

Arkansas Waiver: Arkansas Works

Overview

Arkansas received federal approval from the Centers for Medicare & Medicaid Services (CMS) for an amendment to its Section 1115 Medicaid premium assistance demonstration on March 5, 2018. Previously (in December 2016) the state received approval to extend its Section 1115 premium assistance demonstration through December 31, 2021. The revised demonstration, Arkansas Works, allowed the state to continue providing premium assistance to the new adult group to secure exchange coverage, but added changes to its eligibility provisions including a shortened retroactive eligibility period and a work and community engagement requirement beginning June 1, 2018.

The information in this brief describes Arkansas's demonstration policies as they were approved in March 2018. However, in March 2019 CMS's approval of the amendment was vacated by the U.S. District Court for the District of Columbia and remanded to CMS for further review.¹ This decision was upheld by the U.S. Court of Appeals for the District of Columbia Circuit in February 2020.² The Biden Administration has since withdrawn Arkansas's authority for work and community engagement requirements and notified the state that other elements of the demonstration are under review (CMS 2021).

Demonstration Goals

Arkansas Works seeks to accomplish several goals. These goals will inform the hypotheses in the state's evaluation design plan and include, but are not limited to, determining whether the demonstration aided in:

- providing continuity of coverage;
- improving access to providers;
- improving continuity of care across the continuum of coverage;
- requiring beneficiaries to pay a monthly premium to promote more efficient use of health care services;
- improving health outcomes and promoting independence through employment and community engagement; and
- furthering quality improvement and delivery system reform initiatives.

Populations Included

The demonstration includes adults age 19–64 with incomes up to 138 percent of the federal poverty level (FPL). Individuals who are medically frail individuals are excluded from enrolling in premium assistance and receive traditional Medicaid coverage.

Eligibility and Enrollment

The March 2018 waiver amendment changes the effective date of coverage and adds a work and community engagement requirement as a condition of eligibility, although, as mentioned previously, these policies cannot be enforced at this time.



Effective date of coverage

Under the March waiver amendment, Arkansas is not required to provide the usual three months of retroactive coverage for the new adult group; instead, coverage will begin 30 days prior to the date of application.³ CMS also removed the requirement that Arkansas must have an approved hospital presumptive eligibility state plan amendment in order to receive a waiver of retroactive coverage.

Work and community engagement requirement

Effective June 1, 2018, Arkansas implemented a work and community engagement requirement for members of the new adult group under age 50.⁴ Under the new requirements, during any given month beneficiaries must either meet an exemption or complete at least 80 hours of qualifying activities (Table 1). Beneficiaries must report their participation in qualifying activities into an online portal or by phone by the 5th of the following month.⁵ Beneficiaries may report an exemption by phone or through the online portal at any time.⁶

TABLE 1. Work and Community Engagement Requirement Exemptions and Qualifying Activities

Exempt populations	Non-exempt populations
<p>Beneficiaries who are:</p> <ul style="list-style-type: none"> • identified as medically frail • pregnant or 60 days post-partum • full-time students • exempt from SNAP work requirements • receiving cash assistance or exempt from work requirements under TANF • incapacitated in the short-term or medically certified as physically or mentally unfit for employment, or has an acute medical condition that would prevent him or her from complying with the requirements • caring for an incapacitated person • living in a home with a minor dependent child age 17 or younger • receiving unemployment benefits • participating in a treatment program for alcoholism or drug addiction 	<p>Required participation in 80 hours per month of some combination of the following:</p> <ul style="list-style-type: none"> • employment, self-employment, or having an income consistent with working at least 80 hours per week at Arkansas minimum wage • enrollment in an educational program including high school, higher education, or GED classes • participation in on-the-job or vocational training • community service • participation in job search training or independent job search activities (up to 40 hours per month each) • participation in a class on health insurance, on using the health system, or on healthy living (up to 20 hours per year) • participation in activities or programs available through the Arkansas Department of Workforce Services • participation in and compliance with SNAP or TANF employment initiative programs

Notes. GED is general education development. SNAP is Supplemental Nutrition Assistance Program. TANF is Temporary Assistance for Needy Families.

Source. CMS 2018.

Penalties for non-compliance. Beneficiaries who are subject to the requirements but do not complete required hours and report their participation for three months—either consecutive or non-consecutive months—can be disenrolled for the remainder of the calendar year. Disenrollment is effective on the first day of the month after notice is provided, unless the member files for an appeal or reports a good-cause exemption.⁷ Unless they are eligible through another pathway, individuals who are disenrolled due to non-compliance cannot reenroll in Medicaid until the following plan year, at which point they will have to re-apply for Medicaid.

State assurances. Arkansas is required to make a number of assurances, including maintaining a mechanism to stop payments to an exchange plan following disenrollment, ensuring timely and adequate



beneficiary notices and outreach, and coordinating compliance with the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).⁸ Arkansas must also provide appeal and due process mechanisms, make good faith efforts to connect beneficiaries to existing community supports (e.g., non-Medicaid transportation assistance, child care, and language services), assess areas within the state that have limited employment or educational opportunities to determine further necessary exemptions, and provide reasonable modifications for individuals with disabilities.⁹

Additionally, Arkansas must submit an eligibility and enrollment monitoring plan to CMS within 90 calendar days of the waiver amendment approval (i.e., by June 3, 2018). The plan must include a detailed project implementation plan, including metrics, timelines, and programmatic content. For example, the state must ensure that it is capable of collecting metrics including, but not limited to, the number and percentage of individuals who are exempt, are required to report participation hours, requested good cause exemptions, and who were disenrolled for non-compliance.

Benefits

Arkansas Works enrollees gain coverage through an exchange plan. If certain Medicaid services, such as out-of-network family planning services and early and periodic screening, diagnostic, and treatment (EPSDT) services for 19- and 20-year-olds are not included in the exchange plans, they are provided to enrollees through Medicaid fee for service. Non-emergency medical transportation (NEMT) is provided to exchange plan premium assistance enrollees by the state as a wrap-around service but the state can impose prior authorization. Plans must address providers' prescription drug prior authorization requests within 72 hours instead of 24 hours as was previously required under Arkansas's state policy.

Premiums and Cost Sharing

Beneficiaries with incomes at or below 100 percent FPL are not subject to premiums or cost sharing. Beneficiaries with incomes above 100 percent of the FPL are subject to both premiums and cost sharing at the point of service. Monthly premium payments are limited to 2 percent of household income.¹⁰ Beneficiaries who fail to pay their monthly premiums within two months incur a debt to the state but are not at risk of losing coverage. Total out-of-pocket spending on premiums and cost sharing cannot exceed 5 percent of income, consistent with traditional Medicaid.¹¹

Premium Assistance

Individuals enrolled in the demonstration receive coverage through an exchange plan, with Medicaid providing benefits covered under its traditional program that are not available under the exchange plan and paying cost sharing that exceeds 5 percent of income.¹²

Beneficiaries enrolled in exchange plans may choose among all silver-level exchange plans offered in their geographic areas, with a choice of at least two plans. Those who do not select a plan will be auto-assigned to one.

Enrollees receive coverage through the state's traditional Medicaid program until enrollment in the exchange plan is finalized.

Delivery System

Enrollees have access to the same networks as others enrolled in exchange plans. Services that are not provided through the exchange plan will be provided by the Medicaid program under its fee-for-service delivery system. Enrollees must have access to at least one plan that contracts with at least one federally



qualified health center or rural health center, regardless of whether they are enrolled in exchange or employer-sponsored plans. Otherwise, enrollees can go outside of the plan's network to obtain covered federally qualified health center or rural health center services.

For a summary of the Section 1115 waivers used to test new approaches to coverage please see [Testing New Program Features through Section 1115 Waivers](#).

Endnotes

¹ *Gresham v. Azar* 1:18-cv-01900-JEB (D.D.C. 2019).

² *Gresham v. Azar* 1:18-cv-01900 (D.C. Cir. 2020).

³ Arkansas previously received an approved waiver of retroactive coverage requirements conditional upon Arkansas coming into compliance with the reasonable opportunity period and implementing the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) provision on hospital presumptive eligibility determinations. In the March 5 amendment approval letter, CMS removed the requirement that Arkansas submit a hospital presumptive eligibility state plan amendment.

⁴ For information on other states with approved or pending requests to implement work requirements, see [Medicaid Work and Community Engagement Requirements](#).

⁵ Typically, states are obliged to meet process requirements for verifying eligibility criteria, including regulations at 42 CFR 435.916(c) and 42 CFR 435.945, requiring states to provide multiple means of submission (e.g., online or other electronic means or via regular mail). However, CMS waived multiple means of submission for the work and community engagement requirement, permitting Arkansas to allow beneficiaries to submit documentation or exemptions through the online portal only. Arkansas is required to consider the impact of any reporting obligations on people without access to the internet and assure that to the extent practicable, availability of Medicaid services will not be diminished as a result. In December 2018, Arkansas chose to open a phone line for reporting in addition to the online portal.

⁶ The state may accept an individual's self-attestation of an exemption without further documentation. The state must also consider the impact of reporting obligations on individuals without access to the internet.

⁷ Good cause exemptions can be defined by the state; however, at minimum, exemptions must include beneficiaries who are survivors of domestic violence, or beneficiaries who experience a hospitalization, serious illness, or have a disability as defined by federal law and were unable to meet waiver requirements because of that disability, or have an immediate family member living in their home who experiences one of these circumstances.

⁸ Arkansas is not required to extend these assurances to TANF work requirements.

⁹ Reasonable modifications could include providing support services or requiring fewer hours of participation in qualifying work or community engagement activities.

¹⁰ These premium payments take the place of contributions to Independence Accounts, which were previously authorized under the demonstration but were formally terminated with the 2016 renewal.

¹¹ The state intends to offer incentives for individuals who make timely premium payments and engage with a primary care physician. However, Arkansas will need to submit and receive approval for an amendment in order for this to go into effect.

¹² Arkansas previously adopted an employer-sponsored insurance premium assistance program for certain enrollees, but terminated the program in the March 2018 waiver amendment.



References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Letter from Elizabeth Richter to Dawn Stehle regarding “The Arkansas Works Demonstration.” March 17, 2021. Baltimore, MD: CMS.
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