficiaries residing in counties that do not have a Life360 HOME program.

Maternal Life360 HOME beneficiaries can be disenrolled if they ask to stop receiving services or if they are uncooperative with receiving services (i.e., stop participating in the program) after three consecutive attempts to schedule a visit. While we expect that the number of beneficiaries who disenroll due to these reasons will be low, their data may have varying levels of completion that can lead to a reduced sample size in some measures. Beneficiaries who do not want to continue receiving services may be inherently different from those who do. Depending on the extent of the potential sample size reduction and the minimum sample size requirements of different models, such a limitation may necessitate a change in the model type

and/or statistical methodology used for analysis of those measures requiring this enrollment/disenrollment data. Depending on when these beneficiaries are disenrolled, we will adjust analyses accordingly to remove or account for beneficiaries with missing or incomplete information.

It is important to consider that the total number of enrolled beneficiaries may be much smaller than expected. Since we are dependent on provider referrals to the Maternal Life360 HOMEs program, a small number of enrolled beneficiaries would impact the type of analyses we are able to perform. Analytic methods are tested and validated by measure to ensure the most appropriate statistical test is used. Changes in analytic methods will be noted in both the **Methodology** and **Results** sections.

Since implementation data collection relies on key informant interviews, provider surveys, and focus groups, several limitations should be noted. The generalizability of these results is limited in that we are not able to interview all individuals and organizations involved in program implementation, and we cannot infer that these qualitative findings would be the same or similar in different regions of the State. PFG sessions were not conducted for two medical groups (AMS, AAFP) in 2025 (as discussed in **Sections 4.3.4 and 4.6.2**). Without sufficient participation and representation of the physician perspective, interpretation of stakeholder feedback is limited. Additionally, key informants were not selected at random and were often referred for an interview at the suggestion of people leading or participating in the Maternal Life360 HOME program at the hospital. While selection bias may exist, the goal was to speak with individuals who were the most informed and knowledgeable of the Life360 HOME program. Also, personal and recall bias may be present as key informants were interviewed as months may have passed since certain parts of the program were implemented. Nonetheless, all feedback is helpful in contextualizing how programs were implemented and identifying the barriers and successes that programs experienced. Even the limited feedback we received from providers who chose not to participate in Maternal Life360 offers insight into the motivations and deterrents for non-participation that is critical in developing and sustaining similar initiatives in the future.

Each hospital will have its own methods for Maternal Life360 HOME data documentation, records maintenance, and file transfer to the QCI portal. Thus, obtaining and standardizing the data received from each hospital and ensuring quality assurance is critical to the successful evaluation of the Maternal Life360 program. While our goal is to maximize the efficiency of data collection, reducing provider burden is equally important. Each participating hospital must follow program guidelines in identifying eligible pregnant women and providing services to them. However, HRSN screening tools are not identical, and documentation of home visits and other Life360 HOME program activities may differ. As hospitals implement the Maternal Life360 program, best practices and lessons learned will likely shape and refine data collection activities as well. Maintaining consistency and standardization of data across all Life360 HOME hospitals is important in reducing the variability among the Life360 HOME population. This can be accomplished by working with hospitals in the application and start-up phase to select appropriate screening tools and develop a list of required data elements in formats that are usable in evaluation.

The Maternal Life360 HOME program is not the only initiative that focuses on healthier outcomes for high-risk mothers and their infants. Other ongoing initiatives in Arkansas include UAMS-led Delta Maternal Outreach and Transformational Health Education Resource (Delta MOTHER) project, CMS' Transforming Maternal Health (TMaH) Model, and the Maternal and Child Health Bureau (MCHB) Healthy Start program. Additionally, Governor Sanders announced the Healthy Moms, Health Babies Act in February of 2025, which plans to invest $45.3 million annually in maternal health through unbundling global payments, presumptive eligibility for pregnancy, increasing provider reimbursements, and expanding access to telemedicine.[47] While these additional state- and nation-wide initiatives are expected to improve health outcomes for all mothers in the State, there may be added benefits for those with high-risk pregnancies in Maternal Life360 HOME.

[47] "Governor Sanders Announces Health Moms, Health Babies Act." 6 February 2025, https://governor.arkansas.gov/news_post/governor-sanders-announces-healthy-moms-healthy-babies-act/. Accessed 24 March 2025.

6.0 RESULTS

This report presents a comprehensive analysis and the results of the ARHOME and Life360 HOMEs metrics. This report is organized into two separate sections. Each section provides an in-depth examination of relevant metrics and insights. It is important to note that the results within each section are grouped for clarity and coherence; therefore, the metrics may not appear in sequential order. The aim of this report is to offer a clear and detailed overview that supports informed decision-making and strategic planning based on the ensuing results.

6.1 ARHOME RESULTS

ARHOME beneficiaries are enrolled in private health insurance plans (QHPs) through the Arkansas Health Insurance Marketplace, allowing them to access both traditional Medicaid benefits and additional benefits offered by private insurers. On the other hand, Medicaid FFS beneficiaries receive direct coverage for medical services through the traditional Medicaid program. Their benefits are managed directly by Medicaid without the involvement of private insurers. These coverage differences could lead to varied healthcare experiences.

Results in this section are presented as tables and figures that show group sample sizes, group rates, differences in group rates, and P-values for statistical significance of the group differences, by each measurement year. Graphs present labeled group rates with 95% confidence interval (C.I.) error bars. If differences between group rates were statistically significant in a given measurement year (P-value ≤ 0.05), the difference is shown at the bottom of the graph as the average treatment effect (ATE) with an asterisk (*).

For measures in which propensity-score weighting was specified, results are presented from the final models performed, IPWS or IPWREG. Both types of models incorporated weights to adjust for baseline age, gender, minority, rural, income,[48] and other ZCTA-level sociodemographic variables.[49] The IPWREG model also used regression adjustment for race/ethnicity, measurement-year risk score and enrollment region, prior experience in Arkansas Works, and all confounders. Sample sizes were adjusted (reduced) at two levels: 1) PSM, which removes potential demographic bias by ensuring that the target and comparison groups have similar underlying distributions in the covariates included in the PSM; 2) Trimming to remove outliers, which was conducted following the PSM step and before the outcome modeling step. Trimming at the 95% confidence level was chosen as the default method. Regression-adjusted measure results are shown for the few measures in which covariate balance was not achieved using propensity score weights. A summary of metrics that could not be propensity score matched due to unbalanced covariates, small sample sizes, or lack of model convergence is included in **Table D** in **Appendix 10.4**.

[48] Baseline income not included for small-denominator measures BCS, HIV, PBH, SAA, SPD
[49] Not included for small-denominator measures BCS, HIV, MPM, PBH, SAA, SPD, and Continuity of Specialist Care

6.1.1 CONTINUITY OF CARE RESULTS

In this section, results are based on responses from the BRFSS Survey focusing on Continuity of Care. The results provide valuable insights into various aspects of care, such as access to regular healthcare providers, continuity of physician care, care avoidance due to cost, coverage gap and routine annual checkup. The subsequent sections of this report will delve into the detailed results and highlight significant differences between baseline and remeasurement during early demonstration. Results for Arkansas are compared to West Virginia, a similar Medicaid expansion state.

BRFSS Survey Results (Metric 1.C.1, 1.C.2, 1.C.3, 2.C.1, 2.C.5)

At baseline (2017-2021), a smaller proportion of Arkansas respondents (72.7%) from the BRFSS survey who were similar in age and income to the ARHOME population reported having a personal doctor relative to West Virginia (76.4%). Between baseline and early demonstration, rates of having a personal doctor increased in both Arkansas (from 72.7% to 77.3%) and West Virginia (from 76.4% to 82.8%), with the increase being significantly greater in West Virginia than in Arkansas (P<0.001).

From baseline to early demonstration (2022-2023), the proportion of respondents who reported avoiding care due to cost increased from baseline to early demonstration in Arkansas (26.4% to 27.6%) and decreased in West Virginia (22.3% to 20.6%). The proportion of respondents that reported having a routine checkup during the measurement year decreased slightly in Arkansas (from 70.0% to 69.3%) while remaining stable in West Virginia (72.9%). Both measures indicated significantly poorer performance in Arkansas compared to West Virginia (P<0.001).

Additionally, a smaller proportion of Arkansas respondents (81.7%) reported having any form of health plan coverage relative to West Virginia (86.6%). Between baseline and early demonstration, this rate increased slightly in Arkansas (from 81.7% to 81.9%) and more dramatically in West Virginia (from 86.6% to 92.2%), with the increase being significantly greater in West Virginia than in Arkansas (P<0.001).

The proportion of BRFSS respondents that reported having had a flu shot remained relatively stable in Arkansas from baseline (28.7%) to early demonstration years (28.0%) and decreased in West Virgina from 32.7% to 27.1%, indicating significantly poorer performance in Arkansas compared to West Virginia (P<0.001).

Arkansas Medicaid expansion does not appear to have decreased unmet need for healthcare (indicated by increases in those having a personal doctor, decreases in avoiding care due to cost, increased health care coverage or access to care like receiving a flu vaccine) or increased access to care (having had a routine checkup) among low-income adults relative to West Virginia.

Table 24: BRFSS Survey Results

	Time Period[1]		Estimated Differences[2]
	Baseline 2017-2021	Early Demonstration 2022–2023	Early Demonstration – Baseline
1.C.1 Have personal doctor			
Arkansas (n=6,058)	72.7%	77.3%	4.5
West Viginia (n=7,108)	76.4%	82.8%	5.9
Estimated Differences in Differences: AR –WV =			-1.7
			P<0.001
1.C.2 Avoided care due to cost			
Arkansas (n=6,070)	26.4%	27.6%	2.1
West Virgina (n=7,116)	22.3%	20.6%	-0.4
Estimated Differences in Differences: AR – WV =			2.4
			P<0.001
1.C.3 Last routine checkup			
Arkansas (n=6,008)	70.0%	69.3%	-0.4
West Viginia (n=7,033)	72.9%	72.9%	-1.1
Estimated Differences in Differences: AR – WV =			0.7
			P<0.001
2.C.1 Have health care coverage			
Arkansas (n=5,945)	81.7%	81.9%	-0.3
West Virginia (7,018)	86.6%	92.2%	6.7
Estimated Differences in Differences: AR – WV =			-8.4
			P<0.001
2.C.5 Flu vaccine			
Arkansas (n=5,587)	28.7%	28.0%	-2.3
West Virginia (6,893)	32.7%	27.1%	-6.5
Estimated Differences in Differences: AR – WV =			3.9
			P<0.001

[1] The time period columns provide results from the unadjusted interrupted time series model; the proportions are unadjusted.
[2] The estimated differences columns provide results from the DiD models which are adjusted for demographic covariates.

Coverage Gaps (Metric 1.D.1, 1.D.2)

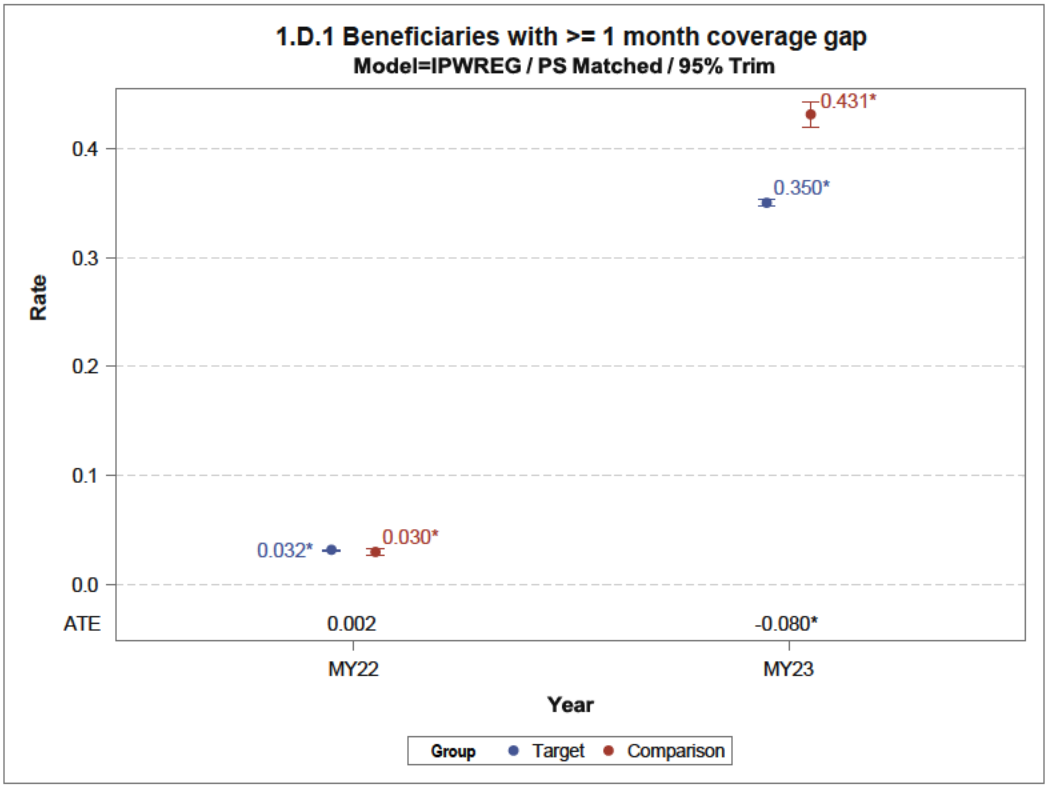
A gap in coverage was defined as a loss of ARHOME coverage of 30 days or more. Gaps at the beginning of the measurement year were counted if the beneficiary had the ARHOME coverage in the year prior to the start of the measurement year.

In MY22, both the target group (3.2%) and comparison group (3.0%) had a low percentage of beneficiaries with one or more gaps in coverage. However, in MY23, both groups saw a drastic increase in coverage gaps. While the target group saw a more than 30% increase in the percentage of beneficiaries with ≥ 1 gap from MY22 to MY23 (35.1%), this percentage was significantly lower (P<0.0001) than the comparison group (43.1%), with a difference of -8.0 percentage points. Due to the COVID-19 PHE, declared under Section 319 of the Public Health Service Act, there was a pause in disenrollment throughout CY22 and through April 1, 2023, after which the PHE unwinding resulted in a higher number of disenrollments in CY23.

Table 25: Percentage of beneficiaries with ≥1 month coverage gap

1.D.1	MY22	MY23
Target Sample Size	262,589	129,899
Comparison Sample Size	75,334	49,611
Target Rate (95% C.I.)	0.032 (0.031 – 0.032)	0.351 (0.347 – 0.353)
Comparison Rate (95% C.I.)	0.030 (0.027 – 0.033)	0.431 (0.419 – 0.442)
Rate Difference (95% C.I.)	0.002 (-0.002 – 0.004)	-0.080 (-0.092 – -0.069)
P Value	0.2989	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 12: Percentage of beneficiaries with ≥1 month coverage gap

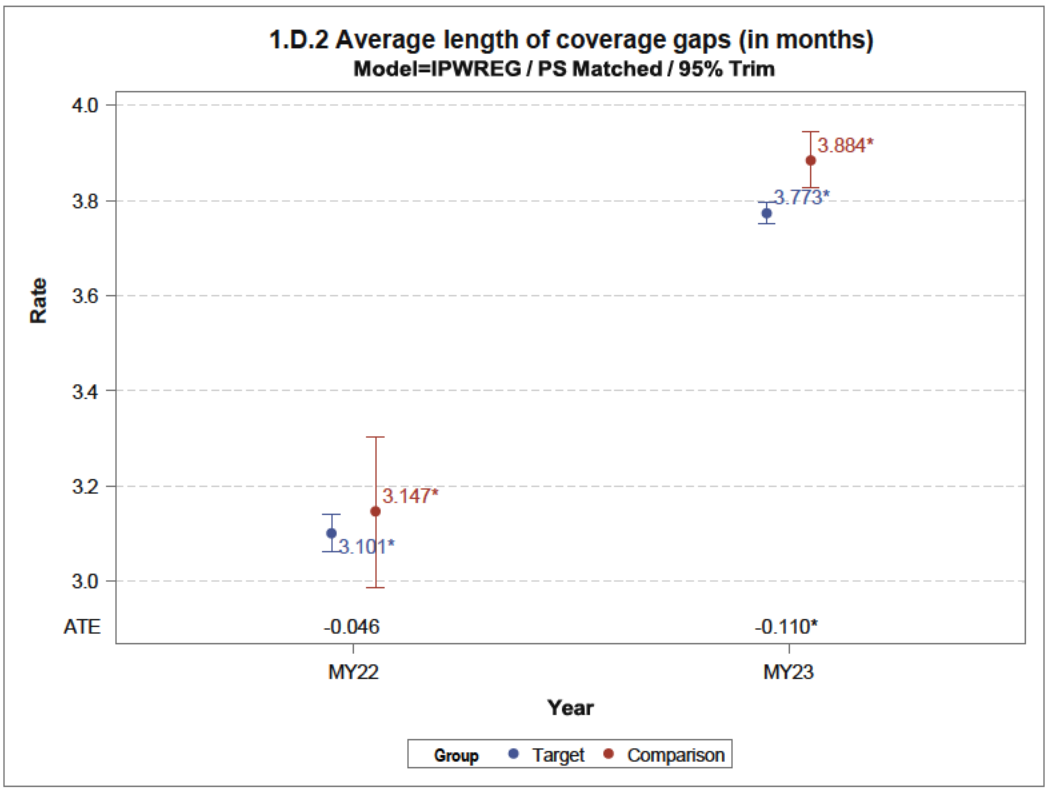


In MY22, the average length of coverage gaps between target (3.10 months) and comparison groups (3.15 months) were not significantly different. However, in MY23, the average gap length for the target group was significantly lower (3.77 months) than the comparison group (3.88 months) (P<0.0001) with a difference of -0.11 months. In MY22, fewer gaps in coverage for both groups were expected due to the COVID-19 PHE pause in disenrollment and redeterminations.

Table 26: Average length of ARHOME coverage gaps, in months

1.D.2	MY22	MY23
Target Sample Size	7,710	45,303
Comparison Sample Size	2,584	24,657
Target Rate (95% C.I.)	3.101 (3.062 – 3.142)	3.773 (3.752 – 3.796)
Comparison Rate (95% C.I.)	3.147 (2.987 – 3.303)	3.884 (3.827 – 3.944)
Rate Difference (95% C.I.)	-0.047 (-0.205 – 0.113)	-0.110 (-0.169 – -0.043)
P Value	0.5633	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Figure 13: Average length of ARHOME coverage gaps, in months



Continuity of Physician Care (Metric 1.E.1, 1.E.2)

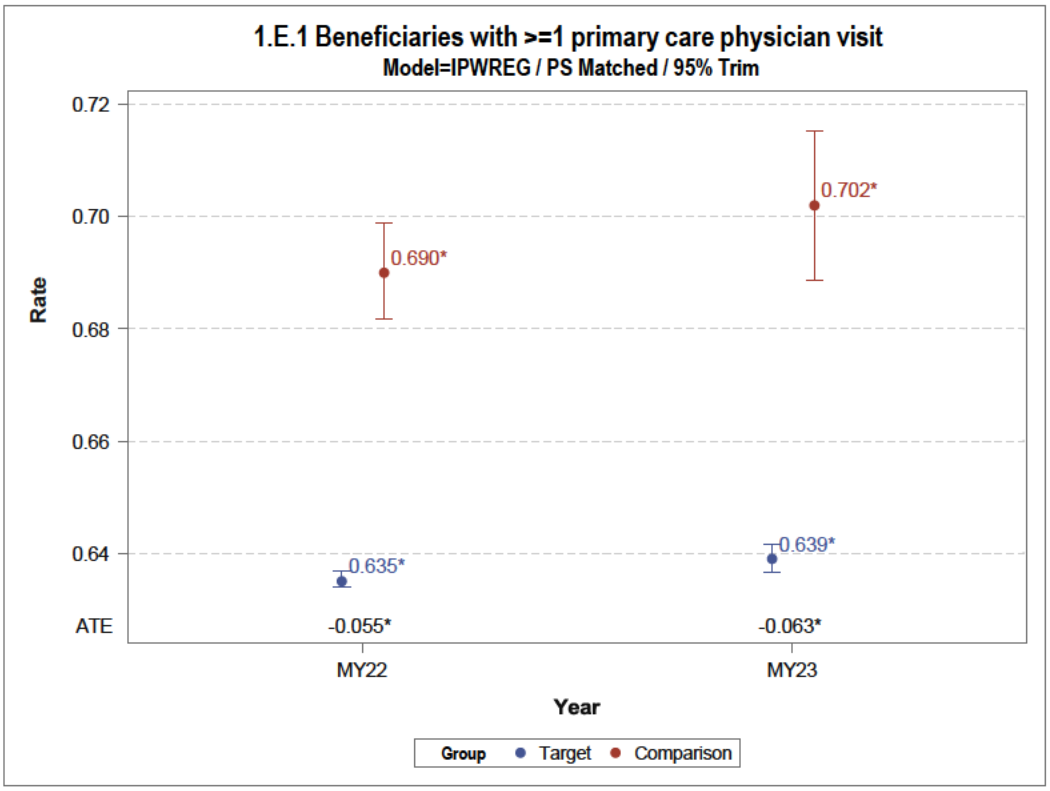
In this section, results are based on responses from the BRFSS Survey focusing on Continuity of Physician Care. The results provide valuable insights into consistency and coherent delivery of healthcare services to beneficiaries enrolled in ARHOME relative to the comparison group.

The analytic population includes beneficiaries with at least 1 PCP visit during the measurement year. In MY22, 63.5% of beneficiaries in the target group had ≥ 1 PCP visit with the same physician during the measurement year compared with 69.0% of beneficiaries in the comparison group, with a difference of -5.5 percentage points. A lower rate of PCP continuity in the target group was also observed in MY23 (P<0.0001) at 63.9% compared with 70.2% in the comparison group, with a difference of -6.3 percentage points. Differences between the two groups were statistically significant (P<0.0001) for both years.

Table 27: Percentage of beneficiaries with ≥1 PCP visit

1.E.1	MY22	MY23
Target Sample Size	121,773	38,265
Comparison Sample Size	24,441	9,849
Target Rate (95% C.I.)	0.635 (0.634 – 0.637)	0.639 (0.637 – 0.642)
Comparison Rate (95% C.I.)	0.690 (0.682 – 0.699)	0.702 (0.689 – 0.715)
Rate Difference (95% C.I.)	-0.055 (-0.064 – -0.046)	-0.063 (-0.077 – -0.050)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Figure 14: Percentage of beneficiaries with ≥1 PCP visit



The following analyses include beneficiaries with ≥1 visit to a specialist during the measurement year and include the following seven specialties: cardiology, endocrinology, gastroenterology, neurology, oncology, pulmonology, and urology.

Overall, the percentage of beneficiaries who continued to see the same specialist over the course of the measurement year was high among both groups, ranging from 86.0% to 100%. No significant differences were observed in rates between the two groups for MY22 or MY23 for beneficiaries seeing cardiovascular specialists, neurologists, oncologists, and urologists.

Target and comparison group beneficiaries who saw a gastroenterologist during the measurement year had the greatest differences in percentages for continuity of specialist care in both MY22 and MY23. In MY22, 91.4% of beneficiaries in the target group had ≥ 1 gastroenterologist visit with the same gastroenterologist during the measurement year

compared with 95.8% of beneficiaries in the comparison group, with a difference of -4.4 percentage points. In MY23, the comparison group rate increased to 99.1% while the target group rate was steady at 91.3%. This resulted in an increased difference between the two groups of -7.8 percentage points. Similarly, a difference of -1.8% in MY22 and -3.0% in MY23 was observed between the two groups regarding seeing the same endocrinologist more than once during the measurement year. This difference was statistically significant in both years.

For beneficiaries seeing a pulmonologist, a significantly lower rate of target group beneficiaries (94.7%) compared to the comparison group (98.5%) saw the same specialist in MY22, with a difference of -3.8 percentage points. However, in MY23, the rate of target group beneficiaries seeing the same specialist decreased to 93.5% (compared to MY22), whereas the comparison group decreased to 86.0%. This resulted in a higher, but nonsignificant, difference of (7.5 percentage points) between the two groups, likely due to a smaller sample size during that measurement year.

Table 28: Percentage of beneficiaries with ≥1 specialist visit

1.E.2	MY22	MY23
Cardiology		
Target Sample Size	3,810	1,480
Comparison Sample Size	681	316
Target Rate (95% C.I.)	0.908 (0.902 – 0.914)	0.909 (0.899 – 0.919)
Comparison Rate (95% C.I.)	0.898 (0.864 – 0.933)	0.914 (0.875 – 0.952)
Rate Difference (95% C.I.)	0.010 (-0.026 – 0.045)	-0.004 (-0.044 – 0.035)
P Value	0.5917	0.8269
Endocrinology		
Target Sample Size	1,552	549
Comparison Sample Size	291	147
Target Rate (95% C.I.)	0.982 (0.978 – 0.987)	0.965 (0.952 – 0.975)
Comparison Rate (95% C.I.)	1.000 (0.984 – 1.000)	0.995 (0.970 – 1.000)
Rate Difference (95% C.I.)	-0.018 (-0.037 – -0.001)	-0.030 (-0.059 – -0.005)
P Value	0.0159	0.0033
Gastroenterology		
Target Sample Size	1,563	506
Comparison Sample Size	242	118
Target Rate (95% C.I.)	0.914 (0.906 – 0.923)	0.913 (0.896 – 0.928)
Comparison Rate (95% C.I.)	0.958 (0.928 – 0.988)	0.991 (0.953 – 1.000)
Rate Difference (95% C.I.)	-0.044 (-0.075 – -0.013)	-0.078 (-0.113 – -0.038)
P Value	0.0057	<0.0001
Neurology		
Target Sample Size	2,616	935
Comparison Sample Size	546	255
Target Rate (95% C.I.)	0.936 (0.929 – 0.942)	0.944 (0.934 – 0.953)
Comparison Rate (95% C.I.)	0.926 (0.895 – 0.957)	0.956 (0.926 – 0.987)
Rate Difference (95% C.I.)	0.009 (-0.022– 0.041)	-0.013 (-0.045 – 0.019)
P Value	0.5587	0.4275
Oncology		
Target Sample Size	2,106	802
Comparison Sample Size	414	226
Target Rate (95% C.I.)	0.961 (0.956 – 0.966)	0.952 (0.942 – 0.962)

1.E.2	MY22	MY23
Comparison Rate (95% C.I.)	0.958 (0.928 – 0.988)	0.949 (0.911 – 0.977)
Rate Difference (95% C.I.)	0.003 (-0.027 – 0.033)	0.003 (-0.028 – 0.042)
P Value	0.8469	0.8466
Pulmonology		
Target Sample Size	1,028	359
Comparison Sample Size	180	68
Target Rate (95% C.I.)	0.947 (0.937 – 0.956)	0.935 (0.918 – 0.953)
Comparison Rate (95% C.I.)	0.985 (0.957 – 1.000)	0.860 (0.777 – 0.942)
Rate Difference (95% C.I.)	-0.038 (-0.068 – -0.009)	0.076 (-0.009 – 0.160)
P Value	0.0115	0.0787
Urology		
Target Sample Size	1,326	435
Comparison Sample Size	205	75
Target Rate (95% C.I.)	0.911 (0.901 – 0.921)	0.895 (0.875 – 0.916)
Comparison Rate (95% C.I.)	0.946 (0.889 – 1.000)	0.871 (0.738 – 1.000)
Rate Difference (95% C.I.)	-0.036 (-0.093 – 0.022)	0.025 (-0.109 – 0.158)
P Value	0.2295	0.7180
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Figure 15: Percentage of beneficiaries with ≥1 annual gastroenterologist visit

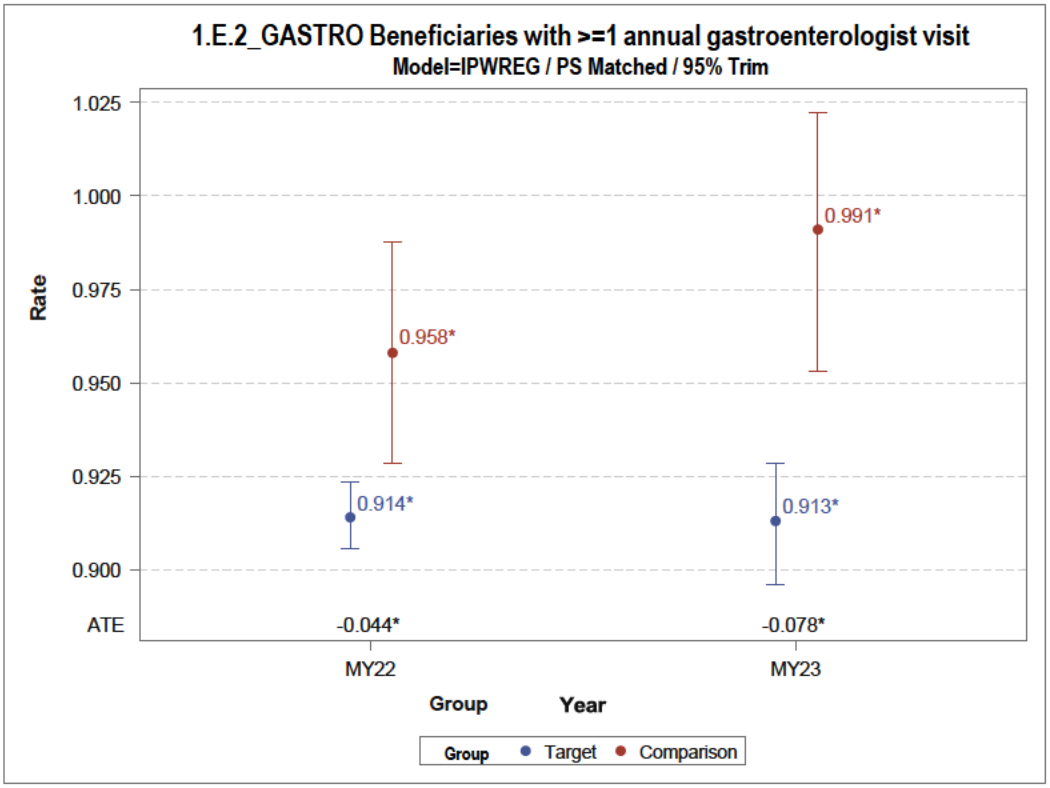


Figure 16: Percentage of beneficiaries with ≥1 annual endocrinologist visit

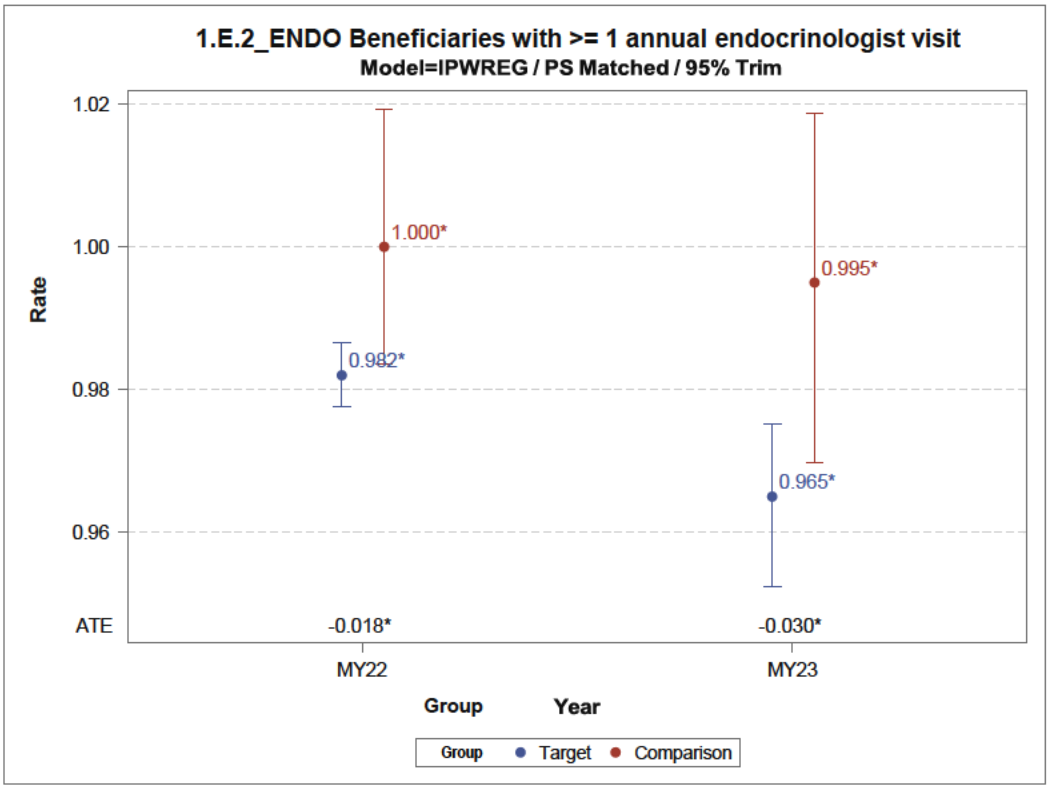
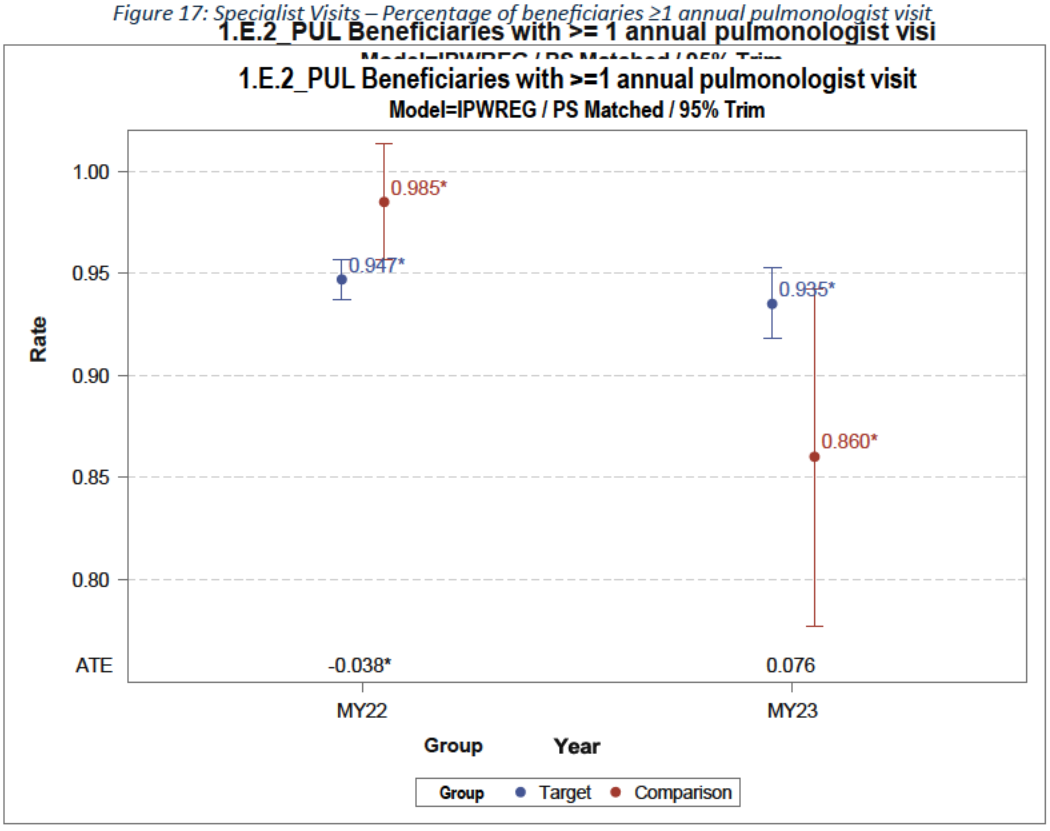


Figure 17: Specialist Visits – Percentage of beneficiaries ≥1 annual pulmonologist visit



Annual PCP Visits (Metric 1.E.3)

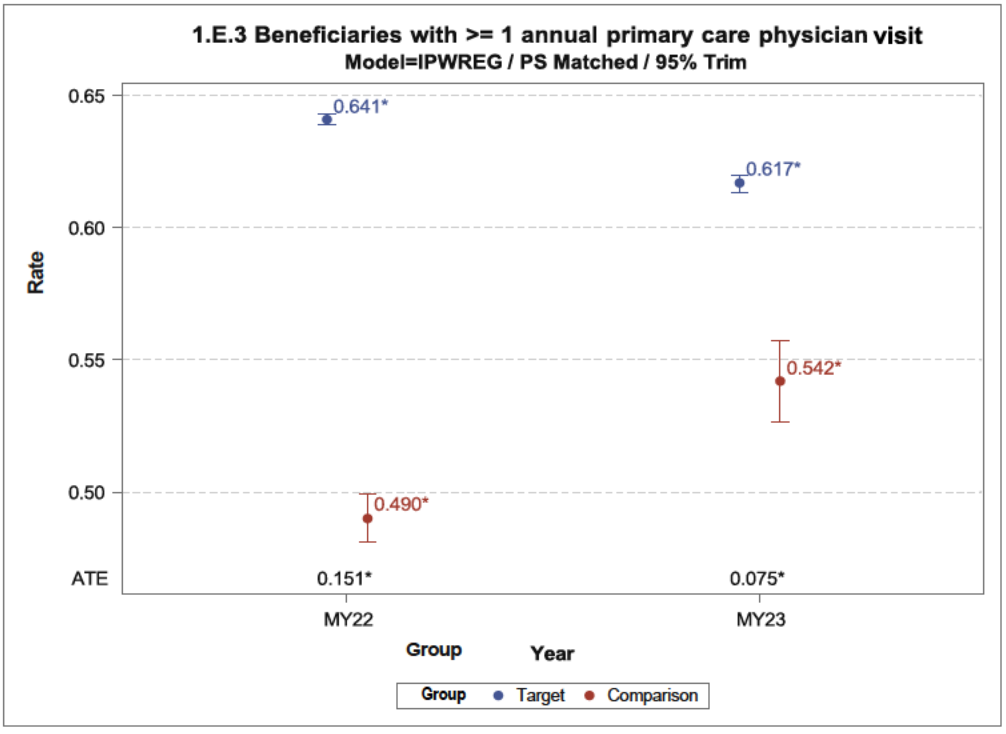
In this section, the results are based on responses from the BRFSS Survey focusing on the theme of "Annual PCP Visits." The results detail the frequency of these visits and provide valuable insights into the differences between the two groups, thereby helping us to better understand healthcare utilization trends within and between target and the comparison group.

The analytic population includes beneficiaries with ≥1 annual PCP visit during the measurement year. In both years, the target group's rates were significantly higher than the comparison group's (P<0.0001). In MY22, 64.1% of beneficiaries in the target group had ≥ 1 PCP visit during the measurement year compared with only 49.0% in the comparison group, with a difference of 15.1 percentage points. While there were 2.4 percentage points less target group beneficiaries (61.7%) with ≥1 PCP visit in MY23 (compared to MY22) and 5.2 percentage points more comparison group beneficiaries (54.2%), the target group still outperformed the comparison group by 7.5 percentage points.

Table 29: Percentage of beneficiaries with ≥1 annual PCP visit

1.E.3	MY22	MY23
Target Sample Size	253,981	90,006
Comparison Sample Size	70,839	27,917
Target Rate (95% C.I.)	0.641 (0.639 – 0.643)	0.617 (0.613 – 0.620)
Comparison Rate (95% C.I.)	0.490 (0.481 – 0.499)	0.542 (0.527 – 0.557)
Rate Difference (95% C.I.)	0.151 (0.141 – 0.160)	0.075 (0.059 – 0.090)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 18: Percentage of beneficiaries with ≥1 annual PCP visit



6.1.2 ACCESS TO CARE RESULTS

In this section, results are based on responses from the hospital association's perspective, focusing on several key aspects of access to care, including the financial health of hospitals, the timeliness of receiving care, cancer screening rates among women, and the availability and utilization of preventive testing and services.

Hospital Financial Health (Metric 2.A.1, 2.A.2, 2.A.3, 2.D.1)

The 2023 Provider Focus Groups (PFGs) included feedback from 3 healthcare associations (AMS, AAFP, AHA). Participant responses to each moderator question were categorized as either positive, negative, neutral, or unknown. Among the three associations, AHA reported the highest percentage of participant willingness to accept ARHOME more readily than Medicaid FFS patients (2.D.1), where percentages were calculated as the ratio of the number of positive responses to the total number of responses (positive, negative, neutral, or unknown). Positive response rates for AMS and AAFP were relatively lower compared to AHA. Among the non-positive responses, only AAFP members indicated that they were less willing to accept ARHOME than Medicaid patients, whereas AMS and AHA members were neutral (i.e., no negative responses). There was some concern among AHA participants that they were at patient capacity and did not anticipate accepting any more insurers. Additionally, contract term issues did not increase the willingness to accept more ARHOME than Medicaid FFS patients. Overall, despite the generally negative response from AAFP, among the unambiguous responses, most participants across the 3 associations reported a general willingness to accept ARHOME patients more readily than Medicaid FFS patients.

Generally positive results were observed related to ARHOME QHP beneficiary contributions to providers' uncompensated care compared with traditional Medicaid patients (2.A.1). The AHA group reported the highest rate of experiencing less uncompensated care (positive response), followed by AAFP and AMS. In the AHA group, all but one participant reported experiencing less uncompensated care, with the one participant reporting that they did not know. Positive response rates for AMS and AAFP were relatively lower compared to AHA. Among the non-positive responses for AMS and AAFP, most were reports of "unknown", rather than reports of experiencing more or equal uncompensated care. Hence the relatively low positive response rates for AMS and AAFP are attributed more to lack of knowledge and awareness of provider compensation for care than to any negative experiences of ARHOME QHP beneficiary contributions to increased uncompensated care. Overall, among the unambiguous responses, most participants across the 3 associations (AHA, AMS, AAFP) reported less uncompensated care with ARHOME patients than with Medicaid FFS patients.

To see if providers had excessive financial strain and subsequently closed (2.A.3), CMS POS files identified a small percentage of providers in Arkansas and comparison states (Kentucky and West Virginia) in MY22 and MY23 that closed. In Arkansas, 1% of providers closed in MY22 (N=997) and MY23 (N=990) while 1.5% of providers in comparison states closed in MY22 (N=2,326) and MY23 (N=2,372).

Further indicators of financial health of the hospital system relative to comparison states (CS), Kentucky and West Virginia, using data from the NASHP Hospital Cost Tool, indicators explored the impact of the ARHOME demonstration on positive operating margins. **Table 30** displays ITS/DiD estimates for the changes in the ratio of hospitals' uninsured/bad debt costs to either net patient revenue or operating expenditures from baseline to early demonstration (2.A.2).

Hospital bad debt, represented as a percentage of net patient revenue or as a percentage of operating expenses, decreased from baseline to the early demonstration period in both Arkansas and the comparison states. There were no significant differences in the reduction in bad debt in Arkansas relative to the comparison states.

Table 30: Adjusted Changes in Uninsured/Bad Debt Costs for Arkansas and Comparison State Hospitals

2.A.2	Time Period		Estimated Difference (Early Demonstration – Baseline)
	Baseline 2020-2021 (Raw %)	Early Demonstration 2022-2023 (Raw %)	
Uninsured/bad debt as a % of net patient revenue			
Arkansas	1.92	1.78	-0.10
Comparison	1.37	1.22	-0.13
Estimated Differences in Differences: AR – CS =			0.02 P=0.8601
Uninsured/bad debt as a % of operating expenditures			
Arkansas	1.76	1.57	-0.17
Comparison	1.35	1.19	-0.15
Estimated Differences in Differences: AR – CS =			-0.03 P=0.7378

Received Care as Soon as Needed (Metric 2.B.1, 2.B.2, 2.B.3, 2.B.4, 2.B.5, 2.B.6, 2.B.7, 2.D.2, 2.B.9, 2.B.10)

Receiving care as soon as needed is an important aspect of health coverage as it contributes to the level of beneficiary satisfaction and affects the resolution or monitoring of health issues. Getting care when needed may also affect a beneficiary's perspective on the types of care options available to them.

Based on the 2022 BESS survey, ARHOME target beneficiaries reported higher percentages of receiving care for their illness or injury (86.4% vs. 77.9%), non-urgent appointments (88.3% vs. 77.7%), ease of care (92.6% vs. 78.3%), and making an appointment with specialists as soon as needed (83.3% vs. 65.7%) than Medicaid FFS comparison beneficiaries. Notably, 85.7% of target beneficiaries reported having a personal doctor compared with 79.1% of comparison beneficiaries, which likely makes it easier for them to receive the care they need. The proportion of beneficiaries with a wait time of 7 days or less between making an appointment and seeing a provider was higher (81.1%) among target group respondents than comparison group respondents (78.3%). In 2024, similar trends were observed except for scheduling an appointment with a specialist where target group respondents reported being less likely to see a specialist as soon as needed than comparison group respondents (79.1% vs. 80.3%), and for the proportion of beneficiaries waiting 7 days or less between making an appointment and seeing a provider (77.0% for ARHOME vs. 78.1% for Medicaid FFS).

Additionally, the percentage of beneficiaries who reported needing an interpreter to speak with health care providers (2.B.9) was very low (<3%) for both groups in both 2022 and 2024 BESS surveys. Results for receiving an interpreter when needed (2.B.10) were not reported for either survey year due to small sample sizes (N<10).

While target group beneficiaries seemed to have been more satisfied with receiving care as needed, results from logistic regression analyses for the 2024 survey showed that there were no significant differences in responses between the two groups.

*Table 31: Received care as soon as needed **

2.B.1-9	MY22	MY24
2.B.1 Care for illness/injury as soon as needed		
Target Percentage	86.4% (N=103)	87.3% (N=221)
Comparison Percentage	77.9% (N=122)	79.6% (N=206)
OR (95% C.I.)	NA	1.6210 (0.7461 – 3.5219)
P-value	NA	0.2217
2.B.2 Non-urgent appointment as soon as needed		
Target Percentage	88.3% (N=111)	84.8% (N=329)
Comparison Percentage	77.7% (N=139)	79.1% (N=296)
OR (95% C.I.)	NA	1.2673 (0.7366 – 2.1803)
P-value	NA	0.3915
2.B.3 Ease of necessary care, tests, or treatment		
Target Percentage	92.6% (N=136)	86.7% (N=347)
Comparison Percentage	78.3% (N=152)	79.9% (N=328)
OR (95% C.I.)	NA	1.1831 (0.6820 – 2.0522)
P-value	NA	0.5491
2.B.4 Have a personal doctor		
Target Percentage	85.7% (N=203)	82.8% (N=580)
Comparison Percentage	79.1% (N=235)	81.0% (N=485)
OR (95% C.I.)	NA	0.9931 (0.6482 – 1.5215)
P-value	NA	0.9745
2.B.5 Appointment with specialist as soon as needed		
Target Percentage	83.3% (N=96)	79.1% (N=244)
Comparison Percentage	65.7% (N=99)	80.3% (N=208)
OR (95% C.I.)	NA	0.8918 (0.4563 – 1.7430)
P-value	NA	0.7372
2.B.6 Wait time between appointment and seeing a provider		
Target Percentage	81.1% (N=111)	77.0% (N=322)
Comparison Percentage	78.3% (N=138)	78.1% (N=292)
OR (95% C.I.)	NA	1.2038 (0.7214 – 2.0086)
P-value	NA	0.4771
2.B.7 Wait for an appointment due to provider's limited availability		
Target Percentage	86.5% (N=111)	NA
Comparison Percentage	86.9% (N=137)	NA
OR (95% C.I.)	NA	NA
P-value	NA	NA
2.D.2 Time to first appointment for immediate care		
Target Percentage	NA	88.2% (N=212)
Comparison Percentage	NA	92.0% (N=200)
OR (95% C.I.)	NA	0.7688 (0.2832 – 2.0869)

2.B.1-9	MY22	MY24
P-value	NA	0.6051
2.B.9 Needed Interpreter Services		
Target Percentage	1.56% (N=128)	2.30% (N=348)
Comparison Percentage	2.13% (N=141)	2.36% (N=297)
OR (95% C.I.)	NA	1.7128 (0.4122 – 7.1158)
P-value	NA	0.4586

*NOTE: some questions were asked for only one BESS survey, either 2022 or 2024. Regression analysis was conducted only for the 2024 survey as there were not enough responses from the 2022 survey to conduct a proper analysis. Consequently, the odds ratio (OR) and P-value data are not available for the 2022 survey. The question related to metric 2.B.8 (ease of getting a specialist referral) was included only in the 2020 survey and was subsequently omitted from the 2022 and 2024 surveys.

Based on results from the 2022 and 2024 BESS surveys, ARHOME beneficiaries were more likely to report higher percentages of receiving care for their illness or injury, non-urgent appointments, ease of care, making appointments with specialists as soon as needed in MY22, and having a lower wait time to first appointment for immediate care in MY24.

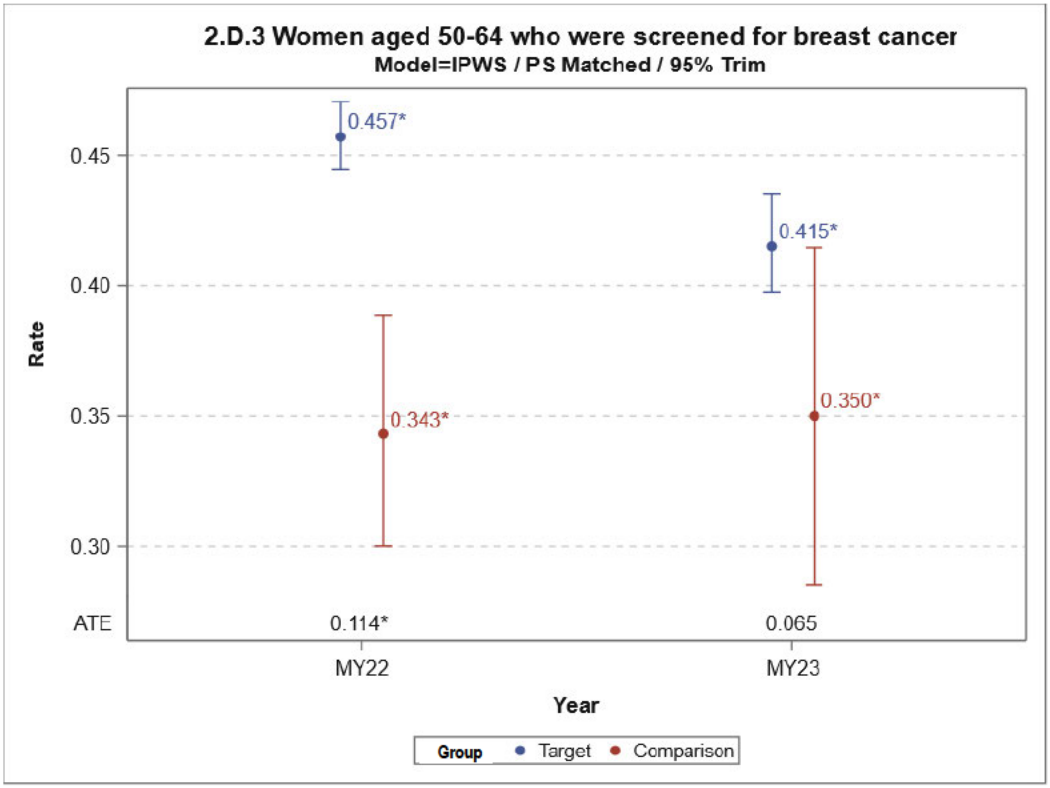
Cancer Screenings Rates Among Women (Metric 2.D.3, 2.D.4, 2.D.5)

The eligible population included women aged 50 to 64 who had ≥ 1 mammogram either during the measurement year or in the 15 months leading up to it. In MY22, a significantly higher percentage of women in the target group (45.7%) had a mammogram compared to the comparison group (34.3%) with a rate difference of 11.4 percentage points, which was statistically significant (P<0.0001). In MY23, the target group still had a higher percentage of women having mammograms at 41.5%, but this difference was not statistically significant compared to the comparison group (35.0%).

Table 32: Percentage of women aged 50–64 who had a mammogram screening for breast cancer

2.D.3	MY22	MY23
Target Sample Size	5,429	2,351
Comparison Sample Size	412	220
Target Rate (95% C.I.)	0.457 (0.444 – 0.471)	0.415 (0.398 – 0.435)
Comparison Rate (95% C.I.)	0.343 (0.300 – 0.389)	0.350 (0.285 – 0.415)
Rate Difference (95% C.I.)	0.114 (0.066 – 0.159)	0.065 (-0.001 – 0.138)
P Value	<0.0001	0.0572
Propensity scores trimmed at the:	**5th–95th percentiles**	
Regression Model:	**IPWS**	

Figure 19: Percentage of women aged 50–64 who had a mammogram screening for breast cancer

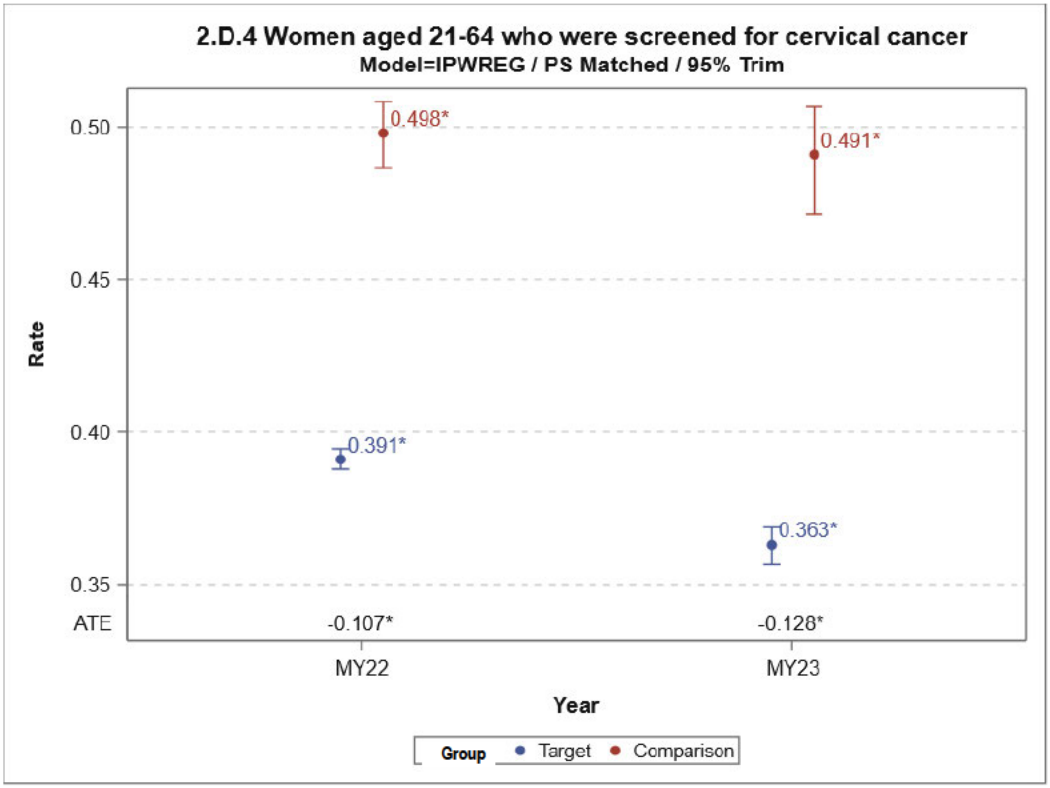


In contrast to breast cancer screening, cervical cancer screenings among women aged 21-64 in MY22 was significantly lower (P<0.0001) among the target group (39.1%) than the comparison group (49.8%), with a difference of -10.7 percentage points. In MY23, the target group rate remained low at 36.3%, which was significantly lower (P<0.0001) than the comparison group (49.1%), with a rate difference of -12.8 percentage points.

Table 33: Percentage of women aged 21–64 who were screened for cervical cancer

2.D.4	MY22	MY23
Target Sample Size	114,029	34,101
Comparison Sample Size	48,592	17,856
Target Rate (95% C.I.)	0.391 (0.388 – 0.395)	0.363 (0.357 – 0.369)
Comparison Rate (95% C.I.)	0.498 (0.487 – 0.509)	0.491 (0.471 – 0.507)
Rate Difference (95% C.I.)	-0.107 (-0.112 – -0.095)	-0.128 (-0.147 – -0.108)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 20: Percentage of women aged 21–64 who were screened for cervical cancer

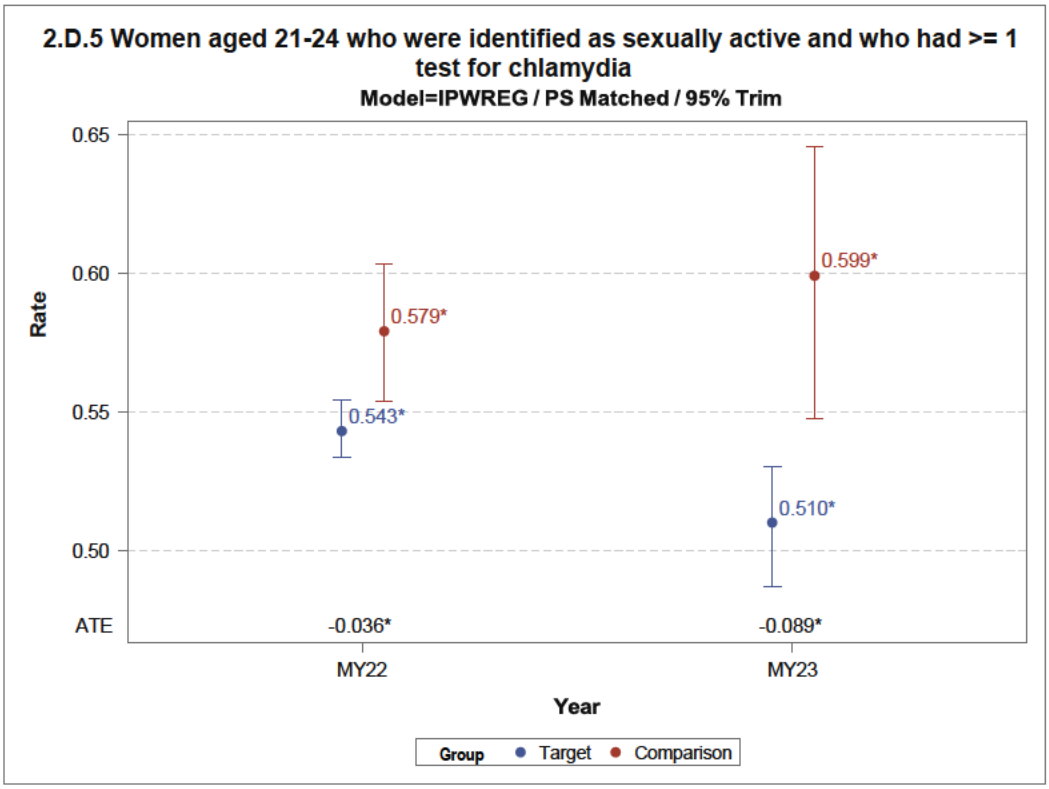


The eligible population consisted of women aged 21-24 who were identified as sexually active and who had ≥ 1 test for chlamydia during the measurement year. In MY22, the target group had a significantly lower (P=0.0124) rate of women who screened for chlamydia (54.3%) than the comparison group (57.9%), with a rate difference of -3.6 percentage points. In MY23, this rate dropped 3.3 percentage points to 51.0%, which was significantly lower (P=0.0011) than the comparison group (59.9%), with a rate difference of -8.9 percentage points.

Table 34: Percentage of women aged 21-24 who had ≥1 screening for chlamydia during the measurement year

2.D.5	MY22	MY23
Target Sample Size	11,665	3,012
Comparison Sample Size	5,055	1,463
Target Rate (95% C.I.)	0.543 (0.533 – 0.554)	0.510 (0.487 – 0.530)
Comparison Rate (95% C.I.)	0.579 (0.554 – 0.604)	0.599 (0.548 – 0.646)
Rate Difference (95% C.I.)	-0.036 (-0.062 – -0.009)	-0.089 (-0.147 – -0.034)
P Value	0.0124	0.0011
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 21: Percentage of women aged 21-24 who had ≥1 screening for chlamydia during the measurement



Preventative Testing and Services (Metric 2.D.6, 2.D.7, 2.D.8, 2.D.9)

The following analysis included beneficiaries aged 40 to 64 with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who were dispensed ≥1 statin medication of any intensity during the measurement year. In MY22, 53.0% of target group beneficiaries with diabetes was dispensed ≥1 statin medication, which was slightly higher (P=0.6435) than the comparison group at 49.4%. In MY23, the target group rate dropped slightly to 52.6% while the comparison group rate increased to 67.3%. Differences in both years were not statistically significant.

Table 35: Percentage of beneficiaries aged 40–64 with diabetes who do not have ASCVD who were dispensed ≥1 statin medication of any intensity during the measurement year

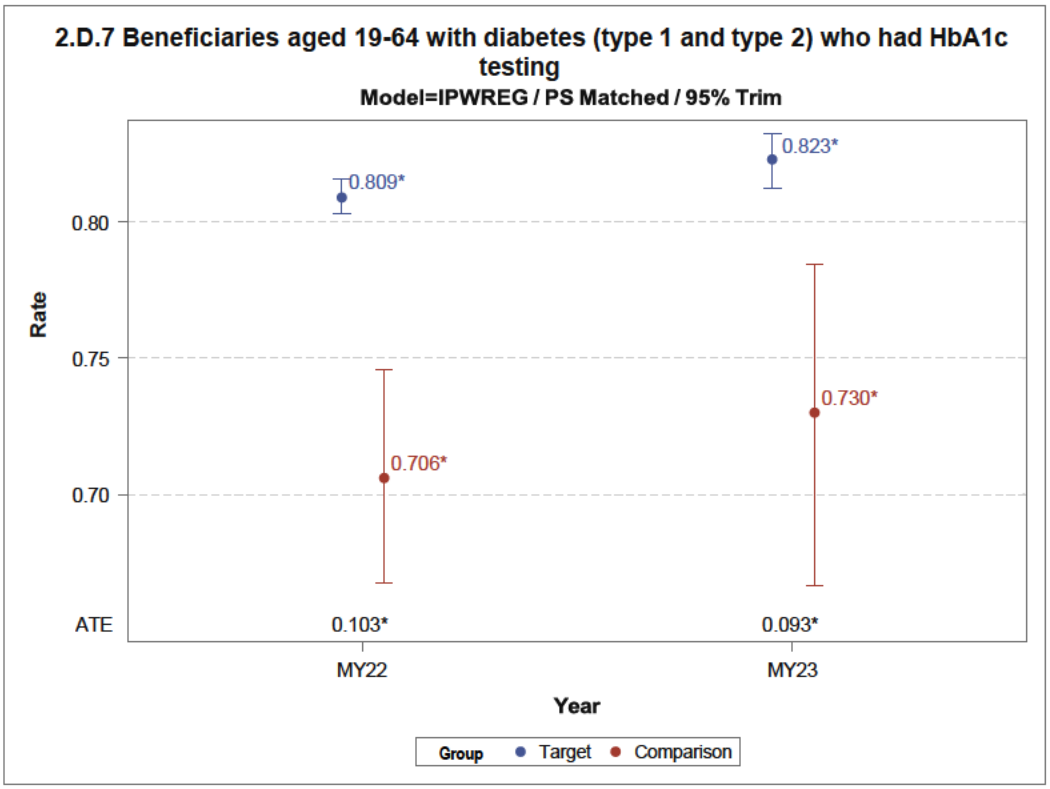
2.D.6 (4.D.17)	MY22	MY23
Target Sample Size	6,130	2,359
Comparison Sample Size	979	463
Target Rate (95% C.I.)	0.531 (0.517 – 0.544)	0.526 (0.504 – 0.549)
Comparison Rate (95% C.I.)	0.494 (0.342 – 0.647)	0.673 (0.454 – 0.811)
Rate Difference (95% C.I.)	0.036 (-0.117 – 0.190)	-0.147 (-0.287 – 0.080)
P Value	0.6435	0.1046
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

The rate of target group beneficiaries aged 19-64 with diabetes (type I and II) who underwent Hemoglobin A1c (HbA1c) testing during MY22 was 80.9%, which was significantly higher (P<0.0001) than the comparison group (70.6%), with a rate difference of 10.3 percentage points. In MY23, the target group rate increased to 82.3%, whereas the comparison group rate increased to 73.0%, with a rate difference of 9.3 percentage points, which was also significantly different (P=0.0024).

Table 36: Percentage of beneficiaries aged 19-64 with diabetes who had HbA1c testing during the measurement year

2.D.7 (4.D.18)	MY22	MY23
Target Sample Size	18,137	7,046
Comparison Sample Size	3,229	1,406
Target Rate (95% C.I.)	0.809 (0.803 – 0.816)	0.823 (0.813 – 0.832)
Comparison Rate (95% C.I.)	0.706 (0.668 – 0.746)	0.730 (0.666 – 0.784)
Rate Difference (95% C.I.)	0.103 (0.063 – 0.142)	0.093 (0.038 – 0.158)
P Value	<0.0001	0.0024
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 22: Percentage of beneficiaries aged 19-64 with diabetes who had HbA1c testing during the measurement year



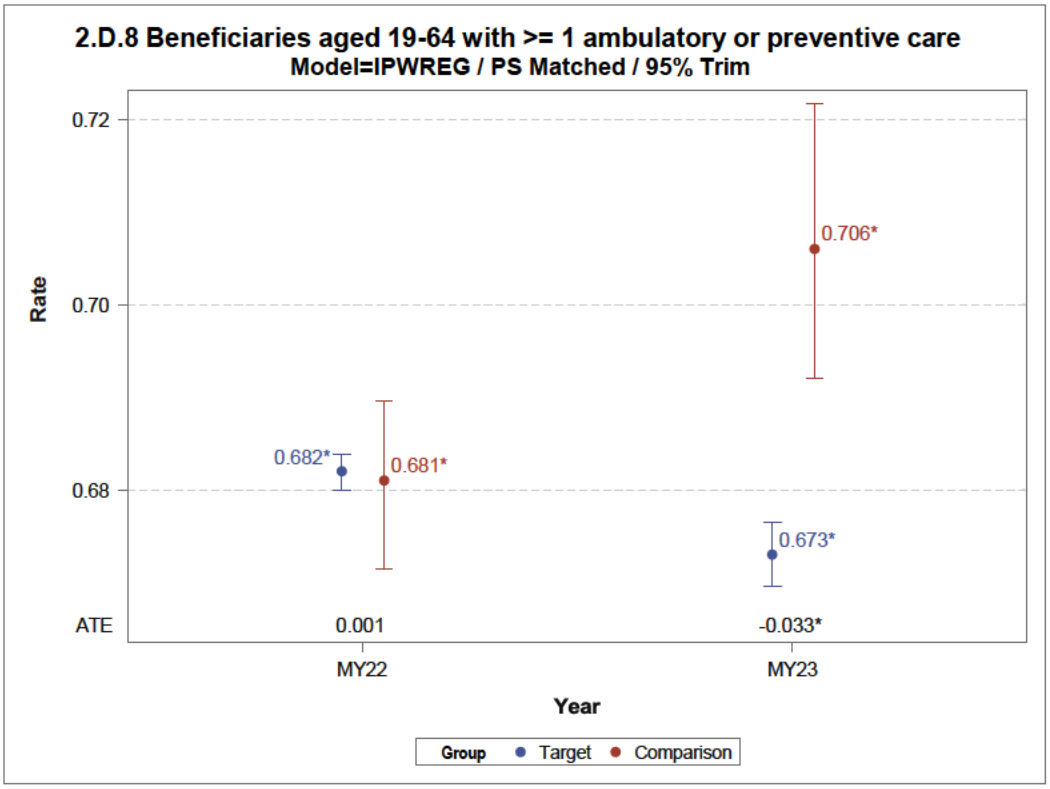
In MY22, the rate of target group beneficiaries aged 19 to 64 who received ≥1 ambulatory or preventive care visit was 68.2%, which was similar to the comparison group (68.1%). In MY23, the target group rate decreased to 67.3% and was significantly lower (P<0.0001) than the increased comparison group (70.6%), with a difference of -3.3 percentage points.

In MY22, the rate of beneficiaries who received ≥1 ambulatory or preventive care visit was not significantly different between the two groups. The significant decrease in both groups in MY23 (compared to MY22) was largely due to the ending of the COVID-19 PHE in April-May 2023, which resulted in a drop in enrollment of eligible beneficiaries. As a result, the 3.3 percentage point difference between the two groups in MY23 may have been affected by the change in analytic sample sizes.

Table 37: Percentage of beneficiaries aged 19-64 receiving ≥1 ambulatory or preventive care visit during the measurement year

2.D.8 (4.D.19)	MY22	MY23
Target Sample Size	252,726	82,937
Comparison Sample Size	70,480	24,766
Target Rate (95% C.I.)	0.682 (0.680 – 0.684)	0.673 (0.670 – 0.677)
Comparison Rate (95% C.I.)	0.681 (0.672 – 0.690)	0.706 (0.692 – 0.722)
Rate Difference (95% C.I.)	0.001 (-0.008 – 0.011)	-0.034 (-0.049 – -0.019)
P Value	0.8252	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 23: Percentage of beneficiaries aged 19-64 receiving ≥1 ambulatory or preventive care visit during the measurement year



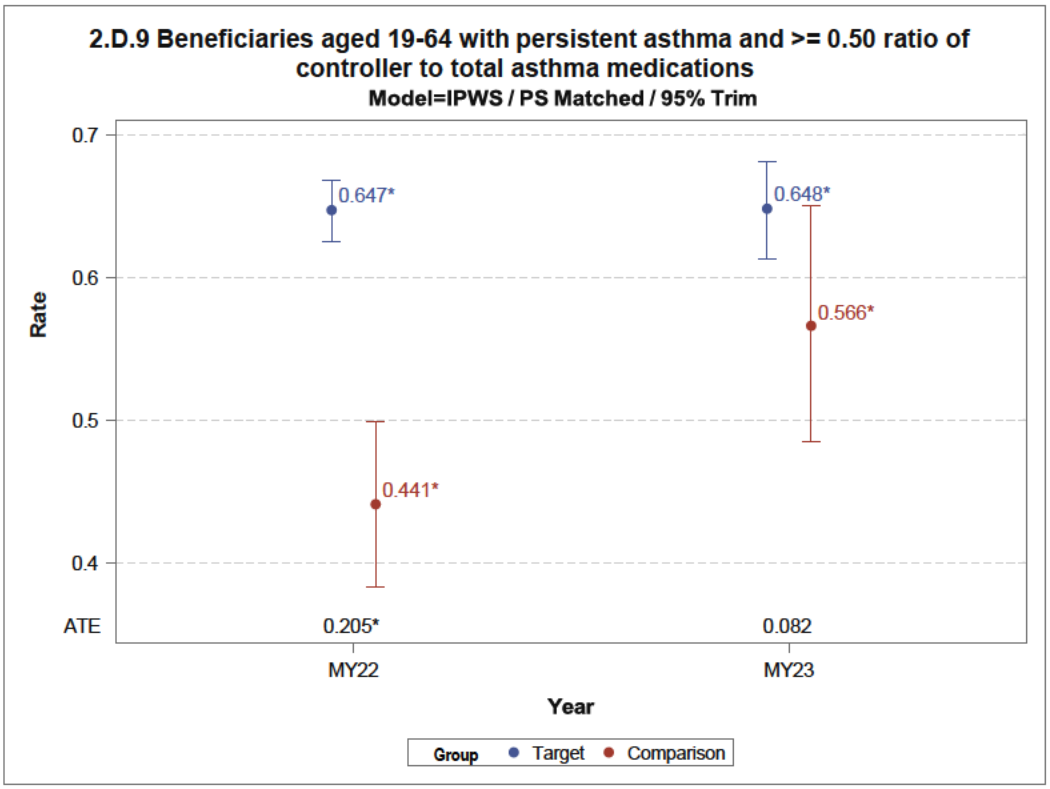
The analytical population comprised of beneficiaries aged 19 to 64, having persistent asthma and who had a ratio of controlled medications to total asthma medications of 0.50 or greater during the measurement year. In MY22, 64.6% of target group beneficiaries achieved the ≥ 0.50 ratio, which was significantly higher (P<0.0001) than the comparison group (44.1%), with a difference of 20.5 percentage points. However, in MY23, the target group rate was 64.8% and

was insignificantly higher (P=0.0602) than the comparison group (56.6%), due to an increase in the comparison group rate during that measurement year.

Table 38: Percentage of beneficiaries aged 19-64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year

2.D.9	MY22	MY23
Target Sample Size	2,117	729
Comparison Sample Size	369	189
Target Rate (95% C.I.)	0.647 (0.625 – 0.668)	0.648 (0.613 – 0.681)
Comparison Rate (95% C.I.)	0.441 (0.383 – 0.499)	0.566 (0.484 – 0.650)
Rate Difference (95% C.I.)	0.205 (0.139 – 0.266)	0.082 (-0.008 – 0.173)
P Value	<0.0001	0.0602
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 24: Percentage of beneficiaries aged 19-64 who were identified as having persistent asthma and had a ratio of controlled medications to total asthma medications of 0.50 or greater during the measurement year



EPSDT Measures (Metric 2.D.10, 2.D.11, 2.D.12)

The following three EPSDT measures were used to assess beneficiary access to EPSDT benefits while enrolled in ARHOME:

- Adolescent Well-Care Visits (AWC)
- Preventive Dental Screening Visits (PDENT)
- Preventive Vision Screening Visits (PVIS)

All EPSDT measures used the same analytical sample. In the following tables (**Tables 39–41**), the cohort column denotes the measurement year in which beneficiaries were ages 19–20 while enrolled in a QHP. The value in cohort is repeated for the following three periods per cohort:

- Rate 1: measurement year: QHP ages 19−20
- Rate 2: measurement year - 1: EPSDT-eligible Medicaid FFS ages 18−19
- Rate 3: measurement year - 2: EPSDT-eligible Medicaid FFS ages 17–18

The LSMean column shows the estimated proportion of beneficiaries passing the measure and the associated standard error. The Sample Size column shows the cohort size used to calculate each rate, with the year prior to the measurement year having the smallest sample size due to the calendar-year cutoff for the eligible age ranges.

In each cohort, differences between the proportion of beneficiaries passing the measure in the two periods of FFS eligibility were tested to assess any effect of time. The statistical significance of these tests is shown in the column “P Value for Diff from FFS Ages 17–18” for rows labeled “FFS ages 18–19," and is repeated in the column “P Value for Diff from FFS Ages 18–19” for rows labeled “FFS ages 17–18." Tests for differences between each FFS period and the QHP period are shown in the column “P Value for Diff from QHP Ages 19–20.” P values have been adjusted for multiple comparisons.

To evaluate beneficiary access to the EPSDT benefit of an annual well-child screening while enrolled in ARHOME, the eligible population included beneficiaries aged 19–20 who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OBGYN) during the measurement year.

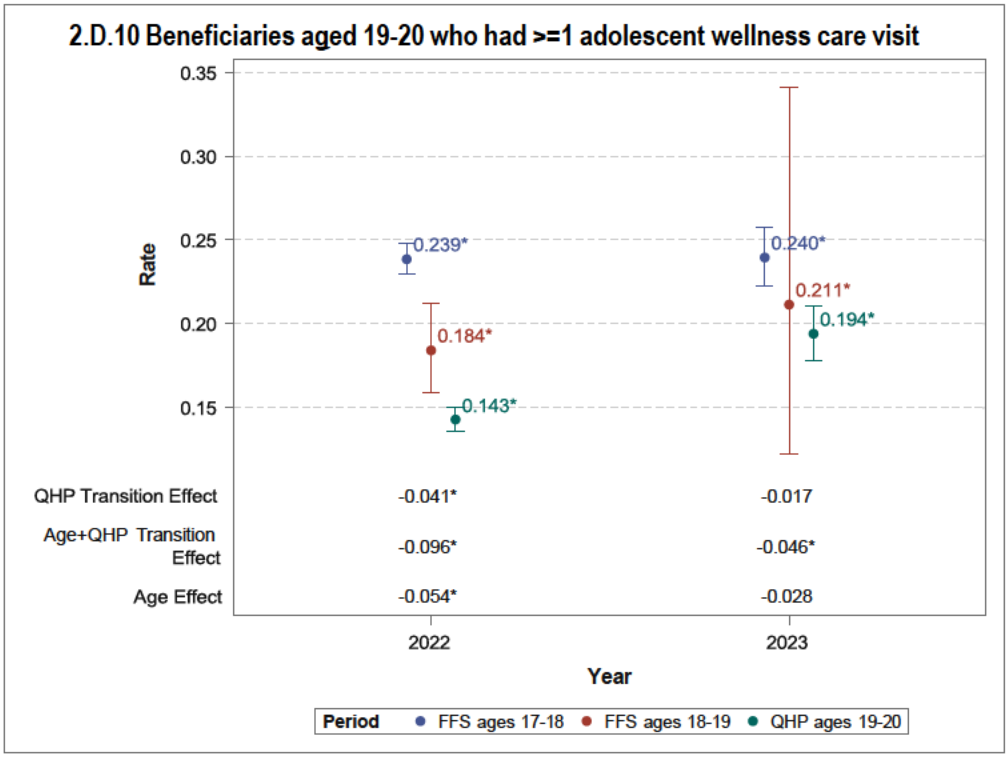
In the MY22 cohort, there was a significant decrease in the proportion of beneficiaries with an AWC visit between the ages of 17–18 and 18–19 in traditional Medicaid FFS (P=0.0009). This downward trend persisted during the ARHOME period for ages 19–20 (P=0.0032). In the MY23 cohort, both the age trend and QHP transition trend also declined, but these decreases were statistically insignificant (P=0.8807 and 0.9453, respectively), likely due to the substantially smaller sample size of beneficiaries in the ages 18-19 period compared to the other two periods.

The overall combined age and QHP transition effect was significantly negative (P<0.0001) in both the MY22 and MY23 cohorts. Thus, the age effect during the FFS period and the impact of transitioning from FFS to QHP coverage both exhibited significantly negative trends in the MY22 cohort, but were insignificant in the MY23 cohort. The combined effect of age and QHP transition consistently showed a significantly negative trend in both the 2022 and 2023 cohorts. The negative trend of the QHP transition effect (significant in MY22 but insignificant in MY23) is probably due to the AWC visits being a wrap-around service, which is not promoted by the QHP plan.

Table 39: Beneficiaries aged 19-20 who had ≥1 well-care visit with a PCP or OBGYN during the measurement year

Measure			2.D.10			
Cohort	Period	LSMean (StdErr)	Sample Size	P Value for Diff from FFS Ages 17–18	P Value for Diff from FFS Ages 18–19	P Value for Diff from QHP Ages 19–20
2022	FFS ages 17–18	0.239 (0.005)	8,528	N/A	0.0009	<0.0001
2022	FFS ages 18–19	0.184 (0.013)	819	0.0009	N/A	0.0032
2022	QHP ages 19–20	0.143 (0.004)	8,600	<0.0001	0.0032	N/A
2023	FFS ages 17–18	0.240 (0.009)	2,263	N/A	0.8807	0.0001
2023	FFS ages 18–19	0.211 (0.056)	50	0.8807	N/A	0.9453
2023	QHP ages 19–20	0.194 (0.008)	2,263	0.0001	0.9453	N/A

Figure 25: Beneficiaries aged 19-20 who had ≥1 well-care visit with a PCP or OBGYN during the measurement year



In the MY22 cohort, there was a significant decrease in the proportion of beneficiaries with a PDENT visit between the ages of 17–18 and 18–19 in traditional Medicaid FFS (P=0.0453). This trend continued during the ARHOME demonstration period for ages 19–20 (P<0.0001). In the 2023 cohort, the downward age trend was insignificant (P=0.7315), whereas the downward trend associated with the QHP transition was significant (P=0.0002). The insignificant MY23 cohort age trend was likely due to the substantially smaller sample size of beneficiaries in the FFS ages 18-19 period compared to the other two periods.

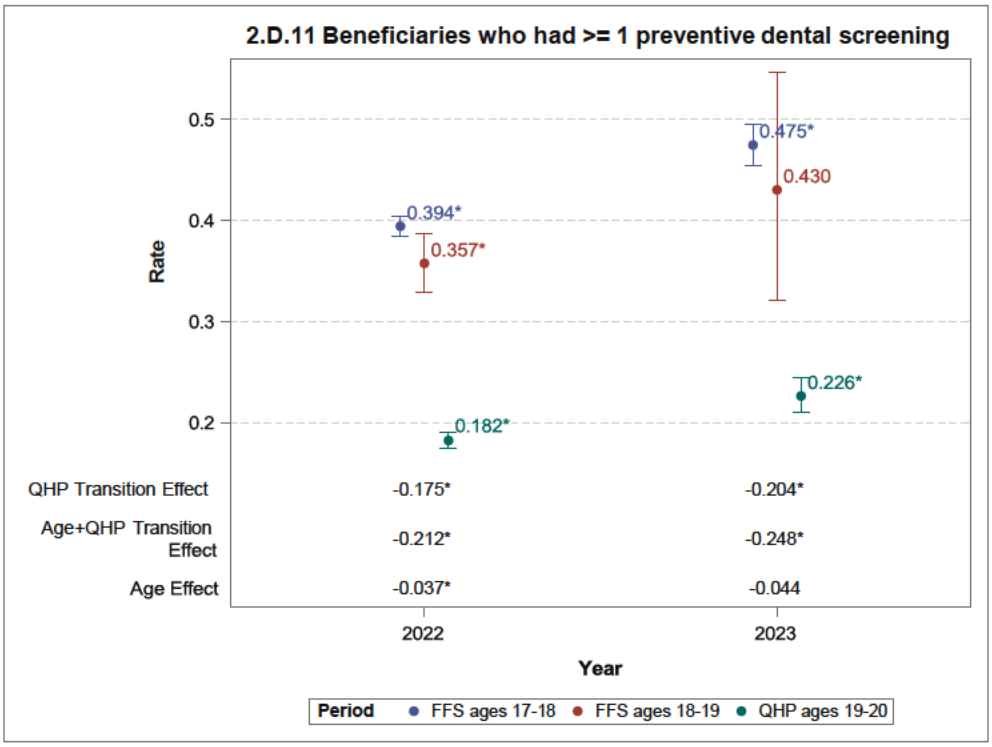
The overall combined age and QHP transition effect was significantly negative (P<0.0001) in both the 2022 and 2023 cohorts. Thus, the age effect during the FFS period and the impact of

transitioning from FFS to QHP coverage both exhibited significantly negative trends in the 2022 cohort. In contrast, in the 2023 cohort, while the age effect was not significant, the negative QHP transition effect was significant. Nonetheless, the combined effect of age and QHP transition consistently showed a significantly negative trend in both the 2022 and 2023 cohorts. The significant negative trend of the QHP transition effect is probably due to the PDENT visits, which are a wrap-around service not promoted by the QHP plan.

Table 40: Beneficiaries aged 19-20 who had ≥1 preventive dental service during the measurement year

Measure			2.D.11			
Cohort	Period	LSMean (StdErr)	Sample Size	P Value for Diff from FFS Ages 17–18	P Value for Diff from FFS Ages 18–19	P Value for Diff from QHP Ages 19–20
2022	FFS ages 17–18	0.394 (0.005)	8,528	N/A	0.0453	<0.0001
2022	FFS ages 18–19	0.357 (0.015)	819	0.0453	N/A	<0.0001
2022	QHP ages 19–20	0.182 (0.004)	8,600	<0.0001	<0.0001	N/A
2023	FFS ages 17–18	0.475 (0.011)	2,263	N/A	0.7315	<0.0001
2023	FFS ages 18–19	0.430 (0.058)	50	0.7315	N/A	0.0002
2023	QHP ages 19–20	0.226 (0.0089)	2,263	<0.0001	0.0002	N/A

Figure 26: Beneficiaries aged 19-20 who had ≥1 preventive dental service during the measurement year



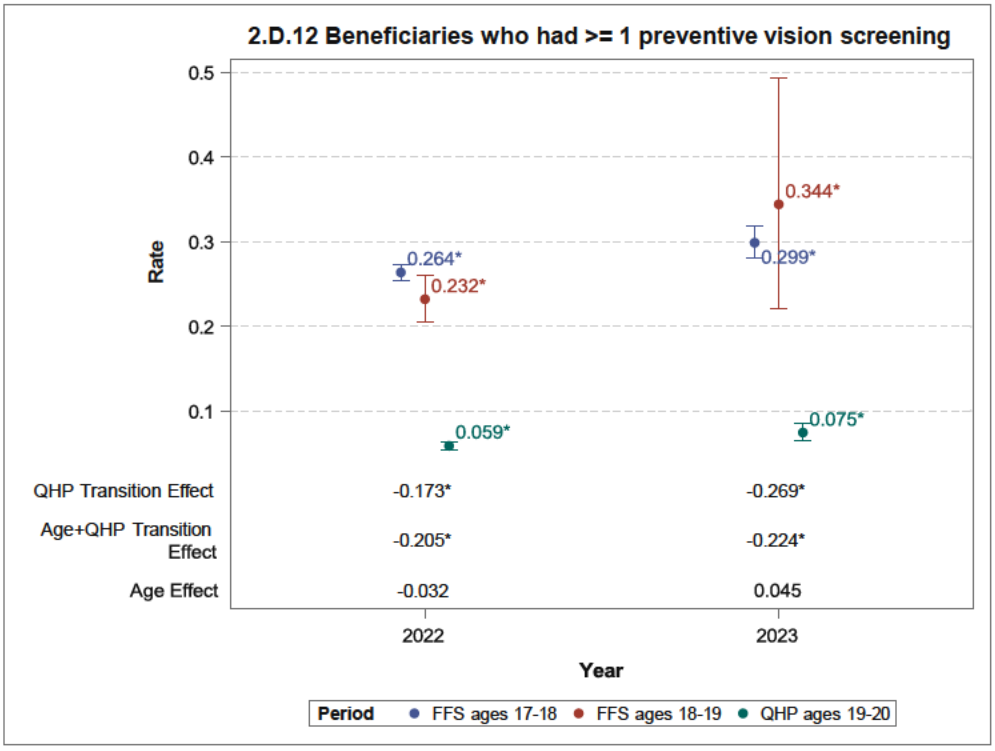
In the MY22 and MY23 cohorts, there were non-significant changes in the proportion of beneficiaries with a PVIS visit among 17–18 and 18–19-year-olds in traditional FFS (P=0.0868 and P=0.7880, respectively). In contrast, transitioning from FFS to QHP coverage had a significantly negative trend (P<0.0001) in both MY cohorts. This negative trend remained

consistent when combining age and QHP transition effects (P<0.0001). The lack of significance in the age trend may be attributed to the smaller sample size of beneficiaries aged 18-19 in the FFS period. The significant negative trend of the QHP transition effect is probably due to the PVIS visits, which are a wrap-around service not promoted by the QHP plan.

Table 41: Beneficiaries aged 19-20 who had ≥1 preventive vision screen during the measurement year

Measure			2.D.12			
Cohort	Period	LSMean (StdErr)	Sample Size	P Value for Diff from FFS Ages 17–18	P Value for Diff from FFS Ages 18–19	P Value for Diff from QHP Ages 19–20
2022	FFS ages 17–18	0.264 (0.005)	8,528	N/A	0.0868	<0.0001
2022	FFS ages 18–19	0.232 (0.014)	819	0.0868	N/A	<0.0001
2022	QHP ages 19–20	0.059 (0.003)	8,600	<0.0001	<0.0001	N/A
2023	FFS ages 17–18	0.299 (0.010)	2,263	N/A	0.7880	<0.0001
2023	FFS ages 18–19	0.344 (0.071)	50	0.7880	N/A	<0.0001
2023	QHP ages 19–20	0.075 (0.006)	2,263	<0.0001	<0.0001	N/A

Figure 27: Beneficiaries aged 19-20 who had ≥1 preventive vision screen during the measurement year



Utilization of NET Services (2.D.13, 2.D.14)

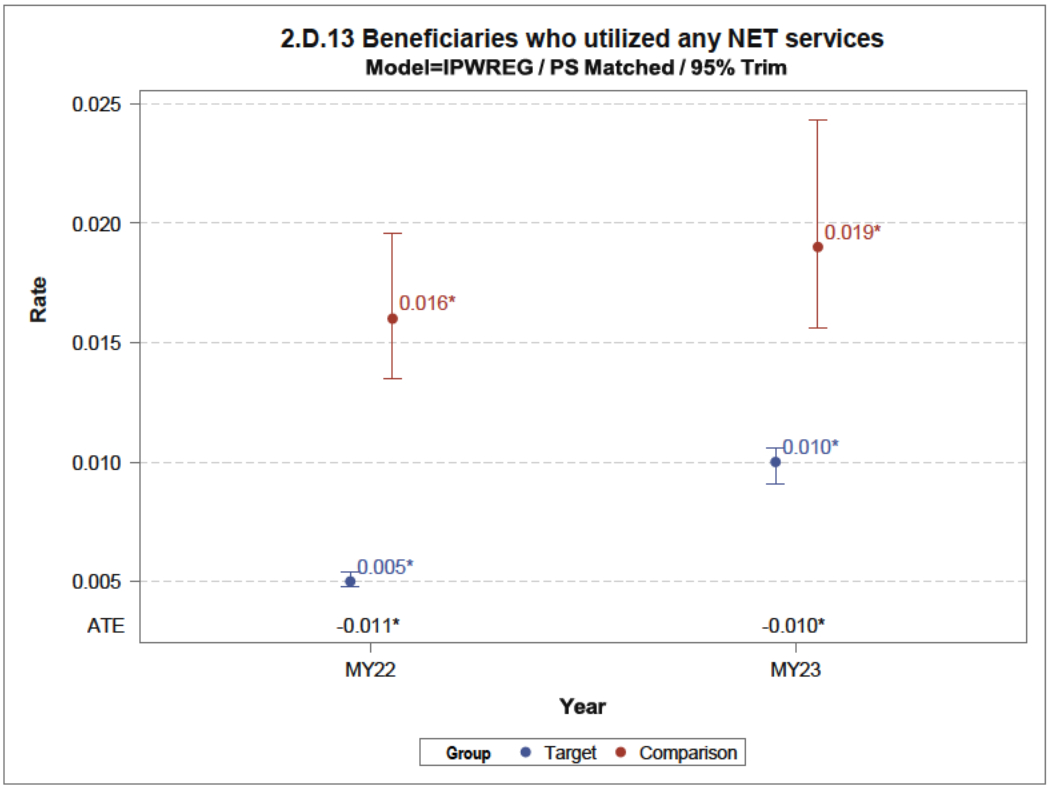
In MY22, 0.5% of target group beneficiaries utilized NET services. This percentage was significantly lower (P<0.0001) than the comparison group's 1.6%, with a difference of -1.1 percentage points. In MY23, the target group's utilization was 1.0%, which was also significantly

lower (P<0.0001) than the comparison group's 2.0%, with a rate difference of -1.0 percentage points.

Table 42: Percentage of beneficiaries that utilized NET services during the measurement year

2.D.13	MY22	MY23
Target Sample Size	253,981	90,006
Comparison Sample Size	70,839	27,917
Target Rate (95% C.I.)	0.005 (0.005 – 0.005)	0.010 (0.009 – 0.011)
Comparison Rate (95% C.I.)	0.016 (0.014 – 0.020)	0.0195 (0.016 – 0.024)
Rate Difference (95% C.I.)	-0.011 (-0.015 – -0.008)	-0.0097 (-0.015 – -0.006)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 28: Percentage of beneficiaries that utilized NET services during the measurement year

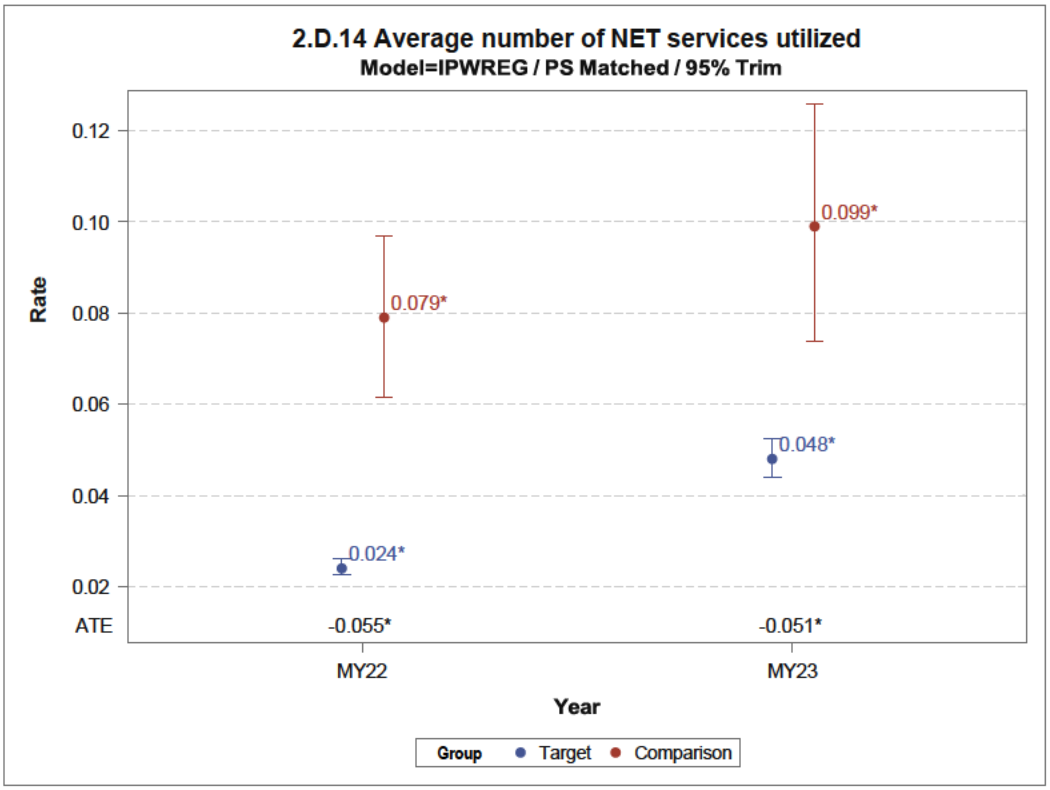


For the following results, counts of NET services represent a round trip to and from medical services. These results are limited to beneficiaries who were eligible for and utilized NET services during the study period. In MY22, among beneficiaries that utilized NET services, the target group averaged 2.4 trips per beneficiary. This was significantly lower (P<0.0001) than the comparison group's average of 7.9 trips, representing a difference of -5.5 trips. In MY23, the target group's average increased to 4.8 trips but was still significantly lower (P<0.0001) than the comparison group's average of 9.9 trips, with a difference of -5.1 trips.

Table 43: Average number of NET services utilized per eligible beneficiary during the measurement year

2.D.14	MY22	MY23
Target Sample Size	253,981	90,006
Comparison Sample Size	70,839	27,917
Target Rate (95% C.I.)	0.0243 (0.0227 – 0.0261)	0.0482 (0.0441 – 0.0524)
Comparison Rate (95% C.I.)	0.0788 (0.0614 – 0.0969)	0.0992 (0.0739 – 0.1258)
Rate Difference (95% C.I.)	-0.0545 (-0.0722 – -0.0369)	-0.0511 (-0.0780 – -0.0258)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Poisson log	

Figure 29: Average number of NET services utilized per eligible beneficiary during the measurement year



Network Adequacy and Accessibility Among Primary Care and Specialty Providers (Metric 2.D.16, 2.D.17, 2.D.18, 2.D.19, 2.D.20)

Network adequacy was assessed by geospatial analysis to identify the proportion of Arkansas without a PCP within 30 miles or without one of six in-network specialists within 60 miles. The network adequacy distance standards are set by CMS for QHPs. There were essentially no areas in the state without a primary care provider within 30 miles and without a behavioral health (BH)/SUD provider, cardiologist, OB/GYN, oncologist, and pulmonologist, within 60 miles. Although there are very small portions of the state (2.5% or less) without an endocrinologist within 60 miles, any difference in coverage between the QHP and FFS networks are minimal. Overall, there are no meaningful differences in network adequacy between the target and comparison networks. Both networks met the network adequacy standards.

Table 44: Network Adequacy, Primary Care and Specialty Providers

2.D.16, 2.D.18	MY22	MY23
	% (Square Miles)	% (Square Miles)
2.D.16 Proportion of service area *without* primary care coverage within 30 miles		
Target	0	0
Comparison	0	0
2.D.18.i Proportion of service area *without* a BH/SUD provider within 60 miles		
Target	0	0
Comparison	0	0
2.D.18.ii Proportion of service area *without* a cardiologist within 60 miles		
Target	0	0
Comparison	0	0
2.D.18.iii Proportion of service area *without* an endocrinologist within 60 miles		
Target	20.3% (10,784.47)	25.8% (13,398.2)
Comparison	24.8% (13,156.69)	25.2% (13,339.87)
2.D.18.iv Proportion of service area *without* an OB/GYN within 60 miles		
Target	0	0
Comparison	0	0
2.D.18.v Proportion of service area *without* an oncologist within 60 miles		
Target	6% (3,197.67)	0
Comparison	0.7% (394.12)	0.6% (319.27)
2.D.18.vi Proportion of service area *without* a pulmonologist within 60 miles		
Target	3.4% (1,854.81)	4.3% (2,300.38)
Comparison	8.6% (4,557.55)	8.7% (4,586.5)

Network accessibility was evaluated using geospatial analysis to determine the proportion of target and comparison beneficiaries residing within 30 miles of a PCP or within 60 miles of one of six in-network specialists. The results showed no difference in the proportion of target and comparison beneficiaries within 30 miles of a PCP or within 60 miles of most specialists. Virtually all clients in both groups were within 30 miles of a PCP over the two-year period.

The only difference observed between target and comparison clients was in proximity to endocrinologists, with the difference being minimal. The proportion of comparison beneficiaries within 60 miles of an in-network endocrinologist was slightly higher than that of the target clients. Both target and comparison networks met the geographic access standards of AID.

Table 45: Network Accessibility, Primary Care and Specialty Providers

2.D.17, 2.D.19	MY22	MY23
	% (number of clients)	% (number of clients)
2.D.17 Proportion of beneficiaries within 30 miles of a primary care provider		
Target	99.5% (279,092)	99.9% (223,644)
Comparison	100% (78,774)	99.9% (56,525)
2.D.19.i Proportion of beneficiaries within 60 miles of a BH/SUD provider		
Target	99.9% (280,461)	99.9% (223,643)
Comparison	100% (78,774)	100% (56,525)
2.D.19.ii Proportion of beneficiaries within 60 miles of a cardiologist		
Target	99.9% (280,461)	99.9% (223,643)
Comparison	100% (78,774)	100% (56,525)
2.D.19.iii Proportion of beneficiaries within 60 miles of an endocrinologist		
Target	95.5% (267,226)	94.9% (212,452)
Comparison	97.6% (76,858)	97.6% (55,176)
2.D.19.iv Proportion of beneficiaries within 60 miles of an OB/GYN		
Target	99.9% (280,461)	99.9% (223,643)
Comparison	100% (78,775)	100% (56,526)
2.D.19.v Proportion of beneficiaries within 60 miles of an oncologist		
Target	98.4% (276,161)	99.9% (223,643)
Comparison	100% (78,774)	100% (56,526)
2.D.19.vi Proportion of beneficiaries within 60 miles of a pulmonologist		
Target	99.9% (280,461)	99.9% (230,637)
Comparison	99.8% (78,614)	100% (56,526)

QHP issuers submit completed ECP Network Adequacy Templates annually, indicating which ECPs they contract with by selecting from an approved list and by writing in any additional providers they contract with which they believe will qualify as ECPs. Given that EPCs may write in providers, and that the Total ECPs available are non-exhaustive, the proportions of ECPs each issuer contracted with must be considered estimates. If the issuer reported contracting with more ECPs than were available from the menu in the ECP template, then the estimated percentage of facility ECPs was 100%.

Table 46 provides the number of ECP the issuers reported in submission of the "ECP Network Adequacy Template." Individual ECPs include only Federally Qualified Health Centers and Rural Health Centers. Facility ECPs include all six allowable categories of ECPs as defined by CMS (Refer to **Section 4.6.6**) All issuers greatly exceeded the minimum threshold set forth by CMS for ECP network adequacy.

Table 46: ECP network adequacy

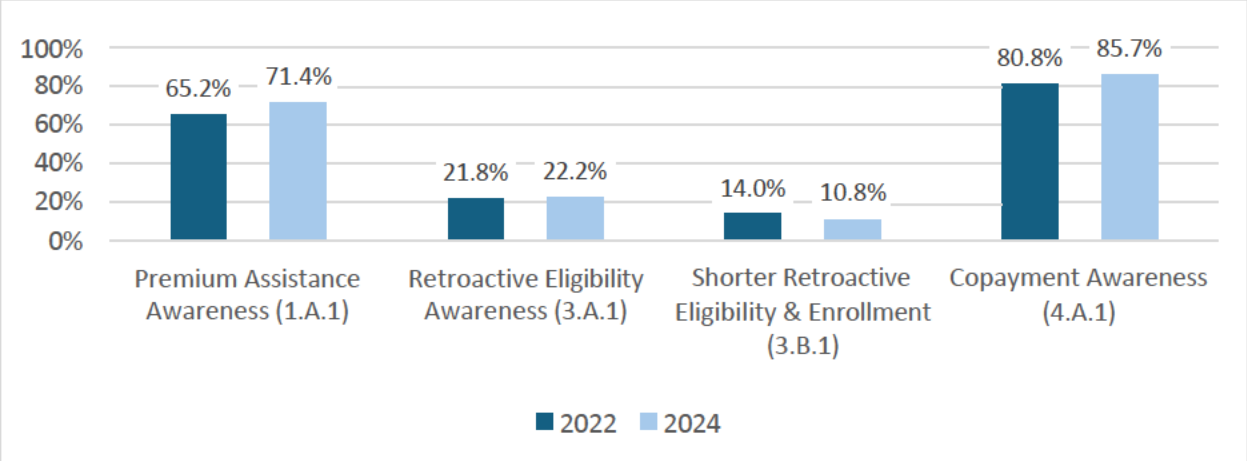
2.D.20	MY22 Estimated % of ECPs Raw N contracted (number Facility, number Individual)	MY23 Estimated % of Facility ECPs Raw N contracted number
Total ECPs Available[1]	225	199
Blue Cross Blue Shield	92% 208 (175 Fac, 33 Ind)	100% 208 Fac
Centene (Ambetter)	100% 229 (188 Fac, 41 Ind)	100% 259 Fac

6.1.3 ENROLLMENT, BENEFITS, AND COVERAGE RESULTS

Coverage and Benefits Awareness (Metric 1.A.1, 1.B.1, 1.B.2, 2.D.15, 3.A.1, 3.B.1, 4.A.1, 4.A.2)

ARHOME beneficiary awareness of premium assistance, retroactive eligibility, and copayment responsibilities were captured with supplemental questions in the 2022 and 2024 BESS surveys. While the knowledge of retroactive eligibility (21.8% to 22.2%) was lower than that of premium assistance (65.2% to 71.4%)and copayment awareness (80.8% to 85.7%) in both the 2022 and 2024 surveys, there was a slight increase in awareness over the years for all three aspects of coverage.

Figure 30: Retroactive eligibility, copayment, and premium assistance awareness by survey year

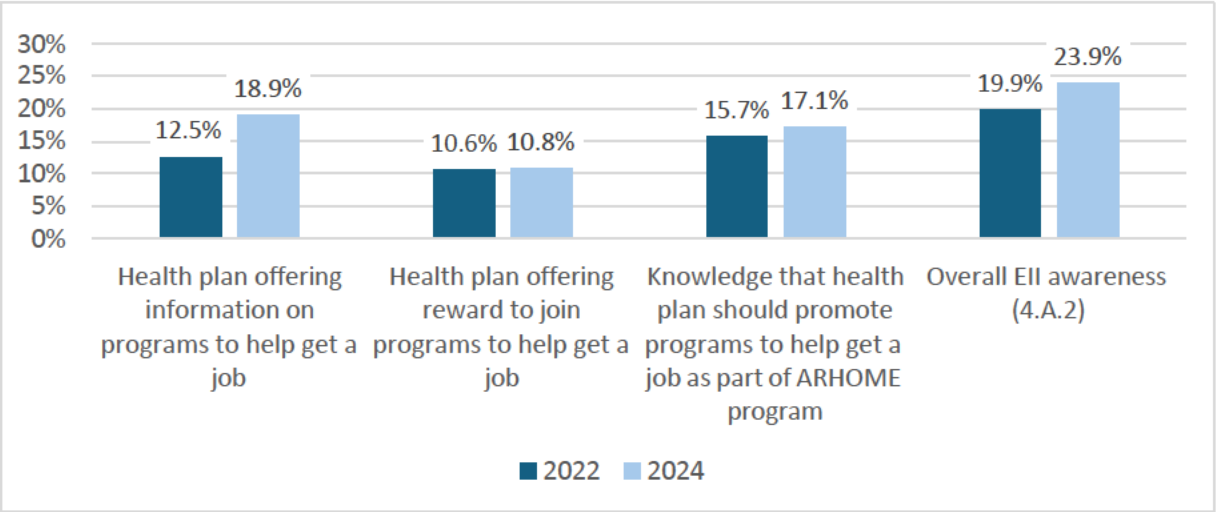


Additionally, only 10.8% of beneficiaries in MY24 responded that knowledge of the shorter retroactive eligibility period would keep them from enrolling in ARHOME. Differences in beneficiary awareness of premium assistance, retroactive eligibility, copayment responsibilities, and premium requirements were not significantly different by year (**Figure 30**).

An additional benefit of enrollment in the ARHOME program is access to incentives like the EII, which aims to promote economic success through job resources. There were a few questions in the 2022 and 2024 BESS survey that were averaged to understand overall awareness of this initiative and of opportunities offered. The overall awareness of EII was 19.9% (N=201) in 2022

and increased to 23.9% (N=578) in 2024, which was not a significant increase between the two years (**Figure 31**).

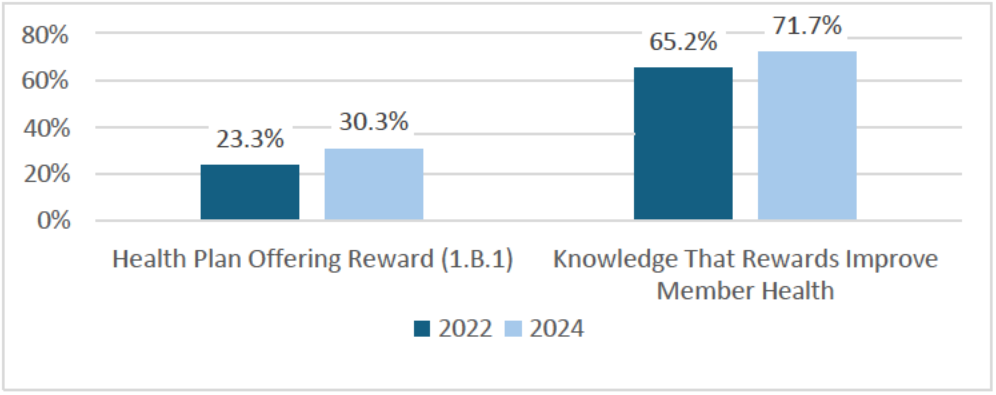
Figure 31: Beneficiary EII awareness



Two questions related to beneficiary HII awareness (1.B.1) were included in the 2022 and 2024 BESS surveys for the target group only (**Figure 32**). In MY22, favorable response rates were higher on the knowledge that the rewards improve member health (65.2%; N=46), but lower for knowing that the health plan offered a monetary reward (23.3%; N=202). Awareness of both HII incentives (30.3%; N=571) and associated monetary rewards (71.7%; N=173) did increase in MY24, but the increases were not significant between the two years.

Consistent with beneficiary responses, 2023 Provider Focus Group (PFG) results interviewing AMS and AAFP providers showed that less than one-half of provider participants were aware of the HII incentive (1.B.2), demonstrating the need to increase efforts to make providers aware of this incentive.

Figure 32: Beneficiary HII awareness



In the 2022 and 2024 BESS surveys, the percentage of target and comparison group beneficiaries aware of NET benefits increased, indicating growing awareness. However, in 2024, only 50% of beneficiaries in the comparison group were aware of these transportation benefits,

compared to just 33.4% of target group beneficiaries. Regression analysis of the 2024 BESS survey further indicated that the target group was significantly less likely to be aware of NET services than the comparison group (P<0.0225). The higher awareness among the comparison group may be attributed to their greater need for transportation services (55.6%) in 2024, compared to only 18.3% of target group beneficiaries.

Table 47: Beneficiary awareness of NET

	MY22	MY24
2.D.15 Beneficiary awareness of NET		
Target Percentage	28.5% (N=200)	33.4% (N=578)
Comparison Percentage	37.4% (N=235)	50.0% (N=36)
OR (95% C.I.)	NA	0.4022 (0.1841 – 0.8788)
P-value	NA	0.0225
Beneficiary trouble getting to doctor visits due to ride unavailability		
Target Percentage	20.1% (N=199)	18.3% (N=191)
Comparison Percentage	27.2% (N=235)	55.6% (N=18)
OR (95% C.I.)	NA	0.2076 (0.0654 – 0.6586)
P-value	NA	0.0077

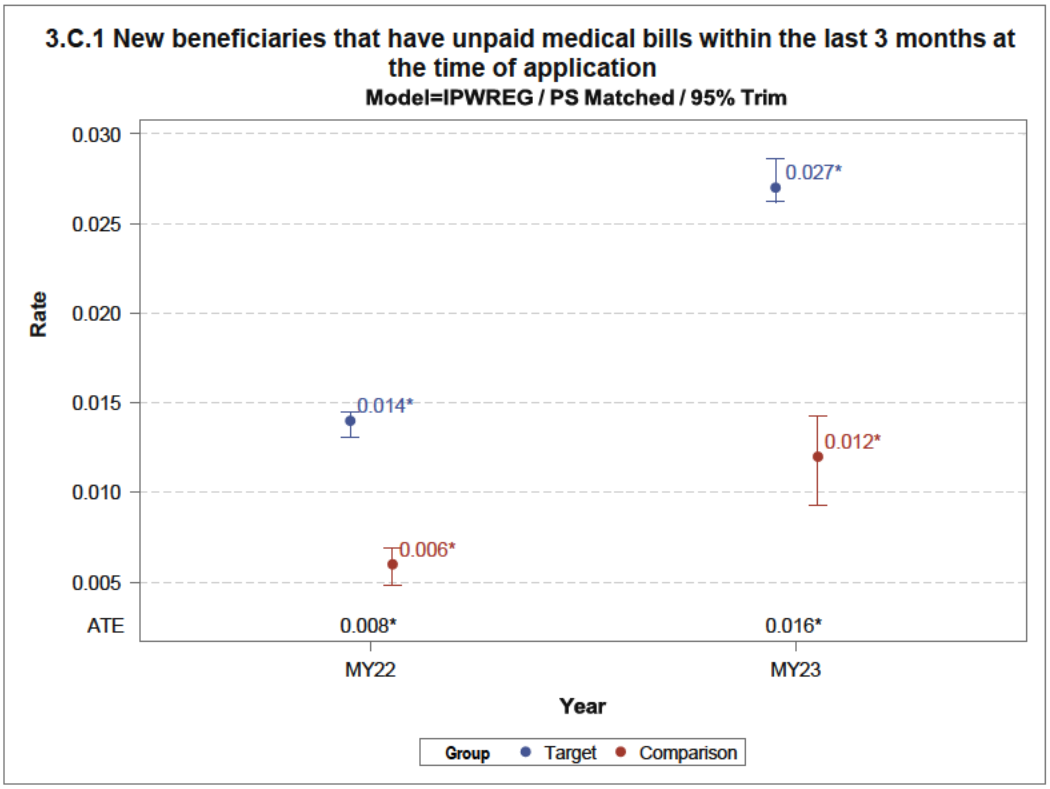
New Beneficiary Medical Debt (3.C.1)

In MY22, 1.4% of new target group enrollees reported having unpaid medical bills within the last three months at the time of application. This was significantly higher (P<0.0001) than the comparison group's percentage of 0.6%, with a rate difference of 0.8 percentage points. In MY23, 2.7% of new ARHOME enrollees had unpaid medical bills, again significantly higher (P<0.0001) than the comparison group's 1.1%, with a rate difference of 1.6 percentage points. Additionally, in MY23, new enrollees to ARHOME and Medicaid FFS had more medical debt compared to MY22.

Table 48: Percentage of new enrollees that have unpaid medical bills within 3 months prior to the ARHOME application

3.C.1	MY22	MY23
Target Sample Size	262,653	129,905
Comparison Sample Size	75,166	49,386
Target Rate (95% C.I.)	0.014 (0.013 – 0.015)	0.027 (0.026 – 0.029)
Comparison Rate (95% C.I.)	0.006 (0.005 – 0.007)	0.012 (0.009 – 0.014)
Rate Difference (95% C.I.)	0.008 (0.007 – 0.009)	0.016 (0.013 – 0.018)
***P* Value**	<0.0001	<0.0001
Propensity scores trimmed at the:	**5th–95th percentiles**	
Regression Model:	**IPWREG: Binary logit**	

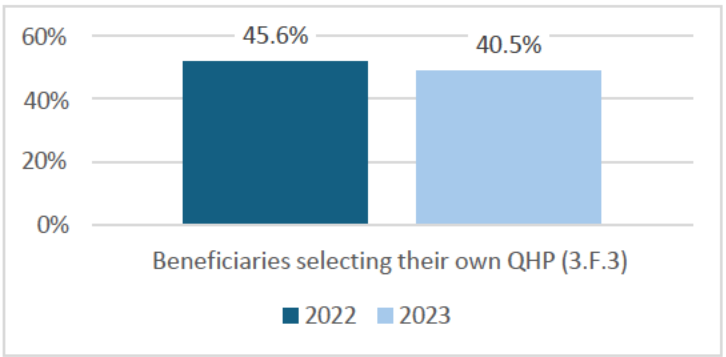
Figure 33: Percentage of new enrollees that have unpaid medical bills within 3 months prior to the ARHOME application



Beneficiaries Selecting their Own QHP (3.F.3)

Once enrolled in ARHOME, new enrollees have the option to select their own QHP or be automatically assigned one. New enrollees were defined as those with no prior non-ARHOME Medicaid eligibility during the year and no Medicaid segments in the 3 months prior to their start date in ARHOME. In MY22, 45.6% (N=17,871) of ARHOME enrollees selected their own QHP. The rate significantly decreased to 40.5% (N=19,539) of new enrollees in MY23, with a difference of -5.1 percentage points and a percent difference of 11.18% (=[45.6-40.5]/45.6) (t-test; P<0.0001). The decrease in this rate between MY22 and MY23 is probably due to the complicating effects of the PHE unwinding in April 2023, adding confusion and more required paperwork for manual enrollment.

Figure 34: Percentage of new enrollees selecting their own QHP



Enrollment Characteristics for beneficiaries at 101-138% FPL (Metric 3.D.1, 3.D.2, 3.E.1, 3.E.2, 3.F.2, 3.G.1, 3.G.2, 3.H.1, 3.H.2)

The analysis for the MY22 period categorizes the eligible ARHOME population into two groups: 1) beneficiaries with incomes between 101-138% FPL, and 2) those with incomes below 100% FPL. The goal is to identify any differences in enrollment, retention rates, and coverage gaps, given that beneficiaries with incomes between 101-138% FPL were required to pay monthly premiums during MY22. During this period, 40.0% of beneficiaries at 101-138% FPL paid a monthly premium (3.F.2).

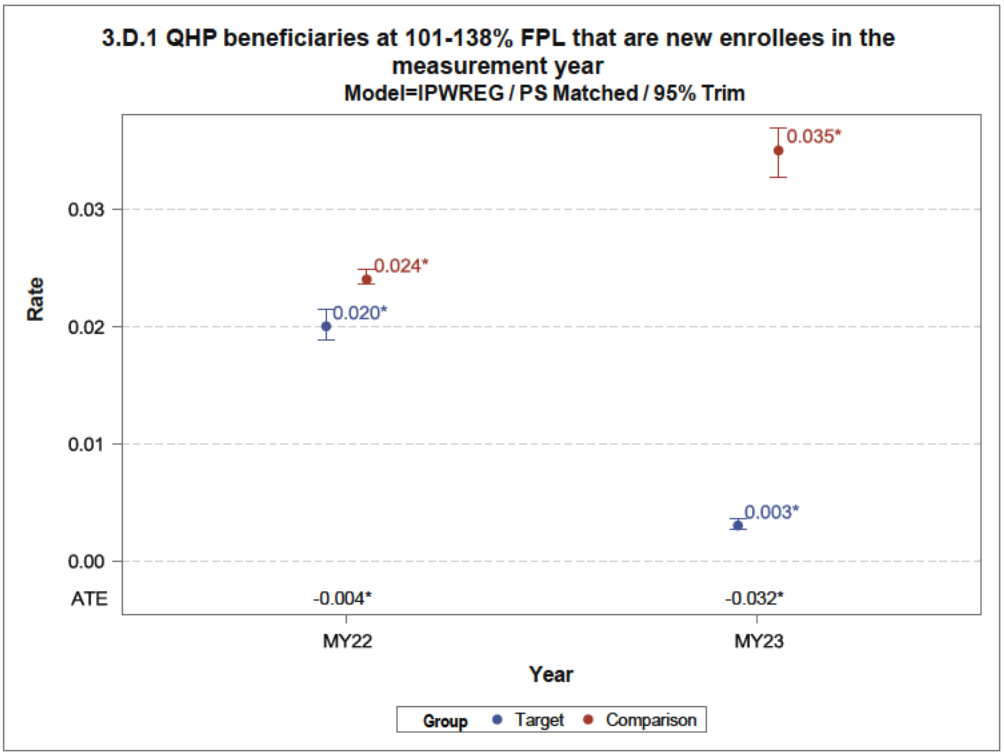
Metrics in this section are distinguished by two metric identifiers. The first identifier analyzes FPL stratifications within MY22 (i.e. 3.D.1), while the second identifier (i.e. 3.G.1) compares beneficiaries at 101-138% FPL in MY22 with those in subsequent years. Although the total number of beneficiaries in the MY22 target population will be consistent with the comparison population in MY23, the reported percentages may vary slightly due to propensity score matching conducted each year.

In MY22, 2.0% of new enrollees were between 101% and 138% FPL (target) at enrollment. This percentage was significantly lower (P<0.0001) than that of new enrollees below 100% FPL (comparison: 2.4%), despite a difference of only -0.4 percentage points. In MY23, the percentage of new enrollees between 101% and 138% FPL (target) was 0.3%, again significantly lower (P<0.0001) than the corresponding percentage in MY22 (comparison: 3.5%), with a rate difference of -3.2 percentage points. This decrease in enrollment among beneficiaries between 101-138% FPL in 2023 was likely influenced by the COVID-19 PHE unwinding efforts.

Table 49: Percentage of QHP beneficiaries at 101-138% FPL that were new enrollees during the measurement year

3.D.1/3.G.1	MY22	MY23
Target Sample Size	60,142	44,535
Comparison Sample Size	210,259	60,142
Target Rate (95% C.I.)	0.020 (0.019 – 0.021)	0.003 (0.003 – 0.004)
Comparison Rate (95% C.I.)	0.024 (0.024 – 0.025)	0.035 (0.033 – 0.037)
Rate Difference (95% C.I.)	-0.004 (-0.006 – -0.003)	-0.032 (-0.033 – -0.030)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 35: Percentage of QHP beneficiaries at 101-138% FPL that were new enrollees during the measurement year

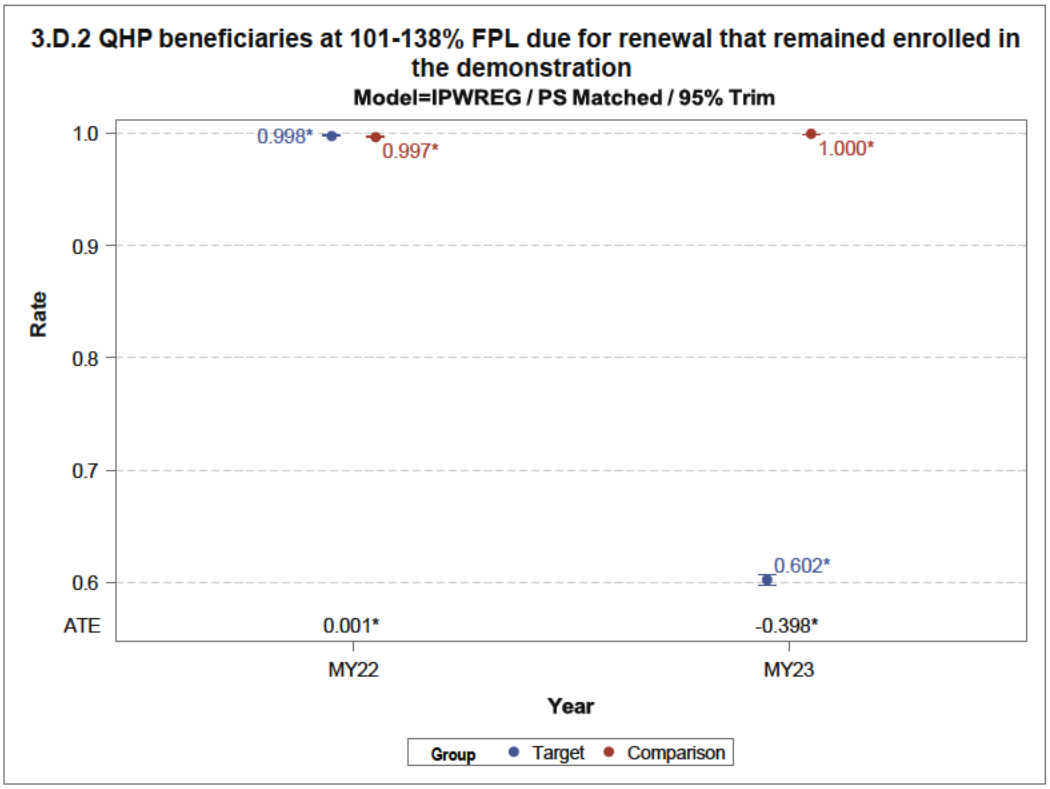


When looking at the retention rate for MY22 and, in comparison with MY23, we see similar trends to enrollment. In MY22, the target group rate of 99.85% was significantly higher (P<0.0001) than the comparison group (99.73%), with a rate difference of 0.12 percentage points. In MY23, the target group rate of 60.2% was significantly lower (P<0.0001) than the comparison group (100.0%), with a rate difference of -39.8 percentage points. Due to the COVID-19 PHE, nearly all beneficiaries between 101-138% FPL were retained in MY22 as expected. This rate was almost 40 percentage points lower in MY23 due to the end of the COVID-19 PHE Medicaid provisions.

Table 50: Percentage of QHP beneficiaries at 101-138% FPL due for renewal that remained enrolled in the demonstration during the measurement year

3.D.2/3.G.2	MY22	MY23
Target Sample Size	48,275	39,115
Comparison Sample Size	162,943	48,275
Target Rate (95% C.I.)	0.999 (0.998 – 0.999)	0.602 (0.597 – 0.607)
Comparison Rate (95% C.I.)	0.997 (0.997 – 0.998)	1.000 (0.999 – 1.000)
Rate Difference (95% C.I.)	0.001 (0.001 – 0.002)	-0.398 (-0.403 – -0.393)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 36: Percentage of QHP beneficiaries at 101-138% FPL due for renewal that remained enrolled in the demonstration during the measurement year

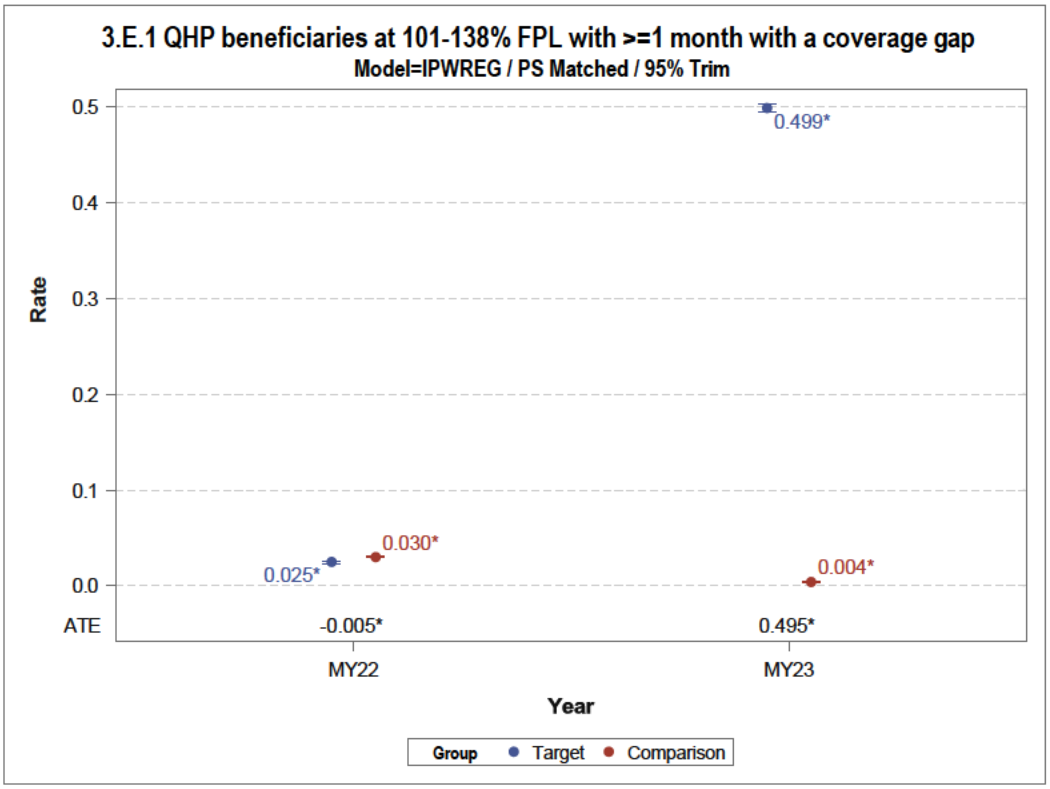


Additionally, the rate of target group beneficiaries at 101-138% FPL with ≥1 month coverage gap in MY22 was 2.5%, which was significantly lower (P<0.0001) than the comparison group (3.0%), with a difference of -0.5 percentage points. In MY23, beneficiaries at 101-138% FPL had a much higher percentage of coverage gaps at 49.9%. This was significantly higher (P<0.0001) than beneficiaries at 101-138% FPL in MY22 (0.4%), with a difference of 49.5 percentage points. An almost 50 percentage point jump in ≥1 month coverage gaps is likely due to the end of the COVID-19 PHE unwinding and is not unexpected.

Table 51: Percentage of QHP beneficiaries at 101-138% FPL with ≥1 month with a coverage gap

3.E.1/3.H.1	MY22	MY23
Target Sample Size	60,142	44,535
Comparison Sample Size	210,259	60,142
Target Rate (95% C.I.)	0.025 (0.023 – 0.026)	0.499 (0.494 – 0.504)
Comparison Rate (95% C.I.)	0.030 (0.030 – 0.031)	0.004 (0.004 – 0.005)
Rate Difference (95% C.I.)	-0.005 (-0.007 – -0.004)	0.495 (0.490 – 0.500)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 37: Percentage of QHP beneficiaries at 101-138% FPL with ≥1 month with a coverage gap

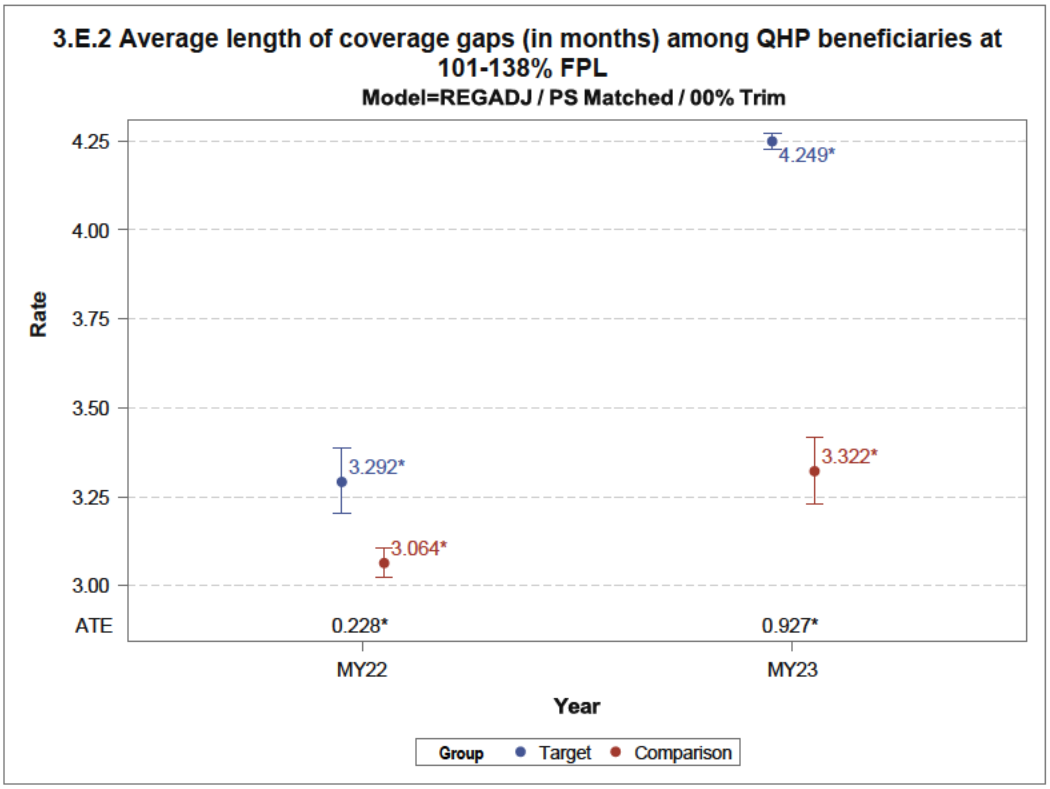


Of those with a coverage gap in MY22, the average length of a gap among target group beneficiaries at 101-138% FPL was 3.29 months and was significantly higher (P<0.0001) than the comparison group beneficiaries at <100% FPL (3.06 months), with a rate difference of 0.23 months. In MY23, the target group rate was 4.25 months, which was significantly higher (P<0.0001) than the comparison group (3.32 months), with a rate difference of 0.93 months.

Table 52: Average length of gaps among QHP beneficiaries at 101-138% FPL with ≥1 month with a coverage gap

3.E.2/3.H.2	MY22	MY23
Target Sample Size	1,419	22,199
Comparison Sample Size	6,477	1,419
Target Rate (95% C.I.)	3.292 (3.204 – 3.386)	4.249 (4.227 – 4.270)
Comparison Rate (95% C.I.)	3.064 (3.024 – 3.106)	3.323 (3.229 – 3.417)
Rate Difference (95% C.I.)	0.228 (0.134 – 0.338)	0.927 (0.830 – 1.023)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	N/A	
Regression Model:	REGADJ: Normal identity	

Figure 38: Average length of gaps among QHP beneficiaries at 101-138% FPL with ≥1 month with a coverage gap



The ACS was further leveraged to explore the impact of monthly premiums on health insurance status among adults in Arkansas aged 19-64 with incomes between 101-138% FPL relative to non-expansion comparison states (Alabama, Mississippi, and South Carolina). The parallel pre-trends assumption was met with no significant differences between groups for the 2017-2021 baseline period. **Table 53** displays ITS/DiD estimates for the changes in the proportion of people covered over time. In Arkansas, there were no significant changes in coverage rates during the year when monthly premiums were in effect, or when they were withdrawn in 2023. There were significant increases in coverage rates in the comparison states in 2022 and 2023 relative to the baseline period.

Table 53: Health Insurance Status of Adults Aged 19-64 at 101-138% FPL

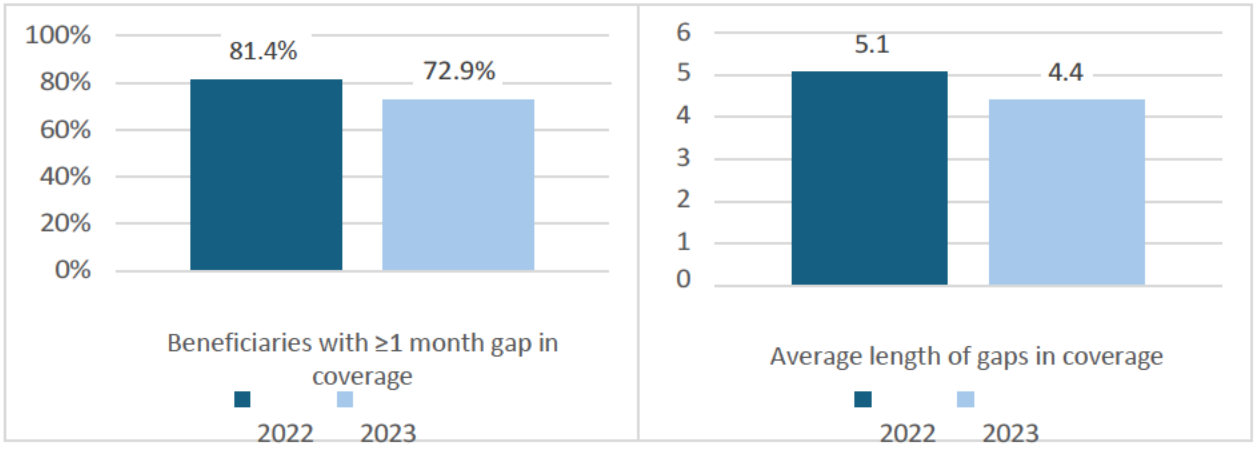
	Time Period[1]			Estimated Differences[2]		
3.F.1	Baseline 2017-2021[1]	Demonstration Period[2] 2022	Post Demonstration[3] 2023	Early Demonstration – Baseline	Post Demonstration – Baseline	Post Demonstration – Early Demonstration
Arkansas (n=6,669)	0.795	0.792	0.751	0.004 P=0.8475	-0.033 P=0.0682	-0.037 P=0.1347
Comparison[4] (n=24,931)	0.706	0.747	0.745	0.036 P=0.0007	0.031 P=0.0049	-0.006 P=0.6921
Estimated Differences in Differences: AR – CS =				-0.030 P=0.2494	-0.067 P=0.0040	-0.037 P=0.2372

[1]The year 2020 is excluded from the baseline period; the American Community Survey excludes 2020 due to the Census.
[2]The Demonstration Period is the year 2022, the year during which Arkansas had authority to charge monthly premiums for beneficiaries with incomes between 101-138% FPL
[3]The year after the premium authority ended, 2023, is considered post-demonstration for this analysis.
[4]Comparison states: Alabama, Mississippi, and South Carolina

Coverage Gaps for Disenrolled Beneficiaries Due to High Income (Metric 3.I.1, 3.I.2)

Focusing on ARHOME beneficiaries in MY22 and MY23 who were at 101-138% FPL and disenrolled due to high income, there was a higher percentage of beneficiaries in MY22 who had ≥1 month in coverage gaps (81.4%) and a higher average length of the coverage gaps (5.1 months) than beneficiaries in MY23 (72.9% and 4.4 months, respectively). The total number of beneficiaries with one or more gaps in coverage was dramatically higher for MY22 (N=10,731) than for MY23 (N=43). Due to the COVID-19 PHE unwinding in April 2023, there were virtually no disenrollments in MY22. Because of this dramatic difference in sample sizes between the two years as a result of the PHE unwinding, it is difficult to compare gap characteristics by measurement year.

Figure 39: Beneficiaries at 101-138% FPL who disenroll due to high income and coverage gap characteristics

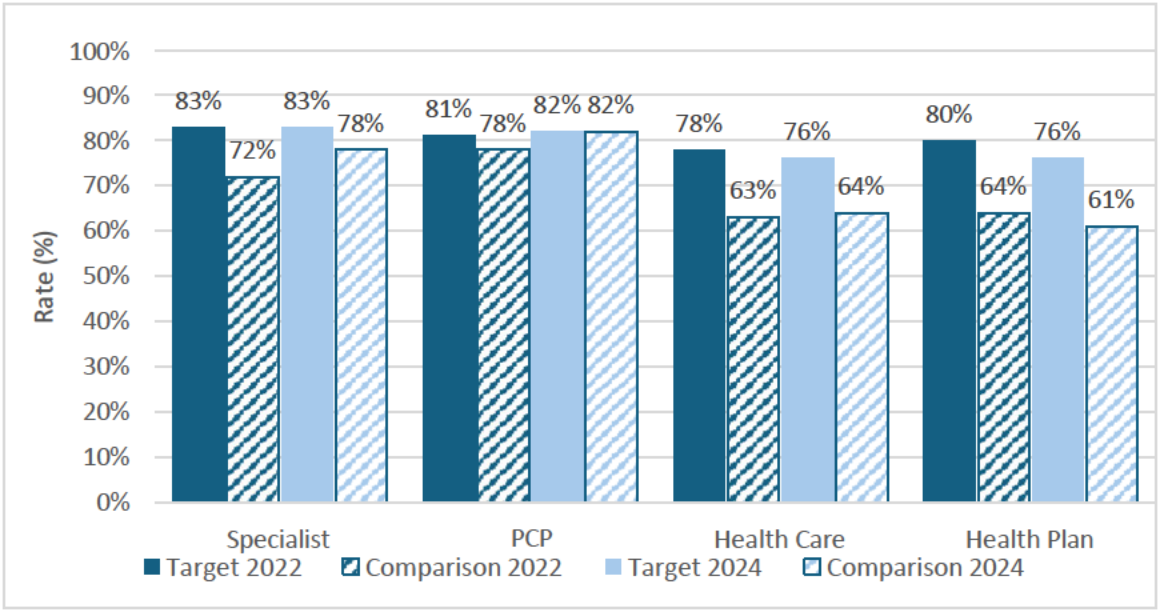


6.1.4 QUALITY OF CARE AND UTILIZATION RESULTS

Average Ratings (Metric 4.B.1, 4.B.2, 4.B.3, 4.B.4)

The following results of the 2022 and 2024 BESS survey describe favorable ratings (8-10) of different aspects of medical care. Average ratings were significantly higher for the target group than the comparison group for health plan (P=0.0010), health care (P=0.0030) in the 2022 survey. Results from the 2024 BESS survey also indicate significantly higher favorable responses among the target group than comparison group for health plan (P<0.0001), health care (P=0.0014). For both years, PCP and specialist care were not significantly different between the two groups and were similarly high for PCP (77.8%-82.4%) and specialist ratings (71.6%-82.6%).

Figure 40: Favorable ratings of medical care



Emergency Department Utilization (Metric 4.C.1, 4.C.2, 4.C.3)

In MY22, the percentage of ED visits classified as preventable by the New York University (NYU) ED Algorithm among the target group was 8.9%, which was insignificantly higher (P=0.6370) than the comparison group (8.8%). In MY23, the target group rate of 9.88% was insignificantly lower (P=0.9802) than the comparison group (9.89%).

In MY22, the percentage of ED visits classified as non-emergent by the NYU ED algorithm among the target group was 29.1% and was significantly lower (P=0.0147) than the comparison group (30.6%), with a rate difference of -1.5 percentage points. In MY23, the target group rate remained steady at 29.4% and was insignificantly lower (P=0.2260) than the comparison group (30.4%).

In MY22, the percentage of ED visits classified as emergent by the NYU ED algorithm among the target group was 70.9%, which was significantly higher (P=0.0147) than the comparison group (69.4%), with a rate difference of 1.5 percentage points. However, in MY23, the target group rate of 70.6% was insignificantly higher (P=0.2260) than the comparison group (69.6%).

Table 54: Percentage of ED visits classified as preventable by the NYU ED algorithm during the measurement year

4.C.1, 4.C.2, 4.C.3	MY22	MY23
Target Sample Size	51,813	24,246
Comparison Sample Size	18,420	10,143
4.C.1 Preventable ED visits		
Target Rate (95% C.I.)	0.0891 (0.0876 – 0.0908)	0.0988 (0.0959 – 0.1016)
Comparison Rate (95% C.I.)	0.0877 (0.0821 – 0.0936)	0.0989 (0.0897 – 0.1080)
Rate Difference (95% C.I.)	0.0015 (-0.0045 – 0.0074)	-0.0001 (-0.0096 – 0.0096)
P Value	0.6370	0.9802
4.C.2 Non-emergent ED visits		
Target Rate (95% C.I.)	0.291 (0.288 – 0.294)	0.294 (0.289 – 0.298)
Comparison Rate (95% C.I.)	0.306 (0.295 – 0.318)	0.304 (0.288 – 0.320)
Rate Difference (95% C.I.)	-0.015 (-0.027 – -0.003)	-0.010 (-0.027 – 0.006)
P Value	0.0147	0.2260
4.C.3 Emergent ED visits*		
Target Rate (95% C.I.)	0.709 (0.706 – 0.712)	0.706 (0.702 – 0.711)
Comparison Rate (95% C.I.)	0.694 (0.682 – 0.706)	0.696 (0.680 – 0.712)
Rate Difference (95% C.I.)	0.015 (0.003 – 0.027)	0.010 (-0.006 – 0.027)
P Value	0.0147	0.2260
Propensity scores trimmed at the:	**5th–95th percentiles**	
Regression Model:	**IPWREG: Normal identity**	

* Regression model: IPWREG: normal identity

Figure 41: Non-Emergent ED Visits as a percentage of all classified ED visits using the NYU ED algorithm

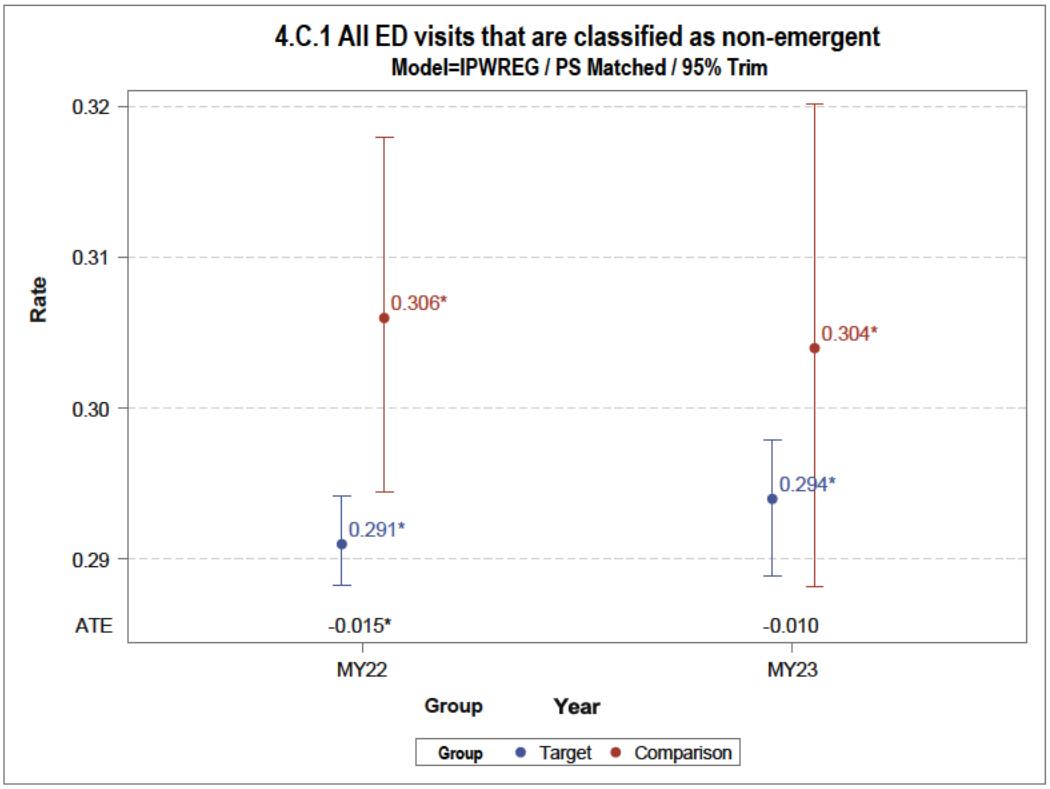


Figure 42: Emergent ED visits as a percentage of all classified ED visits using the NYU ED algorithm

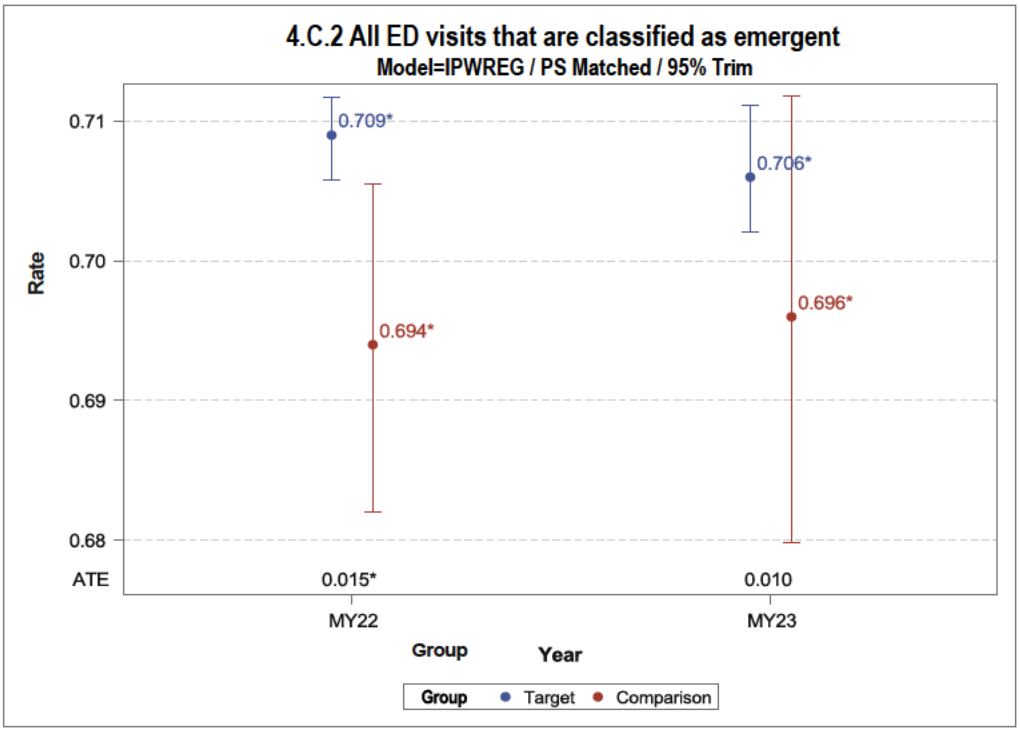
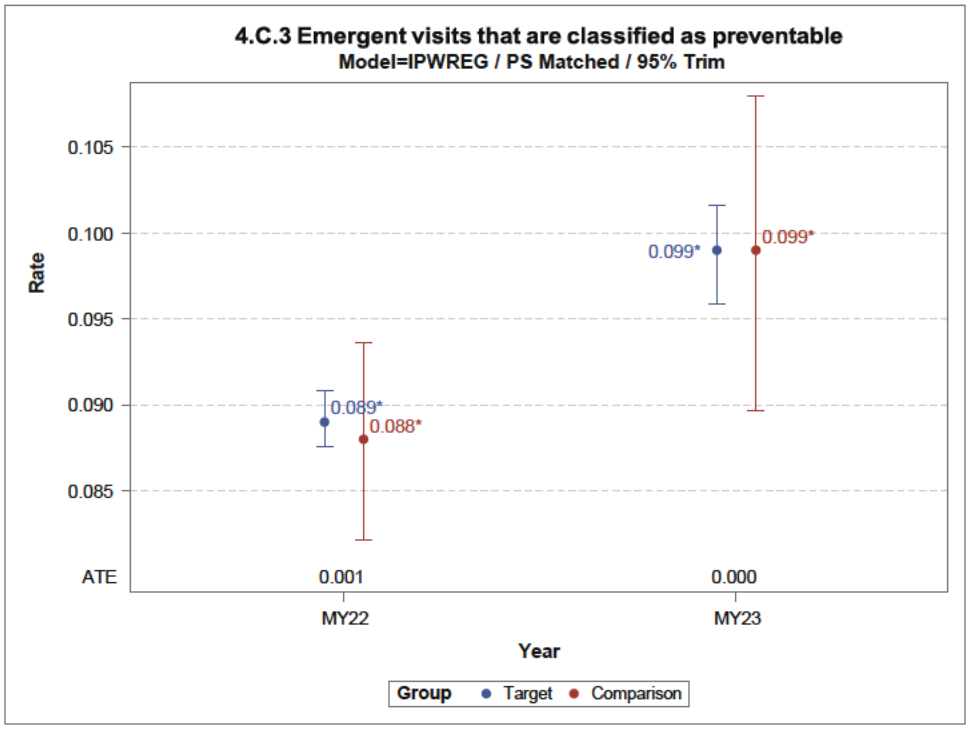


Figure 43: Percentage of ED visits classified as preventable by the NYU ED algorithm during the measurement year



All-Cause Readmission (Metric 4.C.4)

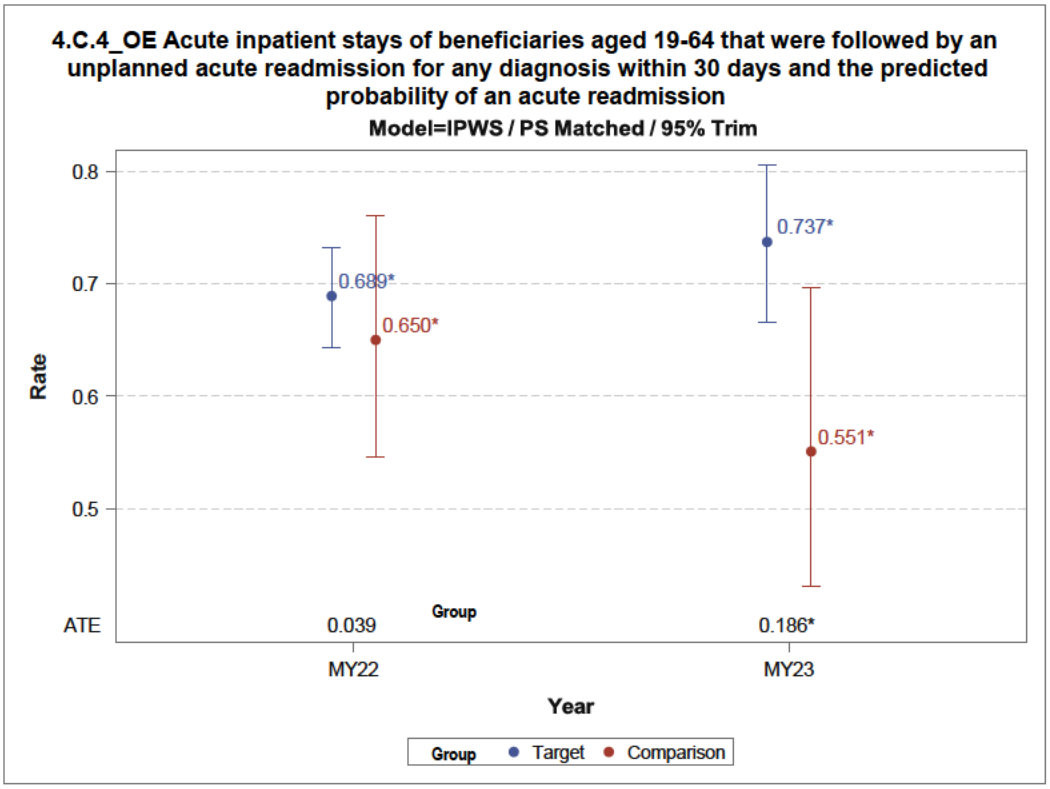
This metric is risk adjusted and reported as a ratio of observed-to-expected (O/E) hospital readmissions. The eligible population consisted of beneficiaries aged 19-64 with acute inpatient

stays during the measurement year that were followed by an unplanned acute readmission within 30 days. In MY22, the target group ratio of 68.9% was insignificantly higher (P=0.5142) than the comparison group ratio of 65.0%, with a ratio difference of 3.9 percentage points. In MY23, the target group ratio of 73.7% was significantly higher (P=0.0129) than the comparison group ratio of 55.1%, with a ratio difference of 18.6 percentage points.

Table 55: Percentage of acute inpatient stays of beneficiaries aged 19-64 during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days

4.C.4	MY22	MY23
Target Sample Size	10,687	5,338
Comparison Sample Size	3,923	2,009
Target Rate (95% C.I.)	0.689 (0.643 – 0.732)	0.737 (0.666 – 0.806)
Comparison Rate (95% C.I.)	0.650 (0.546 – 0.760)	0.551 (0.432 – 0.696)
Rate Difference (95% C.I.)	0.039 (-0.072 – 0.159)	0.186 (0.025 – 0.333)
P Value	0.5142	0.0129
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 44: Percentage of acute inpatient stays of beneficiaries aged 19-64 during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days



Diabetes Short-Term Complications (Metric 4.C.5)

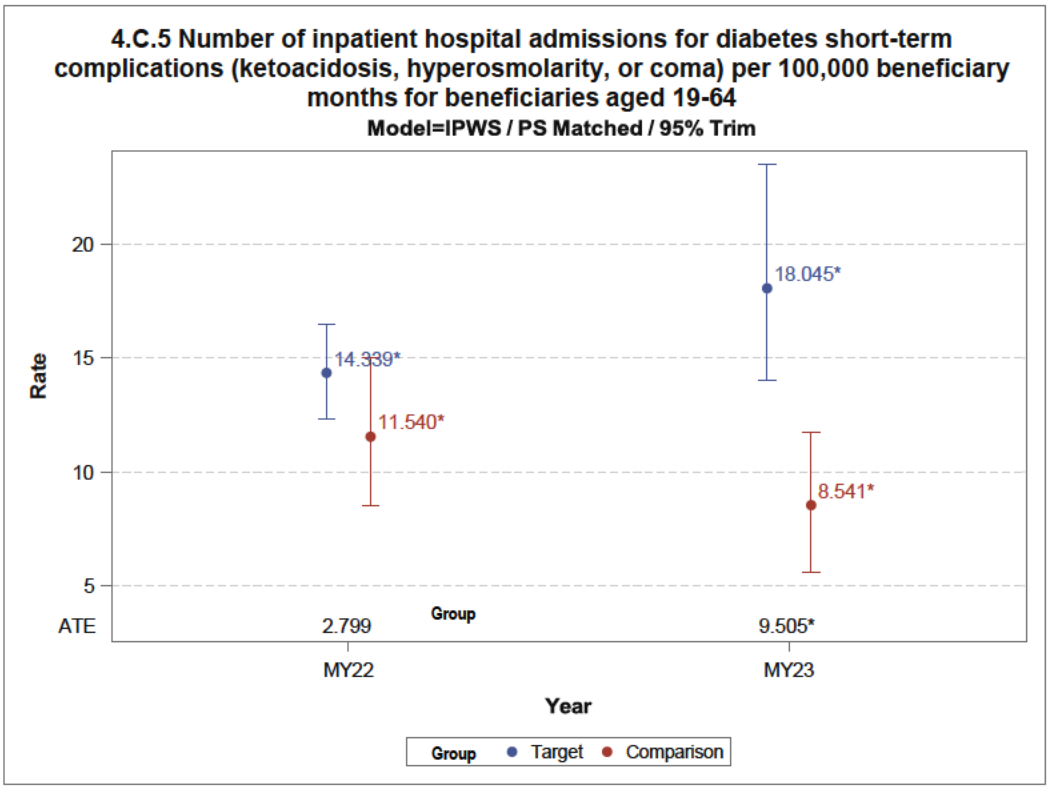
The eligible population includes beneficiaries aged 19-64 with inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma). In MY22, the number of admissions per 100,000 beneficiary months in the target group was 14.34 and was

insignificantly higher (P=0.1547) than the comparison group (11.54). However, in MY23, the target group rate of 18.05 inpatient hospital admissions was significantly higher (P=0.0010) than the comparison group (8.54), with a rate difference of 9.51.

Table 56: Number of inpatient hospital admissions for diabetes short-term complications per 100,000 beneficiary months for beneficiaries aged 19-64

4.C.5	MY22	MY23
Target Sample Size	262,589	129,899
Comparison Sample Size	75,334	49,611
Target Rate (95% C.I.)	14.339 (12.316 – 16.441)	18.045 (14.034 – 23.479)
Comparison Rate (95% C.I.)	11.540 (8.502 – 15.034)	8.541 (5.593 – 11.730)
Rate Difference (95% C.I.)	2.799 (-1.2912 – 6.390)	9.505 (4.452 – 15.790)
P Value	0.1547	0.0010
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 45: Number of inpatient hospital admissions for diabetes short-term complications per 100,000 beneficiary months for beneficiaries aged 19-64 during the measurement year



Hospital Admission Rates (Metric 4.C.6, 4.C.7, 4.C.8)

The eligible population includes beneficiaries aged 40+ with inpatient hospital admissions for asthma or chronic obstructive pulmonary disease (COPD). In MY22, the number of admissions per 100,000 beneficiary months in the target group was 6.35 inpatient hospital admissions and was insignificantly higher (P=0.8329) than the comparison group (5.88). In MY23, the target

group rate of 5.75 inpatient hospital admissions was insignificantly higher (P=0.3280) than the comparison group (3.78).

Table 57: Number of inpatient hospital admissions for COPD or asthma per 100,000 beneficiary months for beneficiaries aged 40 and older during the measurement year

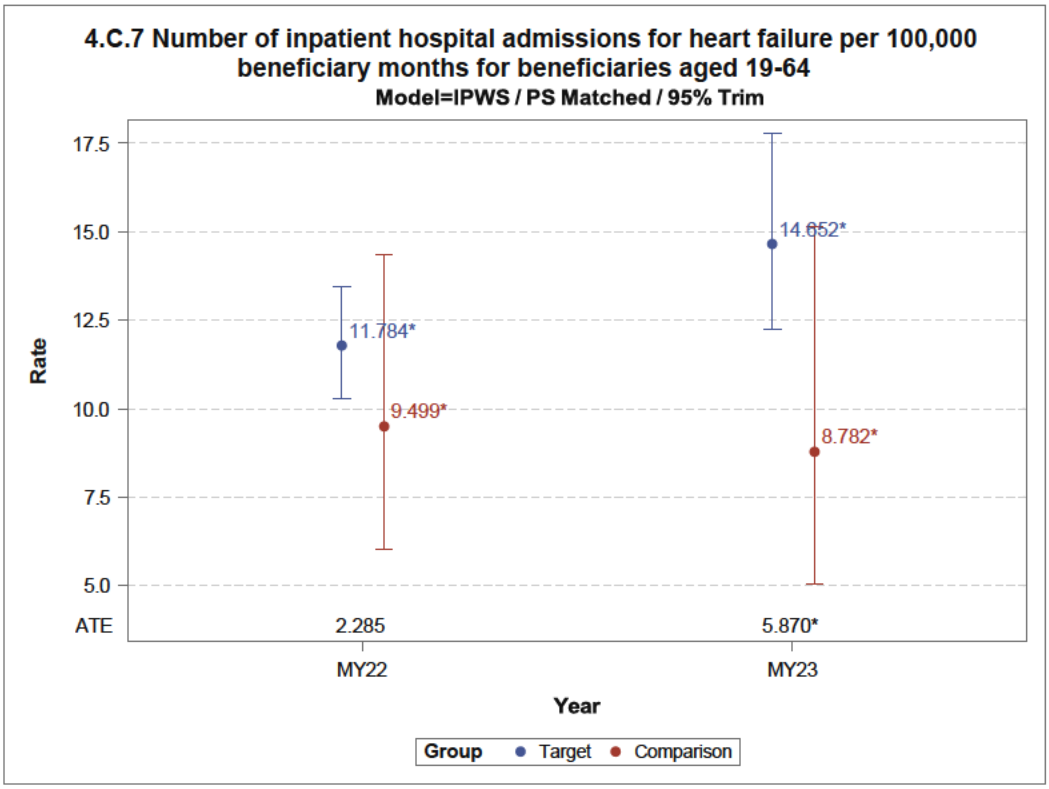
4.C.6	MY22	MY23
Target Sample Size	82,976	43,941
Comparison Sample Size	16,796	12,012
Target Rate (95% C.I.)	6.347 (4.874 – 8.201)	5.746 (3.690 – 8.048)
Comparison Rate (95% C.I.)	5.877 (2.441 – 10.826)	3.773 (1.137 – 7.468)
Rate Difference (95% C.I.)	0.470 (-5.053 – 4.233)	1.973 (-2.287 – 5.323)
P Value	0.8329	0.3280
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Among beneficiaries aged 19-64 in MY22, the target group rate of 11.78 inpatient hospital admissions for heart failure per 100,000 beneficiary-months was insignificantly higher (P=0.2826) than the comparison group (9.50). In MY23, the target group rate of 14.65 inpatient hospital admissions was significantly higher (P=0.0462) than the comparison group (8.78), with a rate difference of 5.87.

Table 58: Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries aged 19-64 during the measurement year

4.C.7	MY22	MY23
Target Sample Size	262,589	129,899
Comparison Sample Size	75,334	49,611
Target Rate (95% C.I.)	11.784 (10.295 – 13.442)	14.652 (12.242 – 17.768)
Comparison Rate (95% C.I.)	9.499 (6.025 – 14.347)	8.782 (5.061 – 15.133)
Rate Difference (95% C.I.)	2.285 (-2.905 – 5.941)	5.870 (-0.170 – 10.995)
P Value	0.2826	0.0462
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 46: Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries aged 19-64 during the measurement year



Among young adults aged 19-39 in MY22, the target group rate of 1.61 inpatient hospital admissions for asthma per 100,000 beneficiary-months was insignificantly lower (P=0.1242) than the comparison group (2.93). In MY23, the target group rate of 1.31 inpatient hospital admissions was also insignificantly lower (P=0.1470) than the comparison group (2.68).

Table 59: Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 19-39 during the measurement year

4.C.8	MY22	MY23
Target Sample Size	156,268	80,683
Comparison Sample Size	59,845	38,611
Target Rate (95% C.I.)	1.607 (0.945 – 2.450)	1.311 (0.630 – 2.277)
Comparison Rate (95% C.I.)	2.932 (1.557 – 4.582)	2.684 (1.216 – 4.799)
Rate Difference (95% C.I.)	-1.325 (-3.165 – 0.335)	-1.373 (-3.455 – 0.282)
P Value	0.1242	0.1470
Propensity scores trimmed at the:	N/A	
Regression Model:	REGADJ: Normal identity	

Follow-Up Rate after Hospitalization or ED Visit (Metric 4.C.9, 4.C.10, 4.D.3, 4.D.9, 4.D.10)

When looking at follow-up with a PCP after hospitalization in MY22, the target group also had a significantly higher rate (P>0.0001) of beneficiaries (14.6%) with a PCP follow-up than the comparison group (10.5%), with a difference of 4.1 percentage points. However, in MY23, the

target group rate of 15.9% was insignificantly higher (P=0.2773) than the comparison group (14.1%).

Figure 47: Percentage of beneficiaries during the measurement year that had a follow-up visit with a PCP after hospitalization

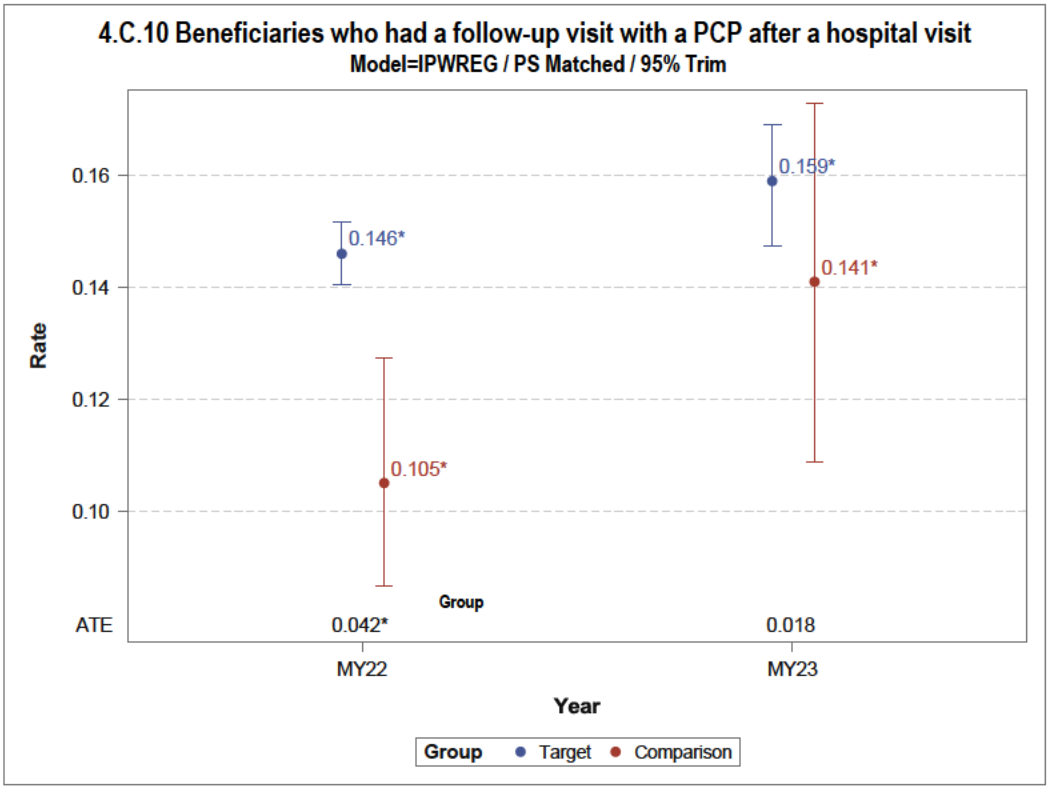


Table 60: Percentage of beneficiaries during the measurement year that had a follow-up visit with a PCP after hospitalization

4.C.10	MY22	MY23
Target Sample Size	16,267	7,558
Comparison Sample Size	7,688	4,130
Target Rate (95% C.I.)	0.1463 (0.1404 – 0.1518)	0.1587 (0.1473 – 0.1690)
Comparison Rate (95% C.I.)	0.1047 (0.0866 – 0.1273)	0.1405 (0.1088 – 0.1729)
Rate Difference (95% C.I.)	0.0416 (0.0194 – 0.0608)	0.0181 (-0.0145 – 0.0510)
P Value	<0.0001	0.2773
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Any follow-up within 7 days after a hospitalization for myocardial infarction (MI) in MY22 was significantly higher (P=0.0075) among the target group (21.3%) than the comparison group (15.7%), with a difference of 5.6 percentage points. In MY23, the target group rate of 18.1% was insignificantly higher (P=0.1971) than the comparison group (14.6%).

Any follow-up within 30 days after a hospitalization for MI in MY22 was also significantly higher (P<0.0001) among the target group at 40.5% than the comparison group (27.5%), with a rate difference of 13.0 percentage points. In MY23, the target group rate was 36.3% and was insignificantly higher (P=0.0662) than the comparison group (29.7%).

Table 61: Percentage of beneficiaries during the measurement year who had a follow-up visit within 7 or 30 days after hospitalization for MI

4.D.3_7, 4.D.3_30	MY22	MY23
Target Sample Size	2,730	1,393
Comparison Sample Size	547	302
Follow-up within 7 days		
Target Rate (95% C.I.)	0.213 (0.198 – 0.228)	0.181 (0.163 – 0.202)
Comparison Rate (95% C.I.)	0.157 (0.124 – 0.201)	0.146 (0.102 – 0.211)
Rate Difference (95% C.I.)	0.055 (0.008 – 0.093)	0.035 (-0.034 – 0.081)
P Value	0.0075	0.1971
Follow-up within 30 days		
Target Rate (95% C.I.)	0.405 (0.386 – 0.422)	0.363 (0.338 – 0.387)
Comparison Rate (95% C.I.)	0.275 (0.230 – 0.323)	0.297 (0.241 – 0.371)
Rate Difference (95% C.I.)	0.130 (0.079 – 0.180)	0.066 (-0.026 – 0.128)
P Value	<0.0001	0.0662
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 48: Percentage of beneficiaries during the measurement year who had a follow-up visit within 7 days after hospitalization for MI

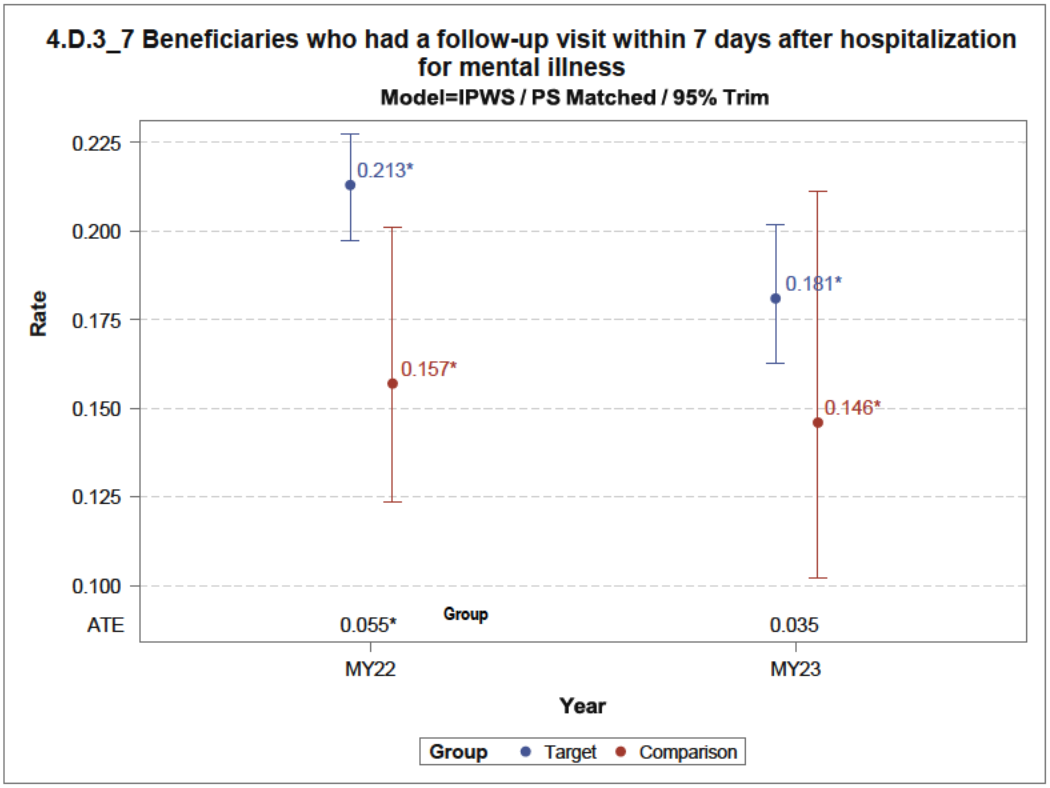
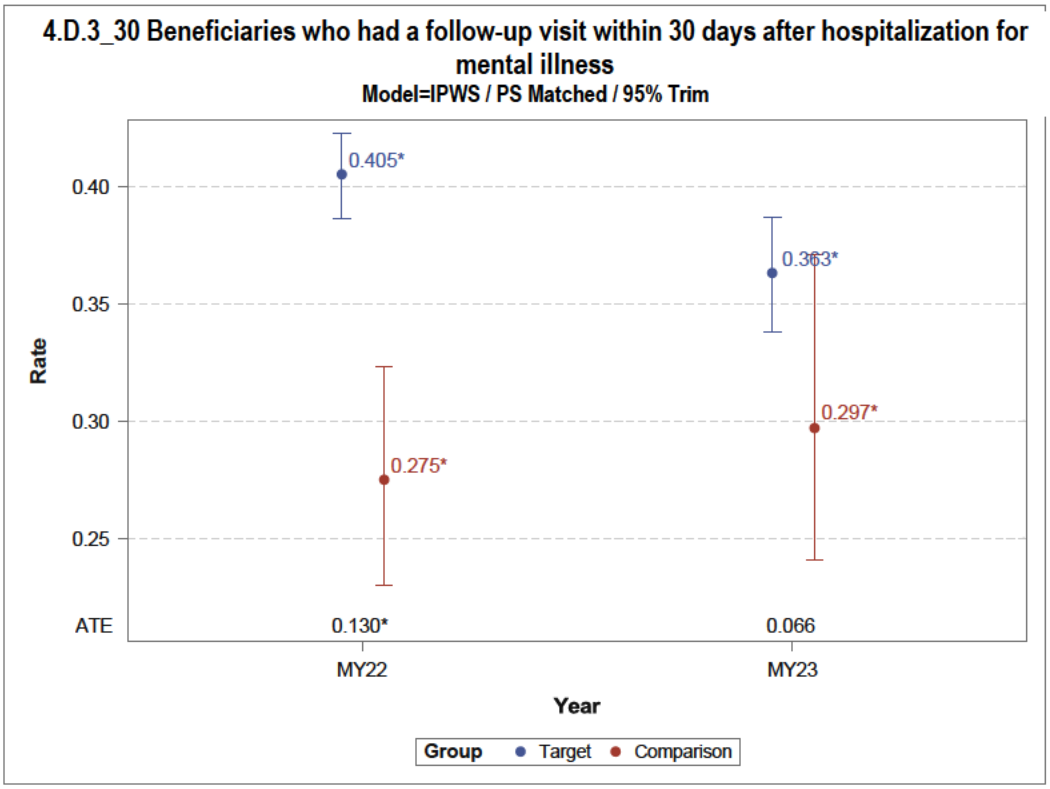


Figure 49: Percentage of beneficiaries during the measurement year who had a follow-up visit within 30 days after hospitalization for mental illness



In MY22, the rate of target group beneficiaries that had a follow-up visit with a PCP after an ED visit was 17.5%, which was significantly higher (P<0.0001) than the comparison group (11.1%), with a difference of 6.4 percentage points. Similarly, in MY23, the target group rate of 16.8% was significantly higher (P<0.0001) than the comparison group (11.6%), with a difference of 5.2 percentage points, demonstrating that more beneficiaries in ARHOME had a follow-up with a PCP than Medicaid FFS beneficiaries.

Table 62: Percentage of beneficiaries during the measurement year that had a follow-up visit with a PCP after an ED visit

4.C.9	MY22	MY23
Target Sample Size	75,327	34,389
Comparison Sample Size	25,914	14,065
Target Rate (95% C.I.)	0.175 (0.172 – 0.178)	0.168 (0.164 – 0.172)
Comparison Rate (95% C.I.)	0.111 (0.102 – 0.119)	0.116 (0.105 – 0.127)
Rate Difference (95% C.I.)	0.064 (0.056 – 0.072)	0.052 (0.040 – 0.063)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

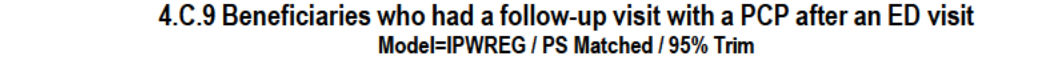
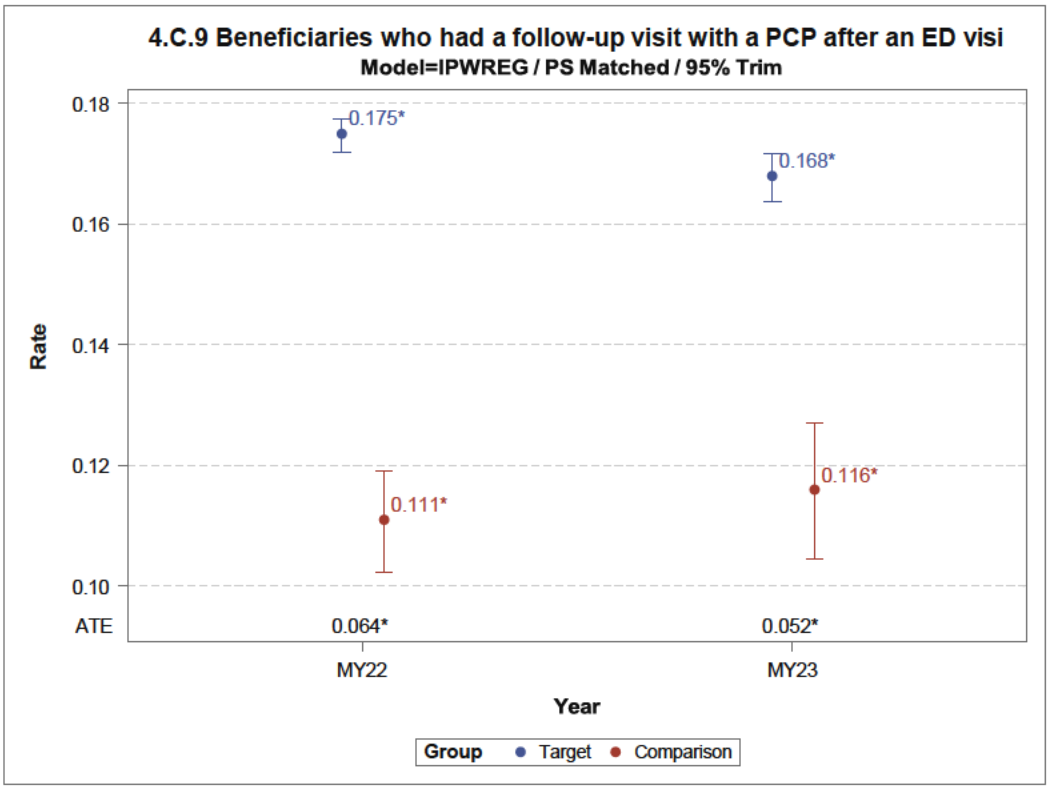


Figure 50: Percentage of beneficiaries during the measurement year that had a follow-up visit with a PCP after an ED visit



In MY22, the rate of beneficiaries in the target group who had a follow-up visit within 7 days of an ED visit for alcohol or other drug abuse or dependence was 15.6%. This was insignificantly higher (P=0.6438) than the comparison group (14.5%). In MY23, the target group rate of 14.4% was also insignificantly higher (P=0.1508) than the comparison group (10.4%).

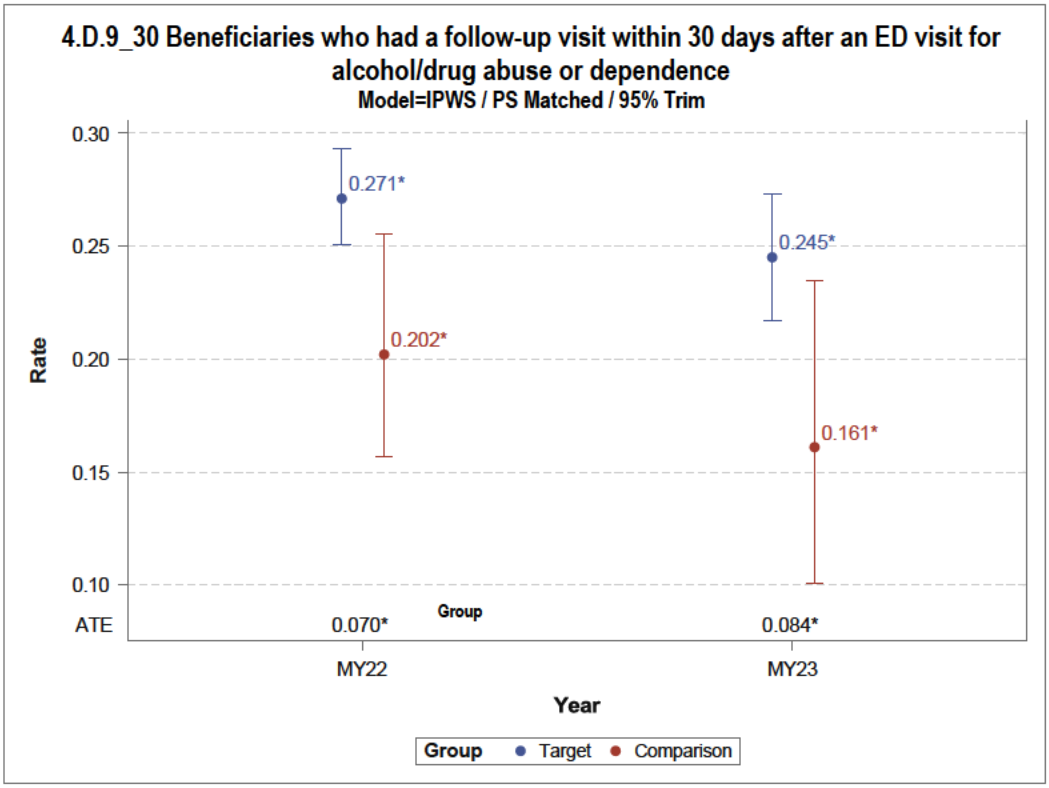
In MY22, the rate of beneficiaries in the target group who had a follow-up visit within 30 days of an ED visit for alcohol or other drug abuse or dependence was 27.1%, which was significantly higher (P=0.0111) than the comparison group (20.2%), with a difference of 6.9 percentage points. In MY23, the target group rate was 24.5% and was also significantly higher (P=0.0162) than the comparison group (16.1%), with a difference of 8.4 percentage points.

Table 63: Percentage of beneficiaries during the measurement year who had a follow-up visit within 7 or 30 days after an ED visit for alcohol or other drug abuse or dependence

4.D.9	MY22	MY23
Target Sample Size	1,612	786
Comparison Sample Size	375	189
Follow-up within 7 days		
Target Rate (95% C.I.)	0.156 (0.140 – 0.176)	0.145 (0.120 – 0.168)
Comparison Rate (95% C.I.)	0.145 (0.104 – 0.199)	0.104 (0.058 – 0.172)
Rate Difference (95% C.I.)	0.011 (-0.044 – 0.055)	0.040 (-0.031 – 0.092)
P Value	0.6438	0.1508
Follow-up within 30 days		
Target Rate (95% C.I.)	0.271 (0.251 – 0.293)	0.245 (0.217 – 0.273)
Comparison Rate (95% C.I.)	0.202 (0.157 – 0.256)	0.161 (0.101 – 0.235)

Rate Difference (95% C.I.)	0.070 (0.012 – 0.120)	0.084 (0.002 – 0.151)
P Value	0.0111	0.0162
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 51: Percentage of beneficiaries during the measurement year who had a follow-up visit within 30 days after an ED visit for alcohol or other drug abuse or dependence



The rate of beneficiaries in the target group who had a follow-up visit within 7 days of an ED visit for MI in MY22 was 18.9%, which was insignificantly lower (P=0.6364) than the comparison group (20.7%). In MY23, the target group rate increased slightly to 20.9%, but was still insignificantly higher (P=0.1822) than the comparison group (15.6%).

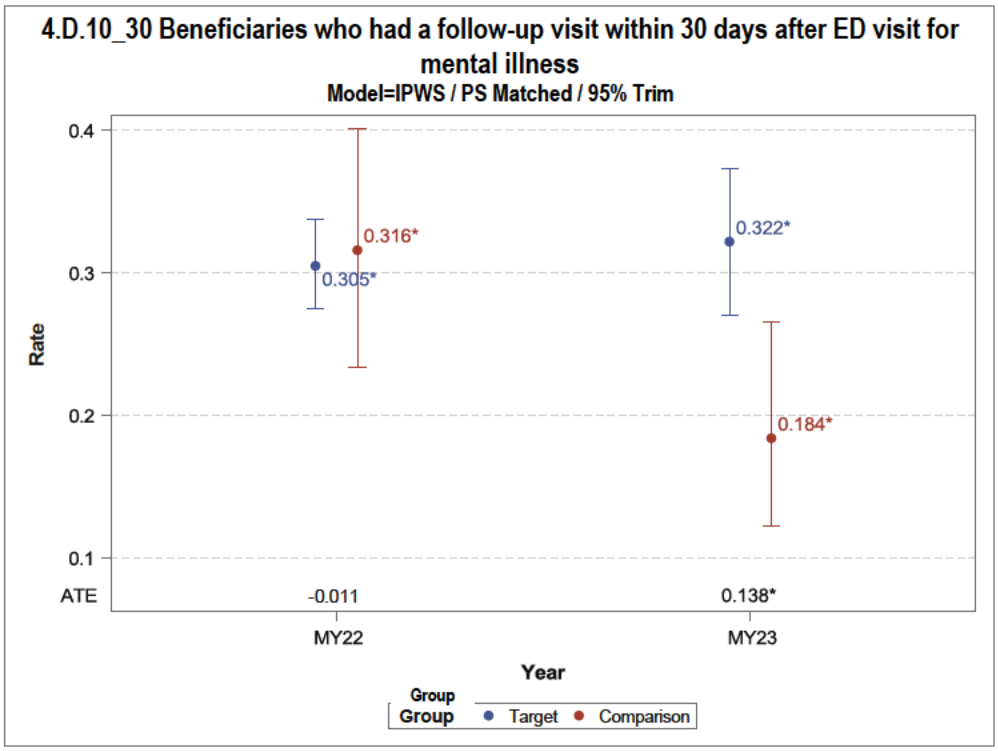
The percentage of beneficiaries in the target group who had a follow-up visit within 30 days of an ED visit for MI in MY22 was 30.5%, which was insignificantly lower (P=0.8009) than the comparison group (31.6%), with a rate difference of -1.1 percentage points. In MY23 the target group rate of 32.2% was significantly higher (P=0.0012) than the comparison group (18.4%), with a rate difference of 13.8 percentage points.

Table 64: Percentage of beneficiaries during the measurement year who had a follow-up visit within 7 or 30 days after an ED visit for mental illness

4.D.10	MY22	MY23
Target Sample Size	833	335
Comparison Sample Size	217	90
Follow-up within 7 days		
Target Rate (95% C.I.)	0.189 (0.164 – 0.219)	0.209 (0.164 – 0.256)

Comparison Rate (95% C.I.)	0.207 (0.141 – 0.287)	0.156 (0.097 – 0.237)
Rate Difference (95% C.I.)	-0.018 (-0.105 – 0.050)	0.053 (-0.037 – 0.127)
***P* Value**	0.6364	0.1822
Follow-up within 30 days		
Target Rate (95% C.I.)	0.305 (0.275 – 0.338)	0.322 (0.270 – 0.374)
Comparison Rate (95% C.I.)	0.316 (0.234 – 0.402)	0.184 (0.123 – 0.265)
Rate Difference (95% C.I.)	-0.011 (-0.106 – 0.076)	0.138 (0.043 – 0.222)
***P* Value**	0.8009	0.0012
Propensity scores trimmed at the:	**5th–95th percentiles**	
Regression Model:	**IPWS**	

Figure 52: Percentage of beneficiaries during the measurement year who had a follow-up visit within 30 days after an ED visit for mental illness



Initiation and Engagement of SUD Treatment (Metric 4.D.1)

The eligible population includes beneficiaries aged 19 to 64 that have a new SUD episode that results in treatment initiation or engagement through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment. The 2 rates include SUD treatment initiation within 14 and 34 days of the SUD episode date.

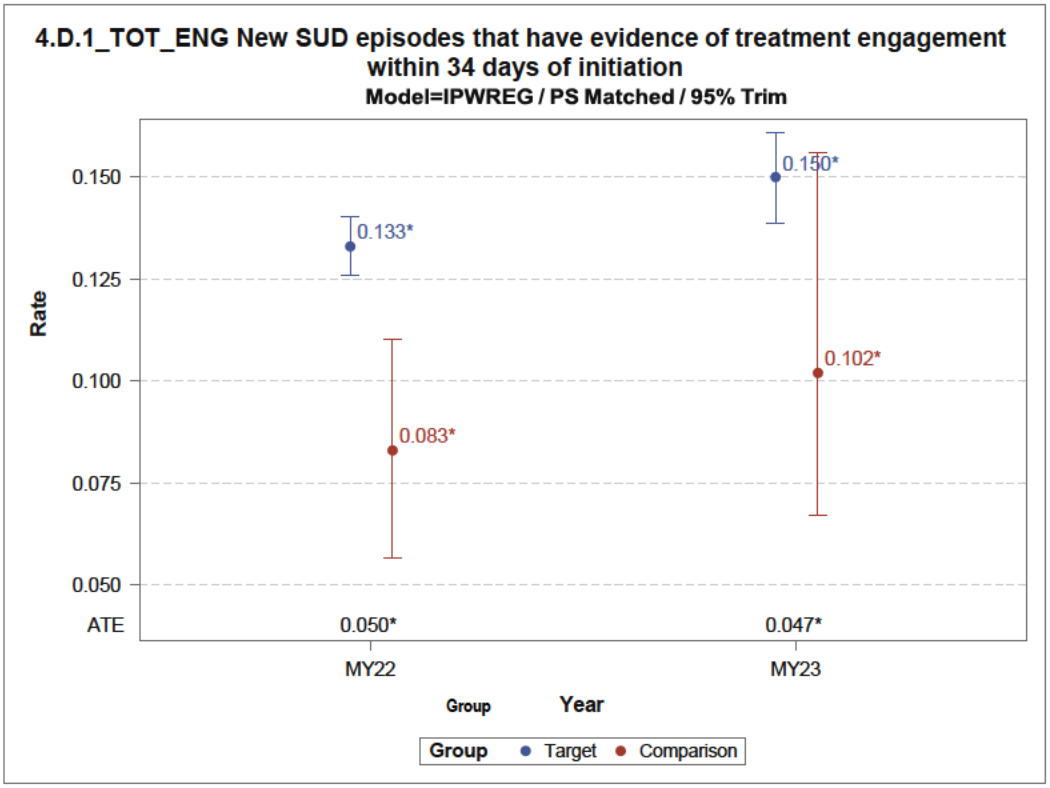
The rate of new SUD episodes in MY22 that initiate treatment within 14 days was 42.3% for the target group, which was insignificantly higher (P=0.3615) than the comparison group (39.7%), with a difference of 2.6 percentage points. In MY23, the target group saw a slight increase in treatment initiation at 44.3% but was insignificantly higher (P=0.1291) than the comparison group (37.8%).

in MY22, rate of target group beneficiaries who were compliant for the initiation of SUD treatment within 34 days was 13.3%, which was significantly higher (P=0.0005) than the comparison group (8.3%), with a difference of 5.0 percentage points. In MY23, the target group rate of 15.0% was also significantly higher (P=0.0405) than the comparison group (10.2%), with a difference of 4.8 percentage points.

Table 65: Percentage of new SUD episodes during the measurement year that result in treatment initiation and engagement

4.D.1	MY22	MY23
Target Sample Size	9,947	4,946
Comparison Sample Size	2,459	1,264
Initiation of SUD treatment within 14 days		
Target Rate (95% C.I.)	0.423 (0.413 – 0.433)	0.443 (0.428 – 0.458)
Comparison Rate (95% C.I.)	0.397 (0.343 – 0.452)	0.378 (0.295 – 0.459)
Rate Difference (95% C.I.)	0.026 (-0.029 – 0.081)	0.065 (-0.020 – 0.153)
P Value	0.3615	0.1291
Engagement of SUD treatment within 34 days		
Target Rate (95% C.I.)	0.133 (0.126 – 0.140)	0.150 (0.139 – 0.161)
Comparison Rate (95% C.I.)	0.083 (0.057 – 0.110)	0.102 (0.067 – 0.156)
Rate Difference (95% C.I.)	0.050 (0.022 – 0.078)	0.047 (-0.007 – 0.085)
P Value	0.0005	0.0405
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Figure 53: Percentage of new SUD episodes during the measurement year that result in treatment initiation within 34 days



Antidepressant Medication Management (Metric 4.D.2)

The analytic population includes beneficiaries ages 19 to 64 who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment during the measurement year. The 2 rates described medication treatment for ≥ 84 days and ≥180 days.

In MY22, the target group rate of 58.9% for treatment ≥ 84 days was significantly higher (P<0.0001) than the comparison group (44.0%), with a rate difference of 14.9 percentage points. In MY23 the target group rate of 60.8% was significantly higher (P=0.0028) than the comparison group (48.6%), with a rate difference of 12.2 percentage points.

In MY22 the target group rate of 40.6% for treatment ≥180 days was significantly higher (P<0.0001) than the comparison group (25.4%), with a rate difference of 15.2 percentage points. In MY23 the target group rate of 44.3% was significantly higher (P<0.0001) than the comparison group (27.9%), with a rate difference of 16.4 percentage points.

Table 66: Percentage of beneficiaries aged 19-64 who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment during the measurement year

4.D.2	MY22	MY23
Target Sample Size	10,622	4,390
Comparison Sample Size	3,070	1,409
Rate 1: Effective acute phase treatment (≥84 days of treatment)		
Target Rate (95% C.I.)	0.589 (0.578 – 0.599)	0.608 (0.592 – 0.624)
Comparison Rate (95% C.I.)	0.440 (0.389 – 0.489)	0.486 (0.403 – 0.561)
Rate Difference (95% C.I.)	0.149 (0.098 – 0.202)	0.122 (0.047 – 0.208)
P Value	<0.0001	0.0028
Rate 2: Effective continuation phase treatment (≥180 days of treatment)		
Target Rate (95% C.I.)	0.406 (0.396 – 0.415)	0.443 (0.426 – 0.460)
Comparison Rate (95% C.I.)	0.254 (0.214 – 0.297)	0.279 (0.209 – 0.353)
Rate Difference (95% C.I.)	0.152 (0.107 – 0.194)	0.164 (0.082 – 0.233)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

4.D.2_R2 Beneficiaries aged 19-64 who had a major depression diagnosis and were treated with and remained on antidepressant medication
Model=IPWREG / PS Matched / 95% Trim

Figure 54: Percentage of beneficiaries aged 19-64 who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment ≥180 days

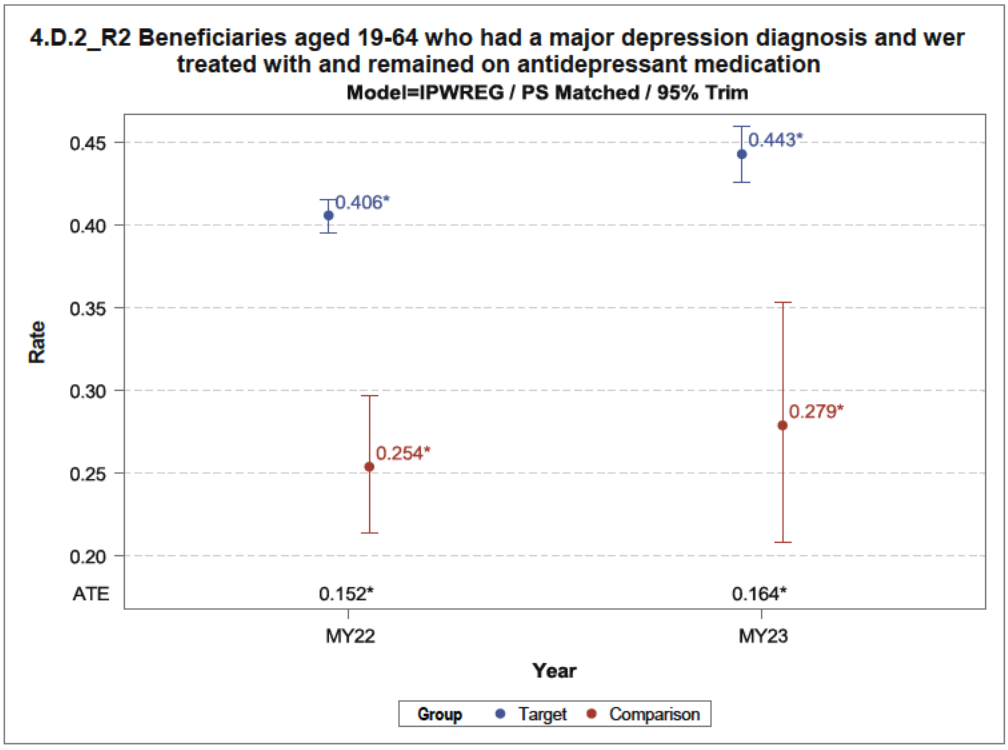
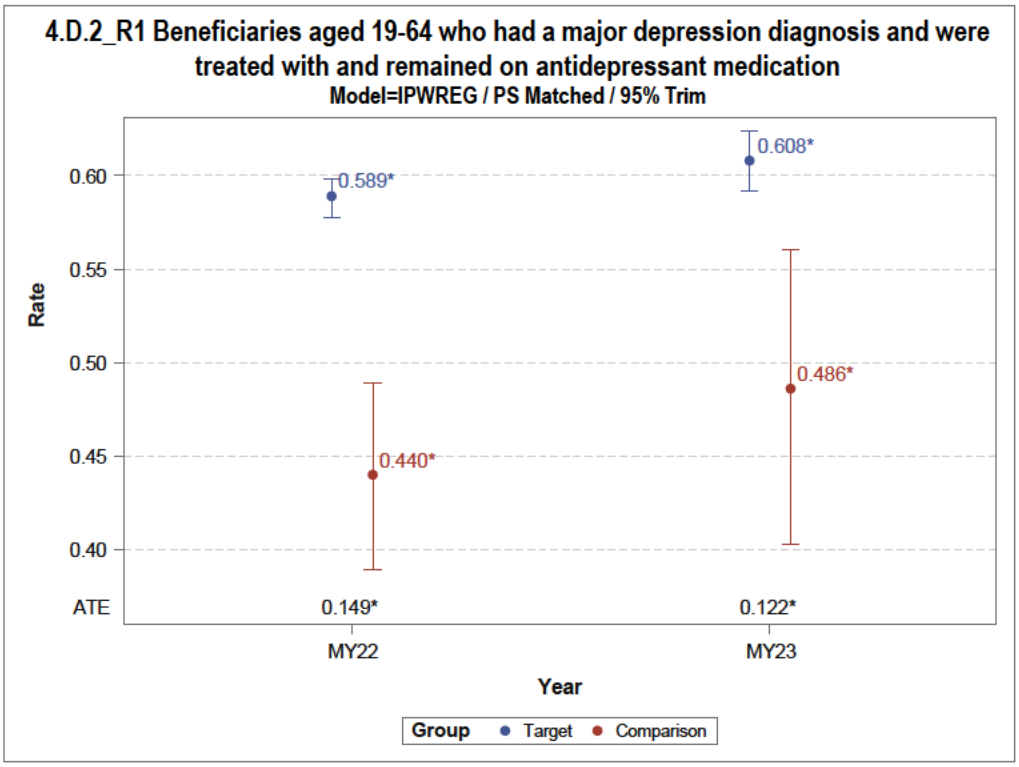


Figure 55:Percentage of beneficiaries aged 19-64 who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment ≥84 days



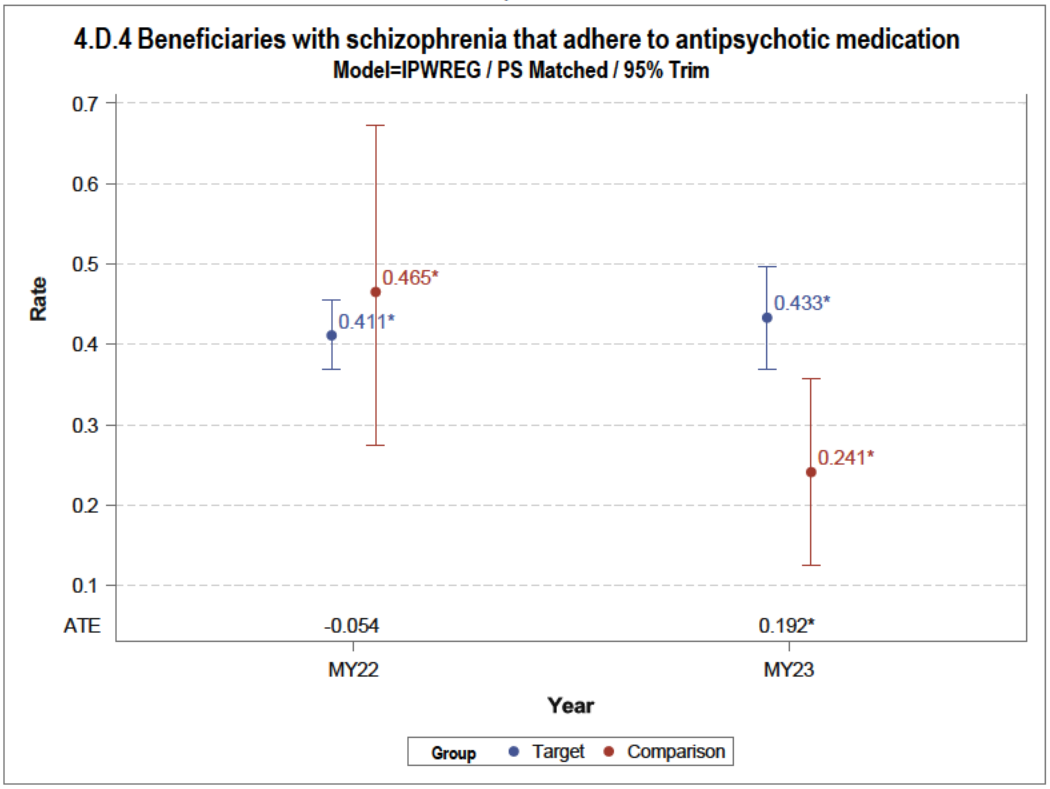
Adherence to Antipsychotic Medications with Schizophrenia (Metric 4.D.4)

In MY22, the rate of beneficiaries with a diagnosis of schizophrenia in the target group who adhered to antipsychotic medication was 41.1%, which was insignificantly lower (P=0.5703) than the comparison group (46.5%). In MY23, the target group rate increased slightly to 43.3% and was significantly higher (P=0.0045) than the comparison group (24.1%), with a difference of 19.2 percentage points.

Table 67: Percentage of beneficiaries with schizophrenia that adhered to antipsychotic medication during the measurement year

4.D.4	MY22	MY23
Target Sample Size	568	256
Comparison Sample Size	125	70
Target Rate (95% C.I.)	0.411 (0.369 – 0.455)	0.433 (0.370 – 0.496)
Comparison Rate (95% C.I.)	0.465 (0.275 – 0.672)	0.241 (0.125 – 0.357)
Rate Difference (95% C.I.)	-0.054 (-0.248 – 0.146)	0.192 (0.060 – 0.325)
P Value	0.5703	0.0045
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 56: Percentage of beneficiaries with schizophrenia that adhered to antipsychotic medication during the measurement year



Diabetes Screening for People with Schizophrenia or Bipolar Disorder (Metric 4.D.5)

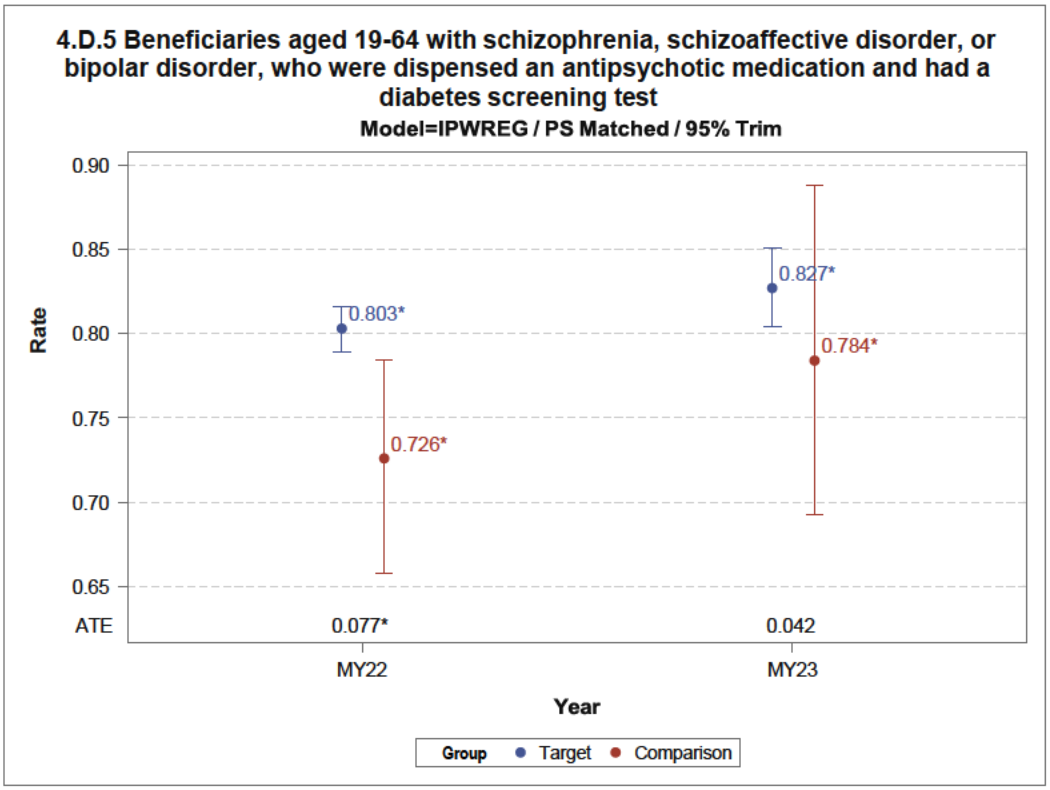
The eligible population consisted of beneficiaries aged 19-64 with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

In MY22, the target group rate of 80.3% was significantly higher (P=0.0225) than the comparison group (72.6%), with a difference of 7.7 percentage points. In MY23, the target group rate of 82.6% was insignificantly higher (P=0.3761) than the comparison group (78.4%).

Table 68: Percentage of beneficiaries aged 19-64 with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year

4.D.5	MY22	MY23
Target Sample Size	3,906	1,424
Comparison Sample Size	1,021	398
Target Rate (95% C.I.)	0.803 (0.789 – 0.816)	0.827 (0.805 – 0.851)
Comparison Rate (95% C.I.)	0.726 (0.658 – 0.785)	0.784 (0.693 – 0.888)
Rate Difference (95% C.I.)	0.077 (0.017 – 0.148)	0.042 (-0.067 – 0.133)
P Value	0.0225	0.3761
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 57: Percentage of beneficiaries aged 19-64 with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year



Use of Opioids and Benzodiazepines (Metric 4.D.6, 4.D.7, 4.D.8)

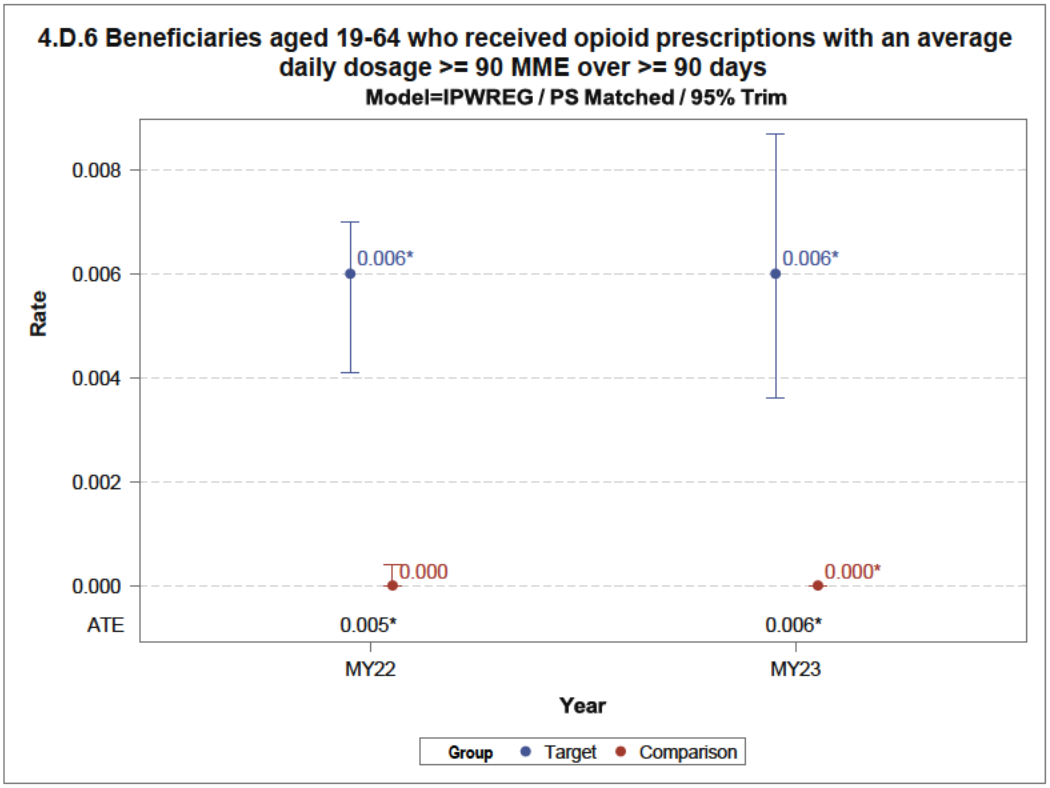
In MY22, the rate of beneficiaries aged 19-64 who received prescriptions for opioids with an average daily dosage ≥90 morphine milligram equivalents (MME) over a period of ≥90 days was 0.56%, which was significantly higher (P<0.0001) than the comparison group (0.01%), with a difference of 0.55 percentage points. In MY23, the target group rate of 0.59% was significantly

higher (P<0.0001) than the comparison group (0.00%), with a difference of 0.59 percentage points.

Table 69: Percentage of beneficiaries aged 19-64 who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine MME over a period of 90 days or more

4.D.6	MY22	MY23
Target Sample Size	9,119	3,457
Comparison Sample Size	2,096	999
Target Rate (95% C.I.)	0.006 (0.004 – 0.007)	0.006 (0.004 – 0.009)
Comparison Rate (95% C.I.)	0.000 (0.000 – 0.000)	0.000 (0.000 – 0.000)
Rate Difference (95% C.I.)	0.006 (0.004 – 0.007)	0.006 (0.004 – 0.009)
P Value	<0.0001	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 58: Percentage of beneficiaries aged 19-64 who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine MME over a period of 90 days or more



In MY22, the rate of target group beneficiaries aged 19 to 64 with concurrent use of prescription opioids and benzodiazepines was 15.7%, which was insignificantly higher (P=0.4116) than the comparison group (14.1%). In MY23, the target group (16.1%) and comparison group (14.0%) rates remained relatively steady, with an insignificant difference between the two groups (P=0.3477).

Table 70: Percentage of beneficiaries aged 19-64 with concurrent use of prescription opioids and benzodiazepines

4.D.7	MY22	MY23
Target Sample Size	11,451	4,029
Comparison Sample Size	2,629	1,222
Target Rate (95% C.I.)	0.157 (0.150 – 0.163)	0.161 (0.150 – 0.173)
Comparison Rate (95% C.I.)	0.141 (0.103 – 0.184)	0.140 (0.101 – 0.186)
Rate Difference (95% C.I.)	0.016 (-0.027 – 0.053)	0.021 (-0.028 – 0.060)
P Value	0.4116	0.3477
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

The following analytic population included beneficiaries between the ages of 19 to 64 who had an opioid use disorder (OUD) and either filled a prescription for or were administered/dispensed an FDA-approved medication for the disorder. Results describe 5 rates:

1. Total use of pharmacy claims (relevant National Drug Code [NDC] code) or through relevant Healthcare Common Procedure Coding System (HCPCS) coding of medical service.
2. Buprenorphine use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service.
3. Oral Naltrexone use of pharmacy claims (relevant NDC code) only.
4. Long-Acting, Injectable Naltrexone use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service.
5. Methadone use of inpatient or outpatient claims through relevant HCPCS coding of medical service only.

In MY22, the rate of target group beneficiaries who were prescribed, administered, or dispensed ≥1 medications for OUD or ≥1 prescriptions for buprenorphine for OUD, was insignificantly lower than the percentage of those in the comparison group in MY22 and MY23.

However, the rates of target group beneficiaries with ≥1 prescriptions for Naltrexone (4.0%) or long-acting injectable Naltrexone (1.2%) were significantly higher (P<0.0001) than that of the comparison group for Naltrexone (1.9%) and long-acting injectable Naltrexone (0.2%) in MY22, with respective differences of 2.1 and 1.0 percentage points.

In MY23, the rate of target group beneficiaries with ≥1 prescriptions for Naltrexone increased to 5.8% and remained significantly higher (P<0.0001) than the comparison group (1.3%), with a difference of 4.5 percentage points. The rate of beneficiaries with ≥1 prescriptions for long-acting Naltrexone was 1.4% and was also significantly higher (P=0.0010) than the comparison group (0.4%), with a difference of 1.0 percentage points.

In MY22, the rate of target group beneficiaries with ≥1 prescriptions for Methadone was 0.2%, which was significantly lower (P=0.0112) than the comparison group (1.3%), with a difference of -1.1 percentage points. In MY23, the target group rate increased slightly to 0.4%, but remained

significantly lower (P=0.0164) than the comparison group (2.3%), with a difference of -1.9 percentage points.

Table 71: Percentage of Medicaid beneficiaries aged 19-64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year

4.D.8	MY22	MY23
Target Sample Size	5,206	2,538
Comparison Sample Size	1,377	680
Rate 1: Total beneficiaries with ≥1 prescribed, administered, or dispensed OUD medication		
Target Rate (95% C.I.)	0.627 (0.612 – 0.641)	0.661 (0.640 – 0.681)
Comparison Rate (95% C.I.)	0.657 (0.589 – 0.725)	0.714 (0.627 – 0.809)
Rate Difference (95% C.I.)	-0.030 (-0.100 – 0.039)	-0.054 (-0.152 – 0.035)
P Value	0.3897	0.2534
Rate 2: Beneficiaries with ≥ 1 prescriptions for buprenorphine		
Target Rate (95% C.I.)	0.592 (0.578 – 0.607)	0.610 (0.589 – 0.632)
Comparison Rate (95% C.I.)	0.630 (0.561 – 0.699)	0.691 (0.600 – 0.781)
Rate Difference (95% C.I.)	-0.038 (-0.108 – 0.032)	-0.081 (-0.174 – 0.016)
P Value	0.2908	0.0915
Rate 3: Beneficiaries with ≥ 1 prescriptions for oral Naltrexone*		
Target Rate (95% C.I.)	0.040 (0.035 – 0.046)	0.058 (0.047 – 0.067)
Comparison Rate (95% C.I.)	0.019 (0.011 – 0.028)	0.013 (0.005 – 0.026)
Rate Difference (95% C.I.)	0.021 (0.010 – 0.030)	0.045 (0.028 – 0.058)
P Value	<0.0001	<0.0001
Rate 4: Beneficiaries with ≥ 1 prescriptions for long-acting injectable Naltrexone*		
Target Rate (95% C.I.)	0.012 (0.009 – 0.015)	0.014 (0.010 – 0.019)
Comparison Rate (95% C.I.)	0.002 (0.001 – 0.004)	0.004 (0.001 – 0.008)
Rate Difference (95% C.I.)	0.010 (0.006 – 0.013)	0.010 (0.004 – 0.016)
P Value	<0.0001	0.0010
Rate 5: Beneficiaries with ≥ 1 prescriptions for Methadone**		
Target Rate (95% C.I.)	0.002 (0.001 – 0.003)	0.004 (0.002 – 0.006)
Comparison Rate (95% C.I.)	0.013 (0.005 – 0.022)	0.023 (0.008 – 0.040)
Rate Difference (95% C.I.)	-0.011 (-0.020 – -0.003)	-0.019 (-0.037 – -0.004)
P Value	0.0112	0.0164
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

* Regression model: IPWS

** Sample sizes differ for Rate 5: Target (MY22: 5,309; MY23: 2,841) and Comparison (MY22: 1,381; MY23: 688).

Figure 59: Rate 3: Percentage of beneficiaries with ≥ 1 prescriptions for Naltrexone

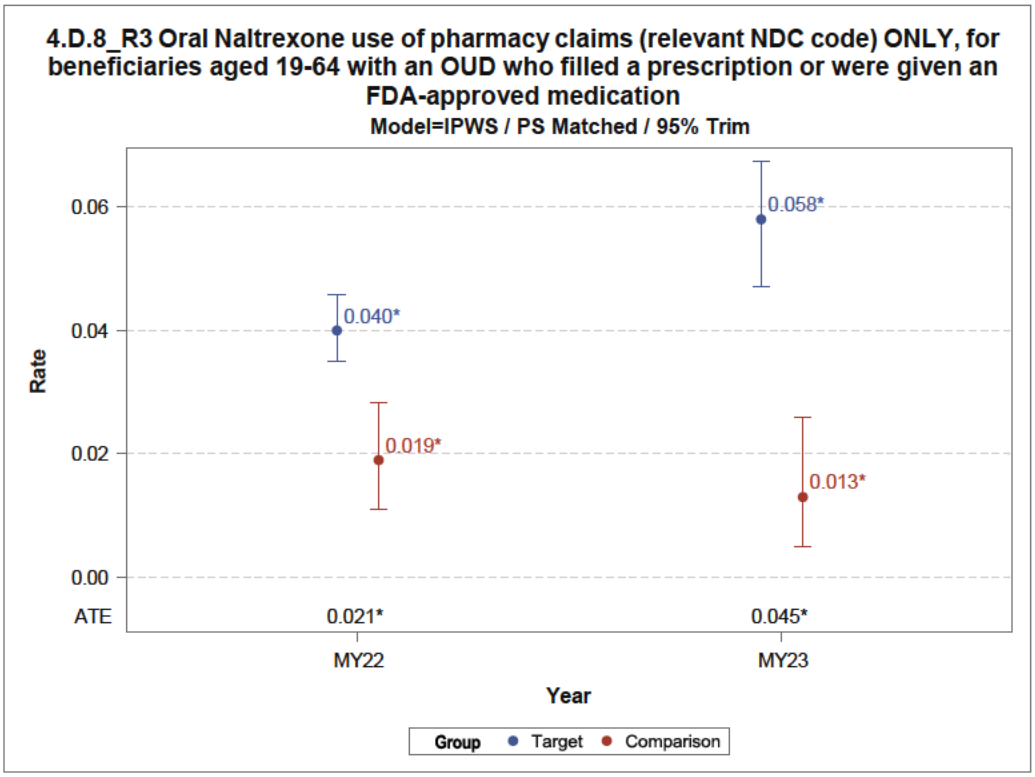


Figure 60: Rate 4: Percentage of beneficiaries with ≥ 1 prescriptions for long-acting injectable Naltrexone

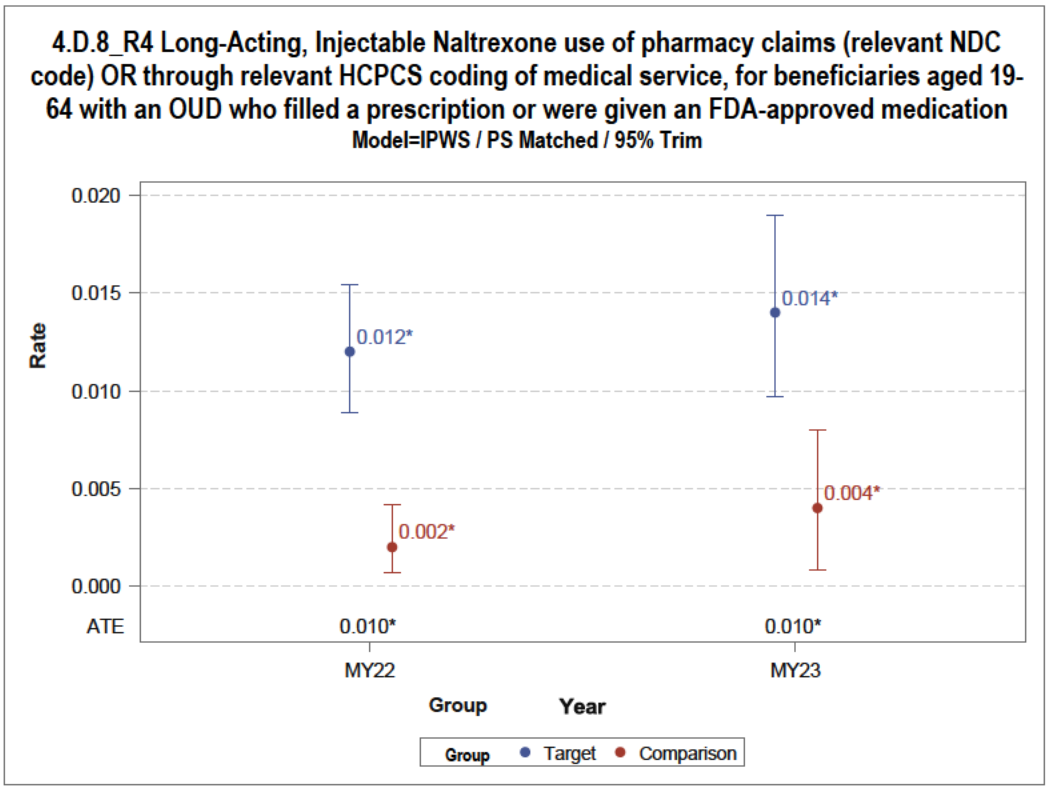
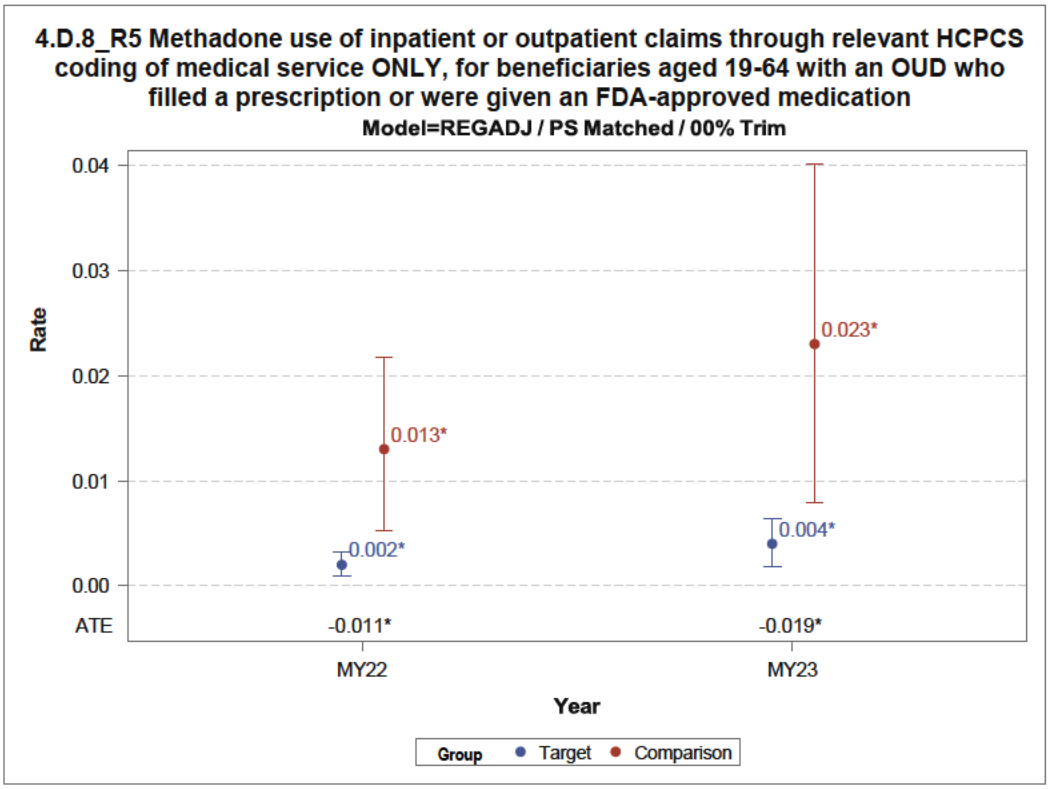


Figure 61: Rate 5: Percentage of beneficiaries with ≥ 1 prescriptions for Methadone



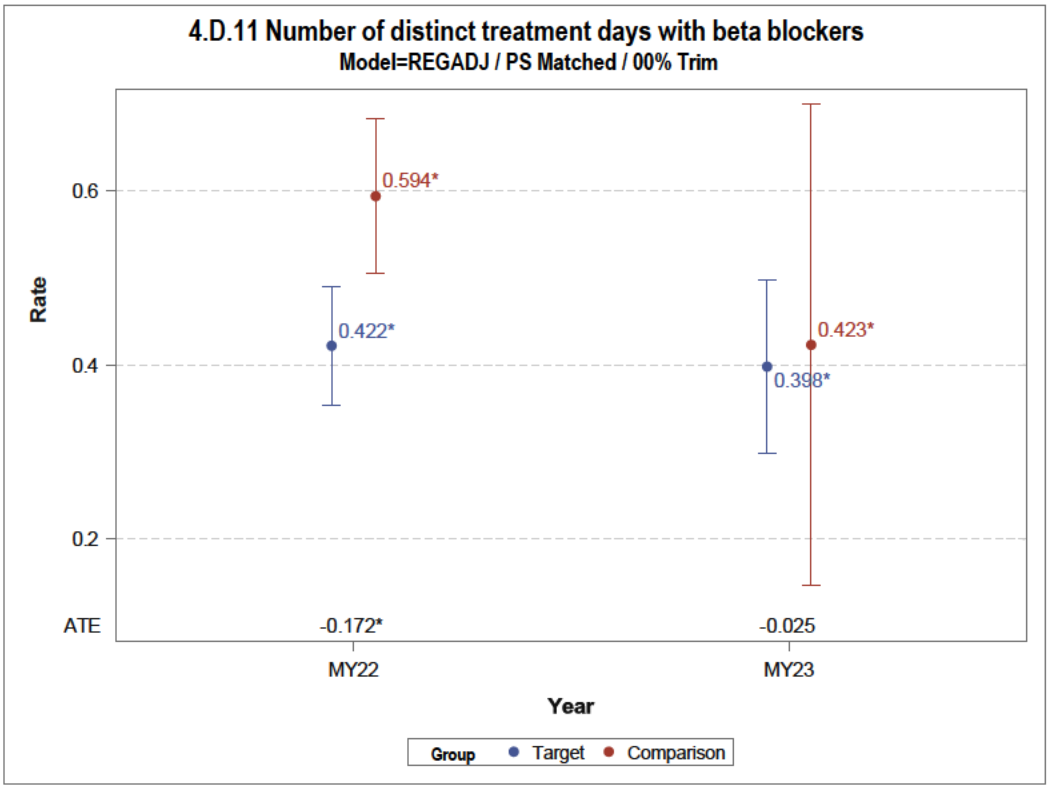
Persistent Medications (Metric 4.D.11, 4.D.12)

In MY22, the rate of beneficiaries with beta blocker treatment after a heart attack in the target group was 42.2%, which was significantly lower (P=0.0017) than the comparison group (59.4%), with a difference of -17.2 percentage points. In MY23, the target group rate (39.8%) was insignificantly lower (P=0.8678) than the comparison group (42.3%).

Table 72: Percentage of distinct treatment days with beta blockers per beneficiary during the measurement year

4.D.11	MY22	MY23
Target Sample Size	201	95
Comparison Sample Size	18	22
Target Rate (95% C.I.)	0.422 (0.354 – 0.490)	0.398 (0.299 – 0.497)
Comparison Rate (95% C.I.)	0.594 (0.506 – 0.683)	0.423 (0.146 – 0.701)
Rate Difference (95% C.I.)	-0.173 (-0.280 – -0.065)	-0.025 (-0.322 – 0.272)
P Value	0.0017	0.8678
Propensity scores trimmed at the:	N/A	
Regression Model:	REGADJ: Binary logit	

Figure 62: Percentage of distinct treatment days with beta blockers per beneficiary during the measurement year



The following results describe the percentage of beneficiaries who are on persistent medications, like ACE inhibitors, Angiotensin Receptor Blockers (ARBs), and diuretics during the measurement year who received ≥180 days of treatment.

In MY22, the rate of target group beneficiaries who were on persistent medications for ACE inhibitors, ARBs, or diuretics was 82.7%, and was significantly higher (P=0.0155) than the comparison group (77.9%), with a difference of 4.8 percentage points. In MY23, the target group rate increased to 85.9%, but was insignificantly higher (P=0.1564) than the comparison group (82.5%). While annual monitoring of persistent medications for ACE inhibitors or ARBs was higher among the target group than the comparison group in MY22 and MY23, they were not significantly different.

In MY22, the rate of beneficiaries among the target group who were on persistent monitoring for diuretics was 82.6% but was insignificantly higher (P=0.0710) than the comparison group (78.0%). However, in MY23, the target group rate was 85.8%, which was significantly higher (P=0.0272) than the comparison group (78.3%), with a difference of 7.5 percentage points.

Table 73: Percentage of beneficiaries who are on persistent medications (i.e., received at least 180 treatment days of ambulatory medication in the measurement year) for ACE inhibitors, ARBs, or diuretics

4.D.12	MY22	MY23
Rate 1: Annual monitoring of all beneficiaries on ACE inhibitors/ARB and diuretics*		
Target Sample Size	20,257	8,377
Comparison Sample Size	3,035	1,506
Target Rate (95% C.I.)	0.828 (0.823 – 0.833)	0.859 (0.851 – 0.867)
Comparison Rate (95% C.I.)	0.779 (0.740 – 0.817)	0.825 (0.780 – 0.871)
Rate Difference (95% C.I.)	0.048 (0.010 – 0.088)	0.034 (-0.013 – 0.080)
P Value	0.0155	0.1564
Rate 2: Annual monitoring of beneficiaries on ACE inhibitors/ARBs		
Target Sample Size	14,804	6,192
Comparison Sample Size	2,201	1,134
Target Rate (95% C.I.)	0.830 (0.824 – 0.837)	0.863 (0.854 – 0.872)
Comparison Rate (95% C.I.)	0.791 (0.745 – 0.833)	0.831 (0.773 – 0.874)
Rate Difference (95% C.I.)	0.040 (-0.003 – 0.086)	0.032 (-0.014 – 0.090)
P Value	0.0805	0.2209
Rate 3: Annual monitoring of beneficiaries on diuretics		
Target Sample Size	11,020	4,415
Comparison Sample Size	1,709	819
Target Rate (95% C.I.)	0.826 (0.819 – 0.834)	0.858 (0.847 – 0.869)
Comparison Rate (95% C.I.)	0.780 (0.730 – 0.830)	0.783 (0.716 – 0.849)
Rate Difference (95% C.I.)	0.046 (-0.004 – 0.096)	0.076 (0.009 – 0.143)
P Value	0.0710	0.0272
Propensity scores trimmed at the:	**5th–95th percentiles**	
Regression Model:	**IPWREG: Binary logit**	

Figure 63: Rate 1: Percentage of beneficiaries who are on persistent medications for ACE inhibitors, ARBs, or diuretics

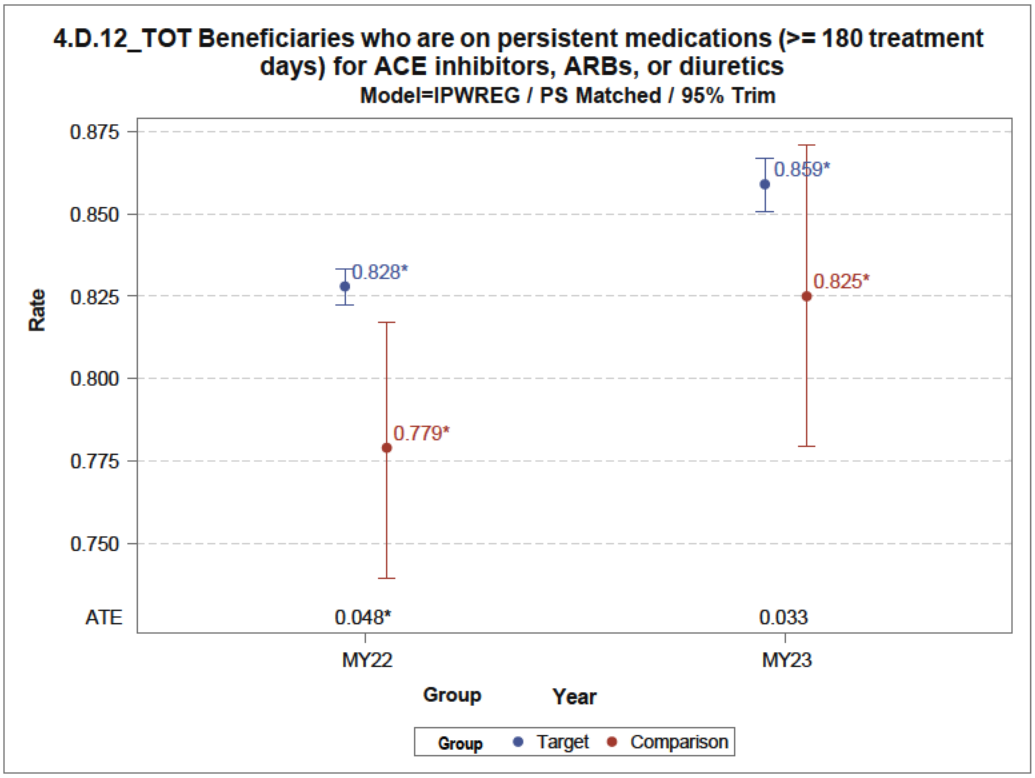
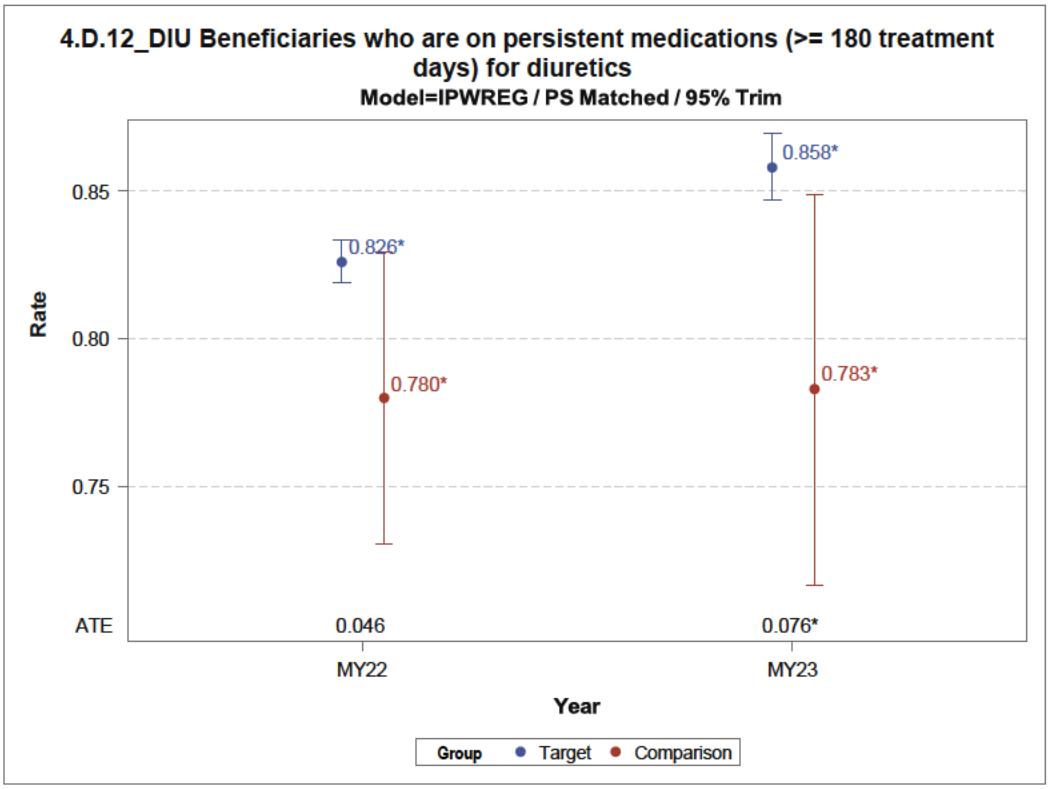


Figure 64: Rate 3: Percentage of beneficiaries who are on persistent medications for diuretics



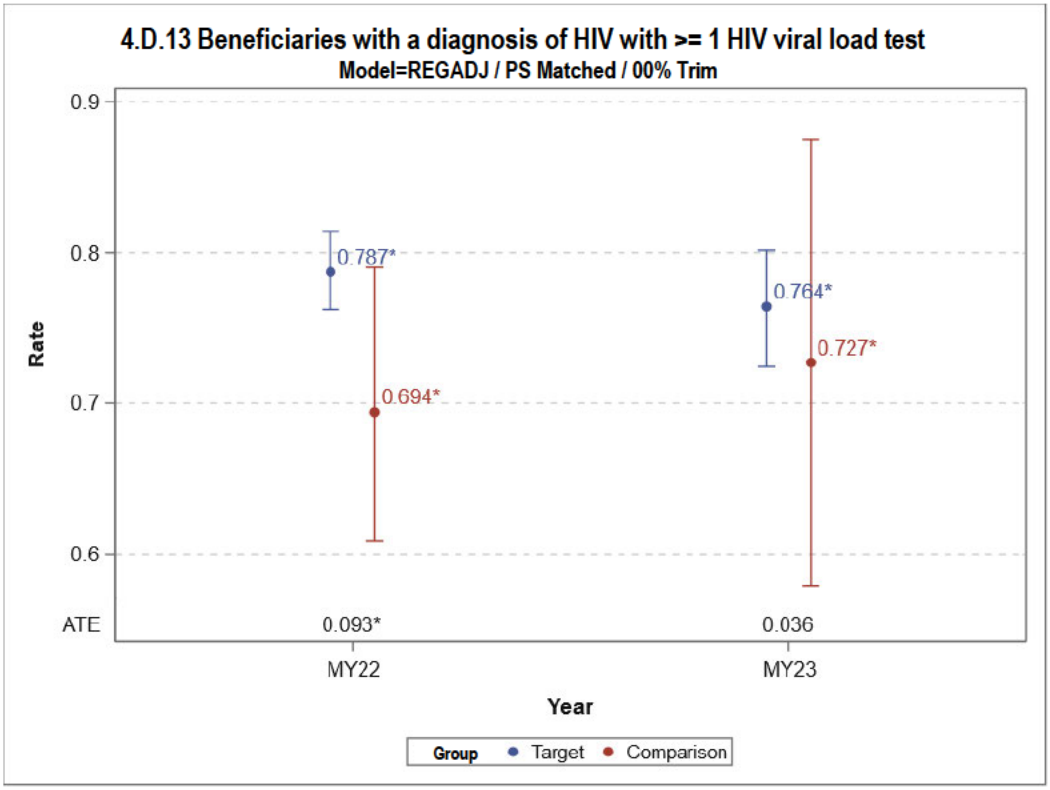
HIV/AIDs Viral Load Test (Metric 4.D.13)

In MY22, the rate of beneficiaries in the target group with an HIV diagnosis who had ≥1 HIV viral load test during the measurement year was 78.7%, which was significantly higher (P=0.0478) than the comparison group (69.4%), with a difference of 9.3 percentage points. However, the target group rate dropped slightly to 76.4%, which was insignificantly higher (P=0.5675) than the comparison group (72.7%).

Table 74: Percentage of beneficiaries with a diagnosis of HIV with ≥1 HIV viral load test during the measurement year

4.D.13	MY22	MY23
Target Sample Size	954	456
Comparison Sample Size	103	55
Target Rate (95% C.I.)	0.787 (0.762 – 0.814)	0.764 (0.724 – 0.802)
Comparison Rate (95% C.I.)	0.694 (0.609 – 0.790)	0.727 (0.579 – 0.875)
Rate Difference (95% C.I.)	0.093 (-0.013 – 0.182)	0.037 (-0.112 – 0.189)
P Value	0.0478	0.5675
Propensity scores trimmed at the:	N/A	
Regression Model:	REGADJ: Binary logit	

Figure 65: Percentage of beneficiaries with a diagnosis of HIV with ≥1 HIV viral load test during the measurement year



C-Section Rate (Metric 4.D.14)

In MY22, 31.9% of target group beneficiaries who had a single live delivery had a c-section, which was insignificantly lower (P=0.1585) than the comparison group (34.0%). Likewise, the c-section rate in MY23 was insignificantly lower (P=0.0538) for the target group (30.5%) than the comparison group (35.9%).

Table 75: Percentage of beneficiaries with a single live delivery who delivered via C-section

4.D.14	MY22	MY23
Target Sample Size	3,926	1,226
Comparison Sample Size	4,870	2,657
Target Rate (95% C.I.)	0.319 (0.298 – 0.339)	0.305 (0.255 – 0.354)
Comparison Rate (95% C.I.)	0.340 (0.319 – 0.361)	0.359 (0.330 – 0.391)
Rate Difference (95% C.I.)	-0.021 (-0.051 – 0.008)	-0.054 (-0.108 – 0.006)
P Value	0.1585	0.0538
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Contraceptive Care (Metric 4.D.15, 4.D.16)

The eligible population for the following measure includes women aged 21 to 44 who had a live birth. In MY22, the rate of target group beneficiaries who were provided the most effective or moderately effective method of contraception within 3 days of delivery was 11.7%, which was insignificantly lower (P=0.0768) than the comparison group (14.0%). In MY23, the target group

rate of 9.9% was significantly lower (P=0.0152) than the comparison group (16.1%), with a difference of -6.2 percentage points.

The rate of women who were provided most effective or moderately effective methods of contraception within 90 days was not significantly different between the two groups in MY22 (44.9% target vs. 45.9% comparison, P=0.6248) or MY23 (44.9% target vs. 48.5% comparison, P=0.3979).

In MY22, the rate of women among the target group who were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery was 0.8%, which was significantly lower (P=0.0017) than the comparison group (1.6%), with a difference of -0.8 percentage points. However, in MY23, the target group rate of 1.6% was insignificantly lower (P=0.2363) than the comparison group (2.4%).

The rate of women who were provided a long-acting reversible method of contraception (LARC) within 90 days was not significantly different between the two groups in MY22 (10.7% target vs. 9.1% comparison, P=0.1488) or MY23 (16.9% target vs. 11.8% comparison, P=0.1159).

Table 76: Among women aged 21-44 who had a live birth, the percentage that were provided a most effective or moderately effective method of contraception or LARC method of contraception within 3 or 90 days of delivery

4.D.15	MY22	MY23
Target Sample Size	2,558	694
Comparison Sample Size	3,519	1,790
Rate 1: Provided with most or moderately effective contraception within 3 days of delivery		
Target Rate (95% C.I.)	0.117 (0.098 – 0.136)	0.099 (0.061 – 0.152)
Comparison Rate (95% C.I.)	0.140 (0.124 – 0.160)	0.161 (0.139 – 0.188)
Rate Difference (95% C.I.)	-0.023 (-0.051 – 0.001)	-0.062 (-0.112 – -0.008)
P Value	0.0768	0.0152
Rate 1: Provided with most or moderately effective contraception within 90 days of delivery		
Target Rate (95% C.I.)	0.449 (0.420 – 0.479)	0.449 (0.373 – 0.535)
Comparison Rate (95% C.I.)	0.459 (0.432 – 0.484)	0.485 (0.451 – 0.521)
Rate Difference (95% C.I.)	-0.010 (-0.047 – 0.035)	-0.037 (-0.120 – 0.058)
P Value	0.6248	0.3979
Rate 2: Provided with a LARC method of contraception within 3 days of delivery*		
Target Rate (95% C.I.)	0.008 (0.005 – 0.011)	0.016 (0.007 – 0.028)
Comparison Rate (95% C.I.)	0.016 (0.012 – 0.020)	0.024 (0.018 – 0.031)
Rate Difference (95% C.I.)	-0.009 (-0.014 – -0.004)	-0.008 (-0.020 – 0.006)
P Value	0.0017	0.2363
Rate 2: Provided with a LARC method of contraception within 90 days of delivery		
Target Rate (95% C.I.)	0.107 (0.092 – 0.126)	0.169 (0.114 – 0.230)
Comparison Rate (95% C.I.)	0.091 (0.079 – 0.105)	0.118 (0.099 – 0.142)
Rate Difference (95% C.I.)	0.016 (-0.005 – 0.039)	0.052 (-0.011 – 0.120)
P Value	0.1488	0.1159
Propensity scores trimmed at the:	**5th–95th percentiles**	
Regression Model:	**IPWREG: Binary logit**	

* Regression model was REGADJ: Binary logit

Figure 66: Rate 1: among women aged 21-44 who had a live birth who had a live birth, the percentage that were provided a most effective or moderately effective method of contraception within 3 days of delivery

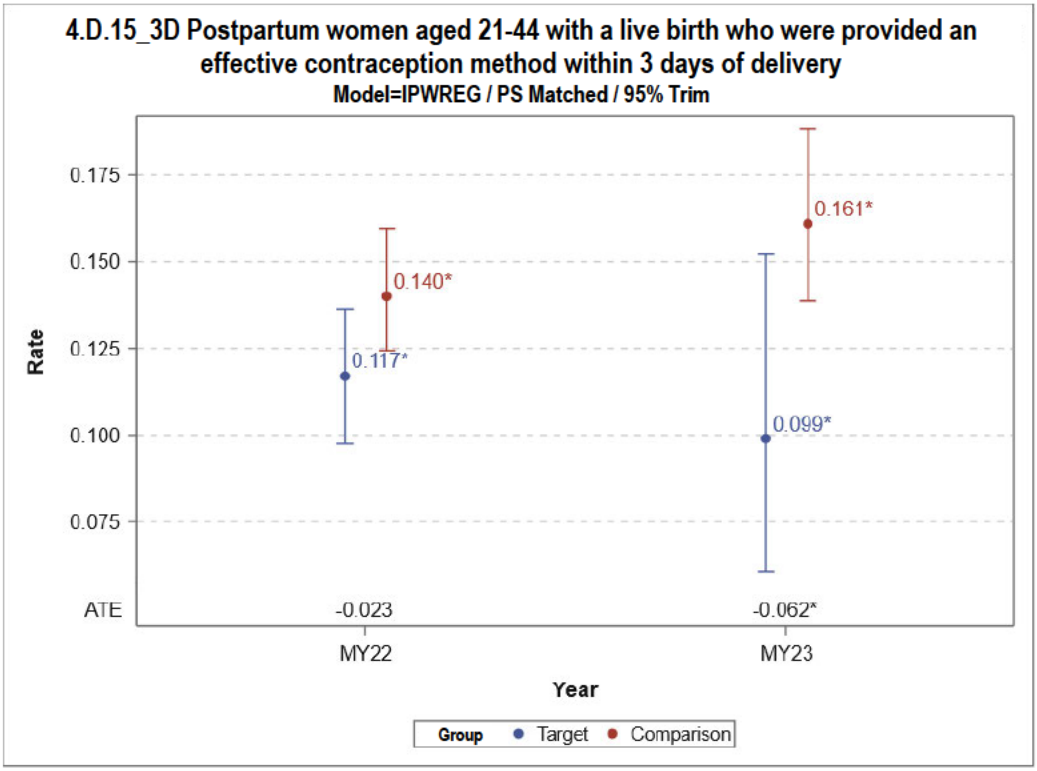
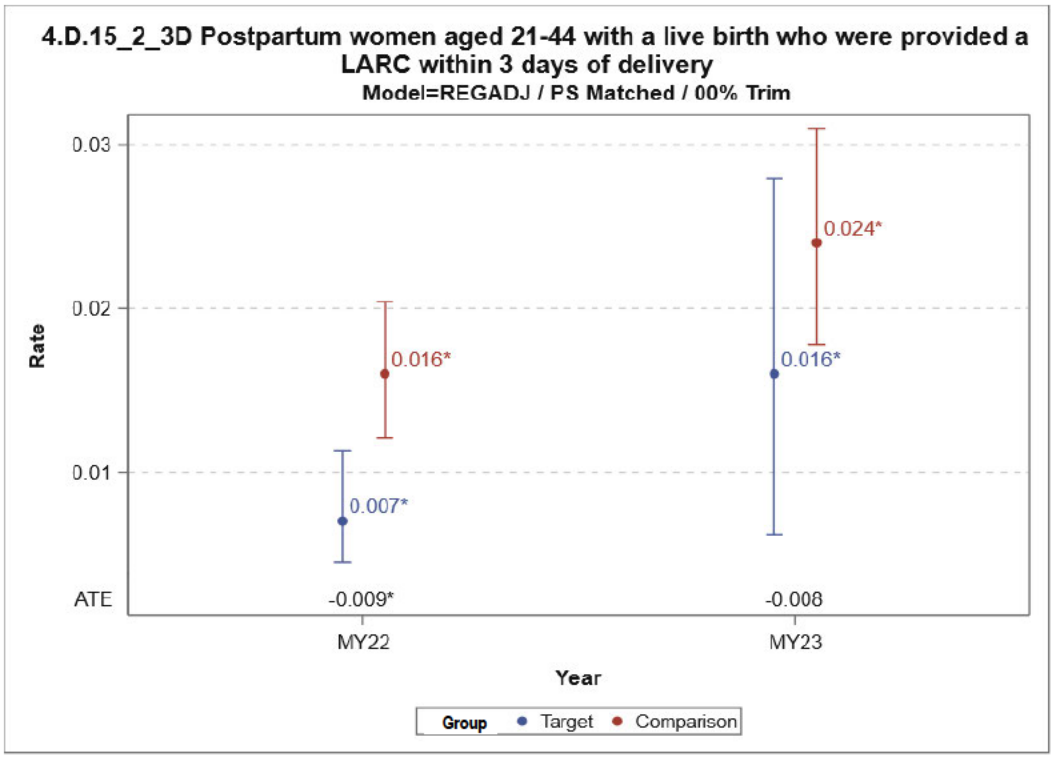


Figure 67: Rate 2: among women aged 21-44 who had a live birth, the percentage that were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery



For women aged 21-44 at risk of unintended pregnancy in MY22, the percentage of beneficiaries in the target group that were provided a most effective or moderately effective method of contraception was 20.0%, which was significantly lower (P=0.0096) than the comparison group (21.1%), with a difference of -1.1 percentage points. In MY23, the target group rate decreased slightly to 19.2%, and remained significantly lower (P<0.0001) than the comparison group (23.4%), with a difference of -4.2 percentage points.

Similarly, the rate of women in the target group who were provided contraception through the LARC method in MY22 was 2.3%, which was significantly lower (P<0.0001) than the comparison group (3.2%), with a difference of -0.9 percentage points. In MY23, the target group rate remained steady at 2.2% and was significantly lower (P=0.0003) than the comparison group (4.4%), with a difference of -2.2 percentage points.

Table 77: Among women aged 21-44 at risk of unintended pregnancy, the percentage that were provided a most effective or moderately effective method of contraception or LARC method of contraception

4.D.16	MY22	MY23
Target Sample Size	79,477	21,177
Comparison Sample Size	43,360	14,932
Rate 1: Provided with most or moderately effective contraception		
Target Rate (95% C.I.)	0.200 (0.197 – 0.203)	0.192 (0.185 – 0.199)
Comparison Rate (95% C.I.)	0.211 (0.203 – 0.220)	0.234 (0.217 – 0.251)
Rate Difference (95% C.I.)	-0.012 (-0.021 – -0.003)	-0.042 (-0.061 – -0.024)
P Value	0.0096	<0.0001
Rate 2: Provided with a LARC method of contraception		
Target Rate (95% C.I.)	0.023 (0.022 – 0.025)	0.022 (0.019 – 0.025)
Comparison Rate (95% C.I.)	0.032 (0.028 – 0.036)	0.044 (0.034 – 0.057)
Rate Difference (95% C.I.)	-0.008 (-0.013 – -0.005)	-0.022 (-0.036 – -0.012)
P Value	<0.0001	0.0003
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 68: Among women aged 21-44 at risk of unintended pregnancy, the percentage that were provided a most effective or moderately effective method of contraception

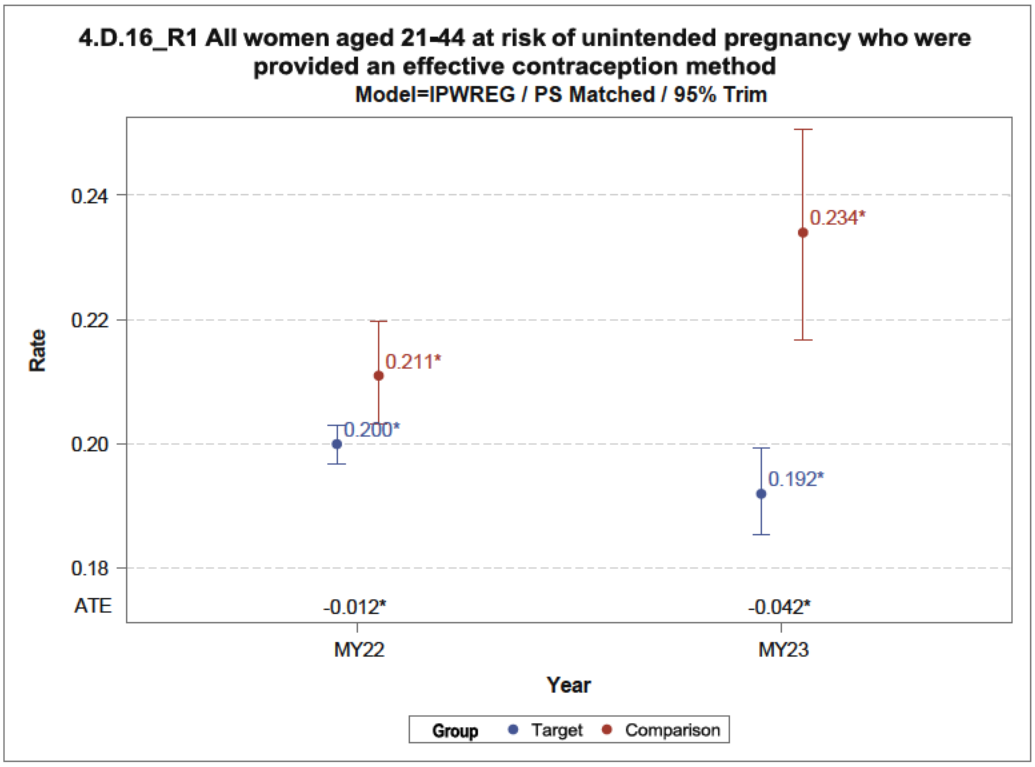
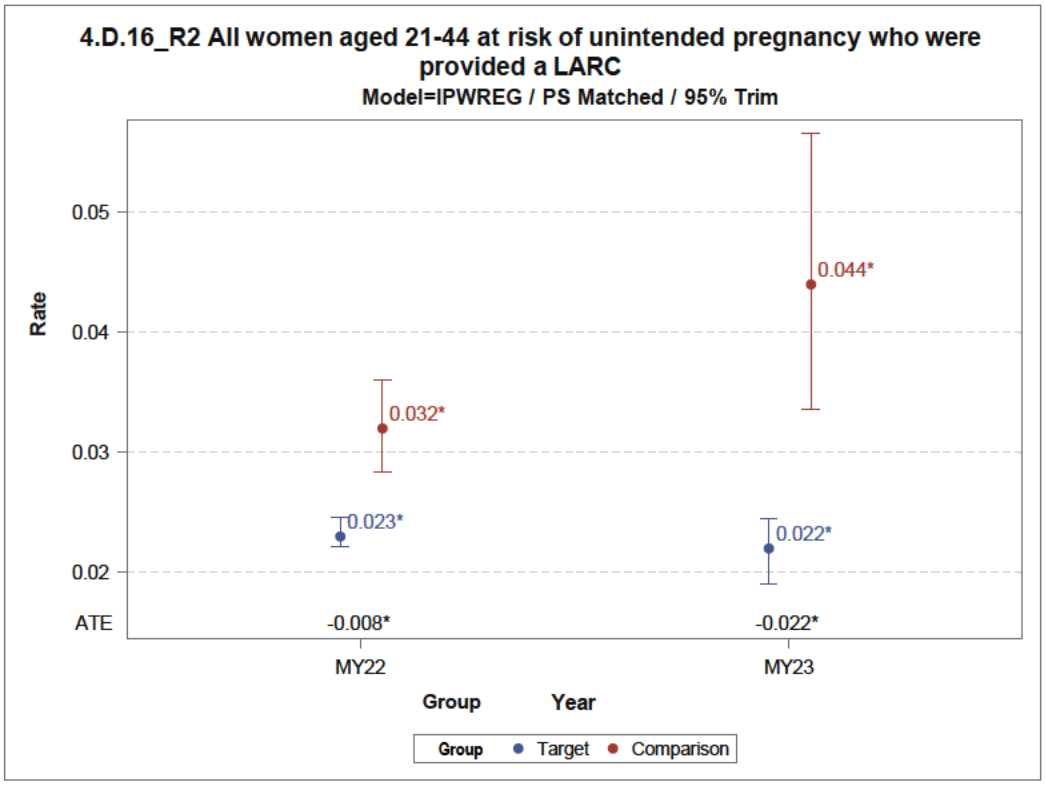


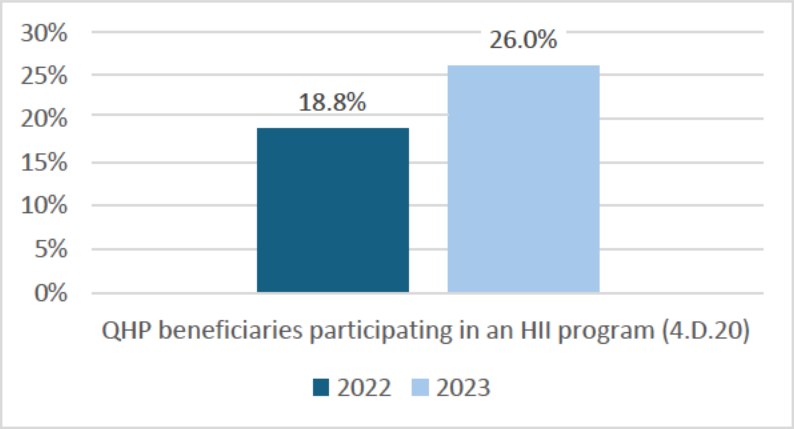
Figure 69: CCW – Among women aged 21-44 at risk of unintended pregnancy, the percentage that were provided a long-acting reversible method of contraception (LARC)



Beneficiaries Participating in an HII Program (Metric 4.D.17)

The percentage of ARHOME beneficiaries who participated in an HII program in MY22 was 18.8% (N=281,869), which significantly (t-test; P<0.0001) increased to 26.0% (N=224,306) in MY23.

Figure 70: Beneficiaries participating in an HII program



Antidepressant Medicaid Management by Copay Status (Metric 4.E.1)

Beneficiaries who had an FPL ≤100% were not subject to copays in MY22. In MY23, beneficiaries who were American Indians or Native Alaskans, enrollees receiving hospice care, pregnant women, and enrollees who were 19 or 20 years of age during the year were also exempt from copays[50]. Some beneficiaries may switch copay status during the measurement year. Thus, beneficiaries who did not pay a copay during the measurement year must have had 6 months of copay exclusion segments during the year.

The eligible population for the following metric consists of target group beneficiaries who were subject to =or not subject to copays between the ages of 19 to 64 who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment for ≥84 or ≥180 days.

In MY22, the rate of target group beneficiaries subject to copays who remained on antidepressant medication for ≥84 days was 61.7%, which was significantly higher (P=0.0063) than the comparison group (58.4%), with a difference of 3.3 percentage points. In MY23, the target group rate decreased slightly to 60.9% while the comparison group rate increased to 61.4%, with the target group being insignificantly lower than the comparison group (P=0.8122).

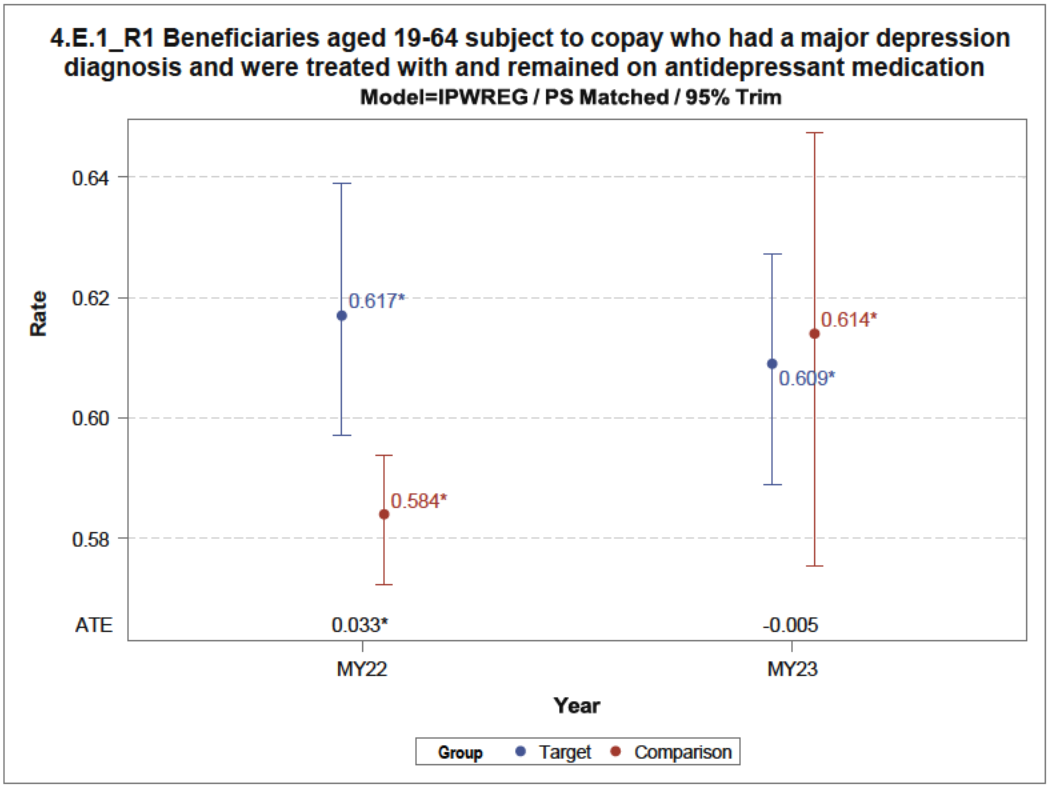
For beneficiaries who remained on antidepressant medication for at least 180 days in MY22, the target group rate of 43.8% was significantly higher (P=0.0005) than the comparison group (39.6%), with a difference of 4.2 percentage points. In MY23, the target group rate decreased slightly to 42.6% while the comparison group rate increased to 42.3%, with the target group being insignificantly higher than the comparison group (P=0.8978).

[50] For 2023-2024, pregnant women were not identified as exempt at the bene level. Starting in 2025, pregnant woman will be flagged with an exemption code and captured in 2025 analytics and forward.

Table 78: Percentage of beneficiaries subject to copays aged 19-64 who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment

4.E.1	MY22	MY23
Target Sample Size	2,108	3,261
Comparison Sample Size	8,462	1,147
Rate 1: Effective acute phase treatment – at least 84 days		
Target Rate (95% C.I.)	0.617 (0.597 – 0.639)	0.609 (0.589 – 0.627)
Comparison Rate (95% C.I.)	0.584 (0.572 – 0.594)	0.614 (0.575 – 0.647)
Rate Difference (95% C.I.)	0.033 (0.010 – 0.058)	-0.005 (-0.045 – 0.040)
P Value	0.0063	0.8122
Rate 2: Effective continuation phase treatment – at least 180 days		
Target Rate (95% C.I.)	0.438 (0.417 – 0.463)	0.426 (0.406 – 0.446)
Comparison Rate (95% C.I.)	0.396 (0.386 – 0.407)	0.423 (0.385 – 0.461)
Rate Difference (95% C.I.)	0.042 (0.020 – 0.069)	0.003 (-0.039 – 0.045)
P Value	0.0005	0.8978
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 71: Percentage of beneficiaries subject to copays aged 19-64 treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for ≥84 days



Rate of Follow-up after Hospitalization or ED Visit by Copay Status (Metric 4.E.2, 4.E.6, 4.E.7)

In MY22, the percentage of beneficiaries in the target group subject to copays who had a follow-up visit with a mental health practitioner within 7 days after hospitalization for MI was 27.4% and was significantly higher (P=0.0097) than the comparison group (20.3%), with a difference of

7.1 percentage points. In MY23, the target group rate of 20.3% was insignificantly lower (P=0.3212) than the comparison group (25.1%).

For beneficiaries subject to copays who had a follow-up visit within 30 days after hospitalization for mental illness in MY22, the target group rate of 47.3% was significantly higher (P=0.0111) than the comparison group (39.2%), with a difference of 8.1 percentage points. In MY23, the target group rate of 39.6% was significantly lower (P=0.0127) than the comparison group (53.7%), with a difference of -14.1 percentage points.

Table 79: Percentage of beneficiaries subject to copays who had a follow-up visit within 7 or 30 days after hospitalization for mental illness during the measurement year

4.E.2	MY22	MY23
Target Sample Size	271	684
Comparison Sample Size	2,389	134
Rate 1: Follow-up visit within 7 days of hospitalization		
Target Rate (95% C.I.)	0.274 (0.224 – 0.330)	0.204 (0.172 – 0.234)
Comparison Rate (95% C.I.)	0.203 (0.188 – 0.219)	0.251 (0.153 – 0.342)
Rate Difference (95% C.I.)	0.071 (0.020 – 0.134)	-0.048 (-0.153 – 0.056)
P Value	0.0097	0.3212
Rate 2: Follow-up visit within 30 days of hospitalization		
Target Rate (95% C.I.)	0.473 (0.414 – 0.543)	0.396 (0.359 – 0.435)
Comparison Rate (95% C.I.)	0.393 (0.375 – 0.412)	0.537 (0.408 – 0.657)
Rate Difference (95% C.I.)	0.081 (0.021 – 0.152)	-0.141 (-0.265 – -0.009)
P Value	0.0111	0.0127
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 72: Percentage of beneficiaries subject to copays who had a follow-up visit within 7 days after hospitalization for mental illness during the measurement year

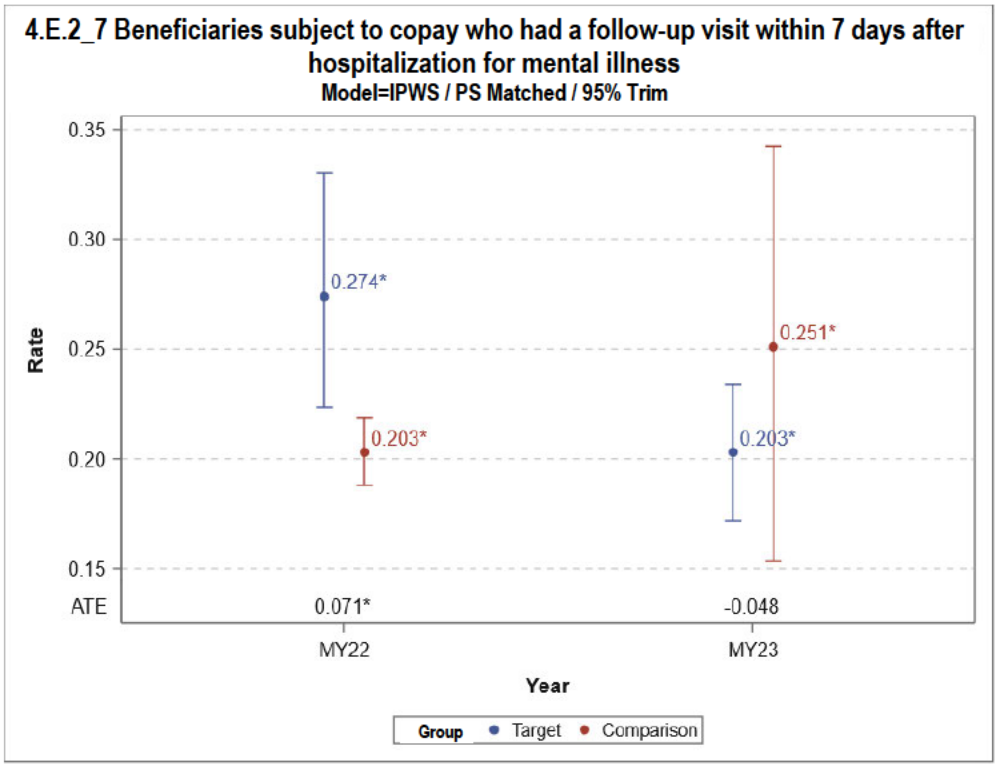
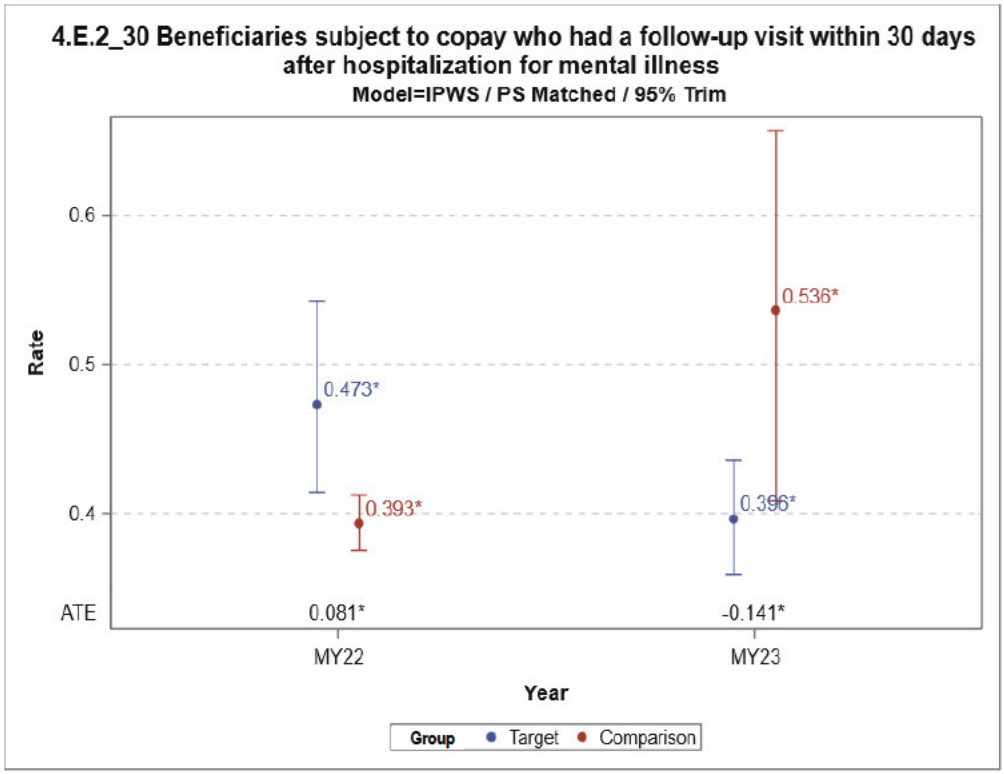


Figure 73: Percentage of beneficiaries subject to copays who had a follow-up visit within 30 days after hospitalization for mental illness during



In MY22, the percentage of beneficiaries in the target group subject to copays who had a follow-up visit within 7 days after an emergency department visit for alcohol or other drug abuse or dependence in the target group was 13.8%, which was insignificantly lower (P=0.5681) than the comparison group (15.5%). In MY23, the target group rate of 15.9% was insignificantly higher (P=0.3163) than the comparison group (11.9%).

In MY22, the percentage of beneficiaries subject to copays who had a follow-up visit within 30 days after an emergency department visit for alcohol or other drug abuse or dependence in the target group was 27.9%, which was insignificantly higher (P=0.6949) than the comparison group (26.4%). In MY23, the target group rate of 31.8% was also insignificantly higher (P=0.0855) than the comparison group (22.0%).

Table 80: Percentage of beneficiaries subject to copays who had a follow-up visit within 7 or 30 days after an emergency department visit for alcohol or other drug abuse or dependence

4.E.6	MY22	MY23
Rate 1: Follow-up visit within 7 days of ED visit		
Target Sample Size	156	1,012
Comparison Sample Size	1,460	223
Target Rate (95% C.I.)	0.138 (0.088 – 0.204)	0.160 (0.137 – 0.185)
Comparison Rate (95% C.I.)	0.155 (0.139 – 0.173)	0.119 (0.047 – 0.239)
Rate Difference (95% C.I.)	-0.017 (-0.070 – 0.050)	0.040 (-0.083 – 0.118)
P Value	0.5681	0.3163
Rate 2: Follow-up visit within 30 days of ED visit		
Target Sample Size	156	474
Comparison Sample Size	1,460	80
Target Rate (95% C.I.)	0.279 (0.213 – 0.359)	0.318 (0.274 – 0.358)
Comparison Rate (95% C.I.)	0.264 (0.242 – 0.285)	0.220 (0.120 – 0.359)
Rate Difference (95% C.I.)	0.015 (-0.060 – 0.094)	0.098 (-0.044 – 0.213)
P Value	0.6949	0.0855
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

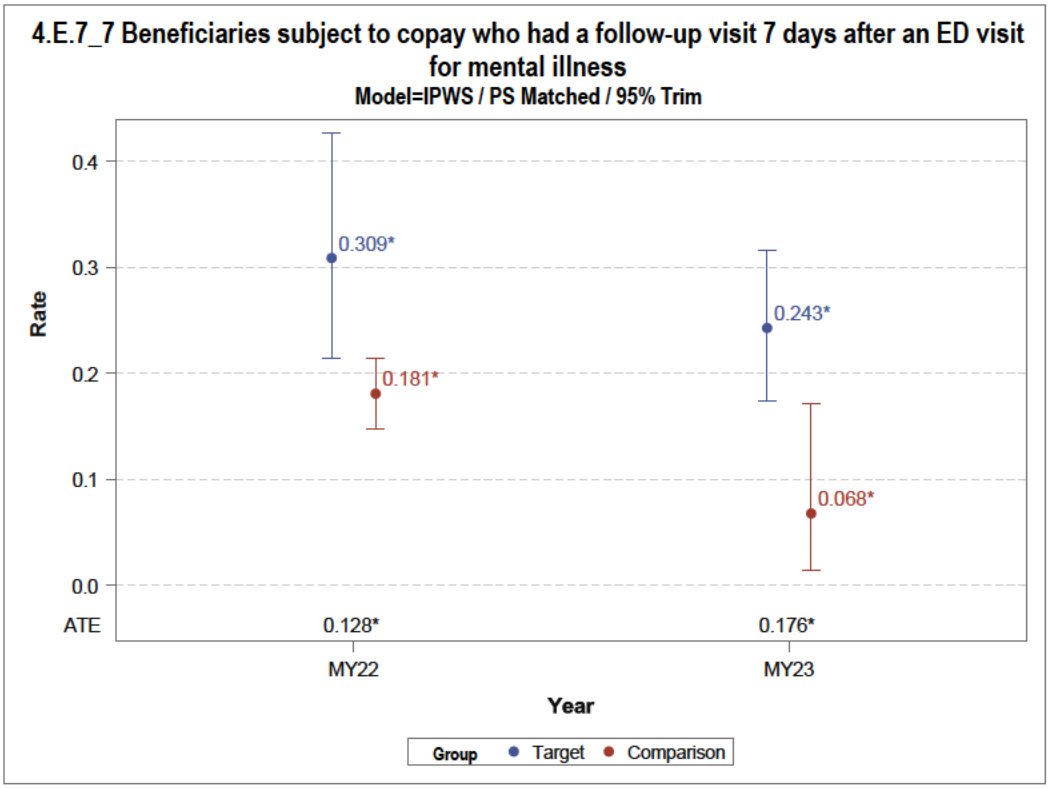
For beneficiaries subject to copays who had a follow-up visit within 7 days after an ED visit for MI in MY22, the target group rate of 30.9% was significantly higher (P=0.0147) than the comparison group (18.1%), with a difference of 12.8 percentage points. Even though the target group (24.4%) and comparison group (6.8%) rates decreased in MY23, the target group was still significantly higher (P<0.0001), with a difference of 17.6 percentage points.

In MY22, the percentage of beneficiaries in the target group subject to copays who had a follow-up visit within 30 days after an ED visit for MI was 41.7%, which was insignificantly higher (P=0.0861) than the comparison group (31.7%). However, the target group rate of 36.8% in MY23 was insignificantly higher (P=0.2172) than the comparison group (23.6%).

Table 81: Percentage of beneficiaries subject to copays who had a follow-up visit within 7 or 30 days after an emergency department visit for mental illness during the measurement year

4.E.7	MY22	MY23
Target Sample Size	66	183
Comparison Sample Size	524	35
Rate 1: Follow-up visit within 7 days of ED visit		
Target Rate (95% C.I.)	0.3089 (0.214 – 0.426)	0.244 (0.174 – 0.317)
Comparison Rate (95% C.I.)	0.181 (0.147 – 0.214)	0.068 (0.015 – 0.171)
Rate Difference (95% C.I.)	0.128 (0.026 – 0.255)	0.176 (0.074 – 0.269)
P Value	0.0147	<0.0001
Rate 2: **Follow-up visit within 30 days of ED visit**		
Target Rate (95% C.I.)	0.417 (0.306 – 0.539)	0.3684 (0.290 – 0.438)
Comparison Rate (95% C.I.)	0.317 (0.281 – 0.357)	0.2362 (0.051 – 0.559)
Rate Difference (95% C.I.)	0.100 (-0.016 – 0.232)	0.1322 (-0.184 – 0.342)
P Value	0.0861	0.2172
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWS	

Figure 74: Percentage of beneficiaries subject to copays who had a follow-up visit within 7 days after an emergency department visit for mental illness during the measurement year



Adherence to Antipsychotic Medications with Schizophrenia by Copay Status (Metric 4.E.3)

In MY22 the percentage of beneficiaries in the target group subject to copays with schizophrenia that adhere to antipsychotic medication was 45.3%, which was insignificantly higher (P=0.3421) than the comparison group (40.2%). In MY23, the target group rate of 48.2% was insignificantly lower (P=0.6486) than the comparison group (51.2%).

Table 82: Percentage of beneficiaries subject to copays with schizophrenia that adhere to antipsychotic medication during the measurement year

4.E.3	MY22	MY23
Target Sample Size	83	371
Comparison Sample Size	821	64
Target Rate (95% C.I.)	0.453 (0.335 – 0.570)	0.483 (0.427 – 0.534)
Comparison Rate (95% C.I.)	0.402 (0.371 – 0.436)	0.512 (0.332 – 0.658)
Rate Difference (95% C.I.)	0.052 (-0.072 – 0.171)	-0.030 (-0.193 – 0.161)
P Value	0.3421	0.6486
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Use of Opioids and Benzodiazepines by Copay Status (Metric 4.E.4, 4.E.5)

In MY22, the percentage of beneficiaries in the target group subject to copays aged 19 to 64 who received prescriptions for opioids with an average daily dosage ≥90 MMEs over a period of 90 days or more was 0.72%, which was insignificantly higher (P=0.9211) than the comparison group (0.71%). In MY23, the target group rate of 0.83% was insignificantly higher (P=0.7435) than the comparison group (0.73%).

Table 83: Percentage of beneficiaries subject to copays aged 19-64 who received prescriptions for opioids with an average daily dosage ≥90 MMEs over a period of 90 days or more during the measurement year

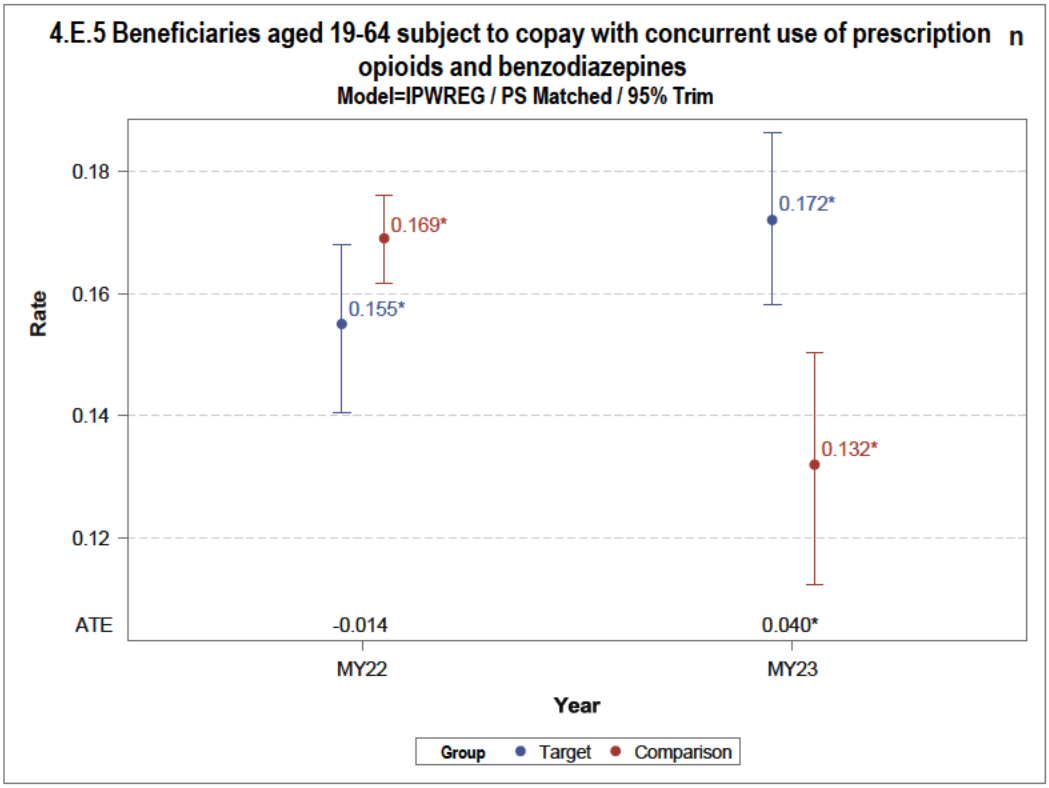
4.E.4	MY22	MY23
Target Sample Size	2,191	3,112
Comparison Sample Size	8,666	1,420
Target Rate (95% C.I.)	0.007 (0.004 – 0.011)	0.008 (0.004 – 0.014)
Comparison Rate (95% C.I.)	0.007 (0.006 – 0.009)	0.007 (0.003 – 0.012)
Rate Difference (95% C.I.)	0.000 (-0.004 – 0.004)	0.001 (-0.005 – 0.008)
P Value	0.9211	0.7435
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

In MY22, the percentage of beneficiaries in the target group subject to copays aged 19-64 with concurrent use of prescription opioids and benzodiazepines was 15.5%, which was insignificantly lower (P=0.0863) than the comparison group (16.9%). However, in MY23, the target group rate of 17.2% was significantly higher (P=0.0010) than the comparison group (13.2%), with a difference of 4.0 percentage points.

Table 84: Percentage of beneficiaries subject to copays aged 19-64 with concurrent use of prescription opioids and benzodiazepines during the measurement year

4.E.5	MY22	MY23
Target Sample Size	2,587	3,673
Comparison Sample Size	10,387	1,634
Target Rate (95% C.I.)	0.155 (0.140 – 0.168)	0.172 (0.158 – 0.186)
Comparison Rate (95% C.I.)	0.169 (0.162 – 0.176)	0.132 (0.112 – 0.150)
Rate Difference (95% C.I.)	-0.014 (-0.029 – 0.003)	0.040 (0.017 – 0.065)
P Value	0.0863	0.0010
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Figure 75: Percentage of beneficiaries subject to copays aged 19-64 with concurrent use of prescription opioids and benzodiazepines during the measurement year



Persistent Medications by Copay Status (Metric 4.E.8, 4.E.9)

In MY22, the percentage of beneficiaries in the target group who had an acute myocardial infarction (AMI) during the measurement year and who received persistent beta blocker treatment for 6 months after discharge was 53.8%, which was insignificantly higher (P=0.0644) than the comparison group (42.5%). In MY23, the target group rate of 37.2% was insignificantly lower (P=0.5451) than the comparison group (41.7%), with a difference of -4.5%.

Table 85: Percentage of distinct treatment days with beta blockers per beneficiary subject to copays during the measurement year

4.E.8	MY22	MY23
Target Sample Size	22	69
Comparison Sample Size	155	57
Target Rate (95% C.I.)	0.539 (0.451 – 0.626)	0.372 (0.262 – 0.482)
Comparison Rate (95% C.I.)	0.425 (0.349 – 0.502)	0.417 (0.314 – 0.521)
Rate Difference (95% C.I.)	0.113 (-0.007 – 0.233)	-0.045 (-0.192 – 0.101)
P Value	0.0644	0.5451
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

The analytic population includes beneficiaries subject to copays who are on persistent medications (i.e., received at least 180 treatment days of ambulatory medication in the measurement year) for ACE inhibitors, ARBs, or diuretics. In MY22, the target group rate of

85.1% was insignificantly higher (P=0.0666) than the comparison group (84.2%). In MY23, the target group rate of 86.7% was also insignificantly higher (P=0.4358) than the comparison group (86.1%). When looking at beneficiaries on persistent medications that include ACE inhibitors and ARBs or diuretics, the target group had a higher rate of adherence for ≥180 days than the comparison group, but the difference was not significant in either year.

Table 86: Percentage of beneficiaries subject to copays who are on persistent medications (i.e., received at least 180 treatment days of ambulatory medication during the measurement year) for ACE inhibitors, ARBs, or diuretics

4.E.9_ACE_ARB	MY22	MY23
Rate 1: Annual monitoring of all beneficiaries on ACE inhibitors/ARB and diuretics*		
Target Sample Size	7,542	8,194
Comparison Sample Size	22,426	4,568
Target Rate (95% C.I.)	0.851 (0.843 – 0.858)	0.867 (0.857 – 0.877)
Comparison Rate (95% C.I.)	0.842 (0.837 – 0.847)	0.861 (0.849 – 0.872)
Rate Difference (95% C.I.)	0.009 (-0.000 – 0.018)	0.006 (-0.009 – 0.021)
P Value	0.0666	0.4358
Rate 2: Annual monitoring of beneficiaries on ACE inhibitors/ARBs		
Target Sample Size	6,049	6,680
Comparison Sample Size	18,124	3,734
Target Rate (95% C.I.)	0.856 (0.847 – 0.864)	0.870 (0.859 – 0.882)
Comparison Rate (95% C.I.)	0.847 (0.841 – 0.853)	0.863 (0.848 – 0.875)
Rate Difference (95% C.I.)	0.009 (-0.002 – 0.019)	0.008 (-0.008 – 0.027)
P Value	0.0968	0.3750
Rate 3: Annual monitoring of beneficiaries on diuretics		
Target Sample Size	4,051	4,360
Comparison Sample Size	12,112	2,394
Target Rate (95% C.I.)	0.853 (0.842 – 0.864)	0.875 (0.862 – 0.886)
Comparison Rate (95% C.I.)	0.840 (0.834 – 0.847)	0.864 (0.848 – 0.881)
Rate Difference (95% C.I.)	0.013 (-0.001 – 0.024)	0.011 (-0.011 – 0.030)
P Value	0.0503	0.2842
Propensity scores trimmed at the:	**5th–95th percentiles**	
Regression Model:	**IPWREG: Binary logit**	

* Regression model: IPWREG: Normal identity

HIV/AIDs Viral Load Test by Copay Status (Metric 4.E.10)

In MY22, the percentage of beneficiaries in the target group subject to copays with a diagnosis of HIV with ≥1 HIV viral load test during the measurement year was 80.1%, which was insignificantly higher (P=0.8308) than the comparison group (79.2%). In MY23, the target group rate of 77.4% was also insignificantly higher (P=0.8634) than the comparison group (76.5%).

Table 87: Percentage of beneficiaries subject to copays with a diagnosis of HIV with at least one HIV viral load test during the measurement year

4.E.10	MY22	MY23
Target Sample Size	141	382
Comparison Sample Size	791	152
Target Rate (95% C.I.)	0.801 (0.717 – 0.882)	0.774 (0.732 – 0.815)
Comparison Rate (95% C.I.)	0.792 (0.763 – 0.820)	0.765 (0.674 – 0.856)
Rate Difference (95% C.I.)	0.009 (-0.086 – 0.093)	0.009 (-0.092 – 0.110)
P Value	0.8308	0.8634
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Statin Therapy for Patients with Diabetes by Copay Status (Metric 4.E.11)

The analytic population included beneficiaries subject to copays aged 40 to 64 during the measurement year with diabetes who do not have clinical ASCVD and who were dispensed ≥1 statin medication of any intensity during the measurement year. In MY22, the target group rate of 59.1% was insignificantly higher (P=0.8440) than the comparison group (58.9%). In MY23, the target group rate of 60.4% was also insignificantly higher (P=0.8139) than the comparison group (60.0%).

Table 88: Percentage of beneficiaries subject to copays aged 40–64 during the measurement year with diabetes who do not have clinical ASCV who were dispensed ≥1 statin medication of any intensity during the measurement year

4.E.11	MY22	MY23
Target Sample Size	2,954	3,258
Comparison Sample Size	8,234	1,912
Target Rate (95% C.I.)	0.591 (0.574 – 0.609)	0.604 (0.582 – 0.624)
Comparison Rate (95% C.I.)	0.589 (0.578 – 0.599)	0.600 (0.573 – 0.626)
Rate Difference (95% C.I.)	0.002 (-0.018 – 0.024)	0.004 (-0.031 – 0.040)
P Value	0.8440	0.8139
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Binary logit	

Beneficiaries Participating in EII (Metric 4.I.1, 4.I.2)

Beneficiaries who participated in education and training programs during the measurement year could participate in QHP offered economic incentives or enroll in educational or employment training programs. In MY22, 8.8% (N=281,869) of QHP target beneficiaries enrolled in educational attainment programs, participated in employment or vocational training, or a QHP offered incentive (4.I.1) as identified from the Arkansas Higher Education Information System (AHEIS) Reporting & Analytics data and QHP reported data. This percentage increased slightly to 9.3% (N=224,306) in MY23. Of those that participated in an educational or training program in 4.I.1, 2.0% of beneficiaries participated in EII training based on QHP reported numbers (4.I.2) in MY22 and 3.3% in MY23. This small increase in participation in MY23 was significant (P<0.0001). Even though these increases are a positive sign that beneficiaries are becoming motivated in taking advantage of EII incentives, efforts to increase beneficiary awareness and promote these resources by providers and QHPs could result in more

beneficiaries accessing these services in future years, further expanding on the successful increase in participation between MY22 and MY23.

Beneficiaries with an Increase in FPL During the Measurement Year (Metric 4.F.1, 4.G.1)

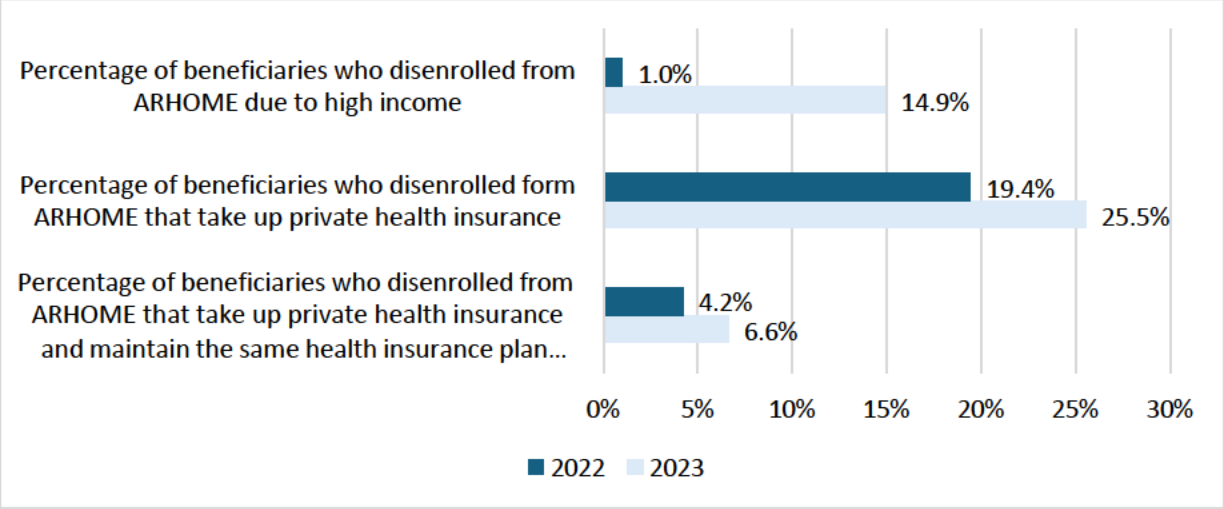
The intention of providing EII opportunities in the ARHOME program is to provide QHP beneficiaries with resources to increase their economic and financial standing over time. For QHP beneficiaries who were ≤ 20% FPL in the beginning of the measurement year, 14.2% (N=9,291) of EII participants in MY22 compared with 21.5% (N=6,484) of EII participants in MY23 increased their income (determined by an increase in FPL) by the end of the year. For those at or under 100% FPL who participated in an EII, 9.8% (N=17,118) of beneficiaries saw an increase in income by the end of MY22 compared with 8.3% (N=11,247) of beneficiaries in MY23.

Beneficiary Characteristics for Those Disenrolled Due to High Income (Metric 4.H.1, 4.H.2, 4.H.3)

While increasing income through participation in EII resources is important, ARHOME's goal is to ultimately aid beneficiaries in increasing their income enough to disenroll from ARHOME and take up private health insurance. In MY22, only 1% (N=15,134) of QHP beneficiaries disenrolled due to high income compared with 14.9% (N=159,493) of beneficiaries in MY23 (t-test; P<0.0001). Due to the COVID-19 PHE almost no beneficiaries were disenrolled for any disqualifying characteristics.

Of the beneficiaries that did disenroll in MY22, 19.4% (N=8,582) compared with 25.5% (N=109,944) in MY23 took up private health insurance, which was significantly higher (t-test; P<0.0001). A small percentage of those who did take up private health insurance remained on the same health insurance that they had in ARHOME in MY22 (4.2%; N=8,582) and MY23 (6.6%; N=109,944). However, the slight increase in MY23 was significantly higher (t-test; P<0.0001) than in MY22, suggesting that more ARHOME beneficiaries were willing to continue with the same carrier.

Figure 76: Percentage of beneficiaries who disenrolled from ARHOME due to high income during the measurement year



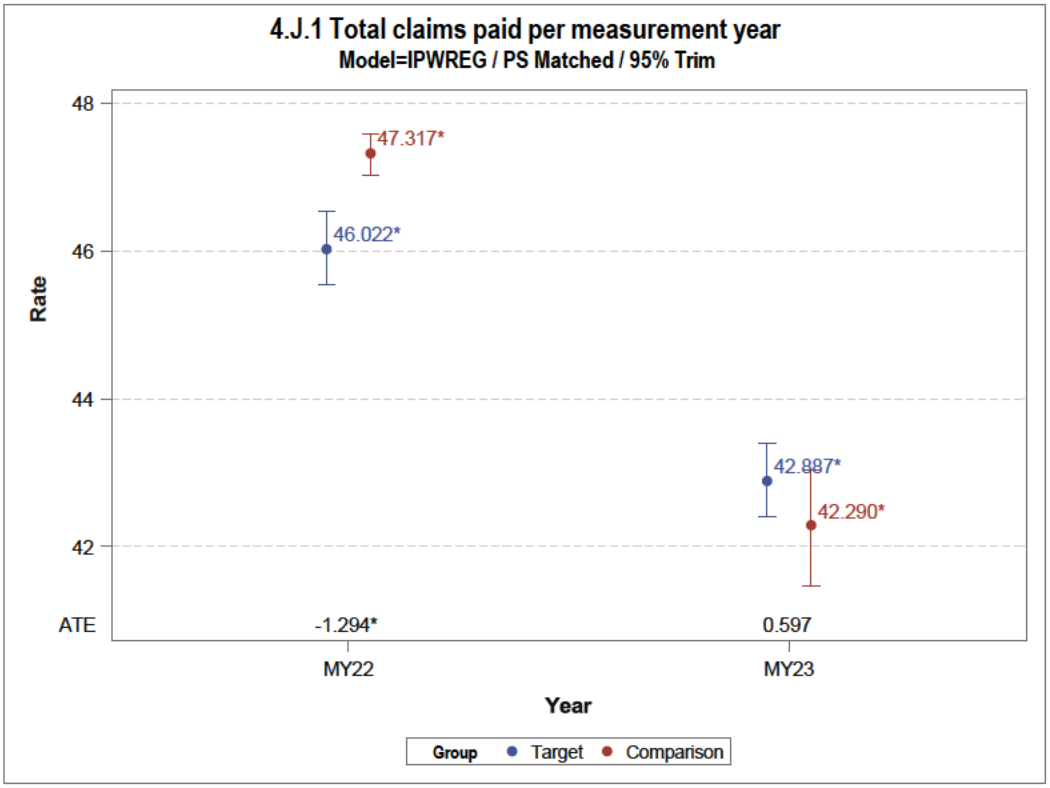
Beneficiary Healthcare Utilization by Copay Status (Metric 4.J.1)

In MY22, the total number of medical claims per target group beneficiary was 46.02 paid claims and was significantly lower (P<0.0001) than the comparison group (47.32 paid claims per beneficiary), with a rate difference of -1.30. In MY23, the target group rate of 42.89 was insignificantly higher (P=0.1797) than the comparison group (42.29).

Table 89: Beneficiary Copayment Healthcare Use Impact – Total claims paid per beneficiary per measurement year

4.J.1	MY22	MY23
Target Sample Size	55,617	95,916
Comparison Sample Size	205,243	37,864
Target Rate (95% C.I.)	46.023 (45.543 – 46.542)	42.887 (42.401 – 43.404)
Comparison Rate (95% C.I.)	47.317 (47.018 – 47.572)	42.290 (41.476 – 43.033)
Rate Difference (95% C.I.)	-1.294 (-1.815 – -0.724)	0.597 (-0.207 – 1.513)
P Value	<0.0001	0.1797
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Figure 77: Beneficiary Copayment Healthcare Use Impact – Total claims paid per beneficiary per measurement year



4.L.1 Average Charlson Comorbidity Index (Metric 4.L.1)

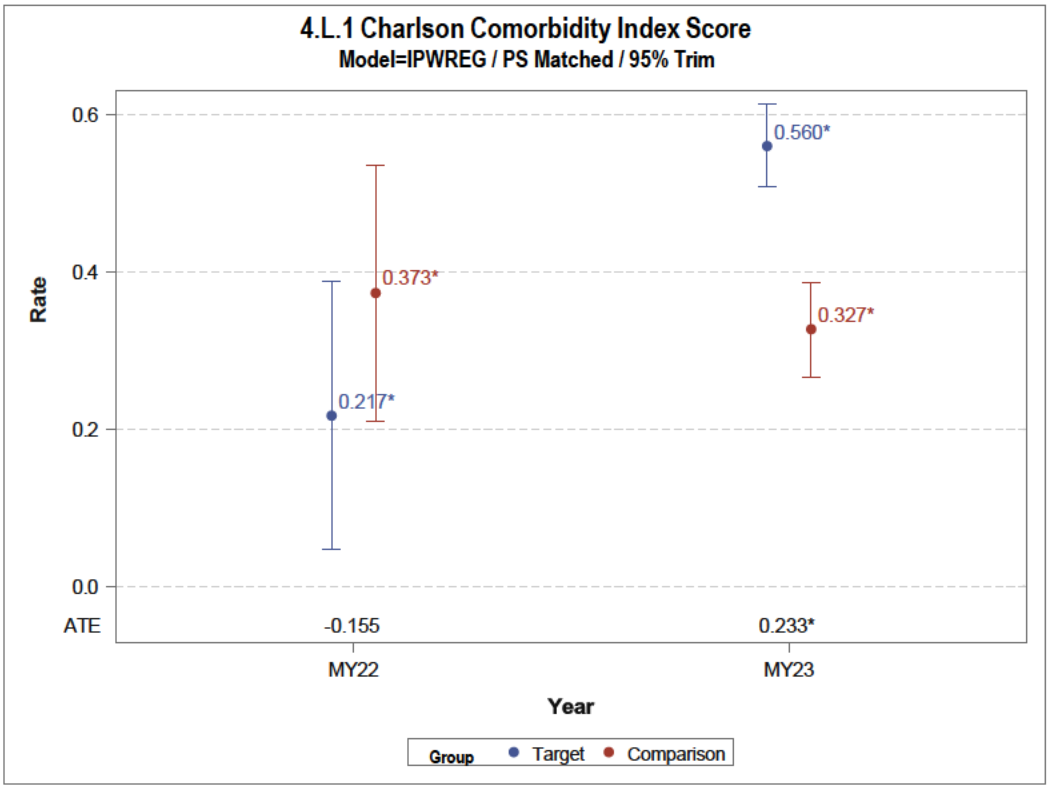
The Charlson Comorbidity Index (CCI) was designed to predict 10-yr mortality risk based on 17 categories of comorbid conditions. The CCI is correlated with the number of comorbidities, meaning the higher the index score, the more medical conditions an individual has. In MY22, the CCI per target group beneficiary was 0.217 and was insignificantly lower (P=0.1887) than the comparison group score of 0.373. In MY23, the target group score increased to 0.560 and was

significantly higher (P<0.0001) than the comparison group score of 0.327, with a score difference of 0.233. The lower number of newly enrolled beneficiaries in MY22 compared with MY23 may have affected the magnitude of results in MY22.

Table 90: Charlson Comorbidity Index Score

4.L.1	MY22	MY23
Target Sample Size	146	1,607
Comparison Sample Size	432	1,035
Target Rate (C.I.)	0.217 (0.047 – 0.388)	0.560 (0.508 – 0.614)
Comparison Rate (C.I.)	0.373 (0.210 – 0.536)	0.327 (0.265 – 0.386)
Rate Difference (C.I.)	-0.156 (-0.387 – 0.076)	0.233 (0.167 – 0.313)
P Value	0.1887	<0.0001
Propensity scores trimmed at the:	5th–95th percentiles	
Regression Model:	IPWREG: Normal identity	

Figure 78: Charlson Comorbidity Index Score



6.1.5 COST-EFFECTIVE CARE RESULTS

Program Growth Rate and Budget Neutrality (Metric 4.K.1, 4.K.2, 4.K.3, 4.M.1)

While expanding and improving upon health care coverage and medical services to the ARHOME Medicaid expansion population are essential goals to the success of this demonstration, ensuring that the rate of growth for annual PMPM costs, total health expenditures (THE), and administrative costs are the same or below that of Arkansas Medicaid FFS is important for providing sustainable and cost-effective care. Cost reporting in this section

is based on information collected at a given point in time and is subject to change based on prior period adjustments that are identified by CMS or the State. Costs were pulled by metric on the same date to ensure comparability between ARHOME and Medicaid FFS.

CMS has established a budget neutrality cap for each demonstration year which is outlined in the "Demonstration Populations Used to Calculate the Budget Neutrality Limit" section of the STCs. The table below details expenditures in relation to the established budget neutrality guidelines. Net payments were calculated as (Premium Expenditures + Advance Cost Share Payments + Wrap Costs) / Number of Paid Member Months. PMPM coverage costs through QHPs remained below the budget neutrality cap for MY22 (-9.25%) and MY23 (-6.82%). The PMPM growth rate between MY22 and MY23 for ARHOME beneficiaries was lower (8.63%) than Medicaid FFS (10.84%, not shown).

Table 91: ARHOME Budget neutrality by year

4.K.1	MY22	MY23
Number of Paid Premium Member Months	3,634,084	2,930,024
Premium Expenditures	$1,752,565,875	$1,541,389,100
Advance Cost Share Payments	$694,258,234	$616,556,526
Wrap Costs	$13,446,111	$18,761,486
Cost Share Reconciliations	$-94,692,284	$-84,290,561
Net Payments Per Individual with a Paid Premium	$650.94	$707.12
Budget Neutrality Cap	$717.25	$758.85
% Difference from Budget Neutrality	-9.25%	-6.82%

Additionally, the PMPM growth rate in MY23 of just ARHOME beneficiaries who were between 101-138% FPL was 3.78% lower than the budget neutrality cap compared with 6.53% lower for those in the same FPL range in MY22.

Table 92: ARHOME PMPM growth rate for QHP beneficiaries at 101-138% FPL

4.M.1	MY22	MY23
Number of Paid Premium Member Months	945,737	689,218
ARHOME Premiums & Cost Sharing	$630,644,171	$502,021,471
Wrap Costs	$3,524,784	$2,681,980
Net Payments Per Individual with a Paid Premium	$670.40	$730.17
Budget Neutrality Cap	$717.25	$758.85
% Difference from Budget Neutrality	-6.53%	-3.78%

Measuring total health expenditures is essential for understanding Arkansas's Medicaid system, identifying challenges, informing policy decisions, and working towards a more equitable, efficient, and sustainable healthcare future. The table below demonstrates that ARHOME total health expenditures remained below FFS expenditures and incurred a significant reduction of 8.97% between 2022 and 2023. This is likely due to Medicaid unwinding beginning in April of 2023 as there was about a 20% decrease in the number of ARHOME beneficiaries that were enrolled in ARHOME for ≥ 6 months of the year (**Methodology section: Table 13**).

Table 93: Total health expenditures growth rate

4.K.2	MY22	MY23	Rate
Total Medicaid FFS	$4,396,120,095	$4,790,014,904	8.96%
Total ARHOME	$2,331,693,947	$2,122,494,789	-8.97%

The administrative cost growth rate provides crucial insights into the efficiency, affordability, and overall performance of the healthcare system, enabling policymakers and stakeholders to make informed decisions about resource allocation, policy reforms, and ultimately, improve patient care and health outcomes. Administrative costs for the ARHOME program increased significantly in 2023 as compared to 2022 (381.9%). This increased rate is largely due to CMS's recommended adjustment to include 1115 waiver allocations in 2023 and forward, making growth rate comparisons between the two years difficult to assess.

Table 94: Total Administrative growth rate

4.K.3	MY22	MY23	Rate
Total Medicaid FFS	$420,579,431	$513,160,192	22.01%
Total ARHOME	$7,048,269	$33,964,361	381.88%

Arkansas Program Characteristics (Metric 4.N.1, 4.N.2, 4.N.3)

ARHOME extends healthcare eligibility to individuals between 19 and 64 years of age with income levels ≤138% FPL. Clients are enrolled in QHPs offered via the Health Insurance Marketplace with premium assistance paid for by the State's Medicaid program. Arkansas was an early adopter of the reforms included in the ACA that expanded coverage and enrollment options for both Medicaid and commercial health plan clients. The ARHOME demonstration utilizes the commercial QHPs offered on the health insurance marketplace as the foundation for the demonstration.

Table 95: Arkansas Statewide and Regional Program Characteristics Results

		2022	2023	2024
Number of Plans (4.N.1)	Total Number of Plans Offered	319	230	231
Actuarial Risk (4.N.1)	Number of Gold, Silver, Expanded Bronze, Bronze, Catastrophic	45, 213, 54, 6, 1	36, 153, 30, 11, n/a	39, 150, 42, n/a, n/a
SLCSP (4.N.1)	Statewide Average	$321.86	$353.52	$376.41
SLCSP by Region (4.N.2)	Rating Area 1	$311.13	$353.52	$376.41
	Rating Area 2	$326.15	$353.52	$376.41
	Rating Area 3	$311.13	$353.52	$376.41
	Rating Area 4	$326.15	$353.52	$376.41
	Rating Area 5	$326.15	$353.52	$376.41
	Rating Area 6	$326.15	$353.52	$376.41
	Rating Area 7	$326.15	$353.52	$376.41

Note: Premium of the Second Lowest Cost Silver Plan (SLCSP) is based on 40-year-old nonsmoker

ARHOME clients are enrolled in silver level QHPs, with premium assistance and cost support from Medicaid. The actuarial values (AV) for QHPs are fixed by the ACA and the Final Actuarial Calculator Methodology released annually by CMS. The AV did not vary for ARHOME clients, and the same plan richness was available for all QHP clients. All plans offered on the Arkansas marketplace must be within the allowable AV ranges to be certified by the AID as a QHP. The total number of plans offered by all ACA issuers decreased between 2022 and 2023 due to one issuer (Oscar) leaving the market.

Section 1302(d)(2)(A) of the ACA outlined that marketplace health plans must be grouped into four tiers: (1) bronze, with an AV of 60%; (2) silver, with an AV of 70%; (3) gold, with an AV of 80%; and (4) platinum, with an AV of 90%, with a deviation of + or – of no more than 2%. More recently, CMS added an "enhanced" bronze plan that allows for a bronze plan that "either covers and pays for at least one major service, other than preventive services, before the deductible, or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), may have an allowable variation in AV for such plans of -4 percentage points and +5 percentage points."[51]

Arkansas had a relatively steady commercial marketplace, with the number of health insurers offering QHPs and the health insurance companies participating remaining largely consistent across the years 2017–2024; Arkansas Blue Cross Blue Shield and Centene (Ambetter) are mainstays. Octave began participating under Blue Cross Blue Shield in 2024. One indication that the market suffered as a result of the ARHOME demonstration would have been companies leaving the marketplace due to the potential uncertainty or the unknown risk profile of the ARHOME eligible clients. This did not happen in Arkansas.

Table 96: Issuers Operating in Arkansas (2017–2021)

Year	2017	2018	2019	2020	2021	2022	2023	2024
Number of Issuers	3	3	3	2	2	2	2	2

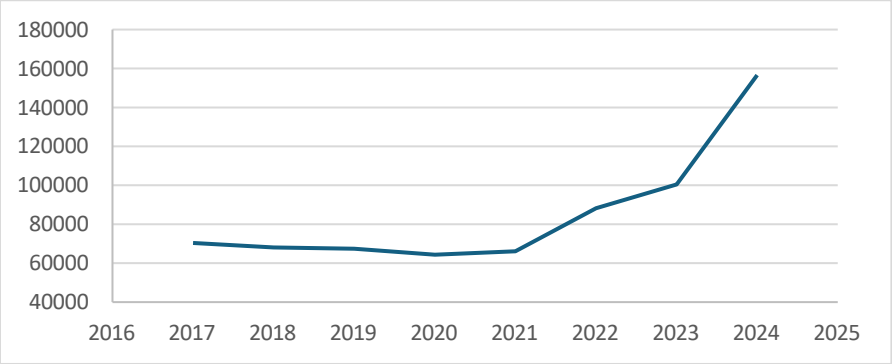
In **Figure 79**[52], open enrollment numbers in the Arkansas QHPs increased from 2021 through 2024, with a particularly large increase from 2023 (100,407) to 2024 (156,607). The increase from 2021 through 2023 is most likely due to the Medicaid continuous enrollment provision that was in effect from March 2020 through March 2023, followed by a redetermination process.[53]

[51] Centers for Medicare & Medicaid Services. "Final 2021 Actuarial Value Calculator Methodology." *Center for Consumer Information & Insurance Oversight*, 6 March 2020, Washington, DC, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-AV-Calculator-Methodology.pdf.

[52] Marketplace Enrollment, *KFF*, 31 December 2025, Marketplace Enrollment, 2014-2025 | KFF State Health Facts.

[53] Tolbert, Jennifer, and Meghana Ammula. "10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision." *KFF*, 9 June 2023, https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/#one.

Figure 79: QHP Open Enrollment in Arkansas (2017–2024)



To gain insights into the impact of ARHOME on the individual Marketplace inside the state, a high-level comparison analysis of states bordering Arkansas at a point in time (2023) used certain aspects of their QHPs, primarily each State's Silver Tier Metal plan as a basis of comparison. ARHOME utilized the individual market QHPs as the basis of the demonstration and clients were enrolled in silver plans. Demographic characteristics of these contiguous states highlighted similarities and differences across the cohort in reviewing trends in enrollment during the annual open enrollment period and premium rate changes over the observation period. While the contiguous states did not closely resemble the demographics of Arkansas, the premium analysis demonstrates that the premium trends in Arkansas across the waiver period were below contiguous states' median.

The following states sharing a common border with Arkansas included Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas. The demographics of the following states vary significantly.

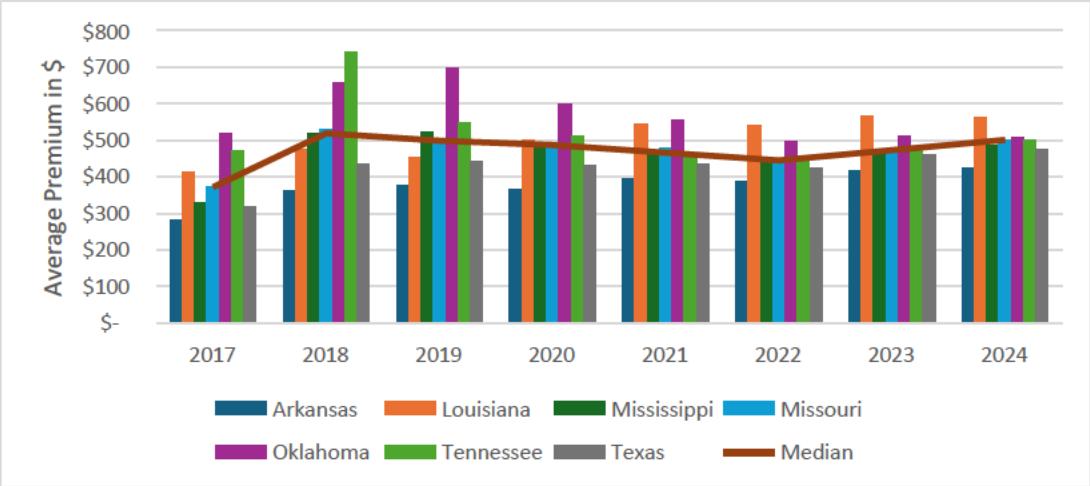
Table 97: Contiguous States Comparison Data (2023)[54, 55, 56,57]

4.N.3	Total Population	Number of Companies on Exchange	Medicaid Clients, number and % of total population	Commercial Insurance Clients, number and % of total population	QHP Open Enrollment Clients, number and % of total population
Arkansas	2,922,500	3	767,000 (26.2%)	1,226,300 (42%)	100,407 (3.4%)
Louisiana	4,498,600	4	1,316,800 (29.3%)	1,882,500 (41.8%)	120,804 (2.7%)
Mississippi	2,867,100	5	693,100 (24.2%)	1,209,700 (42.2%)	183,478 (6.4%)
Missouri	5,939,900	9	975,200 (16.4%)	3,089,700 (52%)	257,629 (4.3%)
Oklahoma	3,826,900	6	576,900 (15.1%)	1,742,700 (45.5%)	203,157 (5.3%)
Tennessee	6,640,900	6	1,293,500 (19.5%)	3,177,400 (47.8%)	348,097 (5.2%)
Texas	28,286,200	15	4,490,000 (15.9%)	13,461,200 (47.6%)	2,410,810 (8.5%)

Arkansas Marketplace Characteristics (Metric 4.N.4, 4.O.1)

In addition, as shown in **Figure 80**[58] below, during the observation period, benchmark plan monthly premium levels (4.N.4) increased at a lower rate per annum in Arkansas compared to the contiguous states and remain consistently below the cohort median.

Figure 80: Marketplace Average Monthly Benchmark Premiums

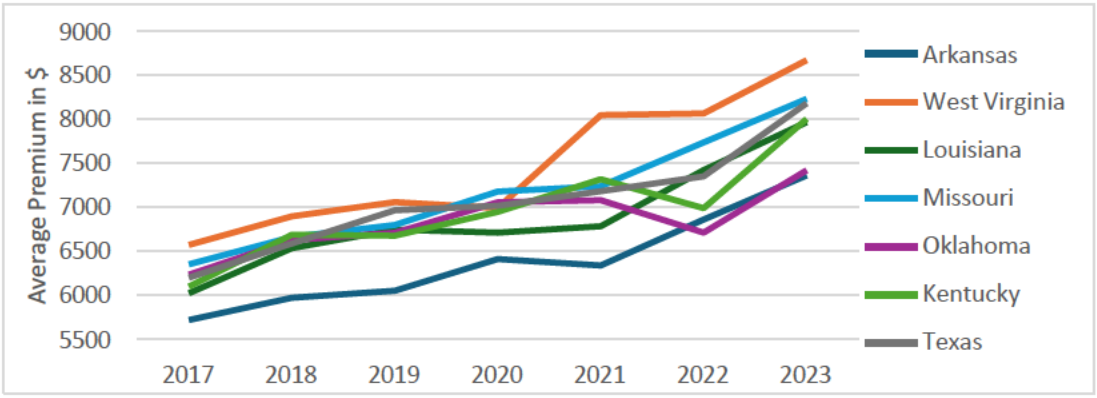


[54] "Health Insurance Coverage of the Total Population." *KFF*, https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed March 2025.
[55] "Insurer Participation on the ACA Marketplaces, 2014-2021." *KFF*, 23 Nov. 2020, https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/. Accessed March 2025.
[56] "Marketplace Enrollment, 2014-2025." *KFF*, https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed March 2025.

[57] "2025 Marketplace Open Enrollment Period Public Use Files." *CMS*, 12 May 2025, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files. Accesses December 2025.
[58] "Marketplace Average Benchmark Premiums." *KFF*, https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/. Accessed March 2025.

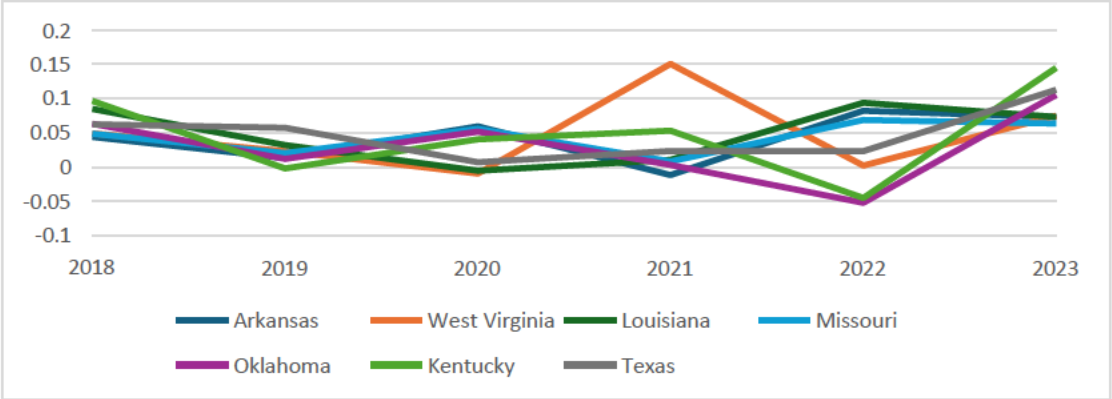
Commercial annual premium rates data from the MEPS explored the impact of the premium assistance model on the rate of increase in commercial insurance premiums (4.O.1) in Arkansas relative to comparison states. **Figure 81**[59] displays the average single premium per enrolled employee at private-sector establishments that offer health insurance from 2017 to 2023. **Figure 82** displays the year-over-year growth rate in such premiums. Commercial insurance premiums in Arkansas, Louisiana, and Missouri appear to fluctuate in a similar way over time, West Virginia, Kentucky, and Oklahoma also appear to trend similarly as a group.

*Figure 81: Trends in Private Sector Insurance Annual Premium**



*Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance

Figure 82: Annual growth rates in private Sector insurance premiums



6.1.6 NET EFFECT OF ARHOME POLICIES

During the ARHOME demonstration, the COVID-19 PHE was in effect through April 2023 when Medicaid unwinding initiated rapid disenrollments of ineligible beneficiaries. Additionally, the termination of premium payments for those over 100% FPL occurred at the end of 2022. To assess the potential impacts of these changes on beneficiary enrollment and medical utilization

[59] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey Insurance Component.

during the first two years of the ARHOME demonstration, multi-year longitudinal analysis (Pre-Post and DiD) were conducted on rates for the following metrics:

- Adult access to preventive/ambulatory health services (2.D.8)
- Emergency department (ED) utilization
- Percent of beneficiaries with ≥1 month coverage gaps (1.D.1)
- Average length of coverage gaps (1.D.2)

Pre-post analysis examined differences in rates between MY22 (defined as the "pre-period") and MY23 (defined as the "post-period"), to assess the effects of Medicaid unwinding in 2023. DiD analysis examined differences in rates among the pre-period (2022), post-period (2023), and 2 income categories (≤100% FPL and >100% FPL) to further assess the effects of the PHE unwinding in 2023 and the termination of the premium requirement in 2022. At each of the two income levels, rate differences were calculated between the pre-period and post-period with the DiD estimate calculated as the difference between these two rate differences. Likewise, for each of the two periods, rate differences were calculated between the high- and low- income levels with the DiD estimate calculated as the difference between these two rate differences.

All measure outcomes were adjusted for client age, gender, and race/ethnicity. Within-client correlations were accounted for with a random residual term in generalized estimating equations (GEE)-type models. P values adjusted for multiple comparisons are reported for estimated differences between groups or periods.

Access to Preventive/Ambulatory Services (Metric 2.D.8)

Compared to the 2022 pre-period, the 2023 post-period showed a significant decrease (P=0.0003) in the rate of beneficiaries with ≥1 ambulatory or preventive visit during the measurement year (68.7% to 68.3%), with a difference of -0.4 percentage points and a percent change of -0.58% (= (68.3-68.7)/68.7). While the difference in rates was significant, the nominal rate value was quite small at 0.004 and demonstrates that the drop in enrollment due to the PHE unwinding did not alter the magnitude of rates between the pre- and post-periods greatly.

Table 98: Pre-Post Model: Percentage of beneficiaries aged 19-64 receiving ≥1 ambulatory or preventive care visit during the measurement year

2.D.8 (4.D.19)	Pre-Post
Pre-Period Sample Size	253,758
Post-Period Sample Size	133,646
Pre-Period Rate (95% C.I.)	0.687 (0.685 – 0.689)
Post-Period Rate (95% C.I.)	0.683 (0.680 – 0.685)
Mean Rate Difference (95% C.I.)	0.004 (0.004 – 0.005)
P Value	0.0003

Looking at the potential effects of ending premium requirements for those over 100% FPL, rates from the pre- and post-periods for beneficiaries with incomes above and below 100% FPL were compared. In the pre-period, the rate of ambulatory or preventive service utilization among those at ≤100% FPL (67.8%) was significantly lower (P<0.0001) than those at >100% FPL (71.9%),

with a rate difference of 4.1 percentage points. In the post-period, there was also a significant difference (P<0.0001) in rates for those at ≤100% FPL (67.5%) and those at >100% FPL (72.0%), with a difference of 4.5 percentage points.

Among those at ≤100% FPL, the rate of receiving ≥1 ambulatory or preventive service during the year decreased slightly between the pre-period (67.8%) and post-period (67.5%), with a rate difference of -0.3 percentage points and a percent change of -0.44% (= (67.5-67.8)/67.8). Conversely, for those >100% FPL, the rate increased slightly from 71.9% to 72.0%), with a rate difference of 0.1 percentage points and a percent change of 0.14% (= (72.0-71.9)/71.9). While the difference in rates between the lower and higher FPL categories were significantly different in both the pre- and post-periods (P<0.0001), there was an insignificant difference in rates of each FPL category across the periods. This demonstrates that the premium requirement termination at the end of 2022, did not significantly affect rates of ambulatory or preventive service utilization for those above 100% FPL.

Table 99: DiD rates for pre/post periods: Percentage of beneficiaries aged 19-64 receiving ≥1 ambulatory or preventive care visit during the measurement year

2.D.8 (4.D.19)	Pre Period		Post Period	
	≤100% FPL	>100% FPL	≤100% FPL	>100% FPL
Sample Size	195,448	58,310	111,926	21,719
Rate (95% C.I.)	0.678 (0.676 – 0.680)	0.719 (0.715 – 0.723)	0.675 (0.672 – 0.678)	0.721 (0.715 – 0.726)

Table 100: DiD rate differences by income and period effects

2.D.8 (4.D.19)	Income Effect		Period Effect		DiD
	Pre	Pos	<100% FPL	>100% FPL	
Rate Difference	-0.041*	-0.045*	0.003	-0.001	-0.004
P-value	<0.0001	<0.0001	0.1113	0.9558	(P=0.1810)

Figure 83: DiD Model: Percentage of beneficiaries aged 19-64 receiving at least 1 ambulatory or preventive care visit during the measurement year – Period Effect

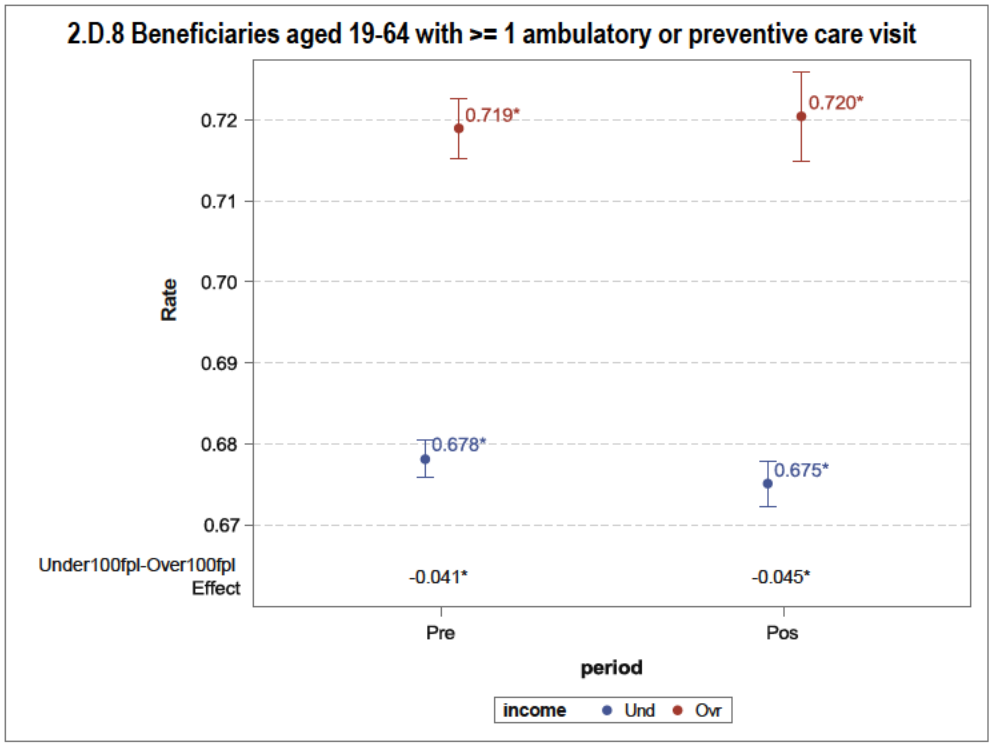
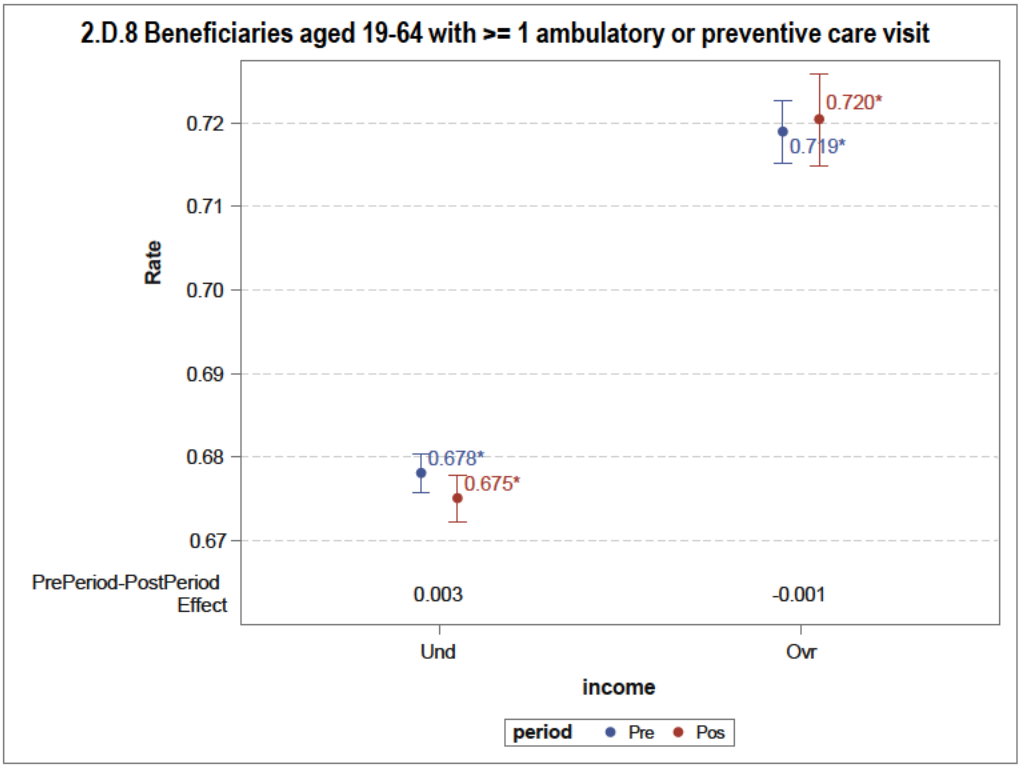


Figure 84: DiD Model: Percentage of beneficiaries aged 19-64 receiving at least 1 ambulatory or preventive care visit during the measurement year – Income Effect



Emergency Department Visits

Compared to the 2022 pre-period, the 2023 post-period showed a significant decrease (P<0.0001) in the rate of beneficiaries with an ED visit from 59.2% to 56.5%, with a difference of -2.7 percentage points and a percent change of -4.56% (= (56.5-59.2)/59.2). It is unclear whether the PHE unwinding or termination of premium requirements contributed to the decrease in the rate of ED visits in the post-period compared with the pre-period.

Table 101: Pre-Post Models: Percentage of beneficiaries with ≥ 1 ED visit during the measurement year

ED Visits	Pre-Post
Pre-Period Sample Size	254,904
Post-Period Sample Size	138,901
Pre-Period Rate (95% C.I.)	0.592 (0.585 – 0.599)
Post-Period Rate (95% C.I.)	0.565 (0.557 – 0.573)
Mean Rate Difference (95% C.I.)	0.027 (0.026 – 0.029)
P Value	<0.0001

To see whether the decrease in ED visits was similar between ≤100% FPL and those >100% FPL, the rates in ED visits for the two income categories were compared in the pre- and post-periods, separately. In the pre-period, beneficiaries at ≤100% FPL had a significantly higher (P<0.0001) rate of ED visits (62.5%) compared with those at >100% FPL (47.0%), with a difference of 15.5 percentage points. In the post-period, a similar significant difference (P<0.0001) was observed with higher rates of ED usage among those at ≤100% FPL (58.6%) compared with those >100% FPL (46.0%), with a difference of 12.6 percentage points, with a DiD of -12.6 + 15.6 = 3.0.

However, when we look at changes in rates for the same income category across the pre-period and post-period, only a significant decrease is seen for those at ≤100% FPL (P<0.0001: a decrease from 62.6% to 58.6%, with a rate difference of -4.0 percentage points and a percent change of -6.39% (= (58.6-62.6)/62.6)) and not for those >100% FPL (P=0.4667: a decrease from 47.0% to 46.0%, with a rate difference of -1.0 percentage point and a percent change of -2.13% (= (46.0-47.0)/47.0)). A decrease of 4.0 percentage points was seen among those at ≤100% FPL, while only a decrease of 1.0 percentage point was observed for those >100% FPL. This demonstrates that the termination of premium requirements for those at >100% FPL did not significantly affect ED utilization among this income group.

Table 102: DiD Models: Percentage of beneficiaries with ≥1 ED visit during the measurement year

ED Visits	Pre Period		Post Period	
	≤100% FPL	>100% FPL	≤100% FPL	>100% FPL
Sample Size	196,387	58,517	115,916	22,984
Rate (95% C.I.)	0.626 (0.618 – 0.633)	0.470 (0.461 – 0.479)	0.586 (0.577 – 0.594)	0.460 (0.446 – 0.473)

Table 103: DiD rate differences by income and period effects

ED Visits	Income Effect		Period Effect		DiD
	Pre	Pos	<100% FPL	>100% FPL	
Rate Difference	0.156*	0.126*	0.040*	0.010	-0.030 (P=0.0092)
P-value	<0.0001	<0.0001	<0.0001	0.4667	

Figure 85: DiD Model: Total number of emergency visits per beneficiary during the measurement year – Period Effect

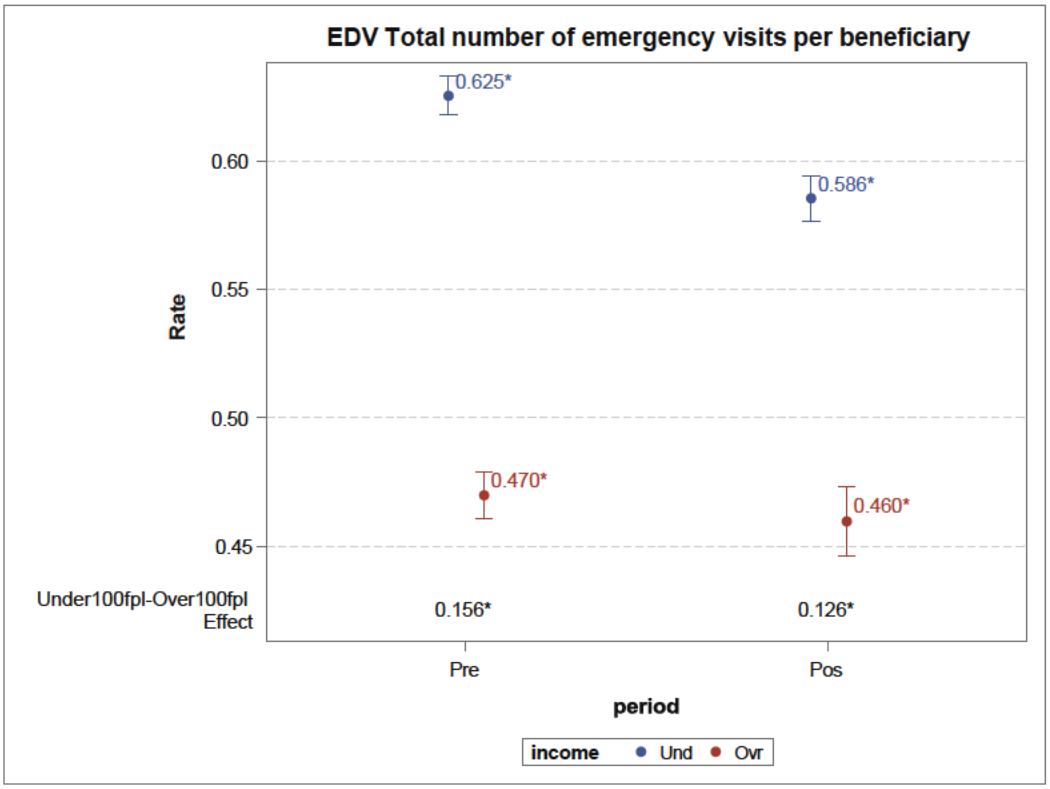
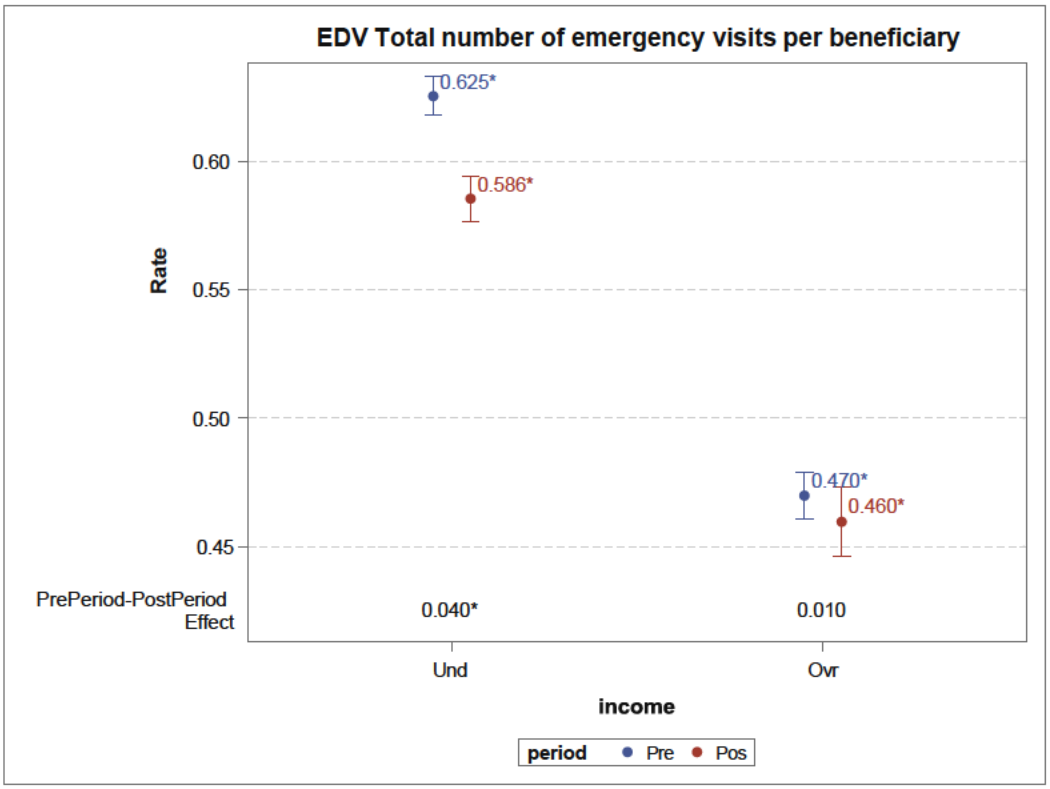


Figure 86: DiD Model: Total number of ED visits per beneficiary during the measurement year – Income Effect



Percentage of beneficiaries with ≥1 month in coverage gaps (Metric 1.D.1)

Compared to the 2022 pre-period, the 2023 post-period showed a significant increase (P<0.0001) from 2.7% to 34.2%, with a difference of 31.5 percentage points and a percent change of 1166.67% (= (34.2-2.7)/2.7). Since the COVID-19 PHE was ongoing at the start of ARHOME in 2022, determination of eligibility was paused, which consequently led to a pause in disenrollment. Thus, the average number of gaps in coverage was lower than expected. Lower disenrollment in 2022 coupled with higher disenrollment in 2023 due to the COVID-19 PHE unwinding resulted in a drastic increase in beneficiaries with ≥1 month in coverage gaps between the years.

Table 104: Pre-Post Model: Percentage of beneficiaries with ≥1 month with a coverage gap during the measurement period

1.D.1	Pre-Post
Pre-Period Sample Size	281,197
Post-Period Sample Size	224,306
Pre-Period Rate (95% C.I.)	0.027 (0.027 – 0.028)
Post-Period Rate (95% C.I.)	0.342 (0.340 – 0.344)
Mean Rate Difference (95% C.I.)	-0.315 (-0.316 – -0.313)
P Value	<0.0001

Comparing the 2022 pre-period to the 2023 post-period for eligible beneficiaries above and below 100% FPL showed a period-income interaction DiD of 20.7%. In the pre-period, rates of gaps in coverage ≥1 month among those at ≤100% FPL was 2.8%, which was significantly higher (P<0.0001) than those at >100% FPL (2.3%), with a difference of 0.5 percentage points. In the post-period, the rates were consistently much higher than in the pre-period and were also significantly different (P<0.0001) between those at ≤100% FPL (30.1%) and those at >100% FPL (50.3%), with a difference of 20.2 percentage points.

Additionally, the rates of gaps in coverage for a given income group across pre-period and post-period were significantly different (P<0.0001). Both income gaps experienced significant increases (P<0.0001) in gaps in coverage from the pre-period to the post-period, with 48.0% of those in the higher income group experiencing a gap in coverage in the post-period, compared to 27.3% in the lower income group, with a difference of 20.7 percentage points. For the ≤100% FPL, the rate significantly increased from 2.8% to 30.1%, with a difference of 27.3 percentage points and a percent change of 975.00% (= (30.1-2.8)/2.8). For the >100% FPL, the rate significantly increased from 2.3% to 50.3%, with a difference of 48.0 percentage points and a percent change of 2086.96% (= (50.3-2.3)/2.3). This is expected, as more people in the higher income group may have been disenrolled due to having a higher income. It is unlikely that the termination of premium requirements in this higher income group would increase the number of beneficiaries with a coverage gap.

Table 105:DiD Models: Percentage of beneficiaries with at least 1 month with a coverage gap during the measurement period

1.D.1	Pre Period		Post Period	
	≤100% FPL	>100% FPL	≤100% FPL	>100% FPL
Sample Size	218,453	62,744	177,513	46,792
Rate (95% C.I.)	0.028 (0.028 – 0.029)	0.023 (0.022 – 0.024)	0.301 (0.299 – 0.304)	0.503 (0.498 – 0.508)

Table 106: DiD rate differences by income and period effects

1.D.1	Income Effect		Period Effect		DiD
	Pre	Pos	<100% FPL	>100% FPL	
Rate Difference	0.005*	-0.202*	-0.273*	-0.480*	-0.207
P-value	<0.0001	<0.0001	<0.0001	<0.0001	(P<0.0001)

Figure 87: DiD Model: Percentage of beneficiaries with at least 1 month with a coverage gap during the measurement period – Period Effect

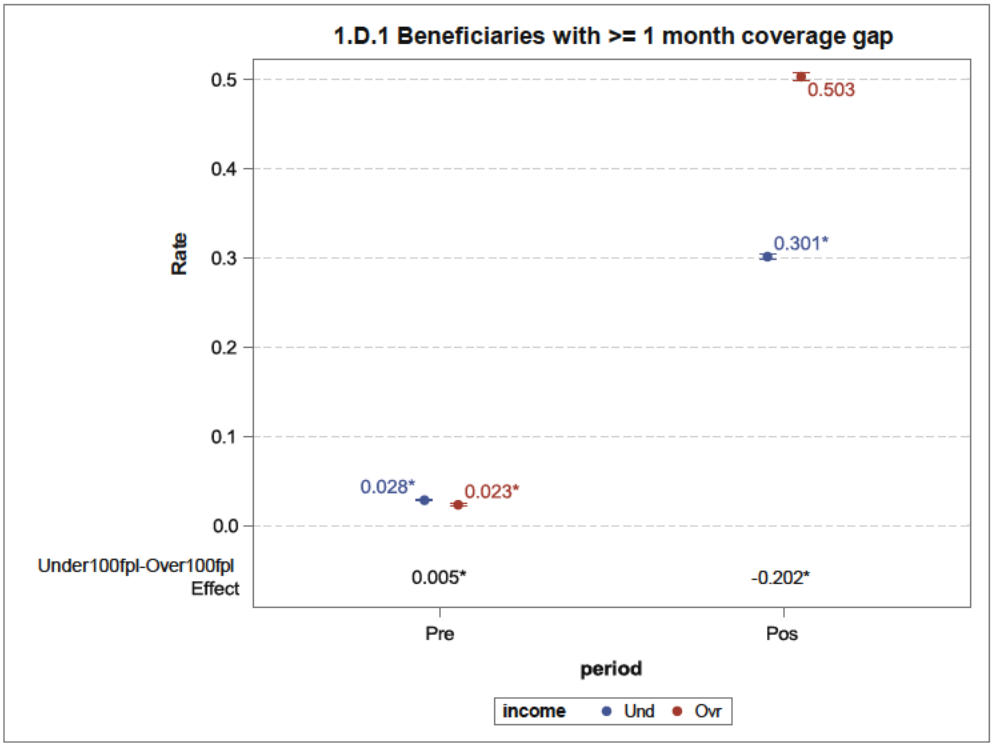
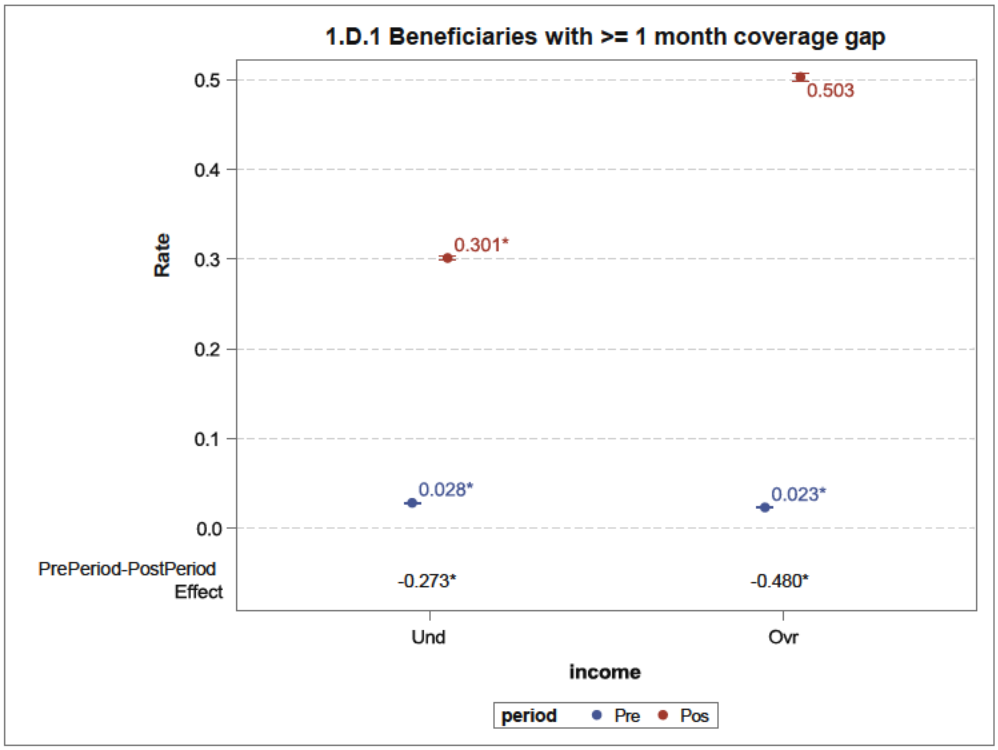


Figure 88: DiD Model: Percentage of beneficiaries with at least 1 month with a coverage gap during the measurement period – Income Effect



Average Length of Gaps in Coverage (Metric 1.D.2)

Focusing on coverage gap length of those with any gaps in coverage, we observed the average length of those gaps increased significantly (P<0.0001) from 3.10 to 3.87 months (an increase of 0.78 months), with a difference of 0.77 months and a percent change of 24.84% (= (3.87-3.10)/3.10). This increase in gap length may also be due to Medicaid unwinding and redetermination of eligibility as beneficiaries likely needed time to provide documentation of eligibility for ARHOME and the State, in turn, needed time to process it.

Table 107: Pre-Post Model: Average length of gaps in insurance coverage, in months, during the measurement period

1.D.2	Pre-Post
Pre-Period Sample Size	281,197
Post-Period Sample Size	224,306
Pre-Period Rate (95% C.I.)	3.098 (3.061 – 3.135)
Post-Period Rate (95%C.I.)	3.869 (3.854 – 3.883)
Mean Rate Difference (95% C.I.)	-0.771 (-0.793 – -0.749)
P Value	<0.0001

In the pre-period, the average length of a coverage gap significantly increased (P<0.0001) from 3.04 to 3.29 months (an increase of 0.25 months), whereas in the post-period, the average length significantly increased (P<0.0001) from 3.72 to 4.21 months (an increase of 0.49 months), with a DiD of 0.49 – 0.25 = 0.25 months. It is unclear whether the higher rate of increase among those in the higher income category was related to the termination of premium requirements or Medicaid unwinding.

Additionally, the average coverage gap length for a given income group across pre-period and post-period were significantly different (P<0.0001). Both income gaps experienced significant increases (P<0.0001) in average coverage gap length from the pre-period to the post-period, with by 0.92 months for the higher income group, compared to 0.68 months for the lower income group, with a difference of 0.24 months. For the ≤100% FPL, average coverage gap length significantly increased from 3.04 to 3.72 months, with a difference of 0.68 months and a percent change of 22.37% (= (3.72-3.04)/3.04). For the >100% FPL, average coverage gap length significantly increased from 3.29 to 4.21 months, with a difference of 0.92 months and a percent change of 27.96% (= (4.21-3.29)/3.29). This is expected, as more people in the higher income group may have been disenrolled due to having a higher income. It is unlikely that the termination of premium requirements in this higher income group would increase the average coverage gap length.

Table 108: DiD Models: Average length of gaps in insurance coverage, in months, during the measurement period

1.D.2	Pre Period		Post Period	
	≤100% FPL	>100% FPL	≤100% FPL	>100% FPL
Sample Size	218,453	62,744	177,513	46,792
Rate (95% C.I.)	3.044 (3.004 – 3.084)	3.289 (3.201 – 3.377)	3.718 (3.701 – 3.735)	4.210 (4.188 – 4.233)

Table 109: DiD rate differences by income and period effects

1.D.2	Income Effect		Period Effect		DiD
	Pre	Pos	<100% FPL	>100% FPL	
Rate Difference	-0.245*	-0.493*	-0.673*	-0.921*	-0.248 (P<0.0001)
P-value	<0.0001	<0.0001	<0.0001	<0.0001	

Figure 89: DiD Model: Average length of gaps in insurance coverage, in months, during the measurement period – Period Effect

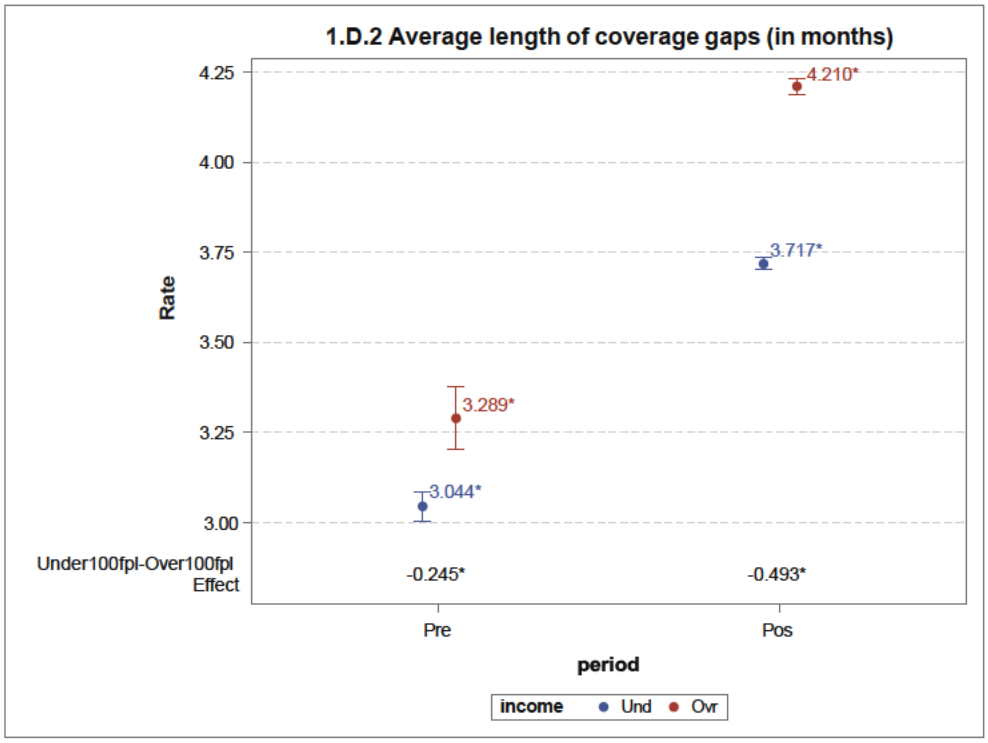
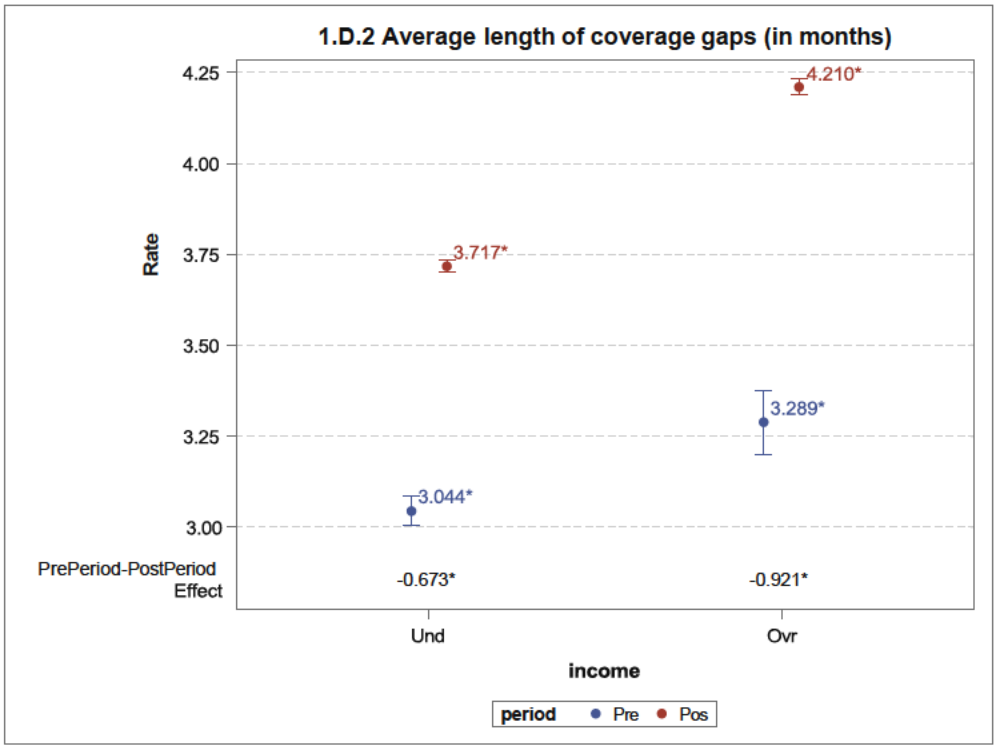


Figure 90: DiD Model: Average length of gaps in insurance coverage, in months, during the measurement period – Income Effect

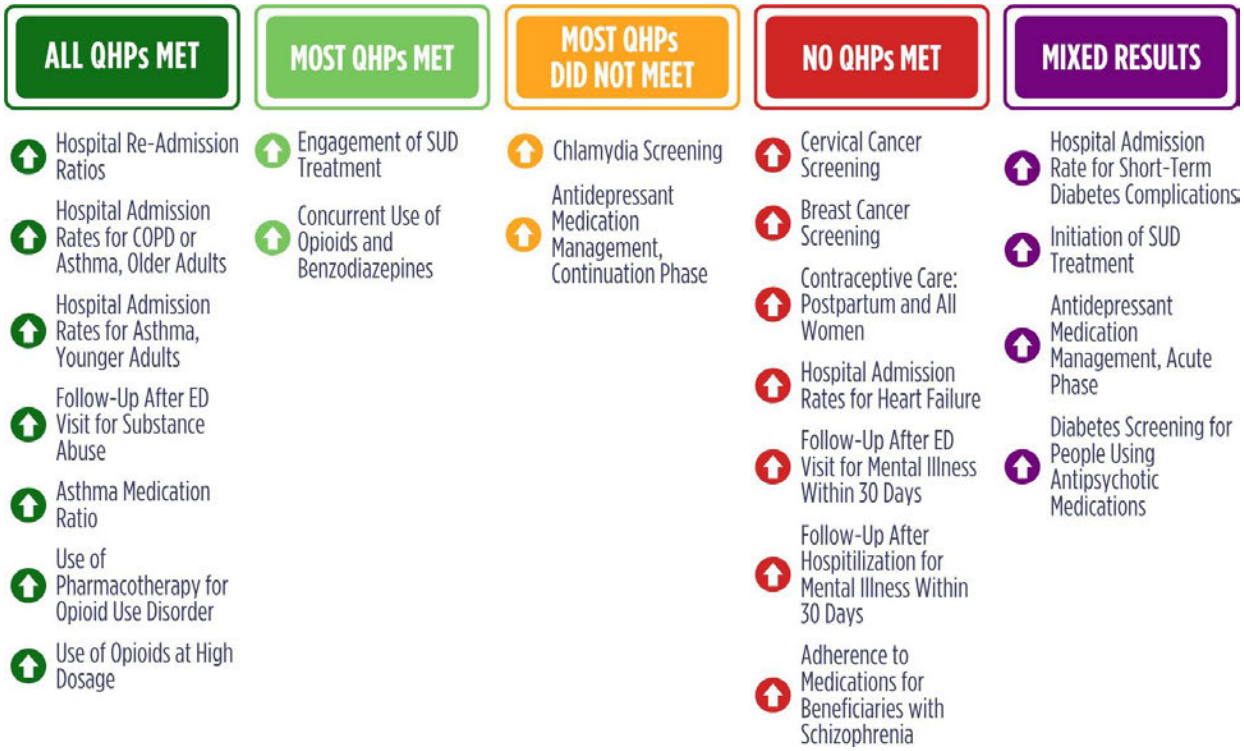


6.1.7 QUALITY HEALTH PLANS (QHP) QUALITY MEASURE RESULTS

DHS measures QHPs' performance on 26 core health quality measures by setting targets with the aim of improving ARHOME beneficiaries' health. The 2022 performance targets on health quality metrics were set in December 2021 based on the best performing QHP for each health quality measure in 2019 and 2020. The 2023 performance targets on the health quality metrics were set in January 2023 based on the best performing QHP for each health quality measure in 2019, 2020 and 2021. Two additional targets were established based on the median performance of all five QHPs across the three years and individual QHP improvement of at least 4% from the best rate. These additional targets allowed QHPs to get credit for improvement, even if they did not match the performance of the best performing QHP.

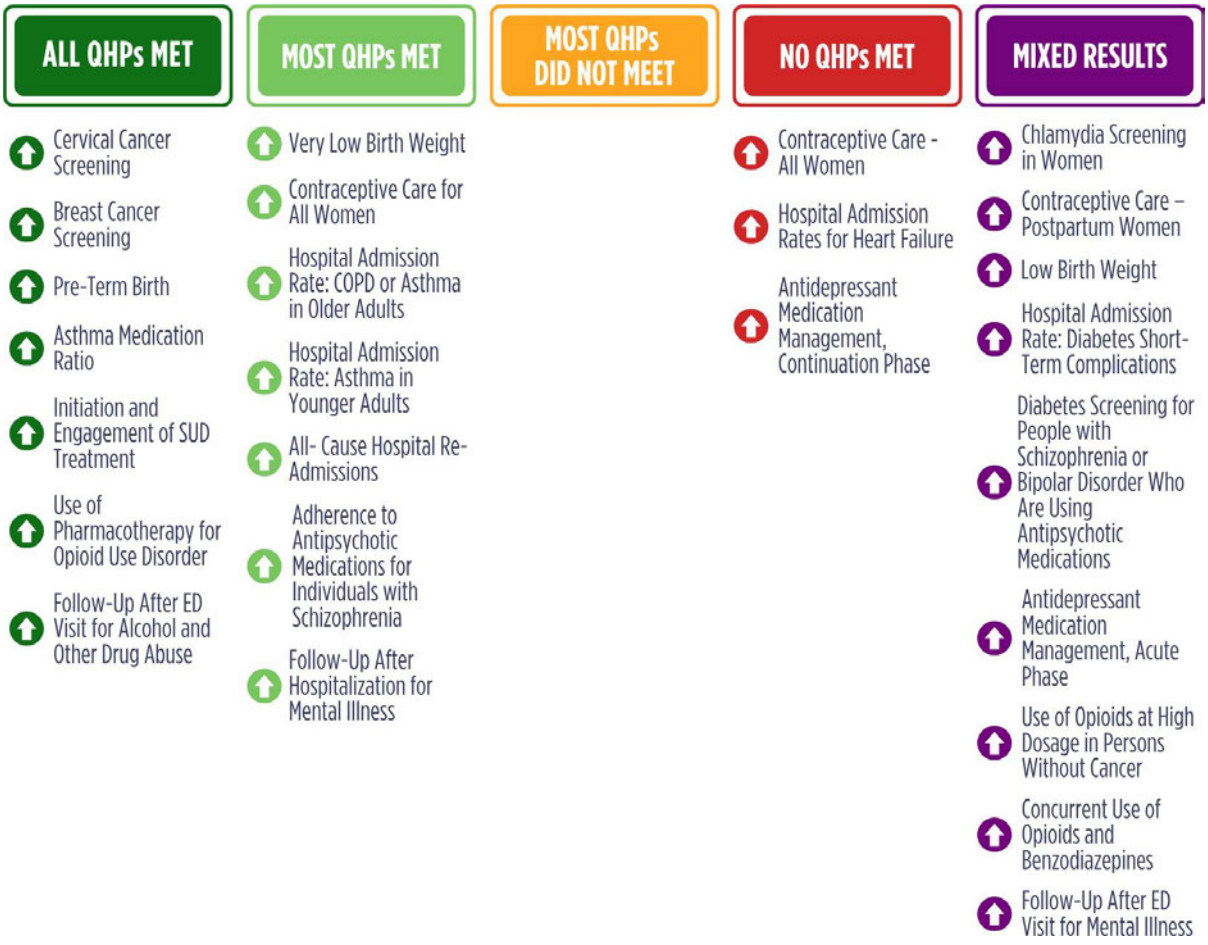
QHPs showed improvement between 2022 and 2023 as shown by the reduction of health quality measures categorized as 'Most QHPs did not meet' and 'No QHPs met' as well as the increase in categorizations of 'Mixed Results,' Most QHPs met,' and 'All QHPs' met.

Figure 91: 2022 QHP performance target results[60]



[60] ARHOME Health and Economic Outcomes Accountability Oversight Advisory Panel. "Quarterly Report." 15 December 2023, https://humanservices.arkansas.gov/wp-content/uploads/Quarterly-report-12.5.23.pdf.

Figure 92: 2023 QHP performance target results[61]



6.1.8 BENEFICIARY ENGAGEMENT SATISFACTION SURVEY (BESS) SUMMARY RESULTS

A high-level summary of the 2022 and 2024 BESS survey results for the ARHOME QHP (target) and Medicaid FFS (comparison) population are provided here as the ARHOME evaluation metrics report results on only specific questions from the surveys.

Demographics

The distribution of most demographic variables was significantly different between the target and comparison groups. These included gender and age group in the 2022 BESS survey, as well as gender, race, age group, urban-rural status, mental health, and taking prescribed medication in the 2024 BESS survey. The target group was generally older in age and had higher levels of self-reported mental health than the comparison group. Respondents in both groups were

[61] ARHOME Health and Economic Outcomes Accountability Oversight Advisory Panel. "Quarterly Report." 12 December 2024, https://humanservices.arkansas.gov/wp-content/uploads/ARHOME-Quarterly-Report-12.12.24.pdf.

mostly White, female, and taking prescribed medication. Distributions did not vary greatly by year of survey except for urban-rural status where the target group had more urban than rural residents in 2022, but slightly less urban than rural residents in 2024.

Perception of Care

The target population respondents scored more favorably in almost all categories of perception of care received (except interpreter needs, and non-emergency medical transportation) than the comparison population, which included the following:

- Getting care quickly (immediate care quickly, routine care quickly)
- Getting needed care (ease of needed care, specialist appointment)
- Doctor communication (explain things clearly, listen carefully, showing respect, spending enough time)
- Health plan customer service (providing information, showing respect)

Accounting for case-mix adjustment in logistic regression analysis, the target population scored higher/more favorably than the comparison population (odds ratio OR > 1) in all categories of rating health plans and perception of care received.

Ratings of Care

In both survey years, the target population reported higher ratings for their health care, personal doctor, specialist, and health plan, than the comparison population. Generally, all ratings were at or above 80% for the target population.

ARHOME Beneficiary Awareness

The ARHOME population's awareness of NET services and knowledge of copay requirements, retroactive eligibility, and health plan incentives increased between 2022 and 2024.

6.1.9 PROVIDER FOCUS GROUP (PFG) RESULTS

2023 PFG Results

The 2023 PFGs were conducted in 3 sessions by medical groups (AMS, AAFP, AHA) with topics covering financial impact, incentive awareness, Life360 HOMEs program, and primary care. Each session included small groups of 9-13 participants, but not all participants answered all of the questions asked by the moderator in the session. Hence it should be cautioned that small sample sizes may skew the significance of the PFG results.

Financial Impact

Overall, participants viewed ARHOME as a positive development for patient care, patient access, and the providers' financial health. All hospital executives in AHA felt that ARHOME had a positive financial impact on their hospitals. While the majority of AAFP providers also agreed on ARHOME's positive financial impact, AMS providers were more mixed in their feedback due to responses of neutrality or unawareness. No participants from any of the 3 medical groups reported any negative financial impact of ARHOME on their hospital or organization. Those that did not provide positive feedback were either neutral (rather than negative) in their stance, were unaware of or did not know the financial impact, or abstained from answering specific questions addressing financial impact issues. Many participants did note that they were either unaware or could not speak to the specific financial impact ARHOME had on their organization. Overall, however, most providers across the 3 medical groups reported a positive financial impact of ARHOME on their hospital or organization.

> *"Anything that allows people to get **subsidized insurance** is like a **WIN** for healthcare organizations."*

Participants were generally satisfied with the speed of payment and the streamlined reimbursement system. They were also aware that reimbursement rates for ARHOME were better than rates for traditional Medicaid. One participant noted that "many of the patients were on self-pay plans, once they were able to get privatized insurance, of course, payments would come through more consistently." This did not greatly affect physicians' willingness to accept ARHOME patients more readily than traditional Medicaid FFS patients as many physicians did not believe there was less uncompensated care for ARHOME patients compared with traditional Medicaid patients. However, most hospital executives responded that there was less uncompensated care among ARHOME patients and that they were more willing to accept ARHOME patients than Medicaid patients.

Participants noted that improved proactive communication between ARHOME plan providers, key hospital staff, and physicians was lacking, and education to ensure they were well-informed about the ARHOME program's financial aspects is needed. Challenges include differing reimbursement policies by plan, inability to be reimbursed for ancillary services, and available financial resources.

Incentive Awareness

Overall, providers expressed a desire for better education regarding plan incentives and resources so they could proactively recommend prevention, wellness, and screening services to patients, as less than one-half of physicians across AMS and AAFP were aware that ARHOME provided incentives to beneficiaries. Providers were not consistently provided incentive resources from ARHOME and believe that "if patients are made aware in a way they understand it, they really would participate." This is supported by half of participating physicians reporting that ARHOME incentives impacted patient health behavior in that ARHOME beneficiaries were more likely to use preventive, screening, and immunization services than traditional Medicaid beneficiaries.

Life360 HOMEs Program

Only members of the AHA were asked for their feedback on the Life360 HOMEs program in 2023 as they would be involved in the decision to participate in the program. Only about half of participants were aware of the Life360 HOMEs program and a third said they were likely to apply for the program. Overall, there was a general agreement that Life360 HOMEs could be a positive development, but the financial aspects were considered the main barrier to participation. Other barriers included cost barriers, staffing, regulatory risk management, and accreditation standards.

> *"I think there are hospitals that would like to **participate**, but don't see it currently as a viable model until it's able to cover **more** than the cost of care."*

Primary Care

Most AHA participants reported that ARHOME coverage had little to no effect on primary care. Less than a quarter of participants felt that ARHOME positively impacted quality of care, reduced ED visits, or improved physician-patient communication. Participants characterized ARHOME beneficiaries as patients with poor health behaviors who do not have regular PCP relationships. A participant said, "even when [patients] have access afterhours to speak with someone, they still like our ER" as their source of primary care. Several participants said in recent years that their organizations had updated their processes around follow-up care, implementing a follow-up primary care visit regardless of payer. As a result, they didn't think they would be able to specifically differentiate the outcomes or communication for the ARHOME population.

2025 PFG Results

The 2025 PFG was limited to a single session with AHA due to logistical constraints with the other medical groups, AMS and AAFP. Additionally, the session focused on topics of financial impact and Life360 HOME. Not all questions were covered in the session due to high participant engagement and feedback for certain questions.

Financial Impact

Participants generally viewed ARHOME as a financially beneficial program compared to traditional Medicaid, and that ARHOME's QHP model, generally produces better reimbursement rates, fewer restrictions, and broader provider acceptance. ARHOME has helped stabilize finances, reduced revenue losses from uncompensated care, and opened access to populations who would otherwise present with no coverage at all.

However, the financial perspective was not universally positive. Rural and smaller hospitals highlighted the high administrative and workforce costs associated with program participation, such as meeting quality metrics, managing complex reporting requirements, and training staff on evolving ARHOME processes.

Undercompensated care remains a persistent challenge. Even when patients are covered, reimbursement may fall short of the actual cost of care. While QHPs typically pay more than FFS, the adequacy of payment still hinges on contract negotiations between hospitals and insurers. While ARHOME has successfully reduced uncompensated care, the degree to which it addresses undercompensated care is uneven. Several participants did tie the reduction in uncompensated care to improvements in patient outcomes. Some participants noted that ARHOME helped reduce avoidable readmissions, shorten hospital stays, and support recovery closer to home.

*"…you don't have routine care or primary care delivered in the emergency department, because there are more physicians who actually will **accept** the qualified health plans as an appropriate payor for their patient panel."*

Implementation in Hospital Operations

Participants reported that the integration of ARHOME into hospital operations varied depending on facility size, location, and existing infrastructure. Large, multi-hospital systems generally reported smoother integration due to established patient navigation processes, robust revenue cycle teams, and dedicated financial counselors. Many of these systems also have long-standing relationships with commercial insurers and were already equipped to manage QHP coverage requirements. For them, implementing ARHOME processes largely meant adjusting workflows to identify eligible patients and ensuring that they were enrolled quickly, often during the initial hospital or ED encounter. Smaller and rural hospitals faced more challenges. Limited staffing capacity meant that any new program, even one with financial benefits, required careful prioritization.

Several participants described ARHOME enrollment as an "event-based" process, typically triggered by a hospital visit, often through the emergency department. While this ensures that coverage is initiated, it also means that the first opportunity to educate patients about their benefits often comes during a crisis or highly stressful situation. This timing can limit how much information patients retain, leading to underutilization of benefits after discharge.

Despite the challenges, most participants stressed that once ARHOME patients are in the system and connected with appropriate providers, operational improvements follow—such as more streamlined discharge planning, increased outpatient follow-up, and reduced strain on emergency services.

Life360 HOME Program

Similar to feedback from the 2023 PFG sessions, birthing hospitals still viewed the Maternal Life360 program as a critical tool in addressing Arkansas's poor maternal and infant health rankings, particularly its high maternal mortality and infant mortality rates. All participants were aware of the Life360 HOME program, but opinions were mixed on whether hospitals would apply to the program. The PMPM reimbursement was generally sufficient to cover the salaries of home visiting staff. However, participants noted that this payment structure did not always offset the full cost of the program, especially when factoring in administrative support, training, and outreach. Hospitals also emphasized that if reimbursement rates were increased and

restrictions relaxed, more providers would participate, potentially increasing the program's statewide impact.

Barriers and Opportunities for Improvement

While participants generally agreed that Life360 HOME has been a positive development for patients and providers, they identified several persistent barriers to maximizing its potential:

- **Financial Barriers**: Startup and ongoing costs for Life360 programs, particularly in rural areas; administrative expenses tied to staffing, training, and quality metric reporting; gaps between reimbursement rates and actual program costs.
- **Operational Barriers**: Difficulty sustaining patient engagement after discharge; reporting requirements, including the need for additional staffing to comply with requirements; confusion among patients about plan names and coverage differences (e.g., Centene vs. Ambetter); inconsistent communication between insurers, providers, and patients about benefits and access; Lack of coordinated marketing, education, and outreach campaign.
- **Patient Education Challenges**: Participants repeatedly stressed that many ARHOME beneficiaries have limited understanding of how insurance works, including the value of preventive care and how to navigate provider networks. This knowledge gap leads to underuse of primary care, overreliance on emergency departments, and missed opportunities for better health outcomes.

Several opportunities for improvement were identified, including:

- **Dedicated Patient Navigators:** Reviving navigator programs from the ACA rollout years could ensure beneficiaries receive tailored, in-person education and assistance.
- **Insurer Accountability:** Participants suggested requesting QHPs take a more active role in patient education and preventive service outreach, rather than placing the full burden on providers.
- **Reimbursement Adjustments:** Increasing rates for Life360 programs could make participation financially viable for more hospitals, especially in rural communities.

> *"…it's a **challenge** to negotiate with payors and making sure that these rates are commensurate with the level of care being provided…"*

- **Policy Stability:** With the ARHOME waiver demonstration period ending in 2026, clear communication and timely updates on program changes will be critical to maintaining provider participation and patient coverage.

6.2 LIFE360 HOME RESULTS

As of quarter three of 2025, the State has approved the applications of five hospitals (St. Bernards Healthcare, White River Health, Baptist Health Little Rock, Baptist Health North Little Rock, and Mercy Northwest Arkansas). The hospitals and their service areas are visualized in Figure 112. Two additional providers (UAMS and CHI St. Vincent Hot Springs) are in the

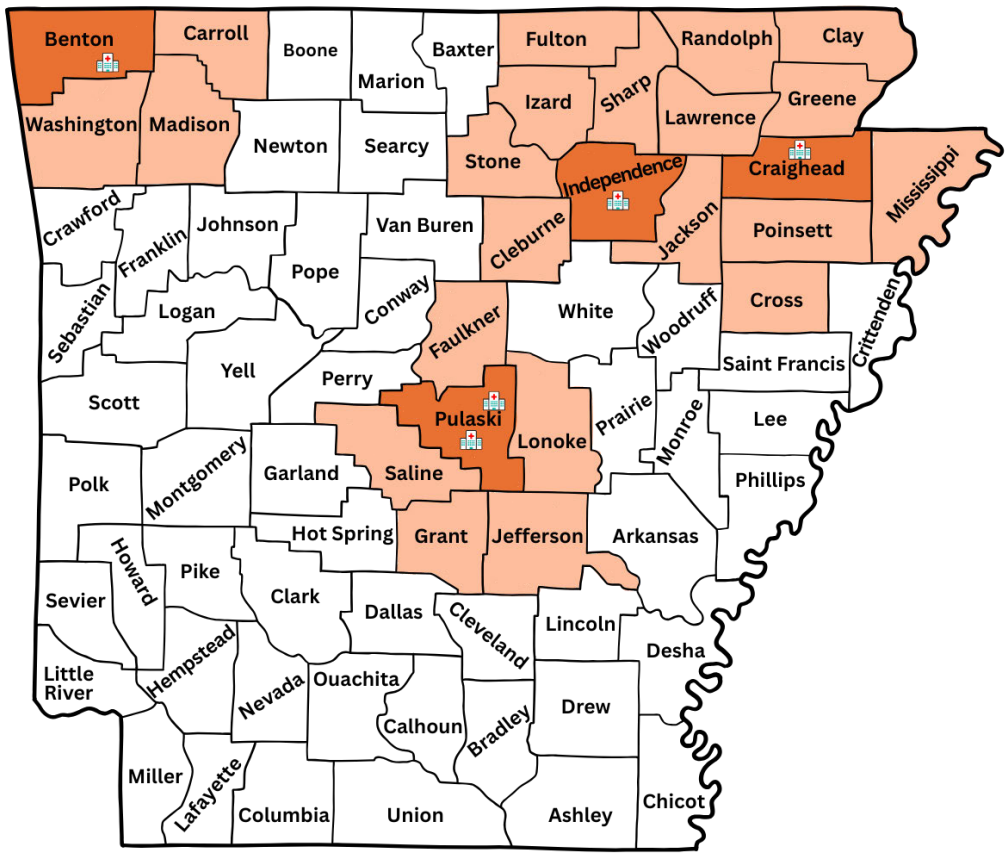
application phase. If approved, their results will be included in the summative evaluation.

St. Bernards, White River, and Baptist Health Little Rock & North Little Rock entered their program start-up periods in 2024, while Mercy Northwest Arkansas has not begun their start-up period. St. Bernards began beneficiary enrollment in late 2024 while White River and Baptist Health Little Rock & North Little Rock started enrollment in early 2025. As of this interim report, beneficiaries have been enrolled in all four locations and hospital-reported home visiting has been documented from St. Bernards, White River, and Baptist Health Little Rock & North Little Rock. As with any demonstration and start-up of a new program, best practices are still being refined as data collection and data transference processes are validated. More information on Maternal Life360 enrollees will be included in the summative evaluation.

Community Health Needs Assessment Findings

Each participating provider serves a diverse population across the state, addressing varying community health needs. St. Bernards' 2022 Community Health Needs Assessment (CHNA) identified chronic disease management, maternal health and mental access as top concerns. Mercy's 2022 CHNA highlighted access to care, behavioral health, diabetes/obesity/nutrition and food insecurity. White River's 2019 CHNA prioritized diabetes, hypertension, and substance abuse as critical concerns, while Baptist Health's 2023-2025 CHNA emphasized chronic disease, behavioral health and maternal health issues as top concerns.

Figure 93: Life360 HOMEs active hospitals and service areas



To enable cross-provider comparisons, county-level CHNA results were consolidated into a single table for each provider (**Table 110**). Except for Mercy, weighted averages based on county population sizes were applied to create representative CHNA profiles, ensuring smaller counties were not overrepresented. Data inconsistencies, such as differing collection years (e.g. St. Bernards' 2022 data vs. White River's 2023 data) were addressed by standardizing age categories and marking unavailable data as missing.

Table 110: Provider's Community Health Needs Assessment Report

	St. Bernards[62]	Baptist Health[63]	Mercy[64]	White River[65]
Total Population (US Census Estimate)	**345,500**	**1,141,667**	**574,985**	**122,450**
Birth to 18 (%)	24	23.4	24.2	23.0*
18-44 (%)	34	35.2	38.2	--
45-64 (%)	25	25.4	22.9	54.8**
65 + (%)	17	15.9	14.7	22.2
Race				
White (%)	75.9	69.6	67.4	92.2
African American (%)	17.4	18	2.3	3.5
Asian (%)	--	1.8	3.5	0.5
Hispanic (%)	6.3	6.2	17.5	1.7
All Other (%)	0.4	3.9	9.3	2.1
Language/Education				
Language Other than English Spoken at Home (%)	4.2	--	--	2.8
Non-High School Graduate (residents aged 25 and over) (%)	15	11.7	13.3	17.5
Bachelor's Degree or Higher (%)	18	--	32.2	14.7
Income				
Median Household Income	$41,718	--	$57,603	$39,124
% Persons Living Below Poverty Level	--	--	12.8	18.8
Gender				
Male (%)	48.8	48.7	48.4	--
Female (%)	51.2	51.3	51.6	--

[62] **St. Bernards Medical Center: Community Health Needs Assessment, September 2022** (*https://www.stbernards.info/app/files/public/79597594-d696-4418-b675-5405e97569e8/Community%20Health%20Needs%20Assessments/SBMC%20CHNA%202022.pdf*)

[63] **Baptist Health: 2023 - 2025 Community Health Needs Assessment** (*https://www.baptist-health.com/wp-content/uploads/2024/04/2023-2025-Community-Health-Report.pdf*)

[64] **Mercy: Community Health Needs Assessment, Mercy Hospital Northwest Arkansas, Fiscal Year 2022** (*https://www.mercy.net/content/dam/mercy/en/pdf/chna/nwa-chna-2022.pdf*)

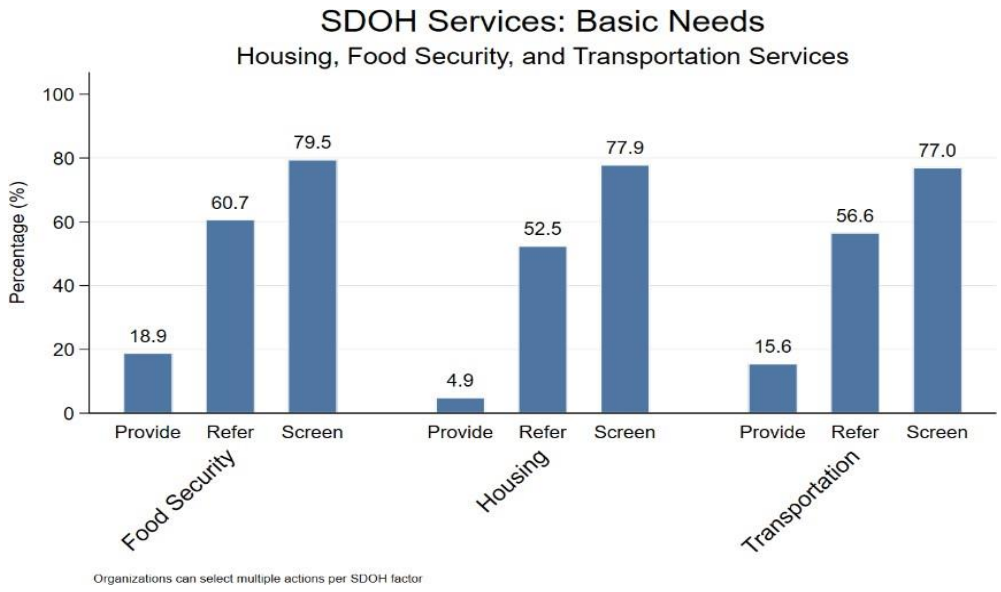
[65] **White River: Community Health Needs Assessment, September 2022** (*https://whiteriverhealth.org/files/documents/Approved%202022%20CHNA.pdf*)

6.2.1 SCREENING FOR SOCIAL DETERMINANTS OF HEALTH IN ARKANSAS (SDOH)

The Department of Health Policy and Management at the University of Arkansas for Medical Sciences (UAMS) College of Public Health, along with collaborators from the Fay W. Boozman College of Public Health at the University of Arkansas, Fayetteville and faculty from the University of Arkansas at Little Rock developed a survey that captured provider feedback for the Arkansas Department of Health and the Arkansas Office of Health Information Technology. The survey assessed how healthcare organizations screen for and respond to social determinants of health (SDOH) such as food insecurity, housing instability, and transportation challenges, identify challenges and gaps in current practices and inform statewide policy and practice improvements to better integrate SDOH data and services into the healthcare system. Relevant findings are presented here to understand the state of current screening and referral practices in Arkansas prior to the start of the Maternal Life360 HOMEs program.

Most of the respondents were primary care providers from small practices. Of these respondents, many Arkansas healthcare organizations (87.1%) screened for SDOH. Despite the widespread adoption of SDOH screening, the survey identified a "Screening-Doing Gap," indicating a significant drop-off between the identification of SDOH and follow-up actions taken to provide direct services, where 66.4% referred patients to external services and only 27.9% provide direct services. The most commonly addressed domains included food insecurity, housing issues, and transportation issues with food insecurity being the most screened item at 79.5% (**Figure 94**).[66]

Figure 94: SDOH Services: Basic Needs



[66] University of Arkansas for Medical Sciences. "Screening for Social Determinants of Health in Arkansas" (Page 24), Arkansas Department of Health, October 2025, SDOH_Final-Arkansas.pdf.

These screenings were conducted either "annually" (50.0%) or "as needed" (45.8%). Notably, 72.0% of screening organizations use a specific, named tool, but there was no clear consensus on which tool to use, with many developing custom or internally tailored tools.

Smaller healthcare facilities encountered considerable barriers such as limited staff capacity, budget constraints, and technological hurdles. The most pressing challenge, reported by 62.3% of organizations, was the difficulty of ensuring follow-up on identified needs. Additionally, only 31.7% of organizations had systems in place to track the success of referrals. A technological gap exacerbated this issue, with 51.3% of providers indicating that their EMR/EHR systems did not integrate with external referral platforms, making closed loop tracking challenging.

6.2.1 LIFE360 HOME STAKEHOLDER AND PROVIDER INTERVIEW RESULTS

Between November 2024 and August 2025, 21 key informants were interviewed and categorized as being a Life360 HOME program staff member (n=11), state official/policymaker (n=3), or community partner involved in a hospital's Maternal Life360 HOME program (n=7). All key informants discussed their background, experience, and role as it related to the Life360 HOME program. Key informants who were directly involved with a program as a hospital staff member or community partner outlined the program's purpose, design, enrollment criteria and data collected. We found that most key informants described the following three broad themes to some extent:

1. Data driven changes needed to address Arkansas maternal and child health outcomes
2. Life360 HOMEs program implementation barriers
3. Maternal Life360 HOME implementation successes and lessons learned

Data Driven Changes

Key informants were aware of the current state of maternal and child health in Arkansas and that pregnant women and new mothers enrolled in the Arkansas Medicaid program are at risk for poor health outcomes. Lack of housing, transportation, and low income contribute negatively as well. Compounding these issues is a growing concern about substance use disorders, mental health, depressive disorders, and other chronic diseases among expectant mothers. The closure of additional birthing hospitals in the State also creates longer distances to services and "maternity deserts."

Key informants indicated that more effort aimed at the early identification of at-risk individuals to offer and deliver needed and supportive resources as early as possible is especially critical. Though some resources exist throughout Arkansas, a clear lack of coordination between these services and the providers or agencies responsible for ensuring the services may limit the ability for patients to get services when needed.

Implementation Barriers

Key informants described several similar implementation barriers. Interviewees indicated that the Maternal Life360 HOME application process was long and drawn out over many months and "felt like years." Informants said they experienced "changing goal posts," and received mixed

feedback about the application. While calls with the State were often found to be helpful, there would be long periods of time when no actionable information would be shared before the application review was complete. Then, the hospitals often had delays as well responding to items to keep the application process moving forward.

Additionally, some key informants explained that changes in administration at the State and federal level created unavoidable delays. Other contributors to delays in the programs' ability to enroll patients in the program activities included completing the required readiness review at the end of the startup phase, which included program design and marketing/public relations activities, as well as development and negotiation of agreements with the hospitals. One key informant characterized these issues as a series of "hurry up and wait" scenarios where in some cases Life360 HOME staff had been hired and trained but weren't able to work with enrolled beneficiaries because of delays.

Other barriers to implementation that were described in less frequency included the lack of a data tracking system for the Life360 HOME metrics (metrics were developed in 2025 while programs were implementing their programs) and the administrative burden on hospital participants, which as stated earlier, caused delays in turning around revisions to the applications and program designs.

Successes & Lessons Learned

Most of the key informants touted various parts of the process and intent of the Life360 HOME maternal program. Some notable early successes of the project were that key informants expressed sincere gratitude for the ability to participate in a meaningful project that helped them fund additional staff and community-based resources for moms and babies who needed resources and education. They also appreciated the engagement from community partners alongside the hospitals who were the primary applicants. The partnerships were considered vital to engaging the primary population of interest and working together to "help the people that need the help." Another notable success was the design of the program as a pilot. While it was acknowledged that this program likely won't move the needle significantly on maternal mortality across Arkansas, it will ideally provide proof of concept that these initiatives work and can be rolled out on a broader scale around the state.

*"Getting them **connected early**, getting them on Medicaid, helping with breastfeeding, helping post-delivery, and connecting with job skills when the mom is ready to go back to work."*

Multiple key informants from multiple health systems touted the speed at which they were able to hire and train staff including community health workers and social workers. In fact, they did this so quickly, in multiple cases, staff were hired and trained more than six months prior to the program being able to enroll patients. Their processes were streamlined where staff were ready to begin acting on referrals once the program passed their readiness review and given official State approval.

In terms of what could have been done differently, key informants noted that improvements in communication between the State and applicants could be made, a focus primarily on maternal

and less on the other Life360 HOME programs (Rural and Success) would have been more efficient as they did not have good uptake, and some programs might have waited to hire staff until closer to the readiness visit.

While initial conversations about sustainability have been initiated at the program and state levels, no material discussions have evolved to date and will be revisited and discussed in greater depth during the next round of interviews. Conjecture about grant funding, donor support and operational budgets were noted as ways to investigate continuing the program following the demonstration period.

Others described the following topics in lesser detail but emphasized their importance within their Maternal Life360 program.

1. Types of HRSN services provided
2. Integration with existing programs
3. Key organizational partnerships and emphasis on maintaining those partnerships
4. Strategies for overcoming barriers, especially beneficiary outreach and enrollment/participation

HRSN Services

Interviewees from all three Maternal Life360 HOME programs discussed the importance of offering support services to the people they were trying to serve through their program. Primarily, and most often, key informants discussed how some of their clients needed stable housing and transportation to appointments. Clients either lacked transportation, did not live near public transportation, or could not afford taxi or other transportation services. The key informants who were community health workers or social workers described how they helped transport patients in the program to and from appointments, and how they helped (in some rare cases) set patients up with housing programs. One key informant described how she would have liked to assist patients more with water, lights, etc. She went on to discuss how sometimes she pays for getting phones started for patients ($10 for a new phone startup for one patient from her own pocket) and wished there was a programmatic fund that she could draw from.

Integration with Existing Programs

Few key informants discussed how the Maternal Life360 HOME program was integrated with other existing hospital or community programs. Most often, staff from the programs offering home visits discussed how the home visiting agency did similar work with their other patients. Moreover, the hospital staff discussed how the program was integrated through recruitment and other processes with physician practice operations. They described how the Maternal Life360 HOME programs were dependent on referrals from existing physician practices for them to be able to identify candidates for the program. These Life360 staff members did all they could to inform providers and staff so they remembered to let them know when a patient may meet the program criteria.

Maintenance of Key Partnerships

A few key informants described their efforts to cultivate and maintain relationships with physicians and their staff. This was perceived as the most important partnership to the establishment and growth of the program. Staff viewed these relationships as critical to timely enrollment of patients into the program. To improve awareness of the program, staff described their efforts to do informal presentations to providers and their staff.

Strategies for Overcoming Barriers

During the interviews, several key informants described how they were able to overcome several of the barriers they experienced. To summarize, they emphasized that getting the program started, enrolling beneficiaries, and getting reimbursed by the State for providing services were the most critical barriers. To overcome these barriers, several strategies were employed.

- **Workforce readiness –** they discussed how they hired and trained their staff prior to the official start of the program. While a financial risk, the programs established the foundation for the program's workforce and were ready once their program was approved by the State. This helped them ramp up operations quickly.
- **Patient outreach –** key informants described how beneficiaries were difficult to reach, engage, and follow up with. To overcome these challenges, the program staff set up routine follow up calls, systems for patient tracking, and developed logs for their communications. Once beneficiaries were engaged in the program, at least one key informant described how it was difficult to get accurate and complete information from them, especially related to smoking or other unhealthy behaviors. These relationships took time to develop, and this program was time limited, so every interaction with the patients was critical to getting them the complete package or services available.
- **Payment –** several key informants described how they had received little payment to date. Some described how they were doing intake on a number of possible patients/enrollees, but they did not ultimately meet program criteria due to insurance or other factors. Moreover, they described a lack of information and communication from the State about how to streamline the process of getting paid. At least one program described their ongoing conversations about eligibility and enrollment of patients with the State at the time of these interviews. They described how they had expected more patients to meet the program criteria and to have better tracking mechanisms for monitoring payments.

The next round of interviews occurring in 12-18 months will further explore implementation but focus more on program sustainability and program impact.

6.2.2 NON-LIFE360 HOME PROVIDER SURVEY RESULTS

Feedback from non-participating providers, surveyed in December 2024, offers further insight into why providers did not apply to the Life360 HOMEs program. Results from 5 surveys are summarized below that describe their awareness, interest, motivations, and perceived barriers to participation in Maternal Life360 HOMEs.

Less than half of surveyed non-participants knew of the Life360 HOMEs program, all providers were “somewhat likely” to participate in the Life360 HOMEs program soon. All providers reported that they already screen for HRSNs and most had referral programs that also followed up with patients and provided resources to address HRSNs. With processes in place to address HRSNs for all patients, pregnant and postpartum women in need of additional support may already be sufficiently identified and directed to appropriate resources.

Responses for the main motivations for participation in the program included addressing community gaps and improving quality measure metrics, while the main barriers included lack of program knowledge and community resource support challenges.

7.0 CONCLUSIONS

Arkansas's history of Medicaid expansion, beginning with the ACA in 2014, set the foundation for ARHOME. The subsequent iterations, Arkansas Works and now ARHOME, continued to refine coverage, eligibility, and quality initiatives to better serve individuals aged 19 to 64 with incomes at or below 138% FPL previously served under the Arkansas Works program.

The ARHOME Act, enacted in March 2021, provides consistency by maintaining similar but advanced benefit packages and service delivery systems in comparison to Medicaid FFS. Noteworthy advancements under ARHOME include mandatory annual strategic plans for QHPs to meet quality and performance standards, incentivized health improvement initiatives, as well as health and economic independence goals. The Life360 HOMEs amendment approved in November of 2022 further addresses HRSNs among women with high-risk pregnancies through expanded home visitation services and coordinated intensive support.

The overall impact of the first two years of the ARHOME demonstration resulted in a mix of significant and non-significant outcomes when compared to non-ARHOME beneficiaries.

GOAL 1: PROVIDING CONTINUITY OF COVERAGE FOR INDIVIDUALS

ARHOME's program structure ensures that the beneficiaries, who were already dependent on the services provided under the Arkansas Works program, continue to receive vital coverage. The transition was designed to minimize disruptions and provide reliable care for the new adult group.

Hypothesis A: ARHOME beneficiaries will be aware of the premium assistance model

The principal findings indicate a notable increase in the percentage of the target group who were aware of premium assistance in MY23 compared to MY22. Despite this increase, this difference was not statistically significant. This suggests that while there is a positive trend in awareness levels, the changes observed may not be substantial enough to reflect a meaningful improvement.

Hypothesis B: ARHOME beneficiaries and QHP contracted providers will be aware of the HII

The evaluation of beneficiary awareness of HII demonstrated an increase in the percentage of the target group awareness of HII in MY23 compared to MY22. However, this increase was not significantly different between the two years. Improving beneficiary awareness would benefit from intentional discussions on health incentive offerings between QHP providers and beneficiaries for a more informed and engaged patient population.

The measure of provider awareness regarding HII showed that a little less than half of participants across the AHA, AMS, and AAFP medical groups in the 2023 Provider Focus Group (PFG) indicated awareness of HII. To build on this awareness, future efforts should aim to increase providers knowledgeable about the initiative, thereby enabling them to better support and promote health improvement activities among beneficiaries.

Hypothesis C: The premium assistance model will lead to less unmet need for healthcare among Arkansas residents aged 19-64 with income up to 138% FPL compared to similar individuals in states that expanded Medicaid

The assessment of residents having a personal doctor revealed that a significantly lower percentage of Arkansas residents reported having a personal doctor in both years compared to West Virginia residents. This significant disparity highlights the need for targeted interventions in Arkansas to increase the number of residents with a personal doctor. Such efforts are crucial for improving continuous and personalized healthcare, which can lead to better overall health outcomes.

The analysis of care avoidance due to cost found that a significantly higher percentage of Arkansas residents reported avoiding care due to cost in both years compared to West Virginia residents. This demonstrates that cost is a more substantial barrier to care for Arkansas residents than for those in West Virginia. The significant difference underscores the importance of addressing financial barriers to healthcare in Arkansas.

The analysis of routine checkups found that a significantly lower percentage of Arkansas residents had a routine checkup in both years compared to West Virginia residents. This significant finding suggests a need for increased healthcare outreach and education in Arkansas to encourage more frequent routine checkups. Routine checkups are essential for the early detection and management of health issues.

Hypothesis D: ARHOME will lead to QHP beneficiaries having better continuity of coverage than Medicaid FFS beneficiaries

The analysis of beneficiaries experiencing coverage gaps revealed that a significantly higher percentage of the target group had a coverage gap of ≥ 1 month compared to the comparison group in MY23. However, this was not observed in MY22. This significant finding for MY23 indicates that the target group was more likely to experiencing coverage gaps compared to the comparison group in that year, most likely due to the Medicaid PHE unwinding as disenrollment was much more prevalent in MY23 than in MY22.

However, the analysis of average coverage gap length among beneficiaries with a gap showed that target group beneficiaries had significantly shorter gaps on average than the comparison group in both MY22 and MY23. These findings suggest that while the target group is more likely to experience coverage gaps, these gaps tend to be shorter in duration compared to those experienced by the comparison group. Gaps in coverage are likely a result of the PHE unwinding in 2023, when beneficiaries left the program and subsequently re-enrolled. The significant differences over both years emphasize the importance of focusing on not only reducing the frequency of coverage gaps but also minimizing their length, thereby improving the continuity of care for all beneficiaries.

Hypothesis E: ARHOME will lead to beneficiaries having better continuity of primary care and specialty providers than Medicaid FFS beneficiaries

The study on continuity of care with PCPs found that a significantly lower percentage of the target group had at least one visit with the same PCP during the measurement year compared

to the comparison group in both years. While this finding may be attributed to QHPs not limiting access to urgent care while traditional Medicaid FFS does, this significant finding also highlights a gap in the continuity of primary care for the target group. Ensuring consistent relationships between patients and their PCPs is crucial for effective ongoing care and better health outcomes. Efforts should be made to strengthen patient-provider communications that support regular and consistent PCP visits.

The analysis of specialist care continuity revealed mixed results. A higher percentage of target group beneficiaries had at least one specialist visit each year compared to the comparison group, except for endocrinology, gastroenterology, and pulmonology (only in MY23). Overall, both target and comparison groups showed high percentages of beneficiaries with at least one specialist visit with the same physician in both MY22 and MY23. However, significantly lower percentages were observed among target group beneficiaries for endocrinology and gastroenterology in both years, and for pulmonology only in MY22. These findings suggest that while the target group is generally accessing specialist care frequently, there are significant gaps in continuity of care for specific specialties.

The evaluation of annual PCP visits revealed that a significantly higher percentage of target group beneficiaries had at least one PCP visit during the measurement year than the comparison group in both years. Results show that the target group is more likely to engage in annual PCP visits, which is indicative of proactive healthcare management. Maintaining and enhancing this positive trend is crucial, as regular PCP visits are associated with better preventive care and early detection of health issues. Continued focus on promoting annual PCP visits among the target group can lead to improved overall health outcomes.

Table 111: Principal findings from continuity of care results

Hypothesis	Measure	Principal Findings	Significance
1.A. ARHOME beneficiaries will be aware of the premium assistance model	1. Beneficiary premium awareness	71% of the target group indicated that they were aware of premiums in MY23 compared with 65% in MY22.	Not significantly different between years
1.B. ARHOME beneficiaries and QHP contracted providers will be aware of the Health Improvement Initiative (HII)	1. Beneficiary Health Improvement Initiative (HII) awareness	30% of the target group indicated that they were aware of HII in MY23 compared with 23% in MY22.	Not significantly different between years
	2. Provider HII awareness	Less than one-half of participants across the AMS and AAFP medical groups in the 2023 Provider Focus Group (PFG) indicated that they were aware of HII.	N/A
1.C. The premium assistance model will lead to less unmet need for healthcare among Arkansas residents aged 19-64 with income up to 138% FPL compared to	1. Have a personal doctor	A lower percentage of AR residents reported having a personal doctor than residents of WV in both years.	Significantly different between AR and WV
	2. Avoided care due to cost	A higher percentage of AR residents reported avoiding care due to cost than residents in WV in both years.	Significantly different between AR and WV

Hypothesis	Measure	Principal Findings	Significance
similar individuals in states that expanded Medicaid	3. Last routine checkup	A lower percentage of AR residents had a routine checkup than residents of WV in both years.	Significantly different between AR and WV
1.D. ARHOME will lead to QHP beneficiaries having better continuity of coverage than Medicaid FFS beneficiaries	1. Percent of beneficiaries with ≥ 1 coverage gap	A higher percentage of the target group had a coverage gap of ≥ 1 month than the comparison group in MY23, but not in MY22.	Significantly different between groups in MY23 only
	2. Average length of coverage gap	Of the beneficiaries with a coverage gap, target group beneficiaries had shorter gaps on average than the comparison group in both years.	Significantly different between groups
1.E. ARHOME will lead to beneficiaries having better continuity of primary care and specialty providers than Medicaid FFS beneficiaries	1. Continuity of primary care physician (PCP) care	A lower percentage of the target group had ≥1 PCP visits with the same physician during the measurement year than the comparison group in both years.	Significantly different between groups
	2. Continuity of specialist care	Overall, a high percentage of target and comparison group beneficiaries had ≥1 specialist visit with the same physician in both years. Significantly lower percentages among the target group were seen in both years for endocrinology and gastroenterology, but only MY22 for pulmonology.	Significantly different between groups, with exceptions noted
	3. Annual PCP visits	A higher percentage of the target group had ≥ 1 PCP visit during the measurement year than the comparison group in both years.	Significantly different between groups

GOAL 2: IMPROVING ACCESS TO PROVIDERS

Establishing adequate access to a wide range of healthcare providers and preventive services is important in ensuring ARHOME beneficiaries receive appropriate health care when needed. There were several key insights from comparative analysis that were used to evaluate the impact of the ARHOME demonstration on provider financial health, beneficiary perceived and realized access to care, as well as the adequacy of provider networks.

Hypothesis A: The premium assistance model will lead to improved financial health among Arkansas healthcare providers compared to providers in other expansion states

Of the participants that responded, most Provider Focus Group (PFG) participants across the 3 medical groups (AHA, AMS, AAFP) expressed a willingness to accept ARHOME patients more readily than Medicaid FFS patients, with the exception of AAFP. Although some participants noted an increase in uncompensated care for ARHOME patients, most participants reported that having ARHOME patients led to a decrease in uncompensated care and a few who reported that they did not know. Generally, feedback was positive on ARHOME reimbursement rates being higher than the rates for traditional Medicaid.

When assessing hospital financial health through bad debt reduction, the data revealed no significant differences between Arkansas and comparison states. Both Arkansas and the comparison states demonstrated similar improvements in hospital bad debt in consecutive years, suggesting that any observed financial health changes were not uniquely attributable to the ARHOME program. There were also minimal provider closures for both Arkansas and comparison states over the observed period. This outcome highlights stability in the provider market irrespective of the implementation of the ARHOME initiative.

Hypothesis B: ARHOME will lead to QHP beneficiaries having better perceived access to care over time and compared to Medicaid FFS beneficiaries

Responses from the BESS survey revealed that a higher percentage of the target group than the comparison group in MY22 and MY24 reported receiving care as soon as needed; higher satisfaction with the timeliness of non-urgent appointments; higher ease in accessing necessary care, tests, or treatment; shorter wait times between scheduling and seeing a provider; and having a personal doctor. In all cases, statistical significance was not reached in MY24, suggesting that while perceived access to care was positive, the magnitude of difference was small.

Additionally, the target group was more likely to report timely specialist appointments in MY22 but not in MY24, with the differences in MY24 not reaching statistical significance. Fewer participants from the target group reported receiving interpreter services in both years, but differences between the target and comparison groups were not significantly different in MY24.

While the metrics under this hypothesis did not result in statistically significant improvements across most measures compared to the comparison group, it did highlight areas where survey respondents perceived better access to care. The mixed feedback, especially regarding financial health and interpreter services, underscores the need for continuous evaluation and targeted improvements in specific areas of the ARHOME program. Effective interventions and sustained efforts are required to address these gaps and enhance the overall effectiveness of the initiative.

Hypothesis C: ARHOME will lead to QHP beneficiaries having better perceived access to care compared to similar beneficiaries in expansion states

In general, our analysis showed residents of Arkansas had more unmet needs than West Virginia. In both years, a significantly lower percentage of Arkansas residents reported having a personal doctor compared to West Virginia residents, indicating that Arkansas residents had less perceived access to personal doctors than their counterparts in West Virginia. Moreover, a significantly higher percentage of Arkansas residents avoided care due to cost compared to West Virginia residents in both years, highlighting that financial barriers to accessing care were more pronounced for Arkansas residents. The data further showed that a significantly lower percentage of Arkansas residents had a routine checkup compared to West Virginia residents in both years, suggesting that Arkansas residents might have had less access to preventive healthcare services. Finally, a significantly lower percentage of Arkansas residents reported having health care coverage compared to West Virginia residents, indicating a gap in health care coverage between Arkansas and West Virginia residents.

Interestingly, a slightly higher percentage of Arkansas residents received the flu vaccine compared to West Virginia residents in both years. Despite the significant difference, the improvement was marginal.

Overall, the results suggest that the ARHOME initiative did not lead to better perceived access to care among QHP beneficiaries in Arkansas compared to similar beneficiaries in West Virginia. Most measures demonstrated poorer outcomes for Arkansas residents, contradicting the initial hypothesis. Significant disparities in access to personal doctors, avoidance of care due to cost, routine checkups, and health care coverage persist in Arkansas, indicating substantial challenges in achieving improved access to care.

Hypothesis D: ARHOME will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries

In terms of provider patient acceptance, among the unambiguous responses, most participants across the 3 medical groups (AHA, AMS, AAFP) in the 2023 Provider Focus Group (PFG) were willing to accept ARHOME beneficiaries more readily than Medicaid FFS patients, with the exception of AAFP. Additionally, a lower percentage of the target group reported a timely first appointment for immediate care in MY24 than the comparison group.

Results related to preventive care and management of chronic conditions did not consistently show higher performance among the target group for either year. For breast cancer screening, a higher percentage of the target group underwent mammogram screenings compared to the comparison group in both years, with significant differences observed only in MY22. Conversely, a significantly lower percentage of the target group was screened for cervical cancer and chlamydia than the comparison group in both years.

Regarding statin therapy for patients with diabetes, a slightly higher percentage of the target group was dispensed at least one statin medication in MY22, while a lower percentage was dispensed the medication in MY23; however, these differences were not statistically significant. In terms of access to preventive or ambulatory services, a significantly lower percentage of the target group had at least one visit compared to the comparison group in MY23, but not in MY22. Additionally, the asthma medication ratio revealed a significantly higher percentage of the target group with controlled medication ratios in MY22, but not in MY23.

Only results from hemoglobin A1c testing showed significantly higher percentages of testing among the target group than the comparison group in both years.

EPSDT services include adolescent well-care visits, preventive dental visits, and preventive vision visits. Adolescent well-care visits revealed that QHP beneficiaries aged 19-20 were the least likely of the studied age groups to have at least one visit. This group showed a significant decrease in visit rates in MY22 due to both aging and the transition to QHP. In MY23, the decrease continued, primarily due to the QHP transition. Preventive dental visits also indicated that QHP beneficiaries aged 19-20 were the least likely to have at least one visit. There were consistent significant decreases in these visits in MY22, influenced by both aging and the QHP transition, and in MY23, driven mainly by the QHP transition. Similarly, the data for preventive vision visits showed significant decreases in the number of visits due to the QHP transition in

both MY22 and MY23. Overall, the negative trends of the QHP transition effect observed for the adolescent well-care, preventive dental, and preventive vision visits are likely due to these EPSDT services being wrap-around services, which are not promoted by QHP plans.

Additionally, a significantly lower percentage of the target group utilized NET services than the comparison group in both years. Beneficiary reported NET awareness was also lower among the target group in both years, with significant differences observed in the MY24 BESS survey.

Both target and comparison provider networks were found to be adequate for primary care and specialty care coverage, which included BH/SUD providers, cardiologists, OB/GYNs, oncologists, endocrinologists, and pulmonologists. Adequacy and accessibility of PCP networks within 30 miles, as well as specialist network accessibility within 60 miles, were deemed sufficient for both groups. All QHP issuers provided good access to essential community providers.

While the metrics examined did not result in universally statistically significant improvements for ARHOME beneficiaries across all measures in this goal, the findings did highlight several areas of self-reported better perceived better access to health care with adequate provider networks. Comparisons made with other states suggest that while ARHOME has made progress, there remains a need for targeted improvements in preventive care.

Table 112: Principal findings from improving access to providers

Hypothesis	Measure	Principal Findings	Significance
2.A. The premium assistance model will lead to improved financial health among Arkansas healthcare providers compared to providers in other expansion states	1. Provider financial health improvement	Among unambiguous responses, most participants across the 3 medical groups (AHA, AMS, AAFP) in the MY23 Provider Focus Group (PFG) reported that ARHOME patients resulted in less uncompensated care.	N/A
	2. Hospital financial health improvement	AR and comparison states showed similar improvements in hospital bad debt in both years. However, there were no significant differences in reduction of bad debt between AR than comparison states.	Not significantly different between AR and other states
	3. Provider closure rate	Arkansas and comparison states showed very few provider closures (1%) in both years.	N/A
2.B. ARHOME will lead to QHP beneficiaries having better perceived access to care over time and compared to Medicaid FFS beneficiaries*	1. Care for illness/injury as soon as needed	A higher percentage of the target group than the comparison group reported that they received care as soon as needed in both years.	Not significantly different between groups (calculated for only MY24)
	2. Non-urgent appointment as soon as needed	A higher percentage of the target group than the comparison group reported that they received care as soon as needed in both years.	Not significantly different between groups (calculated for only MY24)

Hypothesis	Measure	Principal Findings	Significance
(Continued) 2.B. ARHOME will lead to QHP beneficiaries having better perceived access to care over time and compared to Medicaid FFS beneficiaries*	3. Ease of necessary care, tests, or treatment	A higher percentage of the target group than the comparison group were satisfied with the ease of necessary care, tests or treatment in both years.	Not significantly different between groups (calculated for only MY24)
	4. Have a personal doctor	A higher percentage of the target group than the comparison group reported having a doctor in both years.	Not significantly different between groups (calculated for only MY24)
	5. Appointment with specialist as soon as needed	A higher percentage of the target group than the comparison group reported getting an appointment with a specialist as soon as needed in MY22, but not in MY24.	Not significantly different between groups (calculated for only MY24)
	6. Wait time between appointment and seeing a provider	A lower percentage of the target group than the comparison group reported having a wait time between appointment scheduling and seeing a provider in both years.	Not significantly different between groups (calculated for only MY24)
	7. Wait for an appointment due to provider's limited availability	A similar percentage of target and comparison group beneficiaries reported waiting for an appointment due to limited availability (only calculated for MY22).	N/A
	8. Easy to get a referral to a specialist	Captured in 2.B.5	N/A
	9. Received interpreter services	A lower percentage of the target group than the comparison group reported receiving interpreter services in both years.	Not significantly different between groups (calculated for only MY24)
	10. How often got an interpreter when needed one	Not reported due to small sample size (N<10)	N/A
2.C. ARHOME will lead to QHP beneficiaries having better perceived access to care compared to similar beneficiaries in expansion states	1. Have a personal doctor	A lower percentage of AR residents had a personal doctor compared with residents in WV in both years.	Significantly different between AR and WV
	2. Avoided care due to cost	A higher percentage of AR residents avoided care due to cost compared with residents in WV in both years.	Significantly different between AR and WV
	3. Last routine checkup	A lower percentage of AR residents had a routine checkup compared with residents in WV in both years.	Significantly different between AR and WV

Hypothesis	Measure	Principal Findings	Significance
	4. Have health care coverage	A lower percentage of AR residents had health care coverage compared with residents in WV in both years.	Significantly different between AR and WV
	5. Flu vaccine	A slightly higher percentage of AR residents received the flu vaccine compared with residents in WV in both years.	Significantly different between AR and WV
2.D. ARHOME will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	1. Provider patient acceptance	Among unambiguous responses, most participants across the 3 medical groups (AHA, AMS, AAFP) in the 2023 Provider Focus Group (PFG) reported a general willingness to accept ARHOME more readily than Medicaid FFS patients, with the exception of AAFP.	N/A
	2. Time to first appointment*	A lower percentage of the target group than the comparison group reported longer time to first appointment for immediate care in MY24.	Not significantly different between groups
	3. Breast cancer screening (BCS)	A higher percentage of the target group had a mammogram screening for breast cancer than the comparison group in both years.	Significantly different between groups in MY22 only
	4. Cervical cancer screening (CCS)	A lower percentage of the target group was screened for cervical cancer than the comparison group in both years.	Significantly different between groups
	5. Chlamydia screening in women ages 21-24 (CHL)	A lower percentage of the target group had ≥ 1 screenings for chlamydia than the comparison group in both years.	Significantly different between groups
	6. Statin therapy for patients with diabetes (SPD)	A slightly higher percentage of the target group were dispensed ≥1 statin medication of any intensity than the comparison group in MY22, but not in MY23.	Not significantly different between groups
	7. Hemoglobin A1C Testing (HA1C)	A higher percentage of the target group had HbA1c testing than the comparison group in both years.	Significantly different between groups
	8. Adults' access to preventive/ambulatory services (AAP)	A lower percentage of the target group had ≥ 1 ambulatory or preventive care visit than the comparison group in MY23, but not MY22.	Significantly different between groups in MY23 only
	9. Asthma medication ratio among ages 19-64 (AMR)	A higher percentage of the target group had a ratio of controlled medications to total asthma medications of ≥ 0.5 than the comparison group in MY22, but not MY23.	Significantly different between groups in MY22 only

Hypothesis	Measure	Principal Findings	Significance
(Continued) 2.D. ARHOME will lead to QHP beneficiaries having better realized access to care over time and compared to Medicaid FFS beneficiaries	10. EPSDT screening – adolescent well-care visits (AWC)	QHP beneficiaries aged 19-20 during the measurement year, were the least likely to have ≥ 1 AWC visit with a PCP or OBGYN and saw a steady decrease in rates for each age cohort in MY22, with a significant decrease in age effect and QHP transition in MY22 and only the QHP transition in MY23.	Significantly different between groups
	11. EPSDT screening – preventive dental visits (PDENT)	QHP beneficiaries aged 19-20 during the measurement year, were the least likely to have ≥ 1 PDENT visit and saw a steady decrease in rates for each age cohort in MY22, with a significant decrease in age effect and QHP transition in MY22, and only the QHP transition in MY23	Significantly different between groups
	12. EPSDT screening – preventive vision (PVIS)	QHP beneficiaries aged 19-20 during the measurement year, were the least likely to have ≥ 1 PVIS visit and saw a significant decrease in QHP transition in MY22 and in MY23.	Significantly different between groups
	13. Any NET services	A lower percentage of the target group utilized NET services than the comparison group in both years.	Significantly different between groups
	14. Utilization Count of NET services	The target group beneficiaries utilized a lower number of NET services than the comparison group in both years.	Significantly different between groups
	15. NET awareness	A lower percentage of the target group was aware of NET benefits than the comparison group in both years.	Significantly different between groups in MY24 only
	16. PCP network adequacy	Target and comparison provider networks are adequate in PCP coverage for both years (100%).	N/A
	17. PCP network accessibility	Target and comparison group beneficiaries had adequate accessibility to PCPs within 30 miles (100%).	N/A
	18. Specialist network adequacy	Target and comparison provider networks are adequate in specialist care coverage at > 94% in both years (BH/SUD, cardiologist, OB/GYN, oncologist, and pulmonologist). Access to endocrinologists was lacking in a quarter of service areas for both target and comparison groups.	N/A
	19. Specialist network accessibility	Target and comparison group beneficiaries had adequate accessibility to PCPs within 60 miles (> 95%).	N/A

Hypothesis	Measure	Principal Findings	Significance
	20. Essential community providers (ECP) network adequacy	All QHP issuers provided their beneficiaries with good access to ECPs.	N/A

* Unlike claims- and eligibility-based metrics that were analyzed in 2022 and 2023, BESS metrics, 2.B.1-10 and 2.D.2, were administered in 2022 and 2024.

GOAL 3: IMPROVING CONTINUITY OF CARE ACROSS THE CONTINUUM OF COVERAGE

Goal 3 focuses on improving quality of care and maintaining continuity of care across different income levels in promoting better health outcomes for all ARHOME beneficiaries. Despite limited significant results in the first two years of the ARHOME demonstration period, the goal remains to achieve measurable and sustainable success over time.

Hypothesis A: ARHOME beneficiaries will be aware of the shorter period of retroactive eligibility, and the time-limited premium requirements

The hypothesis that ARHOME beneficiaries will be aware of the shorter period of retroactive eligibility, and the time-limited premium requirements was partially supported by the findings. While there was a higher level of awareness for premium requirements compared to retroactive eligibility, the awareness levels did not exhibit significant improvement over time. The consistent relatively low awareness rate regarding retroactive eligibility highlights a gap in effective communication. Similarly, the awareness regarding premiums did not significantly increase, suggesting a need for ongoing and improved outreach and education efforts to beneficiaries that remain enrolled in the ARHOME program.

Hypothesis B: The shorter period of retroactive eligibility will not lead to a lower rate of Medicaid applications among individuals potentially eligible for ARHOME compared to individuals potentially eligible for other Medicaid programs without a reduced period of retroactive eligibility

The findings support this hypothesis, as the percentage of beneficiaries indicating that the shortened retroactive eligibility period would deter their enrollment decreased from MY22 to MY24 and was not significantly different. This suggests that the shorter retroactive eligibility period is not a significant barrier to enrollment in ARHOME and that beneficiaries would still seek coverage under ARHOME despite the reduced period of retroactive eligibility.

Hypothesis C: The shorter period of retroactive eligibility will not lead to greater medical debt among new ARHOME beneficiaries compared to individuals newly enrolled in other Medicaid programs without a reduced period of retroactive eligibility

The hypothesis that the shorter period of retroactive eligibility will not lead to greater medical debt among new ARHOME beneficiaries, compared to individuals newly enrolled in other Medicaid programs without a reduced retroactive period, is not supported by the findings. The data indicated that new beneficiaries in the target group consistently had a significantly higher

percentage of unpaid medical bills within three months prior to their application than the comparison group, in both MY22 and MY23. The shorter retroactive eligibility period may have contributed to greater medical debt among new ARHOME beneficiaries, suggesting a need for policy reconsideration to mitigate financial burdens on newly enrolled individuals.

Hypothesis D: During Year 1 of ARHOME, monthly premiums will not lead to lower take-up and retention rates among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those ≤ 100% FPL

The hypothesis that monthly premiums during Year 1 of ARHOME would not lead to lower take-up and retention rates among Arkansas residents aged 19-64 with incomes at 101-138% FPL compared to those with incomes at or below 100% FPL is partially supported by the findings. New enrollment was adversely affected, with significantly fewer participants from the higher income group joining the program. However, the retention rate was higher among the target group in the MY22. The data indicates that beneficiaries in the target group with higher income levels experienced a significantly lower rate of new enrollment, suggesting that monthly premiums in MY22 negatively affected take-up rates, but not retention rates.

Hypothesis E: During Year 1 of ARHOME, monthly premiums will not lead to more gaps in coverage among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those ≤ 100% FPL

The hypothesis that monthly premiums would not lead to more gaps in coverage for Arkansas residents with incomes at 101-138% FPL compared to those at or below 100% FPL is partially supported by the data. The target group with incomes at 101-138% FPL experienced significantly fewer instances of having a coverage gap compared to the comparison group with incomes at or below 100% FPL during MY22. But among beneficiaries who experienced a coverage gap, those in the target group with incomes at 101-138% FPL had significantly longer coverage gaps than those in the comparison group with incomes at or below 100% FPL.

Hypothesis F: QHP beneficiaries will demonstrate they value QHP coverage, and the implementation of monthly premiums will not reduce QHP beneficiary enrollment

The hypothesis that QHP beneficiaries value QHP coverage and that the implementation of monthly premiums would not reduce QHP beneficiary enrollment is partially supported by the data. Health insurance coverage status indicated stability with no significant reduction due to premiums. The ARHOME population is defined as including the Managed Care (MC) entity APP-91 (PPO beneficiary's portal assignment) and excluding HCA-92 (Health care authority - Member services assignment) and MEM-97 (Member help desk PO enrollment - System assigned, ARHOME auto-assignment). About 40% of the ARHOME population paid premiums in MY22 and 52% of new enrollees selected their QHP. While small in magnitude, there was a significant decrease in active QHP selections from 52% in MY22 to 49% in MY23. The decrease in active QHP selection between MY22 and MY23 may be due to the complex effects of the PHE unwinding in April 2023, adding confusion and more required paperwork for manual enrollment.

Hypothesis G: During Years 2-5 of ARHOME, the cessation of monthly premiums will not increase take-up and retention rates among QHP beneficiaries with income at 101-138% FPL compared with Year 1

The hypothesis that the cessation of monthly premiums in MY23 would not increase take-up and retention rates among QHP beneficiaries with incomes at 101-138% FPL compared to MY22 is supported by the data. Both new enrollment and retention rates were significantly lower in MY23 than in MY22.

Hypothesis H: During Years 2-5 of ARHOME, the cessation of monthly premiums will not increase gaps in coverage among QHP beneficiaries while still eligible for ARHOME than they did during Year 1

The hypothesis that the cessation of monthly premiums during MY23 of ARHOME would not increase gaps in coverage among QHP beneficiaries while still eligible for ARHOME compared to MY22 is not supported by the data. Both the percentage of beneficiaries with coverage gaps and the average gap length were significantly higher in MY23 than in MY22. The cessation of monthly premiums in MY22 did not lead to a reduction in the occurrence or duration of coverage gaps. These findings highlight that other factors like the PHE unwinding may have contributed to coverage instability due to redetermination of eligibility processes.

Hypothesis I: During Years 2-5 of ARHOME, the cessation of monthly premiums will not lead to QHP beneficiaries having more gaps in coverage after earnings exceed Medicaid eligibility limits than they did during Year 1

The hypothesis that the cessation of monthly premiums during MY23 would not lead to QHP beneficiaries having more gaps in coverage after their earnings exceeded Medicaid eligibility limits compared to MY22 is supported by the data. Both the percentage of beneficiaries with coverage gaps and the average length of those gaps were lower in MY23 than in MY22. These findings highlight that removing monthly premiums effectively reduced the incidence and duration of coverage gaps among beneficiaries who surpassed Medicaid eligibility income limits, indicating enhanced coverage stability due to the policy change.

Table 113: Principal findings from improving continuity of care across the continuum of coverage

Hypothesis	Measure	Principal Findings	Significance
3.A. ARHOME beneficiaries will be aware of the shorter period of retroactive eligibility, and the time-limited premium requirements	1. Beneficiary retroactive eligibility awareness	22% of ARHOME beneficiaries were aware of retroactive eligibility in MY22 and MY24.	Not significantly different between years
	2. Beneficiary premium requirement awareness	73% of ARHOME beneficiaries were aware of the premium requirement in MY22, which increased to 76% in MY24.	Not significantly different between years
3.B. The shorter period of retroactive eligibility will not lead to a lower rate of Medicaid applications among	1. New enrollment	11% of ARHOME beneficiaries in MY24 indicated that the knowledge of the shorter retroactive eligibility period would keep them from enrolling in	Not significantly different between years

Hypothesis	Measure	Principal Findings	Significance
individuals potentially eligible for ARHOME compared to individuals potentially eligible for other Medicaid programs without a reduced period of retroactive eligibility		ARHOME. This was lower than the percentage in MY22 (14%).	
3.C. The shorter period of retroactive eligibility will not lead to greater medical debt among new ARHOME beneficiaries compared to individuals newly enrolled in other Medicaid programs without a reduced period of retroactive eligibility	1. New beneficiary medical debt	A higher percentage of new enrollees in the target group had unpaid medical bills within the 3 months prior to the application than the comparison group in both years.	Significantly different between groups
3.D. During Year 1 of ARHOME, monthly premiums will not lead to lower take-up and retention rates among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those ≤ 100% FPL	1. New enrollment	There was a lower percentage of new enrollees at 101-138% FPL in the target group than in the comparison group at ≤ 100% FPL in MY22.	Significantly different between groups
	2. Retention rate	A higher percentage of the target group at 101-138% FPL due for renewal remained enrolled in ARHOME than the comparison group at ≤ 100% FPL in MY22.	Significantly different between groups
3.E. During Year 1 of ARHOME, monthly premiums will not lead to more gaps in coverage among Arkansas residents aged 19-64 with income at 101-138% FPL compared to those ≤ 100% FPL	1. Percent of beneficiaries with ≥ 1 coverage gap	A lower percentage of the target group at 101-138% FPL had ≥1 month coverage gap than the comparison group at ≤ 100% FPL in MY22.	Significantly different between groups
	2. Average length of coverage gaps	Among beneficiaries with a coverage gap, the average length of gaps was higher for the target group than the comparison group in MY22.	Significantly different between groups
3.F. QHP beneficiaries will demonstrate they value QHP coverage, and the implementation of monthly premiums will not reduce QHP beneficiary enrollment	1. Health insurance coverage status	AR showed little to no change in rates of health insurance coverage among adults with income of 101-138% FPL during the premium year. A slight decrease in rates of coverage was observed in MY23.	Not significantly different between groups
	2. Premium payments	40% of beneficiaries at 101-138% FPL paid a monthly premium in MY22	N/A
	3. QHP selections	45.6% of new ARHOME enrollees selected their own QHP in MY22, which decreased to 40.5% in MY23.	Significantly different between years

Hypothesis	Measure	Principal Findings	Significance
3.G. During Years 2-5 of ARHOME, the cessation of monthly premiums will not increase take-up and retention rates among QHP beneficiaries with income at 101-138% FPL compared with Year 1.	1. New enrollment	A lower percentage of the target group at 101-138% FPL in MY23 were new enrollees during the measurement year than the comparison group at 101-138% FPL in MY22.	Significantly different between groups
	2. Retention rate	A lower percentage of the target group at 101-138% FPL in MY23 due for renewal remained enrolled in the demonstration than the comparison group at 101-138% FPL in MY22.	Significantly different between groups
3.H. During Years 2-5 of ARHOME, the cessation of monthly premiums will not increase gaps in coverage among QHP beneficiaries while still eligible for ARHOME than they did during Year 1	1. Percent of beneficiaries with ≥ 1 coverage gap	A higher percentage of the target group at 101-138% FPL in MY23 had ≥1 month coverage gap than the comparison group at 101-138% FPL in MY22.	Significantly different between groups
	2. Average length of coverage gaps	Among beneficiaries at 110-138% FPL in MY23 with a coverage gap, the average length of gaps was higher for the target group than the comparison group at 101-138% FPL in MY22.	Significantly different between groups
3.I. During Years 2-5 of ARHOME, the cessation of monthly premiums will not lead to QHP beneficiaries having more gaps in coverage after earnings exceed Medicaid eligibility limits than they did during Year 1	1. Percent of beneficiaries with ≥ 1 coverage gap	The percentage of ARHOME beneficiaries in MY23 at 101-138% FPL who disenrolled due to high income and had ≥1 month of coverage gaps was lower than that of ARHOME beneficiaries at 101-138% FPL in MY22.	N/A
	2. Average length of coverage gaps	The average length of coverage gaps among ARHOME beneficiaries in MY23 at 101-138% FPL who disenrolled due to high income with a coverage gap was lower than that of ARHOME beneficiaries at 101-138% FPL in MY22.	N/A

GOAL 4: FURTHERING QUALITY IMPROVEMENT AND DELIVERY SYSTEM REFORM INITIATIVES THAT ARE SUCCESSFUL ACROSS POPULATION GROUPS

Hypothesis A: ARHOME beneficiaries will be aware of the point-of-service copayment requirements and the EII

The hypothesis that ARHOME beneficiaries will be aware of the point-of-service copayment requirements and the EII is supported with upward trends in awareness for both aspects. Specifically, the awareness of copayment responsibilities rose to 86% and EII awareness increased to 24% in MY24. Despite these increments, the differences across the years are not statistically significant. While there is a visible improvement in the levels of awareness among beneficiaries, the current efforts have not generated a significantly impactful change. This

suggests a need for enhanced or additional strategies to encourage beneficiary awareness in both areas moving forward.

Hypothesis B: The ARHOME program will lead to QHP beneficiaries having greater satisfaction in the care provided over time and compared to Medicaid FFS beneficiaries

The findings for this hypothesis demonstrate that the target group of QHP beneficiaries reported significantly higher satisfaction ratings of their health plan and health care compared to Medicaid FFS beneficiaries in both MY22 and MY24. This significant difference indicates that the ARHOME program continues to successfully provide the type of coverage and care that beneficiaries value. Satisfaction ratings of PCPs and specialists were insignificantly higher than FFS beneficiaries in both years.

Overall, the ARHOME program demonstrated a positive impact on beneficiary satisfaction in overall health care ratings, where significant differences favoring the target group were observed. While the general trend indicates improved satisfaction under the ARHOME program, further efforts to increase beneficiary satisfaction should focus on primary and specialist care providers.

Hypothesis C: The ARHOME program will lead to QHP beneficiaries having lower non-emergent use of the ED, lower potentially preventable use of the ED and hospital admissions, and lower hospital re-admissions over time and compared to Medicaid FFS beneficiaries

Results indicate that the ARHOME program did not influence the rate of preventable ED visits as compared to Medicaid FFS beneficiaries. In MY22, the ARHOME target group displayed a significantly lower percentage of non-emergent ED visits compared to the comparison group, but this trend did not hold in MY23. The initial difference suggested a temporary improvement, but sustained reductions in non-emergent ED visits were not observed. Despite being higher for the target group, emergent ED visit rates were only significantly different between groups in MY22, indicating that the ARHOME program's impact on emergent ED visits was not consistent over time.

Higher observed-to-expected re-admission ratios were identified in the target group in both years, with significant differences observed only in MY23. This implies limited impact of the ARHOME program on reducing re-admissions compared to comparison groups, particularly in MY23.

Admission rates related to short-term diabetes complications were also higher among the target group with significant differences appearing in MY23, suggesting that the ARHOME program could benefit from targeted interventions to manage diabetes-related admissions more effectively. Meanwhile, admission rates for COPD or asthma in older adults were higher in the target group across both years, but without significant differences between groups. This points to a continual challenge in managing chronic respiratory conditions among ARHOME beneficiaries. Regarding heart failure, higher admission rates among the target group were significantly different only in MY23. Like other condition-specific measures, this calls for better management approaches within the ARHOME program for heart failure patients. For younger adults, asthma-related admission rates were consistently lower in the target group, though not

significantly different. This suggests potential effectiveness in managing asthma but requires further improvement to show significant results.

Significantly higher rates of follow-up with a PCP after an ED visit across both years in the target group imply that ARHOME beneficiaries may be better engaged in post-ED care, leading to potentially better health outcomes. Similarly, the target group had higher rates of PCP follow-up post-hospitalization that was significantly different in MY22. This suggests that beneficiary post-discharge care is headed in the right direction, but beneficiaries still need to be encouraged and reminded to follow-up with their physicians when recommended.

Overall, the ARHOME program's impact on non-emergent ED use, potentially preventable ED use, hospital admissions, and hospital re-admissions indicate mixed results. Follow-up care after an ED visit or hospitalization showed significant positive effects, while other areas like emergent ED visits and re-admission rates displayed inconsistent or insignificant differences. This points to the need for the ARHOME program to refine its strategies in sustainably improving beneficiary outcomes over time and across various medical conditions compared to Medicaid FFS beneficiaries.

Hypothesis D: The ARHOME program will lead to QHP beneficiaries receiving better quality of care over time and compared to Medicaid FFS beneficiaries

While new SUD episodes in the target group led to higher initiation rates of treatment within 14 days, the differences were not statistically significant. However, engagement within 34 days of initiation was significantly higher. For those on antidepressant medication management, the ARHOME program led to significantly higher treatment durations, reflecting better management and adherence among beneficiaries with major depression.

Additionally, findings suggested that the ARHOME program had a positive impact on post-hospitalization care, as evidenced by significantly higher follow-up rates within 7 or 30 days after hospitalization for mental illness in MY22. However, this trend did not continue in MY23. Mixed results in adherence levels for MY22 and MY23 suggest variable effectiveness of the ARHOME program's strategies for antipsychotic medication adherence for individuals with schizophrenia. However, adherence was significantly different between target and comparison groups in MY23.

Significantly higher diabetes screening rates were observed among the target group with schizophrenia or bipolar disorder in MY22 but not in MY23. While the rate was not significantly higher in MY23, at-risk beneficiaries in the ARHOME program may need more assistance in scheduling diabetes screenings to ensure that the improvements seen in MY22 can be maintained and built upon in subsequent years.

The significantly higher percentage of high-dose opioid prescriptions for the target group suggests an urgent need for the ARHOME program to more effectively manage opioid usage to meet quality care standards. Similarly, the slight increase in the concurrent use of opioids and benzodiazepines, though not significantly different, indicates that this risk factor is a concern that requires improved management under the ARHOME program. In particular, the higher use of Naltrexone, underscores the need for improvement in managing opioid use disorder under

the ARHOME program. An improper management of opioid prescriptions can lead to increased risks of dependency, overdose, and adverse health outcomes. Thus, addressing this issue is crucial to ensuring safer prescribing practices and enhancing patient safety and overall health of ARHOME beneficiaries.

The higher rates in follow-up care in the 30 days after an ED visit among target group individuals with alcohol or drug abuse or dependence support the effectiveness of the ARHOME program in promoting continuity of care. This is particularly important as it highlights the program's success in ensuring patients receive necessary follow-up care, which can contribute to better health outcomes and recovery. However, continued efforts are needed to maintain and improve follow-up rates within both 7 and 30 days to ensure timely and comprehensive care for all patients.

For individuals with mental illness, the improvement in follow-up rates after 30 days in MY23 indicates that the ARHOME program positively impacted follow-up care for mental illness over time. Despite the progress seen in MY23, attention should still be focused on maintaining and enhancing follow-up care within both 7 and 30 days to ensure consistent, comprehensive care for all individuals with mental illness post-ED visit.

The lower persistence of beta-blocker treatment in the target group, particularly in MY22, highlights an area for improvement in the ARHOME program's management of post-heart attack care. Ensuring consistent and prolonged use of beta blockers is essential for preventing further cardiac events and improving long-term outcomes for heart attack patients. The higher rates of annual monitoring for beneficiaries on persistent medications in the target group, particularly in MY22, emphasize the ARHOME program's success in ensuring appropriate oversight and management of long-term medication use. This is essential for preventing potential adverse effects and enhancing treatment efficacy. Continuation and enhancement of such monitoring practices are crucial to maintaining and improving patient health outcomes through consistent medication management.

The higher rate of annual HIV viral load testing in the target group, particularly in MY22, indicates that the ARHOME program effectively promotes regular monitoring for individuals with HIV. Regular viral load testing is crucial in managing HIV, as it helps monitor treatment effectiveness and viral suppression, ultimately improving patient outcomes.

The lower C-section rate in the target group for both years suggests that the ARHOME program may be effective in promoting lower-intervention delivery methods. Although the difference between target and comparison groups was not statistically significant, this trend is important for monitoring and improving maternal and neonatal health outcomes. Continued efforts are needed to further reduce unnecessary C-sections and to ensure best practices in obstetric care are consistently applied.

Timely access to contraception following delivery is essential for effective family planning and maternal health. The lower rates of postpartum contraceptive use within 3 or 90 days of delivery in the target group, with a significant difference noted within 3 days of delivery in MY23, highlight a critical area for improvement within the ARHOME program. The differences in LARC method uptake within 3 and 90 days of delivery indicate mixed results for the ARHOME

program. The significantly lower LARC method used within 3 days of delivery in MY22 highlights the need to improve immediate postpartum contraceptive care. However, the higher uptake within 90 days suggests that the program is more effective in ensuring longer-term access to LARC methods. These findings underscore the importance of enhancing timely access to postpartum contraceptive care to ensure that all women have the necessary support and resources to make informed choices about their reproductive health. Addressing these gaps is vital for promoting healthier outcomes for postpartum women and their families.

For contraceptive care among all women between ages 21 to 44, the significantly lower rates of contraception use among women in the target group highlight a critical area for improvement within the ARHOME program. Ensuring access to effective contraception is essential for family planning and reproductive health. These findings underscore the need for more effective strategies to provide timely and appropriate contraceptive care for women of reproductive age to better support women's overall health.

Lastly, the increase in the percentage of ARHOME beneficiaries participating in the HII program from MY22 to MY23 demonstrates positive engagement and uptake of health improvement initiatives. This trend is encouraging as it suggests that more beneficiaries are accessing resources aimed at promoting healthier lifestyles and managing chronic conditions. Continued efforts to maintain and further enhance participation in these programs are important for improving overall health outcomes and ensuring the long-term success of the ARHOME program.

Hypothesis E: Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries who are not subject to copays

During MY22, beneficiaries subject to copays demonstrated better adherence to antidepressant medication management compared to those not subject to copays, suggesting that copayments may have enhanced adherence. However, in MY23, both groups showed similar adherence levels, indicating no significant difference. The target group subject to copays exhibited better follow-up rates after hospitalization for mental illness in MY22, whereas in MY23, follow-up rates varied. This variability suggests that other factors, in addition to copayments, may influence follow-up care.

The adherence to antipsychotic medications showed no significant difference between beneficiaries subject to copays and those not subject to copays, suggesting copayments did not adversely affect medication adherence for schizophrenia. Similarly, there was no significant difference in the use of high-dosage opioids between beneficiaries subject to copays and those not subject to copays, implying copayments did not impact opioid prescription patterns. The concurrent use of opioids and benzodiazepines exhibited variations with a significant difference only in MY23, indicating inconsistent effects of copayments on concurrent medication use. Ongoing monitoring and support for adherence is important to ensure medication compliance. It is crucial to continue monitoring opioid use to prevent potential misuse and ensure responsible prescribing practices.

Follow-up after ED visits for alcohol and other drug abuse or dependence were similar between the groups, indicating copayments did not significantly impact follow-up care. However,

beneficiaries subject to copays had better follow-up rates after ED visits for mental illness, particularly within 7 days, indicating that copayments may enhance timely follow-up care for mental illness though not for alcohol or drug abuse/dependence. Furthermore, starting in 2023, the threshold requirement for copay exemption was reduced from <100% FPL to <20% FPL, thus increasing the population subject to copay between 2022 and 2023. The population subject to copay has a generally higher income level than the population exempt from copay and thus may have more adequate financial resources for improved follow-up rates after ED visits. Strategies promoting the importance of follow-up visits should be emphasized to maintain and improve this trend. Continued efforts should be made to facilitate timely follow-up visits to support patient recovery.

Persistence in beta-blocker treatment showed no significant difference between the groups, suggesting copayments did not influence treatment persistence after a heart attack. It is important to ensure continuous patient education on the benefits of long-term beta-blocker therapy post-heart attack. Annual monitoring for persistent medication usage was similar irrespective of copayment status, indicating copayments did not adversely affect consistent medication monitoring. Ongoing support for patients on long-term medications is crucial to ensure adherence and prevent complications.

In assessing annual HIV/AIDS viral load testing, we found that the copayment status also did not significantly impact the rate of annual testing and demonstrated similar adherence to testing in both groups. Continuous encouragement and access to testing services should be maintained to ensure optimal care for individuals with HIV. Similarly, statin therapy rates for patients with diabetes did not significantly differ between the groups, indicating copayments did not affect access to or utilization of statin therapy. Promoting the benefits of statin therapy in diabetic patients should continue to be prioritized for reducing cardiovascular risks.

Overall, the evidence suggests that point-of-service copayments did not lead to worse quality of care for QHP beneficiaries subject to copays compared to those not subject to copays across multiple measures. While some measures indicated significant differences in certain years, many measures showed no significant impact of copayments on the quality of care. To ensure consistent quality of care, it is crucial to continuously monitor and address other influencing factors, optimize adherence strategies, and maintain patient education on the importance of follow-up care and medication adherence.

Hypothesis F: Among QHP beneficiaries with income at or below 20% FPL, the Economic Independence Initiative will lead to an increase in income to above 20% FPL over time.

The modest increase in percentage (7%) of beneficiaries who increased their income during MY23 compared to MY22 among those who participated in educational and training programs shows a positive trend in the effectiveness of these programs at supporting income growth for low-income individuals. To enhance these outcomes further, QHPs should increase program outreach, strengthen and tailor program components, and provide continuous support.

Hypothesis G: Among QHP beneficiaries with income at or below 100% FPL, the Economic Independence Initiative will lead to an increase in the percent of income to 101-138% FPL over time.

The percentage of beneficiaries in the beginning of the year at or below 100% FPL who increased their income during the calendar year saw a 2% decrease from MY22 to MY23. This trend might reflect the inherent challenges faced by individuals at higher income levels in achieving further income growth. It is also possible that some beneficiaries experienced significant income increases, making them ineligible for the ARHOME program. During the PHE unwinding in MY23, enrollees who no longer met the eligibility requirements of the ARHOME program were disenrolled as well.

Hypothesis H: Among QHP beneficiaries who disenroll from ARHOME, the EII will lead to an increase in the percent that disenroll due to increased income over time

The moderate increase (14%) in the percentage of QHP beneficiaries disenrolling due to high income from MY22 to MY23 indicates that the EII is positively impacting beneficiaries' financial situations. This suggests that the initiative supports beneficiaries in achieving income levels that make them ineligible for ARHOME due to increased earnings. More beneficiaries are also attaining income levels that enable them to afford private health insurance, reflecting improved economic independence. While these findings highlight the positive impact of the EII on the financial independence and healthcare coverage of QHP beneficiaries, it is important to note the PHE unwinding in MY23, which may have generally contributed to the higher disenrollment of beneficiaries from ARHOME.

Hypothesis I: The EII will lead to an increase in the percent of QHP beneficiaries that enroll in education and training programs over time

The participation rate of beneficiaries in QHP offered EII incentives showed a modest increase from 2% in MY22 to 3% in MY23. Although this indicates a positive trend, overall participation remains relatively low. However, enrollment in any education, training, and certificate programs demonstrated high participation at around 9% in MY22 and MY23. To further increase enrollment in education and training programs, it is important to enhance the awareness and accessibility of these opportunities. This can be achieved by increasing outreach efforts to inform beneficiaries of their QHP offerings and guidance in enrolling in academic and employment-related training programs.

Hypothesis J: The point-of-service copayments will lead to QHP beneficiaries subject to copays having lower overall healthcare use compared to similar QHP beneficiaries not subject to copays

The findings indicate that in MY22, point-of-service copayments led to a significantly lower overall healthcare use among QHP beneficiaries subject to copays compared to those not subject to copays. However, this trend did not persist in MY23, where no significant difference was observed between the two groups. This suggests that while copayments may initially reduce healthcare use, their long-term impact may diminish. To ensure sustainable outcomes, it may be beneficial to further investigate and address the reasons for the change in impact between MY22 and MY23. Strategies such as continuous beneficiary education on appropriate

healthcare use, regular monitoring, and adjustments to copayment structures as necessary could potentially reinforce the intended effects of copayments. Additionally, exploring supplementary measures to encourage cost-effective healthcare utilization while maintaining access to necessary services could further support the goal of reducing overall healthcare use.

Hypothesis K: The shorter period of retroactive eligibility, the premium assistance model, the point-of-service copayments, the Health Improvement Initiative, and the other financial discipline components will lead to the rate of growth in PMPM QHP costs being no higher than the rate of growth in PMPM costs in Arkansas Medicaid FFS

The implementation of financial discipline components, such as reduced retroactive eligibility periods, premium assistance models, and point-of-service copayments, have successfully kept the PMPM costs for QHPs well-managed. The consistent performance below the budget neutrality cap reinforces the effectiveness of these measures. Also, the significant reduction in ARHOME total health expenditures by roughly 9% between 2022 and 2023, while remaining below the expenditures of the Arkansas Medicaid FFS program, suggests that the combined financial discipline strategies employed by ARHOME are effective. This indicates that the shorter period of retroactive eligibility, premium assistance model, point-of-service copayments, Health Improvement Initiative, and other financial components are successfully controlling healthcare costs.

Hypothesis L: QHP beneficiaries with a shorter period of retroactive eligibility will be healthier at enrollment than Medicaid FFS beneficiaries with a longer period of retroactive eligibility

The findings reveal that, contrary to the hypothesis, QHP beneficiaries with a shorter period of retroactive eligibility were not healthier at enrollment compared to Medicaid FFS beneficiaries with a longer period of retroactive eligibility. Specifically, in MY23, the target group had a significantly higher CCI score, indicating a higher burden of comorbid conditions. There was no significant difference in MY22, further suggesting variability in the health status of new enrollees over time

This outcome suggests that a shorter period of retroactive eligibility may not necessarily result in enrolling healthier individuals. To address this, it may be useful to examine the factors that contribute to the higher comorbidity scores among QHP beneficiaries. Understanding these factors can help in tailoring pre-enrollment health assessments and targeted intervention programs to better manage the health of new enrollees.

Hypothesis M: The cessation of monthly premiums for QHP beneficiaries at 101-138% FPL will lead to a faster rate of growth in PMPM QHP costs in Years 2-5 compared to Year 1

The results indicated that the cessation of monthly premiums for QHP beneficiaries at 101-138% FPL did not lead to a faster rate of growth in PMPM costs in MY23. In fact, the PMPM cost growth rate slowed, as indicated by the greater margin below the budget neutrality cap in MY23. This implies that even without the imposition of premiums, the program's cost control measures have been effective in maintaining lower-than-budgeted healthcare costs. To sustain this positive outcome, it would be beneficial to continue evaluating and refining these cost control strategies, enhance preventive care and chronic disease management programs to

reduce high-cost healthcare needs, and provide targeted support and education to beneficiaries to ensure efficient utilization of healthcare resources. By maintaining focus on these efforts, the program can continue to manage costs effectively while supporting the health and financial stability of beneficiaries.

Hypothesis N: The premium assistance model will lead to a lower rate of increase of PMPM premiums in the Arkansas Marketplace compared to states that expanded Medicaid and provide coverage through means other than premium assistance

The findings suggest that the premium assistance model implemented by the ARHOME demonstration did not directly influence the number of issuers offering QHPs in the marketplace. Additionally, while premium increases were observed during the demonstration period, these increases cannot be directly attributed to the ARHOME program. This implies that other external factors may have a more significant impact on premium rates than the premium assistance model itself. While statewide average premiums increased during the demonstration period, these increases were not directly attributable to the ARHOME program. Nevertheless, Arkansas's premium levels remained consistently below the median of contiguous states, suggesting that the premium assistance model may have helped moderate premium growth.

To build on this success, it would be useful to continue monitoring premium trends and investigating the factors that contribute to premium stability. By understanding these dynamics, Arkansas can refine its premium assistance strategies to further support affordability. Additionally, fostering competition among issuers and promoting efficient healthcare practices can strengthen the marketplace. Continuous evaluation and adaptation of the premium assistance model, combined with targeted efforts to maintain cost-effective coverage, can help ensure that Arkansas continues to benefit from controlled premium growth in the long term.

Hypothesis O: The premium assistance model will lead to a lower rate of increase in average commercial insurance premiums in Arkansas compared to states that expanded Medicaid and provide coverage through means other than premium assistance

The data indicates that commercial insurance premiums in Arkansas kept the market premiums lower but exhibit similar fluctuation patterns over time as those in Louisiana and Missouri. Additionally, West Virginia, Kentucky, and Oklahoma also display comparable premium trends within their group. This indicates that the trend of Arkansas's premium assistance model on premium growth rates is comparable to the outcomes observed in other Medicaid expansion states that do not use premium assistance models.

Table 114: Principal findings from furthering quality improvement and delivery system reform initiatives

Hypothesis	Measure	Principal Findings	Significance
4.A. ARHOME beneficiaries will be aware of the point-of-service copayment	1. Beneficiary copayment awareness	Beneficiary awareness of copayment responsibilities increased from 81% in MY22 to 86% to MY24.	Not significantly different between years

Hypothesis	Measure	Principal Findings	Significance
requirements and the Economic Independence Initiative (EII)	2. Beneficiary EII awareness	The overall awareness of EII increased from 20% in MY22 to 24% in MY24.	Not significantly different between years
4.B. The ARHOME program will lead to QHP beneficiaries having greater satisfaction in the care provided over time and compared to Medicaid FFS beneficiaries.	1. Average rating of health plan	The target group reported a higher average health plan rating than the comparison group in MY22 and MY24.	Significantly different between groups
	2. Average rating of health care	The target group reported a higher average health care rating than the comparison group in MY22 and MY24.	Significantly different between groups
	3. Average rating of primary care provider	The average rating of a PCP was slightly higher among the target group than the comparison group in MY22 and similar in MY24.	Not significantly different between groups
	4. Average rating of specialist	The average rating of a specialist was slightly higher among the target group than the comparison group in MY22 and MY24.	Not significantly different between groups
4.C. The ARHOME program will lead to QHP beneficiaries having lower non-emergent use of the ED, lower potentially preventable use of the ED and hospital admissions, and lower hospital re-admissions over time and compared to Medicaid FFS beneficiaries.	1. Preventable ED visits	Similar percentages of ED visits were classified as preventable by the NYU ED algorithm among the target and comparison groups in both years.	Not significantly different between groups
	2. Non-emergent ED visits	A lower percentage of ED visits were classified as non-emergent by the NYU ED algorithm among the target group than the comparison group in MY22 only.	Significantly different between groups in MY22 only
	3. Emergent ED visits	A higher percentage of ED visits were classified as emergent by the NYU ED algorithm among the target group than the comparison group in both years.	Significantly different between groups in MY22 only
	4. Plan all-cause re-admissions (PCR)	There was a higher ratio of observed-to-expected (O/E) re-admissions within 30 days after an acute inpatient stay among the target group than the comparison group in both years.	Significantly different between groups in MY23 only
	5. Diabetes short-term complications admission rate (PQI-01)	The number of inpatient hospital admissions for short-term diabetes complications per 100,000 beneficiary months was higher for the target group than the comparison group in both years.	Significantly different between groups in MY23 only
	6. Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate (PQI-05)	The number of inpatient hospital admissions for COPD or asthma per 100,000 beneficiary months was higher for the target group than the comparison group in both years.	Not significantly different between groups

Hypothesis	Measure	Principal Findings	Significance
(Continued) 4.C. The ARHOME program will lead to QHP beneficiaries having lower non-emergent use of the ED, lower potentially preventable use of the ED and hospital admissions, and lower hospital re-admissions over time and compared to Medicaid FFS beneficiaries.	7. Heart failure admission rate (PQI-08)	The number of inpatient hospital admissions for heart failure per 100,000 beneficiary months was higher for the target group than the comparison group in both years.	Significantly different between groups in MY23 only
	8. Asthma in younger adults admission rate (PQI-15)	The number of inpatient hospital admissions for asthma per 100,000 beneficiary months was lower for the target group than the comparison group in both years.	Not significantly different between groups
	9. Rate of follow-up with a PCP after an ED visit	A higher percentage of the target group had a follow-up visit with a PCP after an ED visit than the comparison group in both years	Significantly different between groups
	10. Rate of follow-up with a PCP after a hospitalization	A higher percentage of the target group had a follow-up visit with a PCP after a hospital visit than the comparison group in both years.	Significantly different between groups in MY22 only
4.D. The ARHOME program will lead to QHP beneficiaries receiving better quality of care over time and compared to Medicaid FFS beneficiaries.	1. Initiation and Engagement of Substance Use Disorder Treatment (IET)	There was a higher percentage of new SUD episodes that resulted in treatment initiation within 14 days among the target group than the comparison group in both years.	Not significantly different between groups
		There was a higher percentage of new SUD episodes that had evidence of treatment engagement within 34 days of initiation among the target group than the comparison group in both years.	Significantly different between groups
	2. Antidepressant Medication Management (AMM)	A higher percentage of the target group was treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment for ≥84 or ≥180 days than the comparison group for both years.	Significantly different between groups
	3. Follow-up after hospitalization for MI (FUH)	A higher percentage of the target group had a follow-up visit with a PCP within 7 or 30 days after hospitalization for MI than the comparison group in both years.	Significantly different between the groups in MY22 only

Hypothesis	Measure	Principal Findings	Significance
(Continued) **4.D. The ARHOME program will lead to QHP beneficiaries receiving better quality of care over time and compared to Medicaid FFS beneficiaries.**	4. Adherence to antipsychotic medications for individuals with schizophrenia (SAA)	A lower percentage of the target group in MY22 and a higher percentage of the target group in MY23 with schizophrenia adhered to antipsychotic medication than the comparison group.	Significantly different between the groups in MY23 only
	5. Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	A higher percentage of the target group with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication had a diabetes screening test than the comparison group in both years.	Significantly different between groups in MY22 only
	6. Use of opioids at high dosage in persons without cancer (OHD)	A higher percentage the target group received prescriptions for opioids with an average daily dosage ≥ 90 morphine milligram equivalents (MME) over a period of 90 days or more than the comparison group in both years.	Significantly different between groups
	7. Concurrent use of opioids and benzodiazepines (COB)	A slightly higher percentage of the target group had concurrent use of prescription opioids and benzodiazepines than the comparison group in both years.	Not significantly different between groups
	8. Use of pharmacotherapy for opioid use disorder (OUD)	A lower percentage of the target group was prescribed ≥ 1 OUD medication, buprenorphine, or methadone than the comparison group in both years.	Significantly different for Methadone only
		A higher percentage of the target group had prescriptions of oral or long-acting Naltrexone than the comparison group in both years.	Significantly different between groups
	9. Follow-up after ED visit for alcohol and other drug abuse or dependence (FUA)	A higher percentage of the target group had a follow-up visit within 7 or 30 days after an ED visit for alcohol or other drug abuse or dependence than the comparison group in both years.	Significantly different between groups for follow-up after 30 days only
	10. Follow-up after ED visit for mental illness (FUM)	A lower percentage of the target group had a follow-up visit within 7 or 30 days after an ED visit for MI in MY22 than the comparison group. However, a higher percentage of the target group had a follow-up visit within 7 or 30 days after an ED visit for MI in MY23 than the comparison group	Significantly different between groups for follow-up after 30 days in MY23 only
	11. Persistence of beta-blocker treatment after a heart attack (PBH)	A lower percentage of the target group had distinct treatment days with beta blockers than the comparison group in both years.	Significantly different between groups in MY22 only

Hypothesis	Measure	Principal Findings	Significance
(Continued) 4.D. The ARHOME program will lead to QHP beneficiaries receiving better quality of care over time and compared to Medicaid FFS beneficiaries.	12. Annual Monitoring for patients on persistent medications (MPM)	A higher percentage of beneficiaries who were on persistent medications (i.e., received ≥180 treatment days of ambulatory medication in the measurement year) for ACE inhibitors, ARBs, or diuretics was higher than the comparison group for both years.	Significantly different between groups in MY22 only
	13. Annual HIV/AIDS viral load test	A higher percentage of the target group with a diagnosis of HIV had ≥ 1 HIV viral load test than the comparison group in both years.	Significantly different between groups in MY22 only
	14. C-section rate	A lower percentage of the target group had a delivery via C-section than the comparison group in both years.	Not significantly different between groups
	15. Contraceptive care – postpartum women ages 21–44 (CCP)	Among women who had a live birth during the measurement year, a lower percentage of women in the target group received contraception (most/moderately effective or a LARC method) within 3 or 90 days of delivery than the comparison group in both years.	Significantly different between groups within 3 days of delivery in MY23 only
		Among women who had a live birth during the measurement year, a lower percentage of women in the target group received a LARC method of contraception within 3 days of delivery, but a higher percentage received a LARC method within 90 days than the comparison group in both years.	Significantly different between groups within 3 days of delivery in MY22 only
	16. Contraceptive care – all women ages 21–44 (CCW)	A lower percentage of women in the target group received contraception (most/moderately effective or a LARC method) than the comparison group in both years.	Significantly different between the groups
	17. Percent of QHP beneficiaries participating in HII program	The percentage of ARHOME beneficiaries who participated in an HII program increased from 19% in MY22 to 26% in MY23.	N/A
4.E Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries who are not subject to copays.	1. Antidepressant Medication Management (AMM)	A higher percentage of the target group subject to copays, treated with antidepressant medication, and had a diagnosis of major depression, remained on antidepressant medication treatment for ≥84 or ≥180 days than the comparison group not subject to copays in MY22. Similar percentages for both groups were seen in MY23	Significantly different between the groups in MY22 only

Hypothesis	Measure	Principal Findings	Significance
(Continued) 4.E Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries who are not subject to copays.	2. Follow-Up After Hospitalization for MI (FUH)	A higher percentage of the target group subject to copays in MY22 and a lower percentage of the target group subject to copays in MY23 had a follow-up visit within 7 or 30 days after hospitalization for MI than the comparison group not subject to copays.	Significantly different between groups, except for follow-up within 7 days in MY23
	3. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	A higher percentage of the target group with schizophrenia subject to copays in MY22 and a lower percentage of the target group subject to copays in MY23 adhered to antipsychotic medication than the comparison group not subject to copays.	Not significantly different between groups
	4. Use of Opioids at High Dosage in Persons Without Cancer (OHD)	The percentage of beneficiaries who received prescriptions for opioids with an average daily dosage ≥90 MMEs over a period of 90 days or more was similar between target (subject to copays) and comparison groups (not subject to copays) in both years.	Not significantly different between groups
	5. Concurrent Use of Opioids and Benzodiazepines (COB)	A lower percentage of the target group subject to copays in MY22 and a higher percentage of the target group subject to copays in MY23 had concurrent use of prescription opioids and benzodiazepines than the comparison group not subject to copays.	Significantly different between groups in MY23 only
	6. Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Generally, a higher percentage of the target group subject to copays had a follow-up visit with any practitioner within 7 or 30 days of an ED visit than the comparison group not subject to copays in both years.	Not significantly different between groups
	7. Follow-Up After ED Visit for MI (FUM)	A higher percentage of the target group subject to copays had a follow-up visit within 7 or 30 days after an ED visit for MI than the comparison group not subject to copays in both years.	Significantly different between groups within 7 days of follow-up in MY22 only
	8. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	A higher percentage of the target group subject to copays in MY22 and a lower percentage of the target group subject to copays in MY23 had distinct treatment days with beta blockers than the comparison group not subject to copays in both years.	Not significantly different between groups

Hypothesis	Measure	Principal Findings	Significance
(Continued) 4.E Point-of-service copayments will not lead to QHP beneficiaries subject to copays to have worse quality of care compared to QHP beneficiaries who are not subject to copays.	9. Annual Monitoring for Patients on Persistent Medications (MPM)	A higher percentage of the target group subject to copays were on persistent medications (i.e., received ≥ 180 treatment days of ambulatory medication during the measurement year) for ACE inhibitors, ARBs, or diuretics than the comparison group not subject to copays in both years.	Not significantly different between groups
	10. Annual HIV/AIDS Viral Load Test	A slightly higher percentage of the target group subject to copays with a diagnosis of HIV had ≥1 HIV viral load test than the comparison group in both years.	Not significantly different between groups
	11. Statin Therapy for Patients with Diabetes (SPD)	A slightly higher percentage of beneficiaries subject to copays with diabetes who did not have clinical atherosclerotic cardiovascular disease (ASCVD) were dispensed ≥ 1 statin medication of any intensity than the comparison group not subject to copays in both years.	Not significantly different between groups
4.F Among QHP beneficiaries with income at or below 20% FPL, the Economic Independence Initiative will lead to an increase in income to above 20% FPL over time.	1. Percent of QHP beneficiaries at or under 20% FPL at initial measurement that are above 20% FPL at follow up measurement	14% of beneficiaries who started at 20% FPL in MY22 increased their income by the end of the year. This percentage increased to 21% in MY23.	N/A
4.G Among QHP beneficiaries with income at or below 100% FPL, the Economic Independence Initiative will lead to an increase in the percent of income to 101-138% FPL over time.	1. Percent of QHP beneficiaries at or under 100% FPL at initial measurement that are above 100% FPL at follow up measurement	10% of beneficiaries who started at 100% FPL in MY22 increased their income by the end of the year. This percentage decreased to 8% in MY23.	N/A
4.H Among QHP beneficiaries who disenroll from ARHOME, the Economic Independence Initiative will lead to an increase in the percent that disenroll	1. Percent of beneficiaries that are disenrolled due to high income	1% of QHP beneficiaries disenrolled from ARHOME due to high income in MY22 compared with 15% of beneficiaries in MY23.	N/A
	2. Percent of disenrolled beneficiaries that take up private health insurance	Of those who disenrolled from ARHOME, 19% of beneficiaries took up private health insurance in MY22 compared with 36% in MY23.	N/A

Hypothesis	Measure	Principal Findings	Significance
due to increased income over time.	3. Percent of disenrolled beneficiaries that take up private health Insurance and maintain the same health insurance plan they had in ARHOME	Of those who disenrolled from ARHOME, 4% of beneficiaries maintained the same health insurance plan that they had in ARHOME in MY22 compared with 7% in MY23.	N/A
4.I The Economic Independence Initiative will lead to an increase in the percent of QHP beneficiaries that enroll in education and training programs over time.	1. Percent of QHP beneficiaries that participated in education and training programs over time	9% of beneficiaries participated in education and training programs in MY22 and MY23.	N/A
	2. Percent of QHP beneficiaries Participating in the EII Program	A small percentage of ARHOME QHP beneficiaries (2%) in MY22 participated in EII incentives, which increased slightly to 3% in MY23.	Significantly different between years
4.J. The point-of-service copayments will lead to QHP beneficiaries subject to copays having lower overall healthcare use compared to similar QHP beneficiaries not subject to copays.	1. Beneficiary Copayment Healthcare Use Impact	The total number of medical claims per target group beneficiary was slightly lower than the total per comparison group beneficiary in MY22. No difference was seen between the target and comparison groups in MY23.	Significantly different between groups in MY22 only
4.K The shorter period of retroactive eligibility, the premium assistance model, the point-of-service copayments, the Health Improvement Initiative, and the other financial discipline components will lead to the rate of growth in per member per month (PMPM) QHP costs being no higher than the rate of growth in PMPM costs in Arkansas Medicaid FFS.	1. PMPM Growth Rate	PMPM coverage costs through QHPs remained below the budget neutrality cap for MY22 (-6%) and just under the cap in MY23.	N/A
	2. Total Health Expenditure Growth Rate	ARHOME total health expenditures remained below FFS expenditures and incurred a significant reduction of 9% between MY22 and MY23.	N/A
	3. Administrative Cost Growth Rate	Administrative costs for the ARHOME program increased significantly in MY23 as compared to MY22 (382%). This is likely due to the addition of waiver allocations included in MY23 and not MY22.	N/A

Hypothesis	Measure	Principal Findings	Significance
4.L QHP beneficiaries with a shorter period of retroactive eligibility will be healthier at enrollment than Medicaid FFS beneficiaries with a longer period of retroactive eligibility.	1. Average CCI Score	The Charlson morbidity index score per target group beneficiary was lower in MY22 and higher in MY23 than the score per comparison group.	Significantly different between groups in MY23 only
4.M The cessation of monthly premiums for QHP beneficiaries at 101-138% FPL will lead to a faster rate of growth in PMPM QHP costs in Years 2-5 compared to Year 1.	1. QHP PMPM Growth Rate	The PMPM growth rate in MY23 of ARHOME beneficiaries who were between 101-138% FPL was 18% lower than the budget neutrality cap compared with 13% lower for those in the same FPL range in MY22.	N/A
4.N The premium assistance model will lead to a lower rate of increase of PMPM premiums in the Arkansas Marketplace compared to states that expanded Medicaid and provide coverage through means other than premium assistance.	1. Arkansas Program Characteristics	The ARHOME demonstration did not affect the number of issuers offering QHPs.	N/A
	2. Arkansas Regional Average Program Characteristics	Statewide average premiums increased during the demonstration period but was not directly tied to ARHOME.	N/A
	3. Other Medicaid Expansion States' Program Characteristics	Although the contiguous states did not closely resemble the demographics of Arkansas, the trends in Arkansas support premiums across the waiver period being below contiguous states' median.	N/A
	4. Arkansas Marketplace PMPM Growth Rate	Benchmark plan premium levels appeared to increase at a lower rate per annum in Arkansas when compared to the contiguous states and remain consistently below the cohort median.	N/A
4.0 The premium assistance model will lead to a lower rate of increase in average commercial insurance premiums in Arkansas compared to states that expanded Medicaid and provide coverage through means other than premium assistance.	1. Arkansas Commercial Insurance Premium Rates	Commercial insurance premiums in Arkansas, Louisiana, and Missouri appear to fluctuate in a similar way over time. West Virginia, Kentucky, and Oklahoma also appear to trend similarly as a group.	N/A

7.5 NET EFFECT OF ARHOME POLICIES

During the ARHOME demonstration, the COVID-19 PHE was in effect through May 2023 when Medicaid unwinding initiated rapid disenrollments of ineligible beneficiaries. Additionally, the termination of premium payments for those > 100% FPL occurred at the end of 2022. To assess the potential impacts of these changes on beneficiary enrollment and medical utilization during the first two years of the ARHOME demonstration, multi-year longitudinal analysis (Pre-Post and DiD) were conducted on rates for the following metrics (Adult Access to Preventive/Ambulatory Services, Percentage of beneficiaries with ≥ 1 ED Visit, Percent of Beneficiaries with ≥ 1 Month with a Coverage Gap and Average Length of Gaps in Coverage) comparing the MY22 pre-period and MY23 post-period.

Measure 2.D.8: Adult Access to Preventive/Ambulatory Services

For the Adult Access to Preventive/Ambulatory Services measure, results indicated consistent disparities between income groups in both measurement years. Specifically, the rate of visits was persistently higher for the >100% FPL group compared to the ≤100% FPL group. This difference was statistically significant across both years, indicating that income level continues to play a pivotal role in access to preventive and ambulatory services. These findings underscore the need for targeted interventions to address and mitigate access barriers faced by lower-income beneficiaries. Also, for the ≤100% FPL group, the rate of beneficiaries having at least one ambulatory or preventive visit decreased in MY23 compared to MY22. Conversely, for the >100% FPL group, the rate increased in MY23 compared to MY22. Despite these variations, the findings were not statistically significant either between years or between the income groups within the respective years. This suggests that while there are observable trends in access rates, the differences may not be substantial enough to necessitate different interventions or targeted actions.

Measure EDV: Percentage of beneficiaries with ≥ 1 ED Visit

Assessing the percentage of beneficiaries with at least one ED visit revealed a noteworthy decline in ED visit rates in MY23 compared to MY22. Consistent patterns emerged in both measurement years: individuals in the >100% FPL group had lower rates of ED visits than those in the ≤100% FPL group. These disparities between income groups were statistically significant in both MY22 and MY23, highlighting a persistent trend where lower-income beneficiaries are more likely to utilize emergency services. The significant differences observed between years also suggest an overall improvement in reducing emergency visits among beneficiaries, though income-related disparities persist. These findings underscore the importance of ongoing efforts to improve access to preventive and ambulatory care for lower-income groups to reduce reliance on emergency services. Additional trends were also observed within income groups. Specifically, both the >100% FPL group and the ≤100% FPL group experienced a reduction in the rate of ED visits in MY23 compared to MY22. However, the level of statistical significance varied between these groups. For the ≤100% FPL group, the decrease in ED visit rates between MY22 and MY23 was statistically significant, suggesting a meaningful improvement in reducing emergency visits among lower-income beneficiaries. Conversely, for the >100% FPL group, the decrease between these years was not statistically significant, indicating that the observed

reduction may be subject to other variables or not as pronounced. These findings illustrate that while overall ED visits have declined, the most substantial and statistically significant improvements occurred within the lower-income demographic, pointing to the potential effectiveness of interventions targeting this group.

Measure 1.D.1: Percent of Beneficiaries with ≥ 1 Month with a Coverage Gap

An analysis of the percent of beneficiaries experiencing at least one month with a coverage gap showed a significant increase in MY23 compared to MY22. Notably, this analysis revealed distinct shifts in coverage continuity across different income groups. In MY22, the rate of beneficiaries with coverage gaps was lower for the >100% FPL group compared to the ≤100% FPL group. However, this trend reversed in MY23, with the >100% FPL group exhibiting a higher rate of coverage gaps than the ≤100% FPL group. These differences were statistically significant both between the years and among the income groups within each year. The reversal in trend from MY22 to MY23 indicates that beneficiaries with higher income levels experienced more disruptions in coverage in the more recent year, most likely related to the PHE unwinding. These findings emphasize the importance of addressing and ensuring continuous coverage, particularly as the nature of coverage gaps has shifted between income groups over time. For both groups, the rate of beneficiaries experiencing coverage gaps was higher in both MY22 and MY23. These variations were statistically significant between the years for both income groups, underscoring a persistent issue of coverage instability across the ARHOME population. This significant increase in the rate of coverage gaps over time indicates that beneficiaries, regardless of income level, have been facing heightened challenges in maintaining continuous coverage.

Measure 1.D.2: Average Length of Gaps in Coverage

The data revealed that the average duration of coverage gaps lengthened in MY23 compared with MY22. Additionally, both years demonstrated a significant disparity between income groups, with the average length of coverage gaps consistently being higher for the >100% FPL group compared to the ≤100% FPL group. These differences were statistically significant both between the years and among the income groups within each year. The results underscore a critical issue where higher-income beneficiaries experienced longer interruptions in coverage that are likely influenced by being close to the eligibility cut off and also the PHE unwinding. For both the ≤100% FPL and the >100% FPL groups, the average length of coverage gaps increased in MY23 compared to MY22. This upward trend was statistically significant for both income groups, indicating that beneficiaries across the spectrum experienced longer interruptions in their coverage in MY23. These findings highlight the critical need for interventions aimed at reducing not only the occurrence but also the duration of coverage gaps, ensuring that all beneficiaries, regardless of income, have continuous access to healthcare services.

Table 115: Principal findings of the net effect of ARHOME policies

Measure	Principal Findings	Significance
2.D.8. Adult Access to Preventive/Ambulatory Services	There was a decrease in the rate of beneficiaries with ≥1 ambulatory or preventive visits in MY23 than in MY22. In both MY22 and	Significantly different between years and between income groups in both years.

Measure	Principal Findings	Significance
	MY23, the rate was higher for the >100%FPL group than the ≤100%FPL group.	
	For the ≤100%FPL group, this rate was lower in MY23 than MY22, whereas for the >100%FPL group, this rate was higher in MY23 than MY22.	Not significantly different between years or income groups in both years.
EDV: Percentage of beneficiaries with ≥ 1 ED Visit	There was a decrease in the rate of beneficiaries with ≥1 ED visits in MY23 than 2022. In both MY22 and MY23, this rate was lower for the >100%FPL group vs. the ≤100%FPL group.	Significantly different between years and between income groups in both years
(Continued) EDV: Percentage of beneficiaries with ≥ 1 ED Visit	For both income groups, this rate was lower in MY23 vs. MY22.	Significantly different between MY22 and MY23 for the ≤100%FPL group. Not significantly different between MY22 and MY23 for the >100%FPL group.
1.D.1. Percent of Beneficiaries with ≥ 1 Month with a Coverage Gap	There was an increase in the rate of beneficiaries with ≥1 month coverage gap in MY23 than MY22. In MY22, this rate was lower for the >100%FPL group compared with the ≤100%FPL group. However, in MY23, this rate was higher for the >100%FPL group than the ≤100%FPL group.	Significantly different between years and between income groups in both years.
	For both income groups, this rate was higher in both years.	Significantly different between years for both income groups.
1.D.2. Average Length of Gaps in Coverage	There was an increase in the average length of coverage gaps among beneficiaries with ≥1 month coverage gap in MY23 compared with MY22. In both years, average length was significantly higher for the >100%FPL group vs. the ≤100%FPL group.	Significantly different between years and between income groups in both years.
	For both the ≤100%FPL and >100%FPL groups, this rate was higher in MY23 vs. MY22.	Significantly different between MY22 and MY23 for both income groups.

7.6 LIFE360 HOME IMPLEMENTATION

Arkansas's focus on the Maternal Life360 HOME program complements recent national efforts to improve maternal and infant health in the US. The Life360 HOMEs program supports expectant high-risk mothers through the provision of regular home visits while connecting them with community supports that can provide appropriate HRSN services. In this report, we focused initial evaluation efforts on implementation progress as hospitals integrate new processes and procedures specific to the Maternal Life360 HOME program as well as promote the program to high-risk beneficiaries that are eligible to enroll. Understanding implementation barriers and successes of participating hospitals is essential to the success and sustainability of the program.

Hypothesis E: Key entities during the start of Life360 HOME program will report on implementation activities, infrastructure development, overcoming barriers in the facilitation of Life360 HOME, and on adopted strategies that identify and provide services to beneficiaries with HRSN needs

Generally, physicians and hospital executives from AHA, AAFP, and AMS Provider Focus Groups (PFGs) in 2023 had a positive outlook on the Maternal Life360 HOME program and considered this program a crucial initial step in demonstrating the success and sustainability of improved coordination of clinical and community supports. Key informant interviews with staff who were directly involved in implementation activities at active Maternal Life360 HOME hospitals continued to emphasize the importance of this program and its ability to identify high-risk pregnancies early to deliver timely supportive services. Many key informants expressed gratitude in being able to participate in a project that could provide meaningful impacts to moms and babies in their communities. However, there were challenges that started with the lengthy and complex application process, infrastructure creation and integration into their hospital systems, payments rates to support staff and program needs, as well as patient outreach. Integrating the Maternal Life360 HOME program into hospital systems was crucial and facilitated by provider engagement and partnering with existing programs with staff trained and experienced with providing home visits. Cultivating and strengthening relationships with physicians, staff, and other partner organizations was important for timely identification and enrollment of eligible women. Communication between program staff and women with eligible high-risk pregnancies remains challenging. Establishing open lines of communication for follow-up care and services with potential or active enrollees takes time and trust. As each Maternal Life360 HOME program progresses, efficiency of patient identification, data tracking, and financial reimbursement processes will be further assessed.

Table 116: Principal findings from Maternal Life360 start up and implementation activities

Hypothesis	Measure	Principal Findings
4.E. Key entities during the start of Life360 HOME program will report on implementation activities, infrastructure development, overcoming barriers in the facilitation of Life360 HOME, and on adopted strategies that identify and provide services to	1. Key Entities	Key entities who were interviewed consisted of staff members, state official/policymakers, and community partners involved in a hospital's Maternal Life360 HOME program.
	2. HSRN Services	Available housing and transportation services were the main concerns of enrollees.
	3. Integration with Existing Programs and Infrastructure	Staff skills from programs offering home visits are transferable to the needs of the Maternal Life360 HOME program. Recruitment processes are integrated into physician practice operations.
	4. Maintenance of organizational partnerships	Cultivating and maintaining these relationships were crucial to the timely enrollment of patients to the Maternal Life360 program.

Hypothesis	Measure	Principal Findings
beneficiaries with HRSN needs	5. Key Entity Barriers in implementing Amendment	Challenges included a lengthy application process for the Maternal Life360 HOME application, with inconsistent state communication, delays due to staffing changes at the state and federal levels, payment model negotiations (e.g. bundled payments vs. PMPM), and other administrative burdens.
	6. Barriers in Beneficiary Outreach and Participation	Beneficiaries were difficult to reach, engage, and follow up with. It takes time to develop relationships and establish trust to obtain important personal and lifestyle information so that the appropriate services can be provided.
	7. Strategies Adopted to Facilitate and Reduce Barriers in Implementation	• Workforce readiness – hiring and training staff prior to the official start of the Maternal Life360 HOME program • Patient outreach – set up routine follow-up calls, patient tracking systems, logs of communication • Timely payments – ongoing communication with the State on patient eligibility and enrollment
	8. Strategies Adopted to Improve Beneficiary Experience	Intentional communication with patients during the time-limited visits to get services rendered.

8.0 IMPLICATIONS AND INTERACTIONS WITH OTHER STATE INITIATIVES

The ARHOME demonstration and the Maternal Life360 HOME amendment have been impacted by several program and policy changes that occurred within the timeframe covered by this evaluation period. This section summarizes these policy changes and state-led initiatives that occurred during the ARHOME demonstration thus far and discusses their implications for the evaluation, as well as the broader Medicaid and healthcare policy landscape in Arkansas.

8.1 POLICIES IMPACTING ARHOME

Numerous program and policy changes have been or soon will be implemented that may potentially affect ARHOME evaluation enrollment and results. ARHOME program changes included the following:

- Unwinding of the Public Health Emergency
- Changes in Retroactive Eligibility from 90 to 30 days
- Monthly Premium Authority (2022 only)
- Co-payment Exemptions and Cost Sharing
- Suspension of Auto-Assignment into Qualified Health Plans
- Suspension of Rural and Success Life360 HOMEs
- Qualified Health Plan Sanctions in ARHOME

Other policy changes that may indirectly affect ARHOME evaluation results include:

- Introduction of a New QHP: Blue Cross Blue Shield Octave
- Medical Loss Ratio and Pharmacy Rebates
- Rural Health Transformation Program

Public Health Emergency Unwinding

One of the provisions of the COVID-19 PHE was continuous Medicaid enrollment, which prevented the disenrollment of people from Medicaid per routine eligibility redetermination processes. As a result of the conclusion of the federal COVID-19 PHE, Arkansas resumed routine Medicaid eligibility redeterminations, starting on April 1, 2023. Between April and September 2023, Arkansas DHS reviewed eligibility for enrollees, resulting in over 45,000 case renewals and over 53,000 disenrollments. A significant proportion of disenrollments stemmed from procedural issues, such as failure to return renewal forms or requested documentation. These shifts could have influenced enrollment trends and continuity of care during the ARHOME demonstration, potentially affecting access, utilization, and health outcomes, especially for vulnerable populations.

Retroactive Eligibility Changes

Among the Medicaid requirements waived under the ARHOME 1115 waiver is 90-day retroactive eligibility (42 CFR 435.915). Under the ARHOME 1115 demonstration, retroactive Medicaid eligibility is limited to 30 days prior to application. Retroactive eligibility allows for reimbursement of Medicaid covered services provided prior to an individual's application for Medicaid.

The decrease in retroactive eligibility period from 90 to 30 days under the ARHOME 1115 waiver was implemented on July 1, 2022, applies to the adult expansion population, and was intended to increase insurance literacy and encourage proactive enrollment. However, this change may potentially introduce unanticipated challenges, such as uncompensated care for hospitals and providers, delays in care among people uncertain if they will be covered, and may disproportionately affect people with unstable housing, limited literacy, or intermittent access to enrollment help. In addition, this policy change may discourage providers from offering non-emergent services unless coverage is confirmed. Treatment of high-risk or uninsured patients may result in delayed or missed follow-up care due to the individual remaining uninsured or still pending enrollment. Interpretation of evaluation results related to emergency department use and delayed care should take into consideration the impact of this policy change in retroactive eligibility.

Monthly Premium Authority (2022 Only)

During the first year of the demonstration (2022), Arkansas was authorized to charge monthly premiums of up to two percent of household income for ARHOME beneficiaries with incomes above 100% FPL. This authority, which ended in December 2022, was time-limited and intended to promote cost-sharing and accountability. Although temporary, the premium requirement may have affected enrollment decisions, retention, and patterns of continuity of coverage during the demonstration's early phase.

Co-payment Exemptions and Cost Sharing

Effective January 1, 2023, DHS introduced copayment exemptions for specific populations (e.g., pregnant women, American Indians/Alaska Natives, enrollees under hospice care, and enrollees under age 21) as well as for specific services exempted based on purchasing guidelines rather than the memorandum of understanding (MOU) (e.g., pregnancy-related, preventive, emergency, family planning, provider preventable conditions). These exemptions tended to increase the copay-exemption population. However, offsetting this increase, starting in 2023, the copay exemption threshold requirement was reduced from <100% FPL to <20% FPL, which acted to decrease the copay-exemption population based on income requirements for beneficiaries not included in the above-mentioned specific populations. These exemptions, along with caps on quarterly copayment amounts based on income, were intended to mitigate financial barriers to care, thereby increasing utilization of preventive and behavioral health services, for the affected specific populations. These policy changes should be considered when evaluating service utilization, especially among low-income or exempt groups, as observed increases in the use of preventive or behavioral health services may, at least in part, be attributable to the reduced financial burden. By removing cost-related barriers, the policy aimed

to encourage earlier and more frequent engagement with the health care system. Therefore, any post-implementation shifts in utilization patterns, particularly among exempt populations, could reflect the impact of these exemptions and should be interpreted in that context.

Suspension of Auto-Assignment into Qualified Health Plans

Between September 2022 and May 2023, DHS suspended auto-assignment of certain eligible individuals into QHPs. Approximately 25,000 beneficiaries who had been awaiting QHP enrollment at the end of 2022 were not assigned one until mid-2023, with coverage beginning in August 1, 2023. This temporary suspension and later catch-up enrollment may have created short-term fluctuations in the target population size and continuity of care.

Suspension of Rural & Success Life360 HOMEs

On August 16, 2024, Arkansas informed CMS of its intent not to operationalize the Success and Rural Life360 HOMEs and that the state will implement only the Maternal Life360 HOME program. The Maternal HOME model continues under full authority, according to the ARHOME STCs throughout the demonstration period. While the Maternal Life360 HOME remains active, the decision to suspend the other two models reduces the breadth of evaluated populations, particularly those with issues related to behavioral health, rurality, housing instability, criminal justice involvement, and military veteran status that the Rural and Success HOMEs would have targeted. The suspension does not alter the defined operational parameters of the Maternal Life360 HOME, but limits comparative opportunities and system-wide synergies.

QHP Sanctions in ARHOME

Arkansas DHS implemented a more robust process of holding QHPs accountable with the 2023 QHP Memorandum of Understanding (MOU). Arkansas DHS established performance targets on selected metrics, median targets and QHP-specific improvement targets that each QHP must meet during Plan Year 2023. Arkansas DHS required civil money penalties in 2024 from any QHP that fails to meet performance, median or improvement targets during Plan Year 2023.

Introduction of a New QHP: Blue Cross Blue Shield Octave

Effective January 1, 2024, BCBS introduced a new health plan, Octave, into the Arkansas Marketplace. This expanded the choices available to ARHOME beneficiaries and may influence enrollment distributions, provider networks, and outcomes for demonstration participants. It will be important to consider potential effects of new plan entry on access and utilization when interpreting evaluation findings. Although not affecting the two years (2022, 2023) that are reported in this current Interim Report, this new QHP plan may impact the evaluation findings in the final three years (2024-2026) of the 5-year ARHOME demonstration period (2022-2026).

Medical Loss Ratio and Pharmacy Rebates

In April 2025, Act 774 was enacted, which amends the ARHOME statute to strengthen financial oversight and pharmacy rebate requirements. This Act increases the medical loss ratio (MLR) requirement for insurers in ARHOME from 80% to 85% and requires insurers to obtain all eligible pharmacy rebates and remit them to the state. While these changes could affect fiscal models, incentives, and net program costs for ARHOME, it is still too early to assess the extent

of any impacts. This is something to keep in mind in future evaluations as the full effects of Act 774 continue to unfold.

Future Policy Implications

The CMS launched a $50 billion Rural Health Transformation Program[67] on September 16, 2025, which is designed to empower states to transform the existing rural health care infrastructure and build sustainable health care systems that expand access, enhance quality of care, and improve outcomes for patients. The Rural Health Transformation Program invites all 50 states to apply for funding to address each state's specific rural health challenges. The Program enables states to reimagine care delivery and develop innovative, enduring, state-driven solutions to tackle the root causes of poor health outcomes specific to rural America.

The Program has five strategic goals, grounded in the statutorily approved uses of funds:

- **Make rural America healthy again:** Support rural health innovations and new access points to promote preventative health and address root causes of diseases.
- **Sustainable access:** Help rural providers become long-term access points for care by improving efficiency and sustainability.
- **Workforce development:** Attract and retain a highly skilled health care workforce by strengthening recruitment and retention of health care providers in rural communities.
- **Innovative care:** Spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements.
- **Tech innovation:** Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients.

On September 30, 2025, Arkansas Governor Sarah Huckabee Sanders submitted a letter of intent to CMS,[68] notifying the federal agency that Arkansas plans to pursue funding through the Rural Health Transformation Program. The funding will be available in 2026 and could have a substantial impact on ARHOME providers and ultimately ARHOME beneficiaries.

8.2 POLICIES IMPACTING MATERNAL LIFE360 HOME

Numerous legislative and programmatic initiatives and committees have been or soon will be passed and enacted that may potentially affect the Maternal Life360 HOME evaluation enrollment and outcome results, including:

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[67] "CMS Launches Landmark $50 Billion Rural health Transformation Program." *Centers for Medicare & Medicaid Services,* 15 September 2025, https://www.cms.gov/newsroom/press-releases/cms-launches-landmark-50-billion-rural-health-transformation-program.

[68] "Sanders Announces Portal for Rural Health Transformation Program Proposals." 1 October 2025, https://governor.arkansas.gov/news_post/sanders-announces-portal-for-rural-health-transformation-program-proposals/.

- Healthy Moms, Healthy Babies Act
- Arkansas Maternal Mortality Review Committee
- Strategic Committee for Maternal Health
- Non-Medical Transportation (NMT) Amendment
- Baby & Me Expansion
- Pregnancy+ app
- Transforming Maternal Health (TMaH) Model
- Delta Maternal Outreach and Transformational Health Education Resource (Delta MOTHER) project
- Healthy Start Program
- Act 774 amendment of ARHOME financing parameters
- Primary Care Payment Improvement Working Group
- UAMS midwifery and doula training program (2026)
- Ingeborg Initiatives

Arkansas has made maternal health a priority in recent years. In March 2024, Arkansas Governor Sarah Huckabee Sanders established the Strategic Committee for Maternal Health to coordinate a cross-agency plan to support moms, protect babies, and improve maternal health, catalyzing a package of Medicaid and public health actions. In 2025, the *Healthy Moms, Healthy Babies Act* was passed to improve Arkansas's maternal health outcomes. Arkansas plans to invest $45 million annually and implement several changes aimed at addressing high infant mortality rates, racial disparities in maternal mortality, and maternity provider shortages. These changes include expanding Medicaid coverage, streamlining provider payment methods, extending postpartum services, securing additional funding streams, innovating technology, and increasing access in rural areas. **Table 117** highlights legislation impacting the maternal population in Arkansas.

Table 117: Summary of Legislation Impacting Maternal Life360 HOME

Act	Date Approved	Intent
Act 124 - The Healthy Moms, Healthy Babies Act	02/20/25	Authorized the Arkansas Medicaid Program to do the following: • Reimburse depression screening for pregnant women • Reimburse prenatal, delivery, and postpartum services, separately, in lieu of a global payment • Make presumptive eligibility determinations for pregnant women applying for the program • Provide coverage and reimbursement for self-measurement of blood pressure monitoring services for pregnant women and postpartum women • Reimburse medically necessary remote ultrasound procedures when the patient is in residence or other off-site location from the health care provider • Reimburse doulas and community health workers for home visitation for prenatal and postpartum care
Act 556 - To establish Medicaid coverage for mobile health units	02/20/25	Establishes Medicaid coverage for mobile health units, increasing the number of providers available
Act 138 - To amend the full practice authority of a certified nurse midwife to admit and discharge patients.	02/25/25	Amends the existing Act to authorize certified nurse midwives to do the following: • Admit and discharge patients from a licensed hospital if granted privileges • Complete, sign, and submit forms for a certificate of birth or death
Act 435 - To create the Community Health Worker Act	04/03/25	• Establishes a statewide certification process for community health workers • Defines a scope of practice for a community health worker. • Authorizes a community health worker to be compensated by the Arkansas Medicaid Program
Act 627 - To mandate Medicaid coverage for lactation consultant services	04/16/25	• Establishes Medicaid coverage for lactation consultation • Defines a breastfeeding and lactation consultant and requires that they be supervised by a health care provider as a requirement for reimbursement • Authorizes reimbursement by the Arkansas Medicaid Program if the individual meets all participating requirements as a Medicaid provider and is a participating provider
Act 886 - To mandate coverage for delivery of a newborn in a licensed birthing center; and other purposes	04/17/25	Establishes Medicaid coverage for delivery of a newborn in a licensed birthing center.
Act 965 - To establish the Community Certified-Based Doula Certification Act	04/21/25	• Establishes a certification process for the ADH to certify community-based doulas • Creates a registry for certified community-based doulas • Establishes a scope of practice for certified community-based doulas. • Authorizes a certified community-based doula to receive compensation from the Arkansas Medicaid Program and health benefit plans

In addition to passing the *Healthy Moms, Healthy Babies Act,* Arkansas has undertaken several initiatives to improve maternal health outcomes. These are discussed in the following section.

Because these statewide efforts are being implemented in tandem with Maternal Life360 HOME, observed changes may reflect combined effects of the many efforts underway in Arkansas, to improve maternal health outcomes, rather than the demonstration alone. It is important to take this into consideration in interpreting evaluation results.

Beyond the *Healthy Moms, Healthy Babies Act*, Arkansas enacted a series of legislative and programmatic initiatives that reinforce maternal health as a statewide priority. In December 2024, the state formalized the Arkansas Maternal Mortality Review Committee, charged with recommending strategies to reduce preventable deaths.

Alignment with State Maternal Health Strategy

In 2024, via the Arkansas Governor's Executive Order, Arkansas established the Strategic Committee for Maternal Health, which released a report in March 2024. Many of the previously outlined initiatives align with the recommendations of this report. This includes support for presumptive eligibility, improved transportation access, and broader maternal health infrastructure. Together, these efforts demonstrate a statewide policy focus on improving maternal outcomes and addressing social determinants of health through Medicaid demonstration authority.

The recommendations of the Strategic Committee for Maternal Health were later implemented into law, via the *Healthy Moms, Healthy Babies Act*, in 2025. These evolving state policies and program adjustments shape the implementation environment for the ARHOME demonstration and Maternal Life360 HOME amendment. Understanding their interaction and contextual relevance is essential for interpreting observed trends in access, utilization, and outcomes.

Non-Medical Transportation (NMT) Amendment

On December 20, 2024, CMS approved an amendment to cover non-medical transportation services under ARHOME for beneficiaries with a care plan authorizing HRSN services. This limited scope benefit targets a defined population and is not expected to significantly impact overall demonstration costs. Its impact on access to social support services and related outcomes will be integrated into the summative evaluation.

Other State and Federal Initiatives

There are also several state and federal initiatives in progress that may increase the magnitude of the maternal health outcomes, which should be considered when interpreting ARHOME and Maternal Life360 HOME results. Arkansas has also implemented the following, which likely amplify and overlap with ARHOME:

- Baby & Me is a program that offers parenting education to pregnant women and parents of newborns who, receive Women, Infants, and Children (WIC) benefits. As of June 2025, Baby & Me was expanded to three additional counties in Arkansas: Johnson, Pope, and White. The expansion into these three counties brings the total number of counties offering this program to eighteen. The program offers education on essential parenting skills, activities supporting child and parent interactions, and connects families to community services and support as needed.

- The Pregnancy+ Application is a pregnancy app available to all moms with specialized content for Medicaid moms. It allows expecting moms to connect with local maternal health services, early childhood programs and support networks, including content on how to sign up for Medicaid, WIC and more. There are over 800 articles on pregnancy, birth and newborn care within the app. Additionally, many health plans and providers such as UAMS also have pregnancy apps.
- Transforming Maternal Health (TMaH) Model launched in January 2025; this grant provides funding and technical assistance to improve maternal and newborn care for Medicaid and CHIP enrollees, focusing on access, quality, workforce capacity, and data infrastructure.
- The Delta Maternal Outreach and Transformational Health Education Resource (Delta MOTHER) project, a grant-funded initiative concentrated in the Arkansas Delta that provides community outreach, educational and preventative health services, and infrastructure improvements.
- The Healthy Start Program provides a variety of health and social services to pregnant and parenting women, using case management and community outreach approaches. Services provided include parenting education, one-on-one support, home visits, and case management.

Future Policy Implications

Looking ahead, Arkansas has committed additional resources that may further influence maternal outcomes during and beyond the current demonstration period. These include Act 774, which amended ARHOME financing parameters in 2025, and Act 483, which established the Primary Care Payment Improvement Working Group to strengthen foundational care delivery. UAMS is conducting needs assessments for midwifery and doula workforce and is developing awareness campaigns to support the integration of midwives and doulas in the maternal health care team. Philanthropic and community-based efforts such as the Ingeborg Investments continue to invest in maternal health, women's economic opportunity, and early childhood development. These forward-looking initiatives reinforce maternal health as a sustained statewide priority and will provide important context for interpreting ARHOME and Maternal Life360 HOME evaluation results.

9.0 LESSONS LEARNED AND RECOMMENDATIONS

During the initial two years of the ARHOME demonstration period (2022-2023) and the inaugural year of the Life360 HOMEs demonstration period, several operational and policy trends emerged. These developments offer insight and suggestions for ongoing improvements in the remaining years of the demonstration (2024-2026).

9.1 ARHOME

Strengthening QHP Engagement

Enhanced oversight by Arkansas DHS on the submission of timely and accurate QHP data has improved the precision and reliability of performance measurements, facilitating more effective collaboration among policy makers and demonstration oversight personnel to target and mitigate adverse trends. Identifying and implementing structures to ensure regular data submission with required quality assurance steps strengthens overall data integrity in order to guide policymakers and demonstration administration personnel with effective improvement and management of the demonstration.

From a policy perspective, monitoring quality improvement and performance efforts carried out by the demonstration's QHP carriers can positively impact efforts made to improve the health of ARHOME beneficiaries. Building on timely and accurate data submission requirements, the demonstration will benefit from regular and structured reviews of patient outcomes and alignment on improvement efforts with carriers. Arkansas DHS recognizes this impact and has strengthened agreements with the QHPs to improve quality reporting efforts.

To hold plans accountable for meeting and sustaining performance improvements, Arkansas DHS has also implemented financial penalties to be assessed against QHP performance targets for select quality measures starting in 2023. Historically, Arkansas Medicaid, its QHP carriers, and its delivery system have engaged in innovative policy solutions focused on payment reform and improving patient outcomes including financial rewards as public recognition. With quality-of-care levels varying irregularly across observed measures throughout the early demonstration period, carriers and providers would likely benefit from more prominently displayed postings on the agency's website related to trends in specific patient populations or variances between providers across cost and quality measures.

Beneficiary Communication

For most Medicaid agencies, the Medicaid unwinding process brought new and unprecedented experiences for both the beneficiaries and the State. In 2021, the Arkansas State Legislature passed Act 780, which required the state to complete its Medicaid eligibility redeterminations within just six months of the end of the federal Public Health Emergency. This set a much faster timeline than the 12-month period recommended by federal guidance. However, Arkansas DHS was very proactive in their communications with the ARHOME population as they had already conducted a multi-pronged year-long effort to alert beneficiaries, providers, and other stakeholders about the ending of the PHE. To process renewal applications timely, DHS scheduled renewals in phases, and ARHOME beneficiaries were among the first to receive

renewal notices. In analyzing beneficiary satisfaction, the majority of ARHOME beneficiaries remained satisfied with their health plan (80% in MY22, 76% in MY24). If there was any notable disruption in communications, satisfaction scores would have drastically decreased to reflect less clarity around the unwinding process. Even so, redetermination requirements should be communicated often and be easily understood, which should positively impact continuity of care and coverage.

To better understand reasons for loss of ARHOME coverage considering the Medicaid unwinding process, conducting surveys with beneficiaries who had a lapse in coverage could provide valuable insights into continuity of care and efficiency of redetermination processes.

Additionally, beneficiary communications are always a challenge and can be enhanced to better inform, engage, and empower the ARHOME population to make better health decisions by acting on their benefit offerings. It is clear through beneficiary survey responses that ARHOME beneficiaries lack awareness on health and economic incentives offered through their QHP plan, preventive services, and wrap-around benefits (EPSDT and NET services).

Current agreements between DHS and QHPs require the provision of at least one EII and HII in 2022, increasing to two EII and HII incentives in 2023 for high-risk subgroups like pregnant women and individuals with mental illness or substance use disorders. Furthermore, QHPs should highlight access to wraparound services such as NET and EPSDT services in the QHP's new client welcome packets as well as on QHP websites. However, interim evaluation results showed that most beneficiaries surveyed were not aware of HII, EII, or NET benefits and even fewer beneficiaries reported participating in an initiative or utilizing NET services. This demonstrates that ARHOME beneficiaries are lacking the knowledge or ability to utilize these resources. EPSDT benefits were also significantly underutilized as young FFS beneficiaries transitioned to ARHOME.

While these requirements should positively impact early engagement and access to care, notice of any incentives should be highlighted in all client and provider communications, especially toward focused populations such as young adults to establish positive health practices, reduce acute and chronic illnesses, and thus reduce costs. With impending work requirements of the "One Big, Beautiful Bill Act", it would benefit the State to improve QHP care coordination to best equip ARHOME beneficiaries with the tools needed for success.

9.2 LIFE360 HOMES PROGRAM

Life360 Program Development

The Life360 HOMEs Amendment was initially designed to consist of Maternal, Rural, and Success programs that intended to improve outcomes for at-risk populations such as pregnant and post-partum women, individuals with serious mental illness or substance use disorder, formerly incarcerated youth, former foster care, and veterans at risk of homelessness. However, as noted in **Section 2.2**, because of roadblocks in operationalizing Rural and Success Life360 that impacted feasibility, only Maternal Life360 HOME was implemented. Additional preliminary feedback from eligible providers on motivations and barriers to participation may have helped the State to determine program feasibility earlier and make adjustments or

decisions sooner, as the late start in implementing Maternal Life360 has shortened the evaluation timeline to identify meaningful impacts of the program.

Life360 Application Process

Hospitals that completed applications for the Maternal Life360 HOME noted that the application process was lengthy, complex, and needed more effective communication from Arkansas DHS. The new Governor's Strategic Plan process during 2024-2025 was spearheaded by DHS and engaged both Life360 staff and the Life360 hospitals. The Strategic Plan led to a bustle of activities, including the Mom's bill in 2024-2025 and submission of the TMaH grant to CMS, which strained the state's capacity to review and approve Life360 providers. Though stakeholders indicated that periodic calls with the state were helpful, an improvement in clear, consistent and regularly scheduled communication would be of value to both the state and its partners. Since new applications are still being accepted, future improvements to the application process would streamline approval and shorten the time to start up activities.

Life360 HOME Implementation

With both a national and state focus on the current state of maternal health in the Medicaid population, Arkansas DHS has dedicated its efforts to build a system of care to support the desired outcome for optimal results of Medicaid enrolled women from their prenatal period through the postpartum period. The implementation and incorporation of any new program into existing hospital infrastructure requires a startup period to determine best practices in determining patient eligibility, patient enrollment, staff training, and data reporting requirements.

According to state staff working on the Life360 HOME program, there were delays in determining with CMS the correct Medicaid authority to request expansion of the Maternal Life360 HOME target population. The approval of the State Plan amendment finally occurred in April 2024, well over a year after the state began accepting applications. This change needed to be in place before hospitals began enrolling beneficiaries to allow for easier recruitment of the target population. Also, finalizing the Life360 implementation plan and other deliverables with CMS for the state's HRSN services took approximately 18-20 months after the Life360 amendment approval and contributed to some uncertainty about program elements (e.g. coverage of housing and nutrition services) as hospitals' applications were being reviewed.

For most of the current period covered in this interim report, Arkansas DHS has been engaged with hospitals in identifying appropriate services related to the Life 360 HOMEs Amendment, refining screening tools, data templates for reporting, and ensuring hospital readiness. As discussed in the Maternal Life360 HOME Stakeholder and Provider interview results, developing community support and resources as well as building a strong provider network in the state's chosen service areas have presented challenges.

While Arkansas healthcare providers are proactive in screening for SDOH, there are considerable challenges in follow-up and referral tracking. To bridge this gap, it is crucial to implement scalable and feasible solutions tailored for smaller clinic settings and enhance technological integration for effective closed-loop tracking.

Maternal Life360 HOME can address some of these gaps through the program's coordinated care system. While screening tools are difficult to standardize across all participating hospitals, all tools have been reviewed by the State to ensure capture of key elements. Additionally, all screenings are administered on the same timeline, each enrollee is assigned a case manager for follow-up care, and a standardized reporting system was created for patient tracking of screenings, home visits, referrals, and milestones. The program ensures that hospitals have the necessary community partnerships needed to successfully deliver needed home-visiting and HRSN services and solicits beneficiary feedback to engage participants in further enhancing their care.

Life360 Data Collection

Identifying standard data collection elements, quality measures, and other design elements for the Maternal Life360 HOME providers were established after the program had begun. Once data collection methodologies and measures were established, Life360 HOME providers began submitting the data on a quarterly schedule. If data templates and reporting processes were established prior to data submission, the evaluation team would have had earlier access to that data to check data quality and reconcile the data with expected numbers.

Additionally, Stakeholder and Provider feedback noted that there was a lack of direction in how the data were supposed to be provided to the State. With the goal of reducing provider burden, there were discussions on how best to gather data in a way that could be used for multiple purposes. Understanding the methods that different hospitals were using to collect and store their data influenced the creation of the final data template.

10.0 APPENDICES & ATTACHMENTS

10.1 ACRONYM LIST

AAFP	Arkansas Academy of Family Physicians
ACA	Affordable Care Act
ACS	American Community Survey
ADH	Arkansas Department of Health
ADRF	Administrative Data Research Facility
AHA	Arkansas Hospital Association
AMI	Acute Myocardial Infarction
AMS	Arkansas Medical Society
ATSDR	Agency for Toxic Substances and Disease Registry
AID	Arkansas Insurance Department
APCD	Arkansas All Payer Claims Database
AHEIS	Arkansas Higher Education Information System
ARHOME	Arkansas Health and Opportunity for Me
ARIES	Arkansas Integrated Eligibility System
AS	Analyzable Sample Size
ASCVD	Atherosclerotic Cardiovascular Disease
ASR	Analyzable Survey Rate
ATE	Average Treatment Effect
AV	Actuarial Values
AWC	Adolescent Well-Care Visits
BA	Bad Addresses
BCBS	Blue Cross Blue Shield
BESS	Beneficiary Engagement Satisfaction Survey
BH	Behavioral Health
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCI	Charlson Comorbidity Index
CDC	Centers for Disease Control and Prevention
CDF	Cumulative Distribution Functions
CFR	Code of Federal Regulations
CHNA	Community Health Needs Assessment
CHR&R	County Health Rankings & Roadmaps
CMA	Case-Mix Adjustment
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CS	Comparison States
Delta MOTHER	Delta Maternal Outreach and Transformational Health Education Resource

DHS	Department of Human Services
DiD	Difference-in-Difference
DMS	Arkansas Division of Medical Services
DSS	Decision Support System
ECP	Essential Community Providers
ED	Emergency Department
EII	Economic Independence Incentive
EPSDT	Early and Periodic Screening Diagnostic and Treatment
FFM	Federally Facilitated Marketplace
FFS	Fee-For-Service
FORHP	Federal Office of Rural Health Policy
FPL	Federal Poverty Level
GEE	Generalized Estimating Equations
GIS	Geographic Information Systems
GSAT	Group Selection Adjustment Treatment
GDIT	General Dynamics Information Technology
HbA1c	Hemoglobin A1c
HCIP	Health Care Independence Program
HCT	Hospital Cost Tool
HDI	Human Development Index
HCC	Hierarchical Condition Category
HHS	Department of Health and Human Services
HII	Health Improvement Incentive
HRSNs	Health-Related Social Needs
IABP	Interim Alternative Benefit Plan
ICS	Incomplete (But Eligible) Surveys
IES	Ineligible Surveys
IPTW	inverse probability of treatment weight
IPWS	Inverse Probability Weighted Score
IPWREG	Inverse Probability Weighted with Regression Adjustment
ITS	Interrupted Time-Series
KFF	Kaiser Family Foundation
KIIs	Key Informant interviews
LARC	Long-Acting Reversible Method of Contraception
LSM	Least Squares Means
MCHB	Maternal and Child Health Bureau
MEPS	Medical Expenditure Panel Survey
MME	Morphine Milligram Equivalents
MMIS	Medicaid Management Information System
MVI	Maternal Vulnerability Index
MI	Myocardial Infarction

NASHP	National Academy for State Health Policy
NET	Non-Emergency Transportation
NCQA	National Committee for Quality Assurance
NVSS	National Center for Health Statistics
NLIHC	National Low Income Housing Coalition
NMT	Non-Medical Transportation
NR	Non-Responses
NVSS	National Vital Statistics System
OBGYN	Obstetrician/Gynecologist
O/E	Observed-to-expected
OHIT	Office of Health Information Technology
OUD	Opioid Use Disorder
PASSE	Provider-led Arkansas Shared Savings Entity
PCAP	Person-Centered Action Plan
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PDENT	Preventive Dental Screening Visits
PMPM	Per Member Per Month
PFG	Provider Focus Group
PHE	Public Health Emergency
PHS	Public Health Service
POM	predicted outcome metric
POS	Provider of Service
PSM	Propensity Score Model
PVIS	Preventive Vision Screening Visits
QCI	QualityCare Insight
QHPs	Qualified Health Plans
RDD	Regression Discontinuity Design
REGADJ	Regression Adjustment
RS	Returned Surveys
SAS	Statistical Analysis System
SDOH	Social Determinants of Health
SMI	Serious Mental Illness
SLDS	Statewide Longitudinal Data System
STCs	Special Terms and Conditions
SRR	Survey Return Rate
SUD	Substance Use Disorder
SVI	Social Vulnerability Index
THE	Total Health Expenditures
TMaH	Transforming Maternal Health
TRR	Total Response Rate

TS	Total Sample Size
UAMS	University of Arkansas for Medical Sciences
USDA	U.S. Department of Agriculture
ZCTA	Zip Code Tabulation Areas

10.2 LIFE360 KEY INFORMANT INTERVIEW QUESTIONS

Draft Interview Questions for Key Informants from Life360 Participant Organizations:

1. **Interviewee Background**
    a. What organization are you affiliated with or employed by?
    b. How long have you been affiliated with or employed by this organization?
    c. What is your job title and role within the organization?
    d. What role do you play related to the Life360 HOMEs Maternal program?
    e. Over the past year or two, has your role within the organization changed or evolved? If so, how has the role you play changed?
        i. Probe: Was the change prompted by participation in the Life360 HOMEs Maternal program?

2. **Life360 HOMEs Program**
    a. In your own words, please describe the Life360 HOMEs Maternal program that is currently being implemented.
        i. Probe: What are the key components of the program?
        ii. Probe: What criteria must patients meet to be eligible for your specific program?
        iii. Probe: Who are the key partners (internal to the hospital, externally, etc.)

3. **Decision to apply/application process**.
    a. From your perspective, what were the key considerations in determining whether to participate in the Life360 HOMEs Maternal program?
    b. What are your thoughts on the application process?
        i. Probe: Was the application process difficult?
        ii. Probe: Easy or difficult to organize preparation of the materials or design the program?
        iii. Probe: Who was involved in the application process? Was anyone internal or external to your organization perceived to be a key facilitator or a barrier to application completion? In what ways?

4. **Implementation.**
    a. How has implementation of your program gone thus far?
    b. What barriers have you or your organization experienced while implementing the program?
        i. Probe: What strategies have key entities used to overcome barriers?
    c. Have you found that any specific partners or processes have been particularly helpful in helping get your program started? If so, what have they done (or what processes) to help make progress toward getting the program activated?
    d. How has enrollment gone thus far? How many patients have been enrolled in the program to date? What is your target number of patients when fully implemented?

i. Probe: What strategies and tools are being used to identify beneficiaries with social risk factors?
ii. Probe: What strategies or tools are being used increase enrollment?

e. If you have any of this feedback thus far, what barriers to participation do patients experience, and what does this information suggest about the need for refinements to the program, provider outreach, etc.?
f. How is the program implementing HRSN case management and providing HRSN services through the demonstration?
    i. Probe: if you are providing multiple types (e.g., nutrition, housing support), how are these operationalized/being implemented.
g. How, if at all (or what is the future plan), has the program established a process to share and receive screening results among key partners?
    i. Probe: How, if at all, have health care providers modified their clinical practice in response to this information?

5. **Infrastructure Support.**
    a. What new (or enhanced) infrastructure or capacity (e.g., technology platforms, departmental improvements, staffing, etc.) is the program developing or acquiring for Life360?

6. **Sustainability.**
    a. What discussions have you and/or your organization had about sustaining the program following the waiver demonstration period?
        i. Probe: Who is involved in those discussions?
        ii. Probe: If you haven't begun those discussions yet, is there a timetable?
        iii. Probe: What outcomes might be included in your determination as to whether you will continue the program and its operations following the funding period?

7. **Investment in Social Services**.
    a. How, if at all, is the local availability of and investment in social services outside of the demonstration (such as housing supports) changing during the demonstration?
    b. How, if at all, is enrollment in SNAP and/or WIC changing for enrollees in the program?

8. **Other.**
    a. If you had to begin the application and implementation process over again, what is one thing that you would have done differently?
    b. Given the nature of the Life360 program, is there anything that we did not ask about your role or the program, that you believe we should know?

<u>Draft Interview Questions for State Program Staff and other Key Informants</u>:

1. **Interviewee Background**

a. What organization are you affiliated with or employed by?
b. How long have you been affiliated with or employed by this organization?
c. What is your job title and role within the organization?
d. What role do you play related to the Life360 HOMEs Maternal program?
e. Over the past year or two, has your role within the organization changed or evolved? If so, how has the role you play changed?
    i. Probe: Was the change prompted by participation in the Life360 HOMEs Maternal program?

2. Life360 HOMEs Program

c. In your own words, please describe the Life360 HOMEs Maternal program that is currently being implemented.
    i. Probe: What are the key components of the program that you perceive to be critical to the success of the program?
d. Broadly speaking (across the entire Program), what would a successful Maternal program look like to you three years from now? What would a failed Maternal program look like?

3. Questions for State Program Staff.

a. Have you been involved in reviewing or supporting the applicant organizations?
    i. Probe: If yes, what is your perception of the quality of applications you've received thus far. (e.g., are the applications meeting the standard or purpose for what the Life360 HOMEs Maternal program is designed to? Why or why not?)
b. From your perspective, how has the implementation of the Life360 program gone thus far?
    i. Probe: What were the initial barriers to program implementation?
    ii. Probe: How was communication and coordination between the State and the interested Life360 applicants prior to beginning operations?
    iii. Probe: Have applications for program participation been submitted to the state at the rate you expected? Why do you think that has happened?
c. What lessons have you learned that you would implement should you create a similar program in the future?
d. To what extent is the state integrating the demonstration with its other existing programs and infrastructure?

4. Investment in Social Services.

a. What role does the Life360 HOMEs program play in any broader investment in HRSNs or programs focused on addressing the social determinants of health in Arkansas?
    i. Probe: Housing, Nutrition, etc.

5. Other.

a. What role might programs, such as Maternal, play in the development of future 1115 waivers in Arkansas?
b. If you had to begin the process of designing the Program over again, what is one (or multiple) thing(s) that you would have done differently?
c. Given the nature of the Life360 program, is there anything that we did not ask about your role or the program, that you believe we should know?

Additional Questions for Senator Missy Irvin

1.) What are the biggest challenges with getting programs, such as Life360 HOMEs, passed through the legislature?

2.) Who are the key partners that needed to be involved in helping gain support for the Life360 Maternal program? What role did they play in collaborating with you or other legislators while the program was under development? What role did any of the Senate committees play in supporting this program or the waiver more generally?

3.) What, if any, are the most highly politicized issues related to the ARHOME 1115 waiver, and specifically, the Life360 HOMEs program? Why?

4.) What initiatives is the legislature considering that aim to address the social determinants of health in Arkansas?
    a. Are there specific topics being addressed by the either the Senate Public Health, Welfare and Labor Committee or the Hospital and Medicaid Subcommittee that we should be aware of as we consider what is being done to improve maternal outcomes and the delivery of care to women and children?

10.3 SURVEY & PROVIDER FOCUS GROUP QUESTIONS

Table NNNNN: Non-Participating Life360 HOMES Provider Survey Questions

Survey Questions
Program Awareness, Participation, HRSN Screening, Referral Programs, Follow-up
• Is your hospital aware of the Life360 HOMEs program administered by Arkansas Medicaid?
• How likely is your hospital to participate in the Life360 HOMEs program in the near future?
• Does your hospital routinely screen patients (all, subset, none) for health-related social needs (HRSNs)?
○ If you screen for a subset of patients: Does the subset of patients who are screened for HRSNs include women with high-risk pregnancies?
○ If you screen for all or a subset of patients: For patients that screen positive for one or more HRSNs, does your hospital already have referral programs in place that provide appropriate resources to address these HRSNs?
▪ If you have a referral program: Does your hospital follow up with patients who participate in a referral program to see whether their HRSNs have been addressed?
• Please provide any additional comments you may have related to the Life360 HOMEs program below.
Contributions Affecting Respondents' Decision in Becoming a Life360 HOMES Participant
• Which of the following reasons would strongly contribute to your decision in becoming a Life360 HOMEs participant?
▪ Address a gap in patient and/or community needs
▪ Improve quality measure outcomes
▪ Related to hospital goals or initiatives
▪ Builds upon existing programs
▪ Financial reimbursements
▪ Other, please provide additional comments in the comment box below
Barriers Affecting Respondents' Decision in Becoming a Life360 HOMES Participant
• What barriers did you perceive or directly experience when deciding to participate in the Life360 HOMEs program?
▪ Limited information and knowledge about the program
▪ Limited patient participation and/or community need
▪ Referral barriers (i.e. partnerships with community-based organizations, lack of referral resources)
▪ Physical barriers (i.e. staff, equipment, resources, technology)
▪ Infrastructure costs or other financial barriers
▪ Other, please provide additional comments in the comment box below

Table OOOOO: 2023 & 2025 Provider Focus Group (PFG) Evaluation Questions
Arkansas Academy of Family Physicians (AAFP), Arkansas Medical Society (AMS), and the Arkansas Hospital Association (AHA)

Evaluation Questions	2023 PFG Respondents			2025 PFG Respondents
ARHOME	**AAFP**	**AMS**	**AHA**	**AHA**
Do you think that with ARHOME patients you experience more or less uncompensated care than with traditional Medicaid patients?	✓	✓	✓	✓
In comparison to traditional Medicaid patients, how would you characterize the effect ARHOME patients have on your uncompensated care?			✓	✓
Do you accept all ARHOME plans? If you do not accept all ARHOME plans, which do you not accept?	✓	✓	✓	✓
As a rough estimate, what percentage of the patients in your practice are covered by ARHOME health insurance?	✓	✓	✓	✓
Are you more or less willing to accept ARHOME members as patients? What about compared to traditional Medicaid patients? Why?	✓	✓	✓	✓
In your perspective, how does this different reimbursement arrangement for ARHOME patients impact your hospital's likelihood of accepting more ARHOME (Medicaid) patients compared to patients covered by traditional Medicaid? How would you describe it? Positively, negatively, neutral, little bit of both? What about from a patient perspective? Financial perspective? Outcomes? Physician impact? Overall?			✓	✓
Can you tell any difference between ARHOME and traditional Medicaid? Describe.	✓	✓	✓	✓
Incentive Awareness	**AAFP**	**AMS**	**AHA**	**AHA**
Are you aware of provider quality incentive programs in Arkansas fee-for-service Medicaid or ARHOME – such as Patient Centered Medical Home or Primary Care First?	✓			
The ARHOME health plans are required to provide information and incentives for patients to improve their health. Are you aware of any of the incentives? What patient incentives are you familiar with?	✓	✓		
The ARHOME health plans are required to provide information and incentives for patients to improve their health. Are you aware of any of the incentives? What patient incentives are you familiar with?	✓	✓		
What types of resources – for example, training or literature – do you receive from the ARHOME health plans to help you talk to your ARHOME patients about preventive care, screenings and health improvement activities?	✓	✓		
For your patients with mental illness, what are some examples of resources or incentives provided by ARHOME health plans that you might use to improve patient health outcomes? Substance abuse disorder. Two or more chronic conditions. Pregnant patients.	✓	✓		

How are these plans communicating with you as providers?	✓	✓		
Overall, how would you describe the impact of ARHOME's health insurance coverage and incentives on your patients' health behaviors? Are they more or less likely to use preventive, screening and immunization services?	✓	✓		
Can you tell any difference in their approach to their participation in their own healthcare? Are they more proactive? Or do you observe behaviors that are the same as traditional Medicaid patients?	✓	✓		
Quality of Care	**AAFP**	**AMS**	**AHA**	**AHA**
How do you feel ARHOME has impacted quality of care? For example – a reduction of emergency department visits?			✓	
From your perspective, has ARHOME facilitated better communication between primary care physicians and patients compared to the communication between primary care physicians and uninsured patients or patients under traditional Medicaid?			✓	
Think of physician-patient communication relating to, for example, follow up from acute events… how would you characterize how ARHOME is affecting that?			✓	
Have you provided any feedback directly to DMS/Medicaid about questions you may have or dissatisfaction with the plan about this process?	✓	✓	✓	
Implementation	**AAFP**	**AMS**	**AHA**	**AHA**
Describe the impact that ARHOME is having on your practice/hospital. Does it affect it positively, negatively, neutral? Can you tell?	✓	✓	✓	✓
On the positive side, has the implementation improved your service to these ARHOME patients and in turn those covered by traditional Medicaid?	✓	✓	✓	✓
What barriers have you or your organization experienced while providing care to ARHOME beneficiaries? • **Probe**: What strategies have been used to overcome barriers?				✓
Have you found that any specific partners or processes have been particularly helpful in transitioning to ARHOME? If so, what have they done (or what processes) to help make progress?				✓
How has the PHE unwinding impacted ARHOME?				✓
Sustainability	**AAFP**	**AMS**	**AHA**	**AHA**
What discussions have you and/or your organization had about sustaining ARHOME program goals following the waiver demonstration period? • **Probe**: Who is involved in those discussions? • **Probe**: Have ARHOME goals been applied to other patient populations?				✓
Other	**AAFP**	**AMS**	**AHA**	**AHA**
Is there anything else you might want to share about your experience as a provider for the ARHOME population?	✓	✓	✓	
Life360 HOMEs Program	**AAFP**	**AMS**	**AHA**	**AHA**

Is your hospital aware of the Life360 HOME program?			✓	✓
How likely is your hospital to participate in the Life360 HOME programs?			✓	✓
Have you begun the process to become a Life360 participant? If so, what was your motivation to do so? *Which Life360 program are you considering applying for?			✓	✓
Does potential reimbursement for these services - including infrastructure costs - make the Life360 program appealing to your organization? Why, or why not?			✓	✓
From your hospital's perspective, what are the barriers to participating in the Life360 program?			✓	✓

* Only applicable to 2023

Table PPPPP: ARHOME Evaluation Survey Metrics in the BESS Survey Series

Metric ID	Metric Name
1A1	Beneficiary Premium Assistance Awareness: Did you know Medicaid pays all or part of the monthly cost?
1B1	Beneficiary Health Improvement Initiative (HII) Awareness: Did your health plan offer you any reward for healthy behaviors or wellness screenings (such as a mammogram or colonoscopy)? Did you know these rewards or credits are part of the ARHOME program to improve the health of members?
2B1	Got Care for Illness/Injury as Soon as Needed: In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
2B2	Got Non-Urgent Appointment as Soon as Needed: In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
2B3	How Often Was It Easy to Get Necessary Care, Tests, or Treatment: In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
2B4	Have a Personal Doctor: A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?
2B5	Got Appointment with Specialists as Soon as Needed: In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
2B6	Days Wait Time Between Making Appointment and Seeing Provider: In the last 6 months, how many days did you usually have to wait for an appointment for a check-up or routine care?
2B7	How Often Had to Wait for Appointment Because of Provider's Lack of Hours/Availability (2022 survey only): In the last 6 months, how often did you have to wait for an appointment because of a provider's lack of hours/availability (the doctor did not have time)?
2B8	Ease to Get a Referral to a Specialist (2020 survey only): In the last 6 months, how easy was it to get a referral to a specialist?
2B9	Needed Interpreter to Help Speak with Doctors or Other Health Providers: An interpreter is someone who helps you talk with others who do not speak your language. In the last 6 months, did you need an interpreter when visiting with your personal doctor?
2B10	How Often Got an Interpreter When Needed One: In the last 6 months, during visits to your personal doctor's office, how often did you get an interpreter when you needed one?
2D2	Time to First Appointment: In the last 6 months, how many days did you usually have to wait for an appointment when you needed care right away?
2D15	Non-Emergency Transportation (NET) Program Awareness: Did you know that you can get a ride to your doctor visits at no cost? Non-Emergency Transportation (NET) Program Utilization: Have you ever had trouble getting to your doctor's visits because you could not find a ride? In the last year, how often have you used the non-emergency transportation (NEMT) program? How satisfied are you with the non-emergency transportation (NEMT) program?
3A1	Beneficiary Retroactive Eligibility Awareness: Did you know that ARHOME has a shorter period of retroactive eligibility (30 days) than other Arkansas Medicaid programs (90 days)? Retroactive eligibility is when the program starts to cover your health care before the date you turned in your application.
3A2	Beneficiary Premium Requirement Awareness: Did you know that some people have to pay part of the monthly cost because of their income?
3B1	New Enrollment - Shorter Period of Retroactive Eligibility Affecting New Enrollment: Did the shorter period of retroactive eligibility (30 days) keep you from enrolling in ARHOME?
4A1	Beneficiary Copayment Awareness: Did you know some people have to pay copays because of their income? A copay is the amount you pay for a health care service.
4A2	Beneficiary Economic Independence Initiative (EII) Awareness: Did your health plan offer you information on programs to help you get a job? This may include job and career fairs or referrals

	to programs to improve job skills. Did your health plan offer you any reward or ways to earn a reward, to join programs to help you get a job? This may include job and career fairs or referrals to programs to improve job skills. Did you know your health plan should promote programs to help you get a job as part of the ARHOME program?
4B1	Rating of Health Plan: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
4B2	Rating of Health Care: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all of your health care in the last 6 months?
4B3	Rating of PCP: Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?
4B4	Rating of Specialist: We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?

10.4 COVARIATE EXCLUSIONS

Table QQQQQ: Covariate Exclusions from Full PSM Model

Metric	MY22	MY23	Outcome Model
1.D.1	Full	Full	IPWREG PS95: Binary logit
1.D.2	Full	Full	IPWREG PS95: Normal identity
1.E.1	*Age	*Age	IPWREG PS95: Normal identity
1.E.2 Cardiology	*Gender, *Income	*Age, *Gender	IPWREG PS95: Normal identity
1.E.2 Endocrinology	*Age	*Age, *Gender, Population-Over-65	IPWREG PS95: Normal identity
1.E.2 Gastroenterology	Full	*Age, *Gender, Education	IPWREG PS95: Normal identity
1.E.2 Neurology	Full	*Age	IPWREG PS95: Normal identity
1.E.2 Oncology	Full	*Age, *Gender	IPWREG PS95: Normal identity
1.E.2 Pulmonology	Full	*Minority, Education	IPWREG PS95: Normal identity
1.E.2 Urology	Full	*Age, *Gender, *Minority, LBW, Obesity, Poverty	IPWREG PS95: Normal identity
1.E.3	Full	*Age	IPWREG PS95: Binary logit
2.D.3	Full	Full	IPWS PS95
2.D.4	*Age	*Age	IPWREG PS95: Binary logit
2.D.5	Full	Full	IPWREG PS95: Binary logit
2.D.6, 4.D.17	*Age	Full	IPWREG PS95: Binary logit
2.D.7, 4.D.18	*Age	*Age	IPWREG PS95: Binary logit
2.D.8, 4.D.19	Full	*Age	IPWREG PS95: Binary logit
2.D.9	Full	*Age	IPWS PS95
2.D.13	Full	*Age	IPWREG PS95: Binary logit
2.D.14	Full	*Age	IPWREG PS95: Poisson log
3.C.1	Full	Full	IPWREG PS95: Binary logit
3.D.1, 3.G.1	**Income	**Income	IPWREG PS95: Binary logit
3.D.2, 3.G.2	**Income	**Income	IPWREG PS95: Binary logit
3.E.1, 3.H.1	**Income	**Income	IPWREG PS95: Binary logit
3.E.2, 3.H.2	**Income	**Income	REGADJ: Normal identity
EDV	Full	Full	IPWREG PS95: Poisson log
4.C.1_R1	Full	Full	IPWREG PS95: Normal identity
4.C.2_R2	Full	Full	IPWREG PS95: Normal identity
4.C.3_R3	Full	Full	IPWREG PS95: Normal identity
4.C.4	Full	Full	IPWS PS95
4.C.5	Full	Full	IPWS PS95
4.C.6	Full	Full	IPWS PS95
4.C.7	Full	Full	IPWS PS95
4.C.8	Full	Full	REGADJ: Normal identity
4.C.9	Full	Full	IPWREG PS95: Normal identity
4.C.10	*Income	*Minority	IPWREG PS95: Normal identity
4.D.1_tot_eng	Full	*Gender	IPWREG PS95: Normal identity
4.D.1_tot_init	Full	*Gender	IPWREG PS95: Normal identity
4.D.2_R1	Full	Full	IPWREG PS95: Binary logit
4.D.2_R2	Full	Full	IPWREG PS95: Binary logit
4.D.3_7D	Full	Full	IPWS PS95

4.D.3_30D	Full	Full	IPWS PS95
4.D.4	Full	Obesity, Population-Over-65, Smoker	IPWREG PS95: Binary logit
4.D.5	Full	Full	IPWREG PS95: Binary logit
4.D.6	Full	Full	IPWREG PS95: Binary logit
4.D.7	Full	*Gender	IPWREG PS95: Binary logit
4.D.8_R1	*Income	Full	IPWREG PS95: Binary logit
4.D.8_R2	*Income	Full	IPWREG PS95: Binary logit
4.D.8_R3	*Income	Full	IPWS PS95
4.D.8_R4	*Income	Full	IPWS PS95
4.D.8_R5	*Income	Full	REGADJ: Binary logit
4.D.9_7D	Full	Education, Obesity, Rural, Smoker	IPWS PS95
4.D.9_30D	Full	Education, Obesity, Rural, Smoker	IPWS PS95
4.D.10_7D	*Minority, Rural	Population-Over-65, Poverty, Smoker	IPWS PS95
4.D.10_30D	*Minority, Rural	Population-Over-65, Poverty, Smoker	IPWS PS95
4.D.11	*Age, *Minority, LBW, Education, Care-Source, Population-Over-65, Poverty, Rural, Smoker	*Age, *Gender, *Income, LBW, Education, Care-Source, Obesity, Population-Over-65, Poverty, Rural, Smoker	IPWREG PS95, REGADJ: Binary logit
4.D.12_tot	Full	*Age, *Gender, *Income	IPWREG PS95: Binary logit
4.D.12_diu	Full	*Age, *Gender, *Income	IPWREG PS95: Binary logit
4.D.12_ace_arb	Full	*Age, *Gender	IPWREG PS95: Binary logit
4.D.13	*Minority, Care-Source	*Gender, LBW, Education, Care-Source, Population-Over-65, Smoker	IPWREG PS95, REGADJ: Binary logit
4.D.14	Full	Full	IPWREG PS95: Normal identity
4.D.15_1_3D	Full	Full	IPWREG PS95: Binary logit
4.D.15_1_90D	Full	Full	IPWREG PS95: Binary logit
4.D.15_2_3D	Full	Full	REGADJ: Binary logit
4.D.15_2_90D	Full	Full	IPWREG PS95: Binary logit
4.D.16_R1	Full	Full	IPWREG PS95: Binary logit
4.D.16_R2	Full	Full	IPWREG PS95: Binary logit
4.E.4	Full	Full	IPWREG PS95: Binary logit
4.E.7_7D	Full	*Age, *Gender, LBW, Obesity, Population-Over-65, Poverty, Rural, Smoker	IPWS PS95
4.E.7_30D	Full	*Age, *Gender, LBW, Obesity, Population-Over-65, Poverty, Rural, Smoker	IPWS PS95
4.E.1_R1	Full	Full	IPWREG PS95: Binary logit
4.E.1_R2	Full	Full	IPWREG PS95: Binary logit
4.E.2	Full	Full	IPWREG PS95: Normal identity
4.E.2_7D	Full	*Minority, LBW, Care-Source, Poverty, Rural	IPWS PS95

4.E.2_30D	Full	*Minority, LBW, Care-Source, Poverty, Rural	IPWS PS95
4.E.3	Full	*Gender, *Minority, Education, Obesity, Rural	IPWREG PS95: Binary logit
4.E.5	Full	Full	IPWREG PS95: Binary logit
4.E.6	Full	Full	IPWREG PS95: Normal identity
4.E.6_7D	Full	*Minority, LBW	IPWS PS95
4.E.6_30D	Full	*Minority, LBW	IPWS PS95
4.E.9_tot	Full	Full	IPWREG PS95: Normal identity
4.E.9_diu	Full	Full	IPWREG PS95: Binary logit
4.E.9_ace_arb	Full	Full	IPWREG PS95: Binary logit
4.E.8	Education, Population-Over-65	*Age, *Gender, *Minority, LBW, Education, Care-Source, Population-Over-65, Poverty, Rural	IPWREG PS95, REGADJ: Normal identity
4.E.10	Full	Population-Over-65	IPWREG PS95, REGADJ: Binary logit
4.E.11	Full	Full	IPWREG PS95: Binary logit
4.J.1	Full	Full	IPWREG PS95: Normal identity
4.L.1	Full	Full	IPWREG PS95: Normal identity

* Denotes Core Set covariates (i.e., age, gender, income, minority status), which are included (along with their interaction terms) in the PSM model regardless of whether they passed the Balance Table tests (i.e., Standardized Difference test at the 0.1 level; Variance Ratio test at the 0.5-2.0 level).
**Denotes Core Set covariates (e.g., income) that are removed (along with their interaction terms) from the PSM model due to the error: "ERROR"

10.5 ATTACHMENTS

The ARHOME and Life360 HOMEs evaluation designs are available for review and download on the official Medicaid website. Please use the direct links below to access detailed evaluation materials:

- ARHOME Evaluation Design
- Life360 HOMEs Evaluation Design

https://www.macpac.gov/wp-content/uploads/2015/03/Premium-Assistance-Medicaids-Expanding-Role-in-the-Private-Insurance-Market.pdf p.74

Attachment 5: Public Comment

Public Comments Regarding Arkansas Health and Opportunity for Me (ARHome) Program

Alex Sampson, JD MA (Lumbee), Policy Manager, on behalf of

Francys Crevier, J.D., Chief Executive Officer

On behalf of the National Council of Urban Indian Health (NCUIH) and the 41 Urban Indian Organizations (UIOs)

Comment: On behalf of the National Council of Urban Indian Health (NCUIH) and the 41 Urban Indian Organizations (UIOs) for which we serve,[1] we hereby submit our comments and recommendations in response to Arkansas' Department of Human Services' (DHS) December 14, 2025, request for public comment on the Arkansas Health and Opportunity for Me (ARHOME) Section 1115 Demonstration Project Application (hereinafter ARHOME Application).[2]

On behalf of the National Council of Urban Indian Health (NCUIH) and the 41 Urban Indian Organizations (UIOs)

Background

Founded in 1998, NCUIH was created to support the development of quality, accessible, and culturally sensitive health care programs for American Indian and Alaska Native people living in urban communities. NCUIH serves the 41 UIOs receiving grants under the Indian Health Care Improvement Act (IHCIA). Pursuant to IHCIA, UIOs are American Indian and Alaska Native controlled organizations that deliver health care and referral services for American Indian and Alaska Native people residing in the urban centers in which the UIO is located. UIOs provide critically needed primary care, behavioral health services, social and community services, and Traditional Healing and Medicine to American Indian and Alaska Native people living in urban areas. While there are no UIOs in your state, there is still a trust obligation of healthcare to American Indian and Alaska Native people no matter where they live and even more reason to not impose community engagement requirements.

Comments

NCUIH appreciates the opportunity to submit comments to Arkansas DHS concerning the ARHOME Application. We appreciate that Arkansas DHS included an exemption for American Indian and Alaska Native people in the ARHOME Application by including exemptions for individuals who are Indians or Urban Indians.[3] This exemption complies with the One Big Beautiful Bill Act (OBBBA) which exempts American Indian and Alaska Native people from work and community engagement requirements as a condition of Medicaid eligibility.[4]

The United States has a trust obligation to provide "health services to maintain and improve the

health of" American Indian and Alaska Native people.[5] Congress has specifically declared that it is the policy of the United States, in fulfillment of its trust responsibility, to "ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."[6] The United States owes this trust obligation to American Indian and Alaska Native people no matter where they live[7] and contracts with the 41 UIOs to fulfill this obligation to American Indian and Alaska Native people living in urban areas.[8] Medicaid plays a critical role in fulfilling the trust responsibility to American Indian and Alaska Native people and affecting the national policy set forth in the IHCIA. In 2023, over 2.7 million American Indian and Alaska Native people were enrolled in Medicaid, including 47% of American Indian and Alaska Native adults under the age of 65.2.[9] For Arkansas, 12,283 American Indian and Alaska Native people ages 19-64 were enrolled in Medicaid in 2023.[10] Exempting American Indian and Alaska Native people from work and community engagement requirements is consistent with the trust responsibility and the national policy set forth by IHCIA. Additionally, under the OBBBA, states must exempt American Indian and Alaska Native people[11] from the community engagement requirements,[12] including urban American Indian and Alaska Native people.

Accordingly, NCUIH makes the following recommendations in response to the December 14, 2025, Arkansas DHS request for public comment on the ARHOME Application. NCUIH requests Arkansas DHS:

- Ensure that the work and community engagement exemption for American Indian and Alaska Native people in the ARHOME Application is implemented in a way that is inclusive of all American Indian and Alaska Native beneficiaries

<u>Ensure Implementation of the Work and Community Engagement Exemption is Inclusive of All American Indian and Alaska Native Beneficiaries</u>

NCUIH requests that Arkansas DHS ensure that the work and community engagement exemptions for American Indian and Alaska Native people in the ARHOME Application is implemented in a way that is inclusive of all American Indian and Alaska Native beneficiaries. By law, American Indian and Alaska Native people must be exempt from work and community engagement requirements as a condition of Medicaid eligibility. Importantly, the OBBBA requires exemptions for "Indian[s] and Urban Indian[s]" from Medicaid work and community engagement requirements.[13] Therefore, implementing the ARHOME Application in a way that is inclusive of all American Indian and Alaska Native Medicaid beneficiaries- including those who live off Tribal lands- properly implements the exemption requirements set forth in the OBBBA. Ensuring the exemption is implemented in a way that is inclusive of all American Indian and Alaska Native beneficiaries is also consistent with the trust responsibility and the national policy set forth in the IHCIA. Further, exempting all American Indian and Alaska Native beneficiaries is consistent with the Administration's priority to address chronic health challenges through the Make America Healthy Again (MAHA) initiative as addressing health begins with access to healthcare.

Conclusion

NCUIH appreciates the opportunity to provide comments and recommendations to Arkansas DHS on the ARHOME Application. We reiterate that properly implementing exemptions for American Indian and Alaska Native people from Medicaid work and community engagement requirements is required by law. Please contact our Senior Vice President of Policy and Communications, Meredith Raimondi, at mraimondi@ncuih.org with any questions.

CITATIONS:

[1] *NCUIH serves the 41 Urban Indian Organizations receiving grants from the Indian Health Service pursuant to the Indian Health Care Improvement Act (25 U.S.C. §1651 et seq.).*

[2] *Arkansas Dep't of Human Serv., ARHOM Section 1115 Demonstration Project Application (Dec. 14, 2025), https://humanservices.arkansas.gov/wp-content/uploads/CLEAN-ARHOME-Renewal-Application-12-12-25-FINAL.pdf.*

[3] *Arkansas Dep't of Human Serv., ARHOM Section 1115 Demonstration Project Application 36 (Dec. 14, 2025), https://humanservices.arkansas.gov/wp-content/uploads/CLEAN-ARHOME-Renewal-Application-12-12-25-FINAL.pdf.*

[4] *One Big Beautiful Bill Act § 71119(a), 42 U.S.C. § 1396(a)(xx).*

[5] *25 U.S.C. § 1601(1).*

[6] *25 U.S.C. § 1602(1).*

[7] *S. Rep. No. 100-508, at 25 (1988) (stating that "The responsibility for the provision of health care . . . does not end at the borders of an Indian reservation. Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not which to leave their reservations to relocate in urban areas, and the responsibility for the provision of health care services follows them there.").*

[8] *See 25 U.S.C. § 1652.*

[9] *Analysis of 2023 American Community Survey (ACS) data (1-year estimates). Includes data on AI/ANs identified as "Alone" or "In Combination."*

[10] *Analysis of 2023 American Community Survey (ACS) data (1-year estimates). Includes data on AI/ANs identified as "Alone" or "In Combination."*

[11] *The OBBBA includes the following language: "(aa) is an Indian or an Urban Indian (as such terms are defined in paragraphs (13) and (28) of section 4 of the Indian Health Care Improvement Act; (bb) is a California Indian described in section 809(a) of such Act; or (cc) has otherwise been determined eligible as an Indian for the Indian Health Service under regulations promulgated by the Secretary." One Big Beautiful Bill Act § 71119(a), 42 U.S.C. § 1396(a)(xx).*

[12] *One Big Beautiful Bill Act § 71119(a), 42 U.S.C. § 1396(a)(xx).*

[13] *One Big Beautiful Bill Act § 71119(a), 42 U.S.C. § 1396(a)(xx).*

Laura Hoch, Associate Vice President
State Advocacy & Policy National Multiple Sclerosis Society

Comment: The National Multiple Sclerosis Society (Society) appreciates the opportunity to submit comments on the ARHOME Demonstration.

The Society mission is to cure multiple sclerosis (MS) while empowering people affected by MS to live their best lives. To accomplish this, the Society funds cutting-edge research, drives change through advocacy, facilitates professional education, collaborates with MS organizations around the world, and provides programs and services designed to help people with MS and their families live their best lives.

The Society is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage and offers the following comments on the ARHOME Demonstration:

The ARHOME Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21 starting January 1, 2027. Given that work reporting requirements are federally mandated and that the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's waiver request.

Furthermore, the Society urges Arkansas to not implement these requirements any earlier than January 1, 2027. Work reporting requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly result in inappropriate coverage loss. Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person,[i] placing greater administrative and financial burden on the Arkansas Medicaid program.

Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services. Losing access to coverage for someone living with MS would be catastrophic. MS is a highly expensive disease, with the average total cost of living with MS at $88,487 per year[ii]. Without coverage, most living with MS would be required to stop seeking treatment, leading to irreversible disease progression as well as costly stays in the hospital or rehab facilities due to relapses. These costs would ultimately fall to the state. In 2017, Arkansas implemented a work reporting requirement and over 18,000 beneficiaries lost coverage in seven months.[iii] The Society urges the state to not implement these requirements until the January 1, 2027 date.

The Society appreciates the opportunity to provide comments on the ARHOME Demonstration. In order to protect access to affordable and quality healthcare for Arkansans, we urge the state to work with CMS to minimize administrative burden and inappropriate coverage loss.

CITATIONS:

[i] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[ii] B. Bebo et al. The Economic Burden of Multiple Sclerosis in the United States. Neurology. May 3, 2022. Available at: https://www.neurology.org/doi/10.1212/wnl.0000000000200150

[iii] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018.
Available at:
http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

Bre Schmidt, MPH, Associate Director of State Policy and Advocacy, on behalf of
Holly Bode, Vice President of Government Affairs
American Kidney Fund

Comment: The American Kidney Fund (AKF) appreciates the opportunity to submit comments on the ARHOME Demonstration.

The American Kidney Fund fights kidney disease on all fronts as the nonprofit with the greatest direct impact on people with kidney disease. AKF works on behalf 1 in 7 American adults living with kidney

disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention and early detection through post-transplant living. We are also one of the nation's top-rated nonprofits, investing 96 cents of every donated dollar in programs.

The AKF is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage and offers the following comments on the ARHOME Demonstration:

The ARHOME Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21 starting January 1, 2027. Given that work reporting requirements are federally mandated and that the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's waiver request. Furthermore, AKF urges Arkansas to not implement these requirements any earlier than January 1, 2027. Work reporting requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly result in inappropriate coverage loss. Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person,[i] placing greater administrative and financial burden on the Arkansas Medicaid program.

Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services. For people with end-stage renal disease (ESRD), even a short lapse in Medicaid can interrupt the three-times-a-week, four-hour dialysis treatments that keep them alive; missing just one session can trigger fluid overload, life-threatening electrolyte imbalances, and costly emergency hospitalizations. In 2017, Arkansas implemented a work reporting requirement and over 18,000 beneficiaries lost coverage in seven months.[ii] The American Kidney Fund urges Arkansas to prioritize policies that will protect patient access to care throughout implementation of PL 119-21.

The American Kidney Fund appreciates the opportunity to provide comments on the ARHOME Demonstration. In order to protect access to affordable and quality healthcare for Arkansans, we urge the state to work with CMS to minimize administrative burden and inappropriate coverage loss.

CITATIONS:

[i] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[ii] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

Matt Glanville, Arkansas and Oklahoma Government Relations Director American Cancer Society Cancer Action Network

Comment: The American Cancer Society Cancer Action Network (ACS CAN) appreciates the

opportunity to comment on the application for the ARHOME Section 1115 Demonstration Project released on December 14, 2025. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

While federal law now requires states to implement work requirements in Medicaid by January 1, 2027, ACS CAN continues to have grave concerns about their implementation.

Work requirements – passed in federal law in July 2025 despite the strong objections of ACS CAN and many other partners who serve patients and caregivers in Arkansas – are not about promoting work but about adding red tape that jeopardizes patients' access to care. The vast majority of those with Medicaid who can work already do so; nationally, 92% of individuals with Medicaid coverage under age 65 who do not receive Social Security disability benefits are either workers, caregivers, students, or unable to work due to illness.[1]

ACS CAN opposes tying access to affordable health care for lower income persons to employment or income as a proxy for employment, because cancer patients and survivors – as well as those with other complex chronic conditions – could be unable to comply and find themselves without Medicaid coverage. Many cancer patients in active treatment are often unable to work or require significant work modifications due to their treatment.[2,3,4,5,6] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[7,8] Recent cancer survivors often require frequent follow-up visits[9] and suffer from multiple comorbidities linked to their cancer treatments.[10,11] Cancer survivors are often unable to work or are limited in the amount or kind of work they can participate in because of health problems related to their cancer diagnosis and treatment.[12,13,14,15,16]

Arkansas already has the dubious distinction of being the first state to have fully implemented a Medicaid work requirement, which resulted in confusion, endless red tape, and coverage terminations for over 18,000 Arkansans – many of whom remained eligible but could not successfully navigate the byzantine system to report their work or prove their exemption.[17] ACS CAN is very concerned about the ability of people with cancer, cancer survivors, and those in need of cancer screenings to access Medicaid coverage in Arkansas – and the rest of the country.

It is unclear whether the Department's purpose in including work requirements in this waiver proposal is to implement them before the required January 1, 2027 date. We note that the standards in PL 119-21 cannot be waived according to federal law, so there does not appear to be a reason to include these provisions in this application. Because of all the concerns and complexities of

implementation discussed above, we strongly urge the Department to not attempt to implement work requirements earlier than the required January 1, 2027 implementation date.

We appreciate the opportunity to submit comments on this proposal and hope we can work together to mitigate the harms of work requirements on people impacted by cancer. If you have any questions, please feel free to contact me at matt.glanville@cancer.org.

CITATIONS:

[1] Tolbert, Jennifer et al. Understanding the Intersection of Medicaid & Work: An Update. KFF. February 4, 2025. Available at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/

[2] Blinder VS, Gany FM. Impact of Cancer on Employment. J Clin Oncol. 2020;38(4):302-309. doi:10.1200/JCO.19.01856.

[3] Tracy JK, Adetunji F, Al Kibria GM, Swanberg JE. Cancer-work management: Hourly and salaried wage women's experiences managing the cancer-work interface following new breast cancer diagnosis. PLoS One. 2020;15(11):e0241795. Published 2020 Nov 5. doi:10.1371/journal.pone.0241795.

[4] Dumas A, Vaz Luis I, Bovagnet T, et al. Impact of Breast Cancer Treatment on Employment: Results of a Multicenter Prospective Cohort Study (CANTO). JCO. 2020;38(7):734-743. doi:10.1200/JCO.19.01726.

[5] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[6] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi:10.1007/s11764-015-0492-5.

[7] de Boer AG, Taskila T, Ojajärvi A, van Dijk FJ, Verbeek JH. Cancer survivors and unemployment: a meta-analysis and meta-regression.
JAMA. 2009 Feb 18; 301(7):753-62.

[8] Short PF, Vasey JJ, Tunceli K. Employment pathways in a large cohort of adult cancer survivors. *Cancer.* 2005 Mar 15; 103(6):1292-301.

[9] National Cancer Institute. *Coping with cancer: Survivorship, follow-up medical care*. Accessed August 2021. https://www.cancer.gov/about cancer/coping/survivorship/follow-up-care.

[10] Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation*. 2018; 137(7): CIR.0000000000000556.

[11] Dowling E, Yabroff R, Mariotto A, et al. Burden of illness in adult survivors of childhood cancers: Findings from a population-based national sample. *Cancer.* 2010; 116:3712-21.

[12] Blinder VS, Gany FM. Impact of Cancer on Employment. J Clin Oncol. 2020;38(4):302-309. doi:10.1200/JCO.19.01856

[13] Dumas A, Vaz Luis I, Bovagnet T, et al. Impact of Breast Cancer Treatment on Employment: Results of a Multicenter Prospective Cohort Study (CANTO). JCO. 2020;38(7):734-743. doi:10.1200/JCO.19.01726

[14] Guy GP Jr, Berkowitz Z, Ekwueme DU, Rim SH, Yabroff R. Annual economic burden of productivity losses among adult survivors of childhood cancers. *Pediatrics*. 2016; 138(s1):e20154268

[15] Zheng Z, Yabroff KR, Guy GP Jr, et al. Annual medical expenditures and productivity loss among colorectal, female breast, and prostate cancer survivors in the United States. JNCI J Natl Cancer Inst. 2016; 108(5):djv382

[16] Kent EE, Davidoff A, de Moor JS, et al. Impact of sociodemographic characteristics on underemployment in a longitudinal, nationally representative study of cancer survivors: Evidence for the importance of gender and marital status. J Psychosoc Oncol. 2018; 36(3):287-303.

[17] Sommers, Benjamin, et al. Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care. Health Affairs. 2020 Sep;39(9):1522-1530. doi: 10.1377/hlthaff.2020.00538

Rachel Jordan (she/her/hers) *Specialist, State Advocacy*
On behalf of Lynn M. Schuchter, MD, FASCO Chair of the Board
Association for Clinical Oncology

Comment: The Association for Clinical Oncology (ASCO) appreciates the opportunity to provide comments on the proposed amendment to Arkansas Health and Opportunity for Me (ARHOME) 1115 waiver, which would impose work requirements for Medicaid expansion beneficiaries in

Arkansas. ASCO believes work requirements will negatively impact patients with cancer and is deeply concerned that the waiver does not include exemptions. We urge the Department to add a clear exemption for patients with cancer who are under active treatment, and for the exemption to last at least one year after final treatment.

According to research published by ASCO's affiliate, the American Society of Clinical Oncology (the Society), people with cancer, for whom the costs of evaluation and treatment can be high, are particularly in need of insurance coverage to allow for timely diagnosis and high-quality treatment. In addition, the Society emphasizes the importance of timely and unimpeded access to treatment for patients, finding that disruptions to care, such as proposed Medicaid eligibility requirements, like those in Pathways to Prosperity, correlate with poorer cancer outcomes. In particular, the imposition of work or volunteer requirements could result in reduced access to treatment for some of the most vulnerable populations when they need it most. In addition, research shows that reduced access to care could actually add to Medicaid's cost, as patients would present with more complex and late state illness if they were unable to obtain timely and recommended cancer screenings.

Cancer is an unexpected and life-altering event, and the challenges faced by patients during active treatment can significantly impact their lives. The substantial time commitment required for managing treatment, attending appointments, recovering from procedures, and dealing with symptoms and side effects can limit their ability to work. Research supports this, showing that individuals in active cancer treatment often stop working or dramatically reduce their hours. This reality underscores the critical importance of timely care and screening, as failure to obtain these has been shown to worsen cancer care outcomes.

When patients lack access to preventive care like screening, they may unknowingly delay seeking treatment until their disease reaches a more advanced stage. Alarmingly, research reveals that the initial work requirements in Arkansas led to significant healthcare delays among Medicaid expansion beneficiaries between 2018 and 2020, with 56 percent reporting they postponed care and 64 percent delayed necessary medications because of cost. ASCO does not support waiver policies that hinder access to Medicaid for individuals with a cancer diagnosis or who are at increased cancer risk.

ASCO appreciates your consideration of our request to exempt patients undergoing active cancer treatment from this waiver. We offer ourselves as a resource moving forward to help ensure all Arkansans have access to cancer treatments. Please contact Rachel Jordan at Rachel.Jordan@asco.org if you have any questions or if we can be of assistance.

ASCO is an organization representing physicians who care for people with cancer. With over 50,000 members, our mission is to ensure that cancer patients have meaningful access to high quality cancer care.

Kathryn Poe, State Policy Manager and Jamie Sullivan Vice President of Policy
EveryLife Foundation for Rare Diseases

Comment: On behalf of the EveryLife Foundation for Rare Diseases, we are pleased to submit comments regarding the ARHOME Demonstration. The EveryLife Foundation for Rare Diseases is powered by the rare disease community to improve health outcomes by driving change through evidence-based policy, leading science-driven policy and regulatory research, activating the

community to advocate for their rights and needs, and strengthening the rare disease community.

The ARHOME Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21, starting January 1, 2027. Given that work reporting requirements are federally mandated and that the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's waiver request. The EveryLife Foundation urges Arkansas not to implement these requirements before January 1, 2027.

Implementing work requirements is administratively complex and risks abrupt coverage losses for individuals with rare conditions. For this population, clear exemption criteria and accessible appeals processes are essential. This spring, CMS is expected to release additional guidance defining "medically frail," a determination that will significantly affect eligibility for exemptions.[1] While Arkansas's waiver states that individuals with "serious or medically complex conditions" are exempt from community engagement requirements,[2] the criteria for determining eligibility for this exemption remain unclear.

Rare disease patients often have medically complex conditions that may be episodic or progressive, and moving forward without a clear, consistent definition will create confusion and lead to unnecessary coverage churn. The cost of increased churn is estimated to be between $400 and $600 per person,[3] placing a greater administrative and financial burden on the Arkansas Medicaid program.

Arkansas's waiver includes several valuable exemptions for individuals in the rare disease population, including notable exemptions for parents, guardians, and caretaker relatives of disabled adults and children.[4] We encourage the state of Arkansas to continue emphasizing the important role caregivers have in providing medically necessary care to prevent the loss of coverage for impacted family members.

Inappropriate loss of coverage creates gaps in care for patients and disrupts access to critical and often lifesaving services. Rare disease patients rely on access to Medicaid for long-term care, in-home care services, and access to life-saving treatments. In 2017, Arkansas implemented a work reporting requirement, and over 18,000 beneficiaries lost coverage in seven months.[5]

The EveryLife Foundation urges the state not to implement these requirements until January 1, 2027, and to provide comprehensive exemption criteria and clear appeals processes. We appreciate the opportunity to provide comments on the ARHOME Demonstration. To protect access to affordable, high-quality healthcare for Arkansans, we urge the state to work with CMS to minimize administrative burden and inappropriate coverage loss.

Citations:

[1] Musumeci, M., Rao, P., Crays, A., & Shachar, C. (2025). How Medical Frailty Exemption Policies Can Offer a Lifeline to People with Disabilities and Chronic Illnesses When Medicaid Work Requirements Are Implemented. *The Commonwealth Fund Website*.

https://doi.org/10.26099/v6xr-mt03

[2] The State of Arkansas Department of Human Services (2025). ARHOME Section 1115 Demonstration Project Application (p. 36). Can be found at: https://humanservices.arkansas.gov/wp-content/uploads/CLEAN-ARHOME-Renewal-Application-12-12-25-FINAL.pdf

[3] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[4] See footnote 2.

[5] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018.

Lauren Edwards
Director of State Government Affairs

Comment: Blood Cancer United (formerly The Leukemia & Lymphoma Society) appreciates the opportunity to submit comments on the ARHOME Demonstration.

At Blood Cancer United, our mission is to cure blood cancer and improve the quality of life of all patients and their families. Blood Cancer United exists to find cures and ensure access to treatments for blood cancer patients.

Blood Cancer United is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage and offers the following comments on the ARHOME Demonstration:

The ARHOME Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21 starting January 1, 2027. Blood Cancer United urges Arkansas to not implement these requirements any earlier than the January 1, 2027 start date required under federal law. Work reporting requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly result in inappropriate coverage loss. Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person,[i] placing greater administrative and financial burden on the Arkansas Medicaid program.

Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services.

A loss of coverage is a grave prospect for anyone, particularly patients living with a serious disease or condition. Patients diagnosed or living with blood cancer, for example, face a complex mix of carefully-choreographed medical needs: managing their cancer alone will typically require regular visits with numerous primary and specialty healthcare providers, lab work and other diagnostics, inpatient services such as chemotherapy infusions, hospital-based care such as surgeries and transplant services, and prescription drugs, and side effects from their treatment may add significantly to this list of burdens. In 2017, Arkansas implemented a work reporting requirement and over 18,000 beneficiaries lost coverage in seven months.[ii] Blood Cancer United urges the state to not implement these requirements before January 1, 2027, and we urge Arkansas to prioritize policies that will protect patient access to care throughout implementation of PL 119-21.

Blood Cancer United appreciates the opportunity to provide comments on the ARHOME Demonstration. In order to protect access to affordable and quality healthcare for Arkansans, we urge the state to work with CMS to minimize administrative burden and inappropriate coverage loss.

Citation:

[i] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[ii] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

Lee Richardson, Executive Director and Trevor Townsend, Managing Partner Legal Aid of Arkansas

Comment: Legal Aid of Arkansas ("Legal Aid") writes to offer comment on the ARHOME Renewal Application. Legal Aid serves thousands of low-income Arkansans every year and is intimately familiar with the pressures that poverty places on our clients' lives. With respect to Medicaid, Legal Aid has assisted thousands of clients over the years with various aspects of Arkansas's Medicaid programs. Through this work, we have gained valuable insight into how policies such as these can affect low-income beneficiaries in our State.

In 2018, Arkansas became the first state in the country to implement work requirements, serving as a case study of how procedural requirements can result in the rapid loss of coverage for thousands of eligible individuals. Over 18,000 Arkansans lost coverage in just six months before the policy was halted and eventually held unlawful.

More than 95% of persons targeted by the 2018 work requirements either already met the requirements or should have been considered exempt, yet so many lost coverage due to bureaucratic barriers. The Arkansas Department of Human Services ("Department") had inundated recipients with information requests, many of which were delayed or never delivered at all.

Unaware of the work requirements or how they would apply to them, recipients were unable to complete the burdensome administrative tasks to prove their efforts to the specifications of the Department. The work requirements resulted in a significant rise in the percentage of uninsured Arkansans and, critically, no increase in employment. Indeed, some of our clients lost their employment after their health deteriorated as a result of the sudden loss of healthcare.

Against this backdrop, we offer these comments to help the Department and the broader public understand how the proposed ARHome Renewal Application ("Application") would I. Section 1115 Waiver Authority and Federal Statutory Mandates adversely affect our client community.

Pursuant to Section 71119(a)(xx)(10) of the OBBBA, the community engagement provisions set forth in Section 1902(xx) of the Social Security Act are mandatory and expressly excluded from the Secretary of Health and Human Services' waiver authority under Section 1115(a). Any provision of the Application that conflicts with, narrows, or attempts to waive the specific requirements of Section 71119 may not be approved. Consequently, to the extent that this Application attempts to deviate from Section 71119, that deviation is prohibited. Further, as detailed below in Section II, the information provided in the Application is insufficient to provide meaningful comment on critical aspects of the project and therefore does not meet Section 1115 demonstration requirements. 42 U.S.C. § 1315(d)(2)(A), (C); 42 C.F.R. § 431.408(a)(1)(i).

II. The Application Lacks Detail on Ex Parte Verification Processes

The Application's language regarding identifying a "specified excluded individual" and requiring verifications calls into question the Department's plan for processing individuals ex parte as required. The Application only states that "DHS must review and verify all necessary information to determine compliance/exemption at the time of application and at redetermination as a condition of eligibility." It is unclear what the Department means when it identifies groups that will likely be specified excluded individuals, such as those who are medically frail and in Fee-For-Service (FFS) Medicaid or those enrolled in a Provider-Led Arkansas Shared Savings Entity (PASSE), but then indicates that verification will need to occur.

Specifically, the lack of information in the Application with respect to the meaning of "necessary information" is concerning. The State has significant information available to it regarding the conditions and disabilities of these populations that should identify them as "specified excluded individuals" through ex parte processes. Generally, the Application does not describe how the Department will comply with Section 71119's mandate that the Department, with respect to verifying an individual is a "specified excluded individual," "establish processes and use reliable information available to the State . . . without requiring, where possible, the applicable individual to submit additional information." § 71119(a)(xx)(5).

The Department may already have the necessary data to confirm eligibility ex parte for the populations deemed medically frail and receiving FFS Medicaid. This is because the medically frail designation indicates that the State has previously verified significant health needs that differentiate these members from the general expansion population.

In addition, populations assigned to a PASSE have, by definition, already been identified as "Medicaid beneficiaries who have complex behavioral health and intellectual and developmental disabilities service needs." Arkansas Medicaid Manual, PASSE, § 211.000 Purpose and Scope. And Section 71119(a)(xx)(9) states that individuals are excepted from the community engagement requirements to the extent they have "special medical needs . . . ."

Consequently, the Department should already have the necessary data to conduct ex parte verification for these members. To the extent that the Department intends to require additional verification hurdles for groups already known to be vulnerable, such a policy would be inefficient and could cause unnecessary coverage gaps. It may also conflict with provisions of Section 71119 including (a)(xx)(5) (requiring the state to use an ex parte process where available). As currently written, however, it is not possible to meaningfully comment on this issue because it is unclear from the Application's language how the Department plans to verify eligibility for the medically frail, those in PASSE, and other similarly situated populations.

Conclusion

The Application's lack of detail about how the Department intends on complying with section 71119's mandate to establish processes to allow it to verify recipients ex parte who are excepted from community engagement requirements is concerning.

Based on Legal Aid's experience, any implementation that requires individuals that are medically frail and who have complex medical needs to complete and provide additional documentation is likely to lead to churn, loss of healthcare access and related irreparable harms.

Adina Rubenstein, State Policy Specialist, on behalf of
Mary B. Dwight, Chief Policy & Advocacy
Cystic Fibrosis Foundation

Comment: The Cystic Fibrosis Foundation appreciates the opportunity to submit comments on the ARHOME 1115 Demonstration Amendment. On behalf of nearly 320 people with cystic fibrosis (CF) living in Arkansas, we are committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. Our organization urges Arkansas to wait for additional federal guidance before crafting its work reporting requirements policies, as premature or rushed implementation could lead to significant coverage losses. We also ask the state to minimize administrative barriers for the medical frailty exemption and end its tiered coverage structure, which burdens patients and jeopardizes their access to necessary care. The CF Foundation urges Arkansas to refrain from moving ahead with this proposal.

Please find our full comments attached. The Cystic Fibrosis Foundation appreciates your attention to this important issue for the CF community in Arkansas. If you have any questions, please contact Adina Rubenstein, State Policy Specialist.

The Cystic Fibrosis Foundation appreciates the opportunity to submit comments on the ARHOME 1115 Demonstration Amendment. On behalf of nearly 320 people with cystic fibrosis (CF) living in Arkansas, we are committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage. Our organization urges Arkansas to wait for additional federal guidance before crafting its work reporting requirements policies, as premature or rushed implementation could lead to significant coverage losses. We also ask the state to minimize administrative barriers for the medical frailty exemption and end its tiered coverage structure, which burdens patients and jeopardizes their access to necessary care. The CF Foundation urges Arkansas to refrain from moving ahead with this proposal.

About Cystic Fibrosis and the Cystic Fibrosis Foundation

Cystic fibrosis is a progressive, genetic disease that affects the lungs, pancreas, and other organs. There are close to 40,000 children and adults living with cystic fibrosis in the United States, and CF can affect people of every racial and ethnic group. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications. For those with CF, health care coverage is a necessity, and interruptions in care can lead to irreversible lung damage and costly hospitalizations—compromising the health and well-being of those with the disease. Nearly 60% of children and more than 40% of adults living with CF in Arkansas rely on Medicaid for some or all of their health care coverage.

As the world's leader in the search for a cure for CF and an organization dedicated to ensuring access to high quality, specialized CF care, the Cystic Fibrosis Foundation accredits more than 130 care centers nationally— including three in Arkansas—that provide multidisciplinary, specialized care in accordance with clinical practice guidelines. As experts in CF care, the CF Foundation and our care centers understand the critical role of adequate, affordable health coverage, including through programs like Medicaid.

Work and Community Engagement Requirements

The ARHOME Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21 starting January 1, 2027. Given that work reporting requirements are federally mandated and that the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's waiver request. Furthermore, we urge Arkansas to wait for additional federal guidance before submitting its plans to implement this policy. Taking more time will allow Arkansas to provide increased specificity regarding essential details within the proposal for stakeholders to respond to, which is critical for the state to understand the impact of proposed policies on specific communities. Work reporting requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly result in inappropriate coverage loss. Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person,1 placing greater administrative and financial burden on the Arkansas Medicaid program. Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services.

Consistent care and access to specialized therapies are especially necessary for people with cystic fibrosis, and any loss or gap in coverage—even for as little as one month—may put people with CF at risk of declining health by forcing them to forgo daily therapies due to cost.2 According to a 2024 study conducted by the Cystic Fibrosis Foundation and the Dartmouth Institute, over a third of people with CF delayed or went without at least one aspect of their CF care in the last year—including but not limited to skipping medication doses, taking less medicine than prescribed, delaying filling a prescription, or skipping a treatment altogether—due to cost concerns.3 Because CF is a progressive disease, patients who delay or forgo treatment face an increased risk of lung exacerbations, irreversible lung damage, and costly hospitalizations.4 In 2017, Arkansas implemented a work reporting requirement and over 18,000 beneficiaries lost coverage in seven months.5

Barriers to Coverage

To prevent inappropriate coverage loss and ensure continuous access to care, Arkansas must design an exemption process that minimizes the administrative burden on enrollees. Specifically, the state should use all available data sources—particularly medical claims data—to identify eligible individuals and automatically apply and reverify exemptions. Additionally, it is critical that enrollees can self-attest to their eligibility for exemptions, as there will always be people who are not identified through external data sources.

For instance, the ability to work can fluctuate for people with CF as their health changes; pulmonary exacerbations, infections, and other events are common and can take someone out of the workforce for a period of time—which may not always be apparent through the state's proposed data matching process. As such, it is critical that enrollees can self-attest as to whether they are capable of working so that vulnerable populations are not erroneously disenrolled from coverage.

The ARHOME Demonstration lastly seeks to extend a tiered coverage structure in which patients have access to different coverage – Qualified Health Plans (QHPs) or Fee-for-Service (FFS) Medicaid – based on their income, length of time in the Medicaid program and compliance with engagement activities. These

requirements add significant red tape for patients that jeopardize their access to care, and the Cystic Fibrosis Foundation opposes them.

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The Cystic Fibrosis Foundation appreciates the opportunity to provide comments on the ARHOME Demonstration. If you have any questions about cystic fibrosis, please contact Adina Rubenstein, State Policy Specialist, at arubenstein@cff.org .

Thank you for the opportunity to provide comments.

Citations:

[1] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[2] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[3] Cystic Fibrosis Foundation (2024). Cystic fibrosis Outcomes, Social factors, Tradeoffs due to Cost and Financial Burden Survey

[4] Trimble AT, Donaldson SH. Ivacaftor withdrawal syndrome in cystic fibrosis patients with the G551D mutation. J Cyst Fibros. 2018 Mar;17(2): e13-e16. doi: 10.1016/j.jcf.2017.09.006. Epub 2017 Oct 24. PMID: 29079142.

[5] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport

Agata Pelka, Director of State Government Affairs
On behalf of Erin M. Callahan, Chief Operating Officer
Diabetes Patient Advocacy Coalition

Comment: The Diabetes Patient Advocacy Coalition (DPAC) appreciates the opportunity to submit comments on the ARHOME Demonstration. DPAC is an alliance of people with diabetes, caregivers, patient advocates, health professionals, and others working together to support public policy initiatives to improve the lives of Americans living with and at-risk for diabetes and its complications. As an organization run by and for people with diabetes, DPAC seeks to ensure quality of and access to care, medications and devices for our community.

DPAC is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage and offers the following comments on the ARHOME Demonstration:

The ARHOME Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21 starting January 1, 2027. Given that work reporting requirements are federally mandated and that the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's waiver request. Furthermore, DPAC urges Arkansas to not implement these requirements any earlier than January 1, 2027. Work reporting requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly

result in inappropriate coverage loss. Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person,1 placing greater administrative and financial burden on the Arkansas Medicaid program.

Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services. When patients with diabetes lose insurance coverage, they often ration insulin or skip care altogether, leading to dangerous emergencies like diabetic ketoacidosis, preventable hospitalizations, and long-term complications such as kidney disease or vision loss. Gaps in coverage also cut off access to essential monitoring supplies and routine care, worsening blood sugar control. These disruptions create financial strain, mental health challenges, and higher health system costs.

DPAC is also concerned that the current exemption criteria may not capture all individuals with, at risk of, or in the process of being diagnosed with serious and chronic health conditions that prevent them from working. While the demonstration has an exemption for individuals who are medically frail or who have special medical needs, this could still leave many patients with diabetes who are unable to fulfill the work requirements ineligible to get the exemption. Regardless, additional processes to determine patient eligibility and participation in program requirements inherently create opportunities for administrative errors that jeopardize access to care.

DPAC appreciates the opportunity to provide comments on the ARHOME Demonstration. In order to protect access to affordable and quality healthcare for Arkansans, we urge the state to work with CMS to minimize administrative burden and inappropriate coverage loss.

Citation:

[1] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

Camille Richoux, Health Policy Director,
Christin Harper, Policy Director, and
Keesa Smith, Executive Director, for
Arkansas Advocates for Children and Families

Comment: Arkansas Advocates for Children and Families (AACF) appreciates the opportunity to submit comments on Arkansas's proposed five-year renewal of the ARHOME Section 1115 demonstration. AACF is a statewide, nonprofit child and family policy research and advocacy organization whose mission is to ensure that every child and family has the resources and opportunities needed to live healthy, productive lives.

We strongly support the continuation of ARHOME and Arkansas's Medicaid expansion, which has helped hundreds of thousands of Arkansans gain access to health coverage, preventive care, and financial security. ARHOME has strengthened families, stabilized local health care providers, and supported the broader state economy. At a time when more Arkansans are at risk of becoming uninsured, preserving coverage through ARHOME is more important than ever for the health of individuals and the stability of our health care system.

Our comments focus specifically on the proposed adoption and implementation of federally mandated work reporting requirements for Medicaid expansion adults. As you know, with the passage of H.R. 1, work

reporting requirements are now required by federal law for this population. While AACF continues to strongly oppose these requirements as antithetical to the purpose of the Medicaid program, our comments are offered in the spirit of mitigating harm, reducing unnecessary administrative burden, and preserving coverage for as many eligible Arkansans as possible.

Use of Section 1115 Authority

Because H.R. 1 mandates work reporting requirements for Medicaid expansion populations and prohibits waiver of federal standards, it is unclear why Arkansas must seek approval through a Section 1115 demonstration to implement these provisions. To the extent the state is requesting waiver authority solely to comply with federal law, AACF urges DHS to clearly articulate the purpose and added value of using a demonstration rather than implementing the requirements directly through state plan authority. Any demonstration authority should be used to maximize flexibility, protect coverage, and reduce inappropriate coverage losses.

Implementation Timing

The proposed implementation date of January 1, 2027 provides the state with a critical window to prepare for a complex and resource-intensive policy change. AACF strongly urges DHS not to implement work reporting requirements prior to that date.

Adequate preparation time is essential to avoid inappropriate coverage losses. This period should be used to develop and test systems, coordinate across eligibility and enrollment functions, train staff, and conduct meaningful outreach to enrollees using multiple communication channels. Rushing implementation before systems and outreach are fully in place would significantly increase the risk of errors, confusion, and coverage disruptions. This concern is supported by the state's previous implementation of work requirements in 2018 that led to thousands of Arkansans losing coverage and significant issues with verification systems.

Exemptions for Individuals with Significant Health Needs

AACF urges DHS to automatically exempt all individuals determined to be medically frail and all individuals with serious mental illness enrolled in fee-for-service programs or the PASSE system. These individuals have already been identified through state processes as having significant health needs that require uninterrupted access to care.

Requiring these populations to separately verify exemptions introduces avoidable administrative complexity and increases the likelihood of erroneous suspensions due to paperwork barriers or data delays. Automatic exemptions for these groups would better align with Medicaid's role in serving individuals with complex health needs and would allow DHS to focus administrative resources where they are most needed.

Design Choices to Limit Coverage Loss and Churn

DHS retains discretion in how work reporting requirements are operated. We encourage the department to use this discretion to design processes that are realistic for enrollees and manageable for the state. This includes structuring compliance requirements so that individuals are not required to demonstrate ongoing monthly participation. Allowing compliance to be demonstrated for a limited period at application and renewal recognizes the realities of fluctuating work hours common for thousands of Arkansans in hourly, seasonal, and contract-based employment.

DHS should also apply exemption categories using flexible standards and streamlined processes,

particularly for individuals with health-related limitations. Where possible, the department should rely on existing administrative data and enrollee-declared information, while accounting for known lags in claims and health data that can undermine timely verification. In addition, DHS should continue to engage QHPs as partners in outreach and education. These organizations have regular contact with enrollees and can play an important role in helping individuals understand new requirements and avoid unnecessary loss of coverage.

Success Coaching and Supportive Services

AACF appreciates the proposal to offer voluntary Success Coaching services beginning in 2028, particularly for populations such as individuals transitioning from incarceration and youth formerly in foster care. Connecting enrollees to education, training, employment supports, and health-related social services has the potential to improve stability without placing coverage at risk. These services should remain voluntary and clearly separated from eligibility determinations.

Conclusion

Our Medicaid expansion represents one of Arkansas's most significant health policy achievements. As the state moves forward with federally required work reporting requirements, implementation decisions will have real consequences for families, providers, and the health care system as a whole. Coverage losses among eligible individuals not only harm families but also destabilize care delivery and increase uncompensated care costs statewide.

AACF urges DHS to use this renewal to prioritize continuity of coverage, administrative practicality, and flexibility wherever federal law allows. Thoughtful implementation can reduce avoidable harm while preserving the gains Arkansas has made through ARHOME.

Thank you for the opportunity to submit comments. We look forward to continued engagement with DHS to support the health and well-being of Arkansas children and families.

Melissa Horn, MPA, Director of State Legislative Affairs
Department of Advocacy and Access, Arthritis Foundation

Comment: On behalf of more than 640,000 Arkansas residents living with doctor-diagnosed arthritis, the Arthritis Foundation appreciates the opportunity to submit comments on Arkansas' proposed renewal and amendment of the ARHOME Section 1115 Demonstration. Our organization urges Arkansas's Medicaid program to consider the patient population while reviewing program changes and the timeline for implementation in regards to work reporting requirements and waivers.

Arthritis is not a single condition; the term refers to joint pain or joint disease, and there are more than 100 types of arthritis and related conditions. People of all ages, races and sexes live with arthritis, and it is the leading cause of disability in the United States. It's most common among women, and although it's not a disease of aging, some types of arthritis occur in older populations and others more predominantly in younger.

Given the complexity of arthritic diseases and demographics impacted, understanding arthritis is the first step in managing it. Many individuals living with arthritis experience unpredictable flares, functional limitations, chronic pain, and mobility challenges that make it difficult to maintain consistent schedules or complete administrative tasks. Work reporting requirements risk penalizing individuals for circumstances

beyond their control and can lead to inappropriate coverage loss. Gaps in coverage can disrupt access to medications, specialty care, and physical therapy resulting in worsening symptoms, irreversible disease progression, and avoidable long-term costs. Navigating a diagnosis like arthritis and autoimmune disease is difficult enough, so it is important for any changes to requirements to take real life experiences of patients into consideration.

The ARHOME Demonstration proposes to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21 starting January 1, 2027. Given that work reporting requirements are federally mandated and the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's Section 1115 waiver request.

Furthermore, the Arthritis Foundation urges Arkansas to not implement these requirements any earlier than January 1, 2027. Work reporting requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly result in inappropriate coverage loss. Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person, placing greater administrative and financial burden on the Arkansas Medicaid program.[1] Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services. According to a review by the KFF (Kaiser Family Foundation) in 2017, Arkansas implemented a work reporting requirement and over 18,000 beneficiaries lost coverage in seven months.2 The Arthritis Foundation is concerned additional changes could result in additional lost coverage for patients.

The Arthritis Foundation appreciates the opportunity to provide these comments on the ARHOME Demonstration. In order to protect access to affordable and quality healthcare for Arkansans, we urge the state to work with CMS to minimize administrative burden and inappropriate coverage loss.

Citations:
[1] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204
2 Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

Neil Sealy, Executive Director
Arkansas Community Organizations

Comment: Arkansas Community Organizations and the Arkansas Community Institute are membership organizations of low- to moderate-income people in Arkansas. Many of our members are enrolled in Medicaid programs and depend on them for their health care. Over the years we have worked with hundreds of Medicaid recipients in several counties in Arkansas. Our work has consisted of surveying people about their experiences with the Medicaid program in Arkansas and building a strong cohort of members who use Medicaid for their health coverage.

In 2018 we opposed the work requirement for people enrolled in the Medicaid expansion adopted by the state of Arkansas in 2013. The work requirement caused around 18,000 people to lose their health coverage over a short span of time.. Many of these people were not aware that their coverage was gone until they had to buy medicine prescribed by a doctor or went to a clinic for needed health care. Arkansas's

work requirement was overturned due to a successful lawsuit.

The Medicaid expansion, now called ARHOME, has helped thousands of Arkansans receive health coverage that they could not previously afford to buy.

Last summer Congress passed H.R.1 that included work requirements for people who use the Medicaid expansion for their health coverage. The work requirements go into effect on January 1, 2027. We now have almost a year to develop ways in which we can help people keep their health coverage while satisfying the requirements of the federal work requirement.

It is already difficult for many Medicaid recipients to navigate the current system of enrollment and renewal in our state. Many of our members have received letters from DHS that are difficult to understand and contain wrong information about family size and income. Arkansas's short timeline for the unwi=nding of the Public Health Emergency laid bare many of the weaknesses in the system. Some of the problems that Arkansans on Medicaid are currently experiencing can be seen in these clips:

https://katv.com/news/local/thousands-of-arkansans-dropped-from-medicaid-as-state-evaluates-ongoing-eligibility-post-covid-19-emergency-declaration-gavin-lesnick-chief-communications-officer-department-human-services-arkansas-june-seventy-thousand-arkansas-community-organization-al#

https://www.arkansasonline.com/news/2023/jun/16/protesters-blame-computer-glitches-for-medicaid/

https://www.cnn.com/2023/06/21/politics/medicaid-coverage-unwinding-eligibility/index.html

DHS should take steps that help people keep their health insurance through ARHOME. The Medicaid expansion has made a big difference for many people in Arkansas and has actually helped them to become able to work. Here are a few suggestions to make the federal work requirement less burdensome for ARHOME recipients who work, but do not have the means to pay for health insurance and do not receive health benefits from their employer:

Work to end the glitches in the current enrollment and renewal system and make it easier for Arkansans to navigate the system and to get help when they need it.

DHS should begin to exempt all individuals who are classified as medically frail or have a serious mental illness from the work requirements.

Develop a work reporting structure that is less burdensome by requiring work hours to be reported in the months just after enrollment and just before renewal.

We urge DHS to do everything possible to help people keep their health coverage while complying with the new federal work requirements. Let's work to make Arkansas one of the healthiest states in the country.

Health care is a human right.

Travis Frey, Individual Marketing Agent
Arkansas Blue Cross and Blue Shield

Comment: Please consider waiving the work requirement for those aged 55+. I have a customer who is 60 who is planning her retirement, but her income would fall below 138% of the FPL at retirement, and would only qualify for ARHome, except with the proposed, she would be forced to go find a job. I don't believe this is an unreasonable request, especially seeing that those 55+ can have a harder time finding gainful employment.

Michelle Pedro, Policy Advocate & Communications Specialist
Arkansas Coalition of Marshallese

Comment: Thank you for the opportunity to submit comments on the proposed ARHOME Section 1115 Demonstration Renewal. The Arkansas Coalition of Marshallese (ACOM) is a community-based organization dedicated to improving the health, stability, and overall wellbeing of Marshallese families across Arkansas. Through culturally informed outreach, health education, and policy advocacy, ACOM works to ensure that Marshallese and other COFA residents can access the services and support for which they are eligible.

ACOM appreciates the state's ongoing efforts to strengthen Medicaid; however, we have significant concerns about how the proposed changes particularly work-related requirements and additional administrative processes will affect communities that already face substantial barriers navigating state systems.

For Marshallese language access remains one of the most persistent challenges in maintaining Medicaid coverage. During the recent unwinding process, a disproportionate number of Marshallese adults and children lost coverage despite remaining eligible. Many families did not receive notices, received notices they could not understand, or were unable to complete required steps due to limited English proficiency and the lack of culturally and linguistically appropriate assistance. These coverage losses were not the result of ineligibility, but of systemic barriers that continue to place Marshallese at heightened risk.

Introducing additional reporting requirements under ARHOME will likely deepen these disparities. Without robust language access and proactive communication, eligible Marshallese residents may lose coverage again not because they fail to meet program requirements, but because they cannot navigate the administrative systems designed to verify them.

We respectfully urge the Department of Human Services to incorporate stronger, more intentional outreach and support strategies into the ARHOME renewal. This includes translated materials, in-person assistance, and direct engagement with trusted community organizations such as ACOM, which are already working directly with families to help them understand program expectations and maintain their coverage. We also request that DHS directly address in its response how it will ensure that the errors and issues that previously harmed impacted communities, will be acknowledged, corrected and fully considered in the future planning and outreach efforts. Clear, culturally informed communication is essential to ensuring equitable access for all eligible Arkansans.

Thank you for your consideration and for your commitment to improving health outcomes across our state. We appreciate the opportunity to share the concerns of the Marshallese

community, who remain eager to participate fully and successfully in Arkansas's Medicaid programs when provided with the tools and support necessary to do so.

Mike Seilback, AVP, Nationwide Advocacy, State Public Policy, on behalf of Laura Turner
American Lung Association

Comment: The American Lung Association appreciates the opportunity to submit comments on the ARHOME Demonstration.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the more than 35 million Americans living with lung diseases, including more than 459,000 Arkansans. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The American Lung Association is committed to ensuring that Arkansas's Medicaid program provides quality and affordable healthcare coverage and offers the following comments on the ARHOME Demonstration:

The ARHOME Demonstration seeks to implement work reporting requirements for adults in the Medicaid expansion population as outlined in Public Law 119-21 starting January 1, 2027. Given that work reporting requirements are federally mandated and that the standards in PL 119-21 cannot be waived, there is no need to include this policy in the state's waiver request. Furthermore, the Lung Association urges Arkansas to not implement these requirements any earlier than January 1, 2027. Work reporting requirements are administratively complex and burdensome, and an early or rushed implementation would undoubtedly result in inappropriate coverage loss. Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person,1 placing greater administrative and financial burden on the Arkansas Medicaid program.

Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services. For a patient with COPD or asthma, a gap in healthcare coverage can prevent them from receiving medications needed to control their health condition and lead to an exacerbation that requires an emergency room visit costly to both the patient and the state. For individuals in active treatment for lung cancer or other lung diseases, a disruption in coverage could impact access to lifesaving treatment. In 2018, Arkansas implemented a work reporting requirement and over 18,000 beneficiaries lost coverage in seven months.2 The Lung Association urges the state to not implement work reporting requirements until 2027 and to prioritize policies that will protect patient access to care during implementation of PL 119-21.3

The Lung Association appreciates the opportunity to provide comments on the ARHOME Demonstration. In order to protect access to affordable and quality healthcare for Arkansans, we urge the state to work with CMS to minimize administrative burden and inappropriate coverage loss.

Citations:

[1] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[2] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[3] Protecting Patients' Access to Medicaid. Partnership to Protect Coverage, November 20, 2025. Available at: https://www.protectcoverage.org/siteFiles/51921/11%2020%202025%20PPC%20Medicaid%20Priorities.pdf

Kevin Herwig, Health Policy Manager, on behalf of
Carl E. Schmid II, Executive Director
HIV+Hepatitis Policy Institute

Comment: The HIV+Hepatitis Policy Institute is a leading national HIV and hepatitis policy advocacy organization promoting quality and affordable healthcare for people living with or at risk of HIV, hepatitis, and other serious and chronic health conditions.

Thank you for offering the opportunity for public comment on a Section 1115 Demonstration Project Application to implement the new requirements on January 1, 2027.1

We write to urge the Arkansas Medicaid program to include an explicit exemption for all people living with HIV from the community engagement reporting required under HR 1.

People with HIV are living with a lifelong serious and complex medical condition and have special medical needs: they cannot stay healthy without continuous access to their lifesaving HIV treatment. Any gap in treatment risks serious health consequences, including failure of viral suppression and the risk of onward transmission. Longer treatment gaps are potentially disabling, allowing progression to AIDS, after which life expectancy is limited.

People with serious and complex medical conditions and special medical needs are statutorily exempt from the community engagement requirement; however, absent federal guidance, states can define which populations qualify.

Arkansas Medicaid has previously stated that people receiving treatment for HIV will be considered to be in compliance with community engagement requirements ("on track") in responses to public comment on a previously submitted 1115 waiver published in July 2025.2

We urge Arkansas to reaffirm explicitly in the finalized current 1115 amendment that people with HIV – whether symptomatic or asymptomatic, or whether or not they currently receive or have ever received HIV treatment – have special medical needs and are exempted from falling under the new community engagement program.

This interpretation is consistent with long-standing federal precedents. For decades, Congress and Unites States DHHS have considered HIV (both symptomatic and asymptomatic) as a serious, life-threatening, and potentially disabling condition.3

All people with HIV should be exempted from the community engagement automatically, without having to navigate cumbersome new bureaucratic procedures to document their status with each Medicaid recertification.

Under statute, states are directed to maximize ex parte verification of eligibility in relation to the community engagement requirements. Automatic exemption through use of data already available to the Medicaid program (such as diagnostic codes and claims data) minimizes the burden on the enrollee. It also reduces the administrative burden on the state and on the health-care workforce providing care to people with HIV.

Arkansas asserts in its amendment that "DHS must review and verify all necessary information to determine compliance/exemption at the time of application and at redetermination as a condition of eligibility."4

Since HIV is a lifetime condition that will not change over time, any assessment should only be carried out once.

To put the onus on individuals living with HIV to navigate administratively cumbersome forms of verification of HIV status is unnecessary and puts their health at risk. In addition, since people with HIV face continuing stigma and discrimination, many are reluctant to disclose their HIV status in Medicaid enrollment and recertification paperwork, further amplifying the importance of using ex parte verification of HIV status.

Approximately forty percent of people living with HIV nationwide are enrolled in Medicaid, making Arkansas's implementation of the new community engagement requirements of the highest importance to people living with HIV, their care teams, and communities. As the first state in the nation to implement work requirements in Medicaid in 2018, Arkansas has an opportunity to use this experience to put in place humane and clinically sound practice in compliance with HR1.

We encourage Arkansas DHS to engage people living with HIV and their clinicians to better understand the impact of these policies. We are ready to assist in any way. Should you have questions or comments, please feel free to contact me at cschmid@hivhep.org or Kevin Herwig at kherwig@hivhep.org. Thank you very much.

Citations:

[1] https://humanservices.arkansas.gov/wp-content/uploads/ARHOME-Waiver-Long-Notice-12.12.25.pdf
[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-ltr-frm-state-07082025.pdf
[3] For example, 28 CFR 35.108(b)(2) or 78 FR 42233
[4] https://humanservices.arkansas.gov/wp-content/uploads/ARHOME-Waiver-Long-Notice-12.12.25.pdf

Ramon Gardenhire, South Region Government Relations Director
ViiV Healthcare

Comment: ViiV Healthcare Company (ViiV) appreciates the opportunity to submit comments to the Arkansas Department of Human Services (DHS) Division of Medical Services regarding its implementation of Medicaid work requirements beginning January 1, 2027.

ViiV urges the state to ensure that people with HIV are included within the exemption category for "serious or complex medical conditions."[1] We further urge the state to make their exemption automatic and ex parte, when possible.

Recommendation: Clarify that people with HIV are exempted from the work requirements as having a "serious or complex medical condition" and create an automatic ex parte exemption process

ViiV encourages Arkansas to ensure that people with HIV enrolled in the adult Medicaid expansion group are classified as having a "serious or complex medical condition," which would exempt them from the forthcoming work requirements. People with HIV fall squarely within this category per the definition of "serious and complex medical condition[s]" provided in the bipartisan No Surprises Act (2021):[2],[3]

> (2) Serious and complex condition
>
> The term "serious and complex condition" means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health

insurance coverage-

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, a condition that is- 1

is life-threatening, degenerative, potentially disabling, or congenital; and

requires specialized medical care over a prolonged period of time.

Within this definition, people with HIV fall squarely within subsection (B), given that HIV is a chronic condition that is life-threatening, degenerative, potentially disabling, and requires specialized medical care over an entire lifetime. This classification is essential to prevent coverage disruptions and to ensure continuity of care and access to antiretrovirals, which can help improve adherence and reduce HIV transmission.4

We support the state's intent to establish a process for making exemptions automatic and ex parte, whenever possible, as required by H.R.1.5 In a best practice example, in 2018, the state of Michigan submitted a Medicaid

demonstration waiver that exempted medically frail individuals—including people with HIV—through claims analysis codes specific to HIV.6 Arizona proposed the same.7 In Kentucky and Indiana, people with HIV are categorized as medically frail, which would make them exempt.8,9 We recommend that Arkansas follow a similar process by creating an automatic exemption using data matching or claims code analysis, with a backup option for beneficiary self-attestation or provider attestation. This process would allow most people with HIV to be easily excluded without the need for further action and would reduce unnecessary redisclosures of serostatus.

These policies would align with Arkansas' previous 1115 waiver request for work requirements which would have exempted people with HIV by considering them automatically in compliance through data matching.10

Medicaid and people with HIV in Arkansas Medicaid plays a critical role in HIV care as the largest source of coverage for people with HIV.11 ViiV encourages the state of Arkansas to ensure that people with HIV who are Medicaid beneficiaries have continuous access to comprehensive health care, including antiretroviral therapy (ART). We are concerned that without a clear and automatic exemption from the work requirements, people with HIV could have their treatment disrupted, threatening their health and creating a public health risk for the people of Arkansas.

Under the state's proposal, individuals who are unable to meet the work requirements will have their Medicaid coverage suspended. For people with HIV, retention in medical care and adherence to treatment are critical. Individuals with HIV require regular medical care, consistent access to antiretroviral medications, and comprehensive support services to effectively manage their condition.

Effective HIV treatment can help people with HIV live longer, healthier lives and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.12,13 Effective HIV treatment can also prevent transmission of the disease.14 People who are virally suppressed (with an undetectable viral load) cannot transmit HIV to others through sexual contact, a concept known as "undetectable = untransmissible," or U=U.15

People living with HIV who are not retained in medical care, however, may transmit the virus to more than 5 additional individuals per 100 person-years.16 Each person with HIV is estimated to cost the US health care system ~$850,000 over a lifetime.17 Successful HIV treatment for a person with HIV may save the health care system $4.5 million in total by preventing transmission to others.18

Research on the prior work requirement program in Arkansas has found that many individuals who lost their coverage were qualified but lost coverage due to confusion about the requirements and/or burdensome reporting requirements.19 These proposed work requirements would also add an additional administrative burden that could cause lapses in coverage. For people with HIV, these lapses could disrupt their medication adherence or ability to receive care.

For these reasons, we urge Arkansas to automatically exempt people with HIV from work requirements through data matching or claims code analysis (with an option for provider or beneficiary self-attestation), to ensure they receive uninterrupted access to care and treatment through Medicaid.

Clarifying the definition and exempting people with HIV aligns the state's fiscal and healthcare goals with President Trump's Ending the HIV Epidemic in America (EHE) Initiative

During his first term, President Trump announced his Administration's bold goal to end the HIV epidemic in America by 2030. His administration released the "Ending the HIV Epidemic: A Plan for America" (EHE) in 2019 which proposed to use scientific advances in antiretroviral therapy to treat people with HIV and to expand models for effective HIV care and prevention. Arkansas was selected as a priority jurisdiction for the EHE given its high incidence of new cases.20 Arkansas Medicaid, like all state Medicaid programs, has an important role to play in achieving the goals of this national plan. Clarification that people with HIV are exempt would align with our national goals for ending the HIV epidemic.

About ViiV

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in HIV treatment and prevention to support the needs of people with HIV and those vulnerable to HIV. ViiV remains singularly focused on improving the health and quality of life of people affected by HIV and has worked to address

unmet needs in treatment and prevention. In collaboration with the HIV community, ViiV is committed to developing meaningful treatment and prevention advances, improving access to its HIV medicines, and supporting the HIV

community to facilitate enhanced care, treatment, and prevention.

Conclusion

ViiV urges Arkansas DHS to clarify that people with HIV are exempt from the proposed work requirements. Doing so will prevent disruptions to care and treatment, maintain health outcomes, and prevent new infections.

Thank you for your consideration of our comments. Please feel free to contact me with any questions at ramon.c.gardenhire@viivhealthcare.com.

Citations:

[1] Arkansas Department of Human Services (DHS). Medicaid Section 1115 Demonstration Project Application, Arkansas Health and Opportunity for Me Public Notice. December 14, 2025. https://humsanservices.arkansas.gov/wp-content/uploads/ARHOME-Waiver-Long-Notice-12.12.25.pdf. Accessed January 15, 2026.

[2] The Public Health and Welfare, Title 42 U.S.C. §300gg–113(b)(2). 2025. https://uscode.house.gov/view.xhtml?req=(title:42%20section:300gg-113%20edition:prelim)%20OR%20(granuleid:USC-prelim-title42-section300gg-113)&f=treesort&edition=prelim&num=0&jumpTo=true. Accessed November 25, 2025.

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[5] One Big Beautiful Bill Act P.L. 119-21. July 4, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1/text.

[6] State of Michigan. Healthy Michigan Plan 1115 Demonstration Extension Application. Project No. 11-W-00245/5, AMENDED: September 10, 2018. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf. Accessed January 21, 2026.

[7] Arizona Health Care Cost Containment System. AHCCCS Works Waiver Amendment Request. March 30, 2025. https://www.azahcccs.gov/Resources/Downloads/1115Waiver/AHCCCSWorks_Final_Submission2025.pdf. Accessed January 21, 2026.

[8] Kentucky Health. Kentucky Medically Frail Medical Condition Guide v5 for Providers. June 2018. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjn0t--54uSAxXjw_ACHQeeGHkQFnoECB0QAQ&url=https%3A%2F%2Fwww.wellcareky.com%2Fcontent%2Fdam%2Fcentene%2Fwellcare%2Fky%2Fpdfs%2Fprovider%2FKY_CAID_PROV_Medically_Frail_Provider_Attestation_Form_ENG_6_2018_R.pdf&usg=AOvVaw32OtU1cAoePKQx0_tRi6vt_&opi=89978449. Accessed January 21, 2026.

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[10] Arkansas Department of Human Services. Public Comments on Pathway to Prosperity Amendment and Arkansas Department of Human Services Responses. July 8, 2025. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-ltr-frm-state-07082025.pdf. Accessed January 21, 2026.

[11] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/. Accessed January 21, 2026.

DHS Responses to Public Comments Regarding
Arkansas Health and Opportunity for Me (ARHOME) Program - Second Notice

Olalekan Ajayi, PharmD, MBA, President
Arkansas Association of Cancer Professionals
Lynn M. Schuchter, MD, FASCO, Chair of the Board
Association for Clinical Oncology

Comment: The Arkansas Association of Cancer Professions (AACP) and the Association for Clinical Oncology (ASCO) appreciate the opportunity to provide additional comments on the proposed amendment to Arkansas Health and Opportunity for Me (ARHOME) 1115 waiver, which would impose work requirements for Medicaid expansion beneficiaries in Arkansas. We acknowledge and thank the Department of Human Services for its response to our initial concerns regarding the impact of work requirements on patients with cancer. Specifically, we appreciate the Department's acknowledgement that patients undergoing cancer treatment will likely meet the exemptions for "medically frail" and the federal definition of "special medical need." We value the Department's commitment to ensuring that coverage for this vulnerable population will not be terminated ahead of the January 2027 federal implementation deadline.

AACP and ASCO strongly support the Department's stated goal of examining ways to verify cancer treatment through data matching. We encourage the Department to prioritize and implement

automatic processes for both the establishment of exemptions and the verification of community engagement requirements. In cases where available data sources – such as claims data – are insufficient or unavailable, a streamlined process must exist for patients and their oncologists to report or apply for exemptions directly. This safeguard is essential to prevent administrative burden from causing life-threatening disruptions in care.

While we anticipate the federal rules to be promulgated by June 1, 2026, we urge Arkansas to use its existing flexibility to prevent barriers to timely and appropriate cancer care. These flexibilities should include:

- Establishing the expectation that cancer is a long-term disruption for patients. The duration of cancer-related exemptions should reflect medical necessity, and we continue to urge the Department to extend exemptions for at least one year after the conclusion of final treatment.
- Creating systems that do not threaten continuity of care during renewal periods or related to reporting requirements.
- Ensuring the maximum duration of retroactive eligibility allowed by law to protect patients from the devastating medical debt often associated with a new diagnosis.
- Encouraging the use of hardship exemptions to specifically support travel to and participation in clinical trials, which are often a patient's best treatment option.

Our underlying concerns regarding the impact of work requirements remain. As noted in our initial comments:

- People with cancer, for whom the costs of evaluation and treatment can be high, are particularly in need of insurance coverage to allow for timely diagnosis and high-quality treatment. ASCO's affiliate, the American Society of Clinical Oncology emphasizes that disruptions to care, such as proposed Medicaid eligibility requirements, correlate with poorer cancer outcomes.
- The substantial time commitment required for managing treatment, attending appointments, and recovering from procedures and side effects often makes maintaining work hours impossible. Research supports this, showing that individuals in active cancer treatment often stop working or dramatically reduce their hours.
- Reduced access to care adds to the Medicaid program's long-term cost, as patients eventually present with more complex, late-state illness that are more expensive to treat than those caught through timely and recommended screenings.

When patients lack access to preventive care like screening, they often delay seeking treatment until their disease reaches an advanced, more costly stage; this underscores the need for a seamless exemption process. As noted in our previous comments, research reveals that the initial work requirements in Arkansas led to significant healthcare delays between 2018 and 2020, with 56 percent of enrollees reporting they postponed care and 64 percent reporting they delayed

necessary medications.

To avoid repeating these outcomes, the Department must ensure that eligibility policies do not hinder access for individuals with a cancer diagnosis or those at increased risk.

AACP and ASCO appreciate the Department's willingness to protect Arkansans facing a cancer diagnosis. We offer ourselves as a resource to help refine these automated systems and ensure they work for both providers and patients. For more information, we invite you to read ASCO's Position Statement –

Implications for Cancer Care in a New Medicaid Era. Please contact Rachel Jordan at Rachel.Jordan@asco.org if you have any questions or if we can be of assistance.

Founded in 2022, AACP is the largest oncology professional organization in Arkansas, comprising of a powerful community of oncologists, nurse practitioners, physician assistants, pharmacists, and other multidisciplinary care providers involved in the treatment of patients with cancer. ASCO is an organization representing physicians who care for people with cancer. With over 50,000 members, our mission is to ensure that cancer patients have meaningful access to high quality cancer care.